| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335160 | A. Building<br>B. Wing | 02/06/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Lynbrook Restorative Therapy and Nursing | 243 Atlantic Avenue<br>Lynbrook, NY 11563 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>Based on record review and interviews, the facility did not ensure that completed Minimum Data Set assessments were encoded and transmitted within fourteen (14) days after completion. This was identified for two (2) (Resident #21 and Resident #118) of two (2) residents reviewed for Resident Assessment. Specifically, Resident #21's and Resident #118's Minimum Data Set Assessments were transmitted 41 and 40 days late respectively. The finding is: A facility policy titled Minimum Data Set Submission and Transmission dated 08/13/2025 documented to submit and transmit all required Minimum Data Set assessments to the Internet Quality Improvement and Evaluation System (iQIES) Assessment Submission and Processing database in accordance with current Omnibus Budget Reconciliation Act (OBRA) and Skilled Nursing Facility Prospective Payment System (SNF PPS) regulations. The Minimum Data Set Coordinator or designee shall be responsible for ensuring that Minimum Data Set assessments are submitted to the Internet Quality Improvement and Evaluation System Assessment Submission and Processing database in accordance with the Federal and State guidelines. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report revealed the following: Resident #21's Discharge - Return Not Anticipated Minimum Data Set assessment, with an assessment reference date of 12/03/2025, was completed on 12/09/2025 and was not transmitted to the Center for Medicare and Medicaid Services until 02/02/2026. This assessment was submitted 41 days late. Resident #118's Discharge - Return Not Anticipated Minimum Data Set assessment, with an assessment reference date of 12/04/2025, was completed on 12/10/2025 and was not transmitted to the Center for Medicare and Medicaid Services until 02/02/2026. This assessment was submitted 40 days late. During an interview on 02/05/2026 at 2:22 PM, the Minimum Data Set Coordinator stated that the completed Discharge Minimum Data Set assessments for Resident #21 and Resident #118 were not transmitted within fourteen (14) days after their completion. The Minimum Data Set Coordinator stated that they did not know that the assessments were not transmitted and there was a transmittal error until they pulled the Nursing Home Validation Report today. The Minimum Data Set Coordinator stated that they are responsible for reviewing for errors on transmittals. During an interview on 02/05/2026 at 2:25 PM, the Administrator stated that they were not aware that the completed Minimum Data Set assessments for Residents #21 and Resident #118 were not transmitted within the required timeframe. 10 NYCRR 415.11 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, record review, and interviews the facility did not ensure that all drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles. This was identified for one (1) (Resident #77) of two (2) residents reviewed for antibiotic use. Specifically, on 02/01/2026 Resident #77 was receiving the antibiotic Vancomycin intravenously through a peripherally inserted central catheter (a long, thin tube inserted into a vein in the arm and threaded to a large vein near the heart, used for delivering long-term intravenous treatments) in the right upper arm. The resident's name, time/date of administration, and staff member identification were not indicated on the medication vial, normal saline bag, or the intravenous (IV) tubing.The finding is:The facility policy titled Intravenous Medication Infusion and Therapy/Hydration, effective 05/2020, documented to administer intravenous medications as per the physician's order and maintain intravenous lines. All licensed nurses are to ensure that intravenous medications and/or therapy are administered to the right resident, via the right route, right dosage, and right frequency and duration. Intravenous medications that come from the pharmacy have pharmacy labels. If the pharmacy label comes off mistakenly, an intravenous sticker label can be used to ensure the intravenous medication is properly labeled. Intravenous medications and fluids (for hydration therapy) that come from the in-house emergency supply are to be labeled with the intravenous sticker labels.Resident #77 was admitted with diagnoses including diabetes mellitus, peripheral vascular disease, and major depressive disorder. The 01/07/2026 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment. The resident received intravenous medication while a resident.A physician's order dated 12/31/2025 and renewed on 01/27/2026 documented vancomycin 1 gram/250 milliliter in 0.9% sodium chloride intravenous, infuse 1 gram by intravenous route every 12 hours, every day at 9:00 AM and 9:00 PM, for six weeks for diagnosis of extradural and subdural (brain area) abscess (pus collection in the brain).During an observation on 02/01/2026 at 12:25 PM, Resident #77 was in bed receiving the antibiotic vancomycin via the peripherally inserted central catheter line to the right arm. The medication vial, the normal saline bag, and the tubing were not labeled with the resident's name, the time and date of the intravenous antibiotic was started or the initials of the nurse who started the intravenous antibiotic medication.During an observation and interview on 02/01/2026 at 12:28 PM, Licensed Practical Nurse #1 (the medication nurse) entered Resident #77's room and observed the intravenous medication being administered. Licensed Practical Nurse #1 stated the medication was set up and started by Registered Nurse Infection Preventionist #1.During an interview on 02/01/2026 at 12:30 PM, Registered Nurse Supervisor #1 stated Registered Nurse Infection Preventionist #1 initiated Resident #77's vancomycin administration. Registered Nurse Supervisor #1 stated there should be a label on the intravenous medication vial, the normal saline bag, and the tubing as required to ensure the right resident is getting the right medication and that the medication is being administered according to the physician's order.Review of the February 2026 medication administration record revealed that the 9:00 AM dose of intravenous vancomycin was administered to Resident #77 by Registered Nurse Infection Preventionist #1.During an interview on 02/02/2026 at 2:10 PM, Registered Nurse Infection Preventionist #1 stated they administered the morning dose of vancomycin antibiotic to Resident #77 on 02/01/2026. Registered Nurse Infection Preventionist #1 stated the medication vial, the normal saline bag, and tubing should have been labeled to ensure resident safety and prevent medication errors.During an interview on 02/04/2026 at 11:30 AM, the Director of Nursing Services stated to ensure the right resident is getting the right medication and that the medication is being administered according to the physician's order, the intravenous medication should be labeled with the resident name, time and date of the administration, and initials of the staff member who started the administration.10 NYCRR 415.18(d) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility did not ensure medical records were in accordance with accepted professional standards and practices. This was identified for four (4) (Resident #12, Resident #34, Resident #27, and Resident #77) of five (5) residents reviewed for Immunizations. Specifically, information pertaining to each residents' immunization records was either unavailable or incomplete.The finding is:The facility's policy titled Covid-19 Vaccination for Residents and Staff, revised 11/04/2025, documented if an eligible resident is due for and wishes to receive a Covid 19 vaccination, such a dose should be offered and administered or accommodated with 14 days of admission. All resident, representative will be educated regarding the benefits and risks and potential side effects of the vaccine. Declinations will be obtained for residents after being educated regarding risks and benefits and potential side effects. The Consent or the decline will be documented in the medical record. The medical record includes documentation that the resident or representative was provided education regarding benefits, potential risks and potential side effects.During an interview on 02/02/2026 at 10:45 AM, the Director of Nursing Services stated that the resident immunization records were stored on paper in each resident's paper chart at the nursing station.-Resident #12 was last admitted to the facility on [DATE]. The resident's name was not on the Covid-19 Vaccination Consent Form. The Covid-19 form indicated the vaccine was refused due to personal reasons; however, the refusal forms did not document the date of refusal. The form was not signed by the resident or the resident's representative.-Resident #34 was admitted on [DATE]. The Covid-19 vaccination was declined; however, there was no date or whether the declination was received from the resident or representative as there was no signature.The paper medical records for Resident #12 and Resident #34 were reviewed with Registered Nurse #2 (the unit manager) and Registered Nurse Infection Preventionist #1 on 02/02/2026 at 11:00 AM. Registered Nurse #2 and Registered Nurse Infection Preventionist #1 stated the immunizations forms would have to be reviewed and updated for accuracy and completeness.-Resident #27 was admitted on [DATE] and Resident #77 was admitted on [DATE]. The Covid-19 Vaccination Consent Form for both the residents were not completed, and the medical record did not indicate the residents' Covid-19 vaccine status.The paper medical records for Resident #27 and Resident #77 were reviewed with Registered Nurse #3 (unit manager) on 02/02/2026 at 11:20 AM. Registered Nurse #3 stated the Registered Nurse Infection Preventionist #1 may have the vaccine status information for these residents.During an interview on 02/06/2026 at 8:45 AM, Registered Nurse Infection Preventionist #1 stated the immunization forms were supposed to be thoroughly completed. The staff should have documented each resident's full vaccination status on the immunization forms. Any nurse on the unit could fill in the immunization forms. The vaccine information for each resident was on their (Registered Nurse Infection Preventionist #1) vaccination tracker that they kept for their personal records; however, the information was not on the immunization sheets in the residents' medical records.During an interview on 02/06/2026 at 11:32 AM, the Director of Nursing Services stated the admission packet for immunizations is stapled together; the packet has the resident's name label on the first page. If the individual sheets in the packet get separated, there will be pages that would not have the resident's name, which was the case with Resident #12. All sheets in the immunization packet should have the resident's name. The signatures section should indicate who accepted or rejected the vaccine, the resident or the resident's representative. The admission nurse was responsible for initiating the immunization sheets and if the vaccine information was not complete during the admission process, then Registered Nurse Infection Preventionist #1 and the unit managers should have completed the sheets and followed up within 14-21 days. All the immunization sheets in the paper charts for Resident #12, Resident # 34, Resident #27, and Resident #77 should have been complete and up to date.10NYCRR415.22(a)(1-4) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews, the facility did not ensure the resident's medical records for influenza and pneumococcal vaccine did not included documentation that each resident received the influenza and pneumococcal immunizations and the residents or the resident representatives were provided education regarding the benefits or potential side effects of the vaccinations. This was identified for four (4) (Resident #12, Resident # 34, Resident #27, and Resident #77) of five (5) residents reviewed for Immunizations. Specifically, a review of Resident #12, Resident # 34, Resident #27, and Resident #77's medical record indicated that the influenza and pneumococcal immunization records were either unavailable or incomplete.The finding is: The facility's policy titled Pneumococcal Vaccine, dated 04/2025, documented assessments of pneumococcal vaccination status will be conducted within 5 working days of resident's admission. Resident/representatives have the right to refuse vaccination. If refused, licensed nurse will document the resident/representative's refusal in the resident's medical record as appropriate. For the resident who received the vaccine, administering nurse will document in the resident's medical record as appropriate. The resident/representative shall receive information and education regarding the benefits and potential side effects of the vaccine. Provision of such education shall be documented in the resident's medical record. The facility's policy, titled Influenza Vaccination Program, effective 5/2025 documented prior to any administration of medication, residents' current and past medical record is to be reviewed to determine if the vaccine has been administered prior to the admission. This information should be documented on the residents' immunization record. The administration of the vaccine is to be recorded on the resident's immunization record. During an interview on 02/02/2026 at 10:45 AM, the Director of Nursing Services stated that the resident immunization records were stored on paper in each resident's paper chart at the nursing station. -Resident #12 was last admitted to the facility on [DATE]. The resident's name was not on the Flu/Pneumococcal Immunization Screens Consent/Education Records. The influenza and pneumococcal vaccines were rejected; however, the refusal forms did not document the dates of the refusal, and the forms were not signed by the resident or the resident's representative. -Resident #34 was admitted on [DATE]. The status of the pneumococcal vaccine (accepted/rejected) was not completed. The influenza vaccine was rejected, and a verbal consent was obtained; however, the consent form did not indicate if the consent was provided by the resident or their representative. The paper medical records for Resident #12 and Resident #34 were reviewed with Registered Nurse #2 (the unit manager) and Registered Nurse Infection Preventionist #1 on 02/02/2026 at 11:00 AM. Registered Nurse #2 and Registered Nurse Infection Preventionist #1 stated the immunizations forms would have to be reviewed and updated for accuracy and completeness. -Resident #27 was admitted on [DATE] and Resident #77 was admitted on [DATE]. The Flu/Pneumococcal Immunization Screens Consent/Education Records for Residents #27 and Resident #77 did not indicate the residents' Flu/Pneumococcal vaccine status. The paper medical records for Resident #27 and Resident #77 were reviewed with Registered Nurse #3 (unit manager) on 02/02/2026 at 11:20 AM. Registered Nurse #3 stated the Registered Nurse Infection Preventionist #1 may have the vaccine status information for these residents. During an interview on 02/06/2026 at 8:45 AM, Registered Nurse Infection Preventionist #1 stated the immunization forms were supposed to be thoroughly completed. The staff should have documented each resident's full vaccination status on the immunization forms. Any nurse on the unit could fill in the immunization forms. The vaccine information for each resident was on their (Registered Nurse Infection Preventionist #1) vaccination tracker that they kept for their personal records; however, the information was not on the immunization sheets in the residents' medical records. During an interview on 02/06/2026 at 11:32 AM, the Director of Nursing Services stated the admission packet for immunizations is stapled together; the packet has the resident's name label on the first page. If the individual sheets in the packet get separated, there will be pages<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that would not have the resident's name, which was the case with Resident #12. All sheets in the immunization packet should have the resident's name. The signatures section should indicate who accepted or rejected the vaccine, the resident or the resident's representative. The admission nurse was responsible for initiating the immunization sheets and if the vaccine information was not complete during the admission process, then Registered Nurse Infection Preventionist #1 and the unit managers should have completed the sheets and followed up within 14-21 days. All the immunization sheets in the paper charts for Resident #12, Resident # 34, Resident #27, and Resident #77 should have been complete and up to date. 10 NYCRR 415.19 |