STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335161	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the survey, the facility failed to ensure each resident has the right to be free from chemical restraints not required to treat the resident's medical symptoms. This was identified for one (Resident #1) of five (5) residents reviewed for Unnecessary Medications. Specifically, Resident #1 with diagnosis of major depressive disorder was seen by a psychiatrist on 03/31/2026 who provided a recommendation to reduce the resident's quetiapine (an antipsychotic) dosage from 100 milligrams twice a day to 25 milligrams twice a day for seven days and then discontinue the medication. The facility did not respond to the psychiatry consultation until 05/06/2026, when the facility lowered the dosage as per the psychiatrist recommendation.The findings include:The facility's policy titled Psychotropic Medications, dated 12/01/2025, documented after medications are ordered for a resident, the staff and practitioner shall seek an appropriate dose and duration for each medication that also minimizes the risk of adverse consequences. Residents who use psychotropic medications, including antipsychotics, shall receive gradual dose reductions and behavioral interventions unless clinically contraindicated, to discontinue these drugs. The physician and staff will identify target symptoms/behaviors for which a resident is receiving various medications. The staff will monitor for improvement in these target symptoms/behaviors and provide the physician with that information. The staff and practitioners will consider tapering of medications as one approach to finding an optimal dose or determining whether continued use of medication benefits the residents.Resident #1 was admitted with diagnoses including diabetes mellitus, Parkinson's disease, and major depressive disorder. The 03/22/2026 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 0, indicating the resident had severe cognitive impairment; and that the resident was taking an antipsychotic medication and there was an indication for it. The resident had no behaviors; mood indicators included little interest in doing things, feeling or appearing down or depressed, sleeping too much or trouble falling or staying asleep, and feeling tired or having little energy for past 7-11 days.A physician's order dated 02/27/2026 documented quetiapine 100 milligram tablet, give one tablet by oral route every 12 hours for major depressive order. This order was discontinued on 03/01/2026.A medical progress note dated 03/01/2026 written by the medical director documented Chief Medical Officer review, psychoactive medications, depression, psychosis, pending psychiatry for clarification (gradual dose reduction consideration).A physician's order dated 03/01/2026 documented quetiapine 100 milligram tablet, give one tablet by oral route every 12 hours for major depressive order, recurrent, severe with psychiatric symptoms.A review of the medical record indicated the resident went to the hospital on [DATE] and was re-admitted on [DATE].A physician's order dated 03/15/2026 documented quetiapine 100 milligram tablet, give one tablet by oral route two times a day at 9:00 AM and 5:00 PM for major depressive disorder, recurrent, severe with psychiatric symptoms. This order was discontinued on 05/04/2026.A medical progress note dated 03/16/2026 documented resident seen for lethargy, fatigue and hypotension. Under assessment/plan: for hypotension and lethargy-start intravenous normal saline for three days; for major depression/intellectual disability- Seroquel and (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Remeron (for depression), ropinirole (for Parkinson's); [provide] supportive care and psychiatry follow-up.A psychiatry consult dated 03/31/2026 documented that the resident has intellectual disability/developmental delay and is a poor historian. The resident was re-hospitalized on [DATE] due to unresponsive episode and was found to have atrial fibrillation with rapid ventricular response. The resident lived with family who could no longer care for the resident. The resident had behaviors and was difficult to wean off the quetiapine due to delirium from pneumonia, and quetiapine was used by an outside provider for severe depression. There were no psychosis or mania concerns, no suicidal or homicidal ideation, no hallucinations. History of delirium can complicate weaning of quetiapine and would recommend use of Lexapro while wean off is being ensued. Recommendations to start Lexapro 5 milligram by mouth for one week and then 10 milligram every day onwards and to lower Seroquel to 25 milligrams by mouth twice a day for one week and then stop.A physician order dated 04/09/2026 documented psychiatric consultation and follow up as needed.During an observation on 05/04/2026 at 10:55 AM, Resident #1 was observed in the day room during a recreation program. The resident's head was resting on the table, and the resident appeared to be sleeping. An attempt was made by the surveyor to speak to the resident, but the resident looked at the surveyor and put their head back on the table.A physician's order dated 05/04/2026 documented quetiapine 50 milligram tablet, give one tablet by oral route two times a day at 9:00 AM and 5:00 PM for major depressive disorder, recurrent, severe with psychiatric symptoms. This order was discontinued on 05/06/2026.A psychiatry consulted dated 05/06/2026 documented a recommendation to further lower Seroquel to 25 milligrams twice a day for one week and then stop (consistent with the psychiatry consult dated 03/31/2026).A physician's order dated 05/06/2026 documented quetiapine 25 milligram tablet, give one tablet by oral route every 12 hours at 9:00 AM and 9:00 PM for major depressive disorder, recurrent, severe with psychiatric symptoms for one week.On 05/06/2026 at 10:00 AM the Social Worker Director approached the surveyor and stated normally the psychiatry consultation reports were stored in the progress notes section. The psychiatry consultation dated 03/31/2026 was misfiled and was erroneously stored in the wrong section of the electronic medical record and they found it today (05/06/2026).During an interview on 05/06/2026 at 1:27 PM, Physician Assistant #1 stated that normally the psychiatry consultation reports are kept in the progress notes; being that the consultation was stored in wrong section of the electronic medical record, it may have been missed. Physician Assistant #1 stated when they came in 05/04/2026, they noticed that a gradual dose reduction had not been done for Resident #1 and that is why they lowered the quetiapine dosage to 50 milligrams twice a day. A review of the medical record indicated that Physician Assistant #1 saw Resident #1 a total of thirteen (13) times from 03/31/2026 to 05/04/2026. Each of the progress notes documented major depression/intellectual disability-Seroquel, Remeron, ropinirole, supportive care, psychiatry follow up. During an interview on 05/06/2026 at 1:42 PM, Psychiatrist #1 stated they had no idea why the consultation report was stored in the documents section of the electronic medical record and not in the progress notes section. There should be a trial to eliminate the quetiapine for Resident #1 to determine if the resident can live without quetiapine. Psychiatrist #1 stated that for people who are intellectually disabled it is always best to try to lower the dose because there may not be a true psychotic condition or diagnosis. During an interview on 05/06/2026 at 1:45 PM, Primary Physician #1 stated the physician assistant changed the quetiapine to 50 milligrams twice a day on 05/04/2026 because they did not see the psychiatry consult; if the physician assistant saw the consult, they would have changed the dosage to 25 milligrams twice a day as per the consult. The quetiapine was further lowered today to 25 milligrams twice a day as per the consults dated 3/31/2026 and 05/06/2026.A review of the medical record indicated no documentation of quetiapine gradual dose reduction until 05/04/2026; however, the recommendations made by the psychiatrist on 3/31/2026 to decrease quetiapine dosage to 25 milligrams twice a day for one week and then discontinue, were not implemented until 05/06/2026.During an observation on 05/07/2026 at 8:32 AM, Resident #1 was observed in the hallway in their wheelchair. The resident was awake, alert, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsive to simple questions like how are you?During an interview on 05/07/2026 at 10:10 AM, the Director of Nursing Services stated the doctors know they are supposed to put their notes in the progress notes section of the electronic medical record. The primary doctor is expected to address the recommendations made by the consultants; however, the psychiatry consult dated 03/31/2026 was stored in the wrong section in the electronic medical record therefore, the primary physician did not see the psychiatry consult and did not address the recommendations made by the Psychiatrist. 10 New York State Code Rules and Regulations 415.4(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews during the survey, the facility failed to ensure it implemented a comprehensive person-centered care plan that includes measurable objectives and time frames to meet each resident's medical and nursing needs that are identified in the comprehensive assessment. This was identified for one (1) (Resident #43) of two (2) residents reviewed for skin conditions. Specifically, Resident #42 had a physician's order to offload heels at all times. On multiple occasions while the resident was in bed, the resident's heels were directly in contact with a pillow and were not being offloaded.The findings include:Resident #43 was admitted with diagnoses including diabetes mellitus, peripheral vascular disease, and cerebrovascular accident. The 04/16/2026 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 10, indicating the resident had moderate cognitive impairment. The resident had a diabetic ulcer and was at risk for pressure ulcer development. The resident required partial/moderate assistance for bed mobility; had no behaviors; and no documented non-compliance.The Braden scale (a scale for determining risk for pressure ulcer development) dated 04/10/2026 documented a score of 14, indicating the resident was at moderate risk for pressure ulcer development.A Comprehensive Care Plan effective 04/13/2026 titled Skin Integrity: Presence of Skin Breakdown Right Heel Diabetic Foot Ulcer documented interventions including monitor for signs and symptoms of infection and apply local treatments as ordered by the physician.A physician's order dated 04/20/2026 documented to offload the heels at all times.A physician's order dated 04/27/2026 documented right heel diabetic foot ulcer, cleanse with normal saline, apply skin prep (applied to create a protective barrier against adhesives, body fluids, and friction), and cover with dry dressing.A wound consult dated 04/27/2026 documented the right heel diabetic foot ulcer was resolved, the area remained tender. Recommendations were to cleanse with normal saline, apply skin prep and cover with dry dressing. Offload the heels at all times. The resident remained at increased risk for wound deterioration due to immobility and underlying medical comorbidities.During an observation on 05/04/2026 at 10:00 AM, Resident #43 was in bed. The resident was wearing socks and there was no sheet covering the resident's lower legs. The resident's heels were resting directly on a pillow and were not offloaded.During an observation on 05/05/2026 at 08:00 AM, Resident #43 was sleeping in bed. The resident had socks on and there was no sheet covering the lower legs. The resident's heels were directly resting on a pillow and were not offloaded.During an observation with Registered Nurse Unit Manager #5 on 05/05/2026 at 08:45 AM, Resident #43 was sleeping in bed. Registered Nurse Unit Manager #5 stated when the heels are resting on a pillow, it is considered offloading. Registered Nurse Unit Manager #5 did not re-adjust the pillow to offload the heels.During an observation on 05/06/2026 at 08:35 AM, Resident #43 was in bed. The resident had socks on and there was no sheet covering the lower legs. The resident's heels were resting directly on a pillow and were not offloaded.During an interview on 05/06/2026 at 08:45 AM, the Nursing Educator stated offloading heels means no pressure on heels. The heels should not be touching any surface including the pillows. During an interview on 05/07/2026 at 07:58 AM, Wound Care Physician #1 stated offloading heels means the heels are off the surface. The pillow must be placed under the lower legs to keep the heels off the bed or the pillow.During an interview on 05/07/2026 at 10:19 AM, the Director of Nursing Services stated offloading heels implies that the heels are not touching anything. The staff should be repositioning and readjusting the pillow to ensure the heels are offloaded. 10 New York Code Rules and Regulations 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews during survey, the facility failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team to reflect each resident's preferences and status after each assessment. This was identified for one (1) (Resident #117) of three (3) residents reviewed for skin conditions. Specifically, Resident # 117 had a physician order for compression socks for both legs in the morning and remove at bedtime. Resident #117's care plan did not include the use of ace bandage (an elastic compression wraps designed to reduce swelling) on both legs during the day and remove at night for chronic venous insufficiency (a condition when the leg vein valves are damaged or weakened).The findings include:The facility's policy and procedure titled, Care Plans last revised on 12/2025 documented that all residents will have a plan of care review initially and then no less than every 90 days. Problem statements, goals and interventions will be reviewed, discussed and dated at the time with revisions made as necessary. Criteria for determining a change in status once identified should be reviewed prior to changing the status assessment. Consideration of a change in status should be documented in the residents' record with decision making rationale included.Resident #117 was admitted with diagnoses including, cellulitis (a bacterial infection characterized by swollen, red, hot and painful skin), diabetes (high blood sugar levels) and chronic venous insufficiency (a condition when the leg vein valves are damaged or weakened). The Annual Minimum Data Set (MDS) assessment dated [DATE] documented Resident #117 had a Brief Interview for Mental Status (BIMS) score of five (5) which indicated that Resident #117 had severe cognitive impairment. The Annual Minimum Data Set documented an active diagnosis of peripheral vascular disease.A Comprehensive Care Plan (CCP) titled, Skin Integrity: Presence of Skin Breakdown Left lower leg dated 01/07/2026 documented interventions including applying local treatment as ordered by the Physician and monitoring for signs and symptoms of infection.A Physician's Order dated 04/06/2026 documented the use of compression socks in both legs in the morning and remove at bedtime.A review of the electronic medical record revealed that the comprehensive care plan was not revised to indicate the use of the compression socks as per the physician's orders.During an observation on 05/04/2026 at 10:28 AM, Resident #117 was in their room sitting on their wheelchair with ace wraps on both the lower extremities.During an observation on 05/05/2026 at 8:15 AM, Resident #117 was sitting in their wheelchair with ace wraps on both the lower extremities.During an interview on 05/06/2026 at 8:42 AM, Registered Nurse #1, Charge Nurse stated that Resident #117 had a Physician's order for the use of the ace wraps. Registered Nurse #1 stated that the ace wrap was not included as an intervention on the resident's comprehensive care plan because Resident #117 had a chronic cardiac condition. Registered Nurse #1 stated they should have included the use of the ace wrap as an intervention on Resident #117's comprehensive care plan.A Comprehensive Care Plan (CCP) titled Chronic Venous Insufficiency dated 05/06/2026 had intervention including applying ace wraps on bilateral lower extremity daily at 9:00 AM and remove daily at 9:00 PM. During an interview on 05/07/2026 at 10:11 AM, the Director of Nursing Services stated that the ace wraps should have been included in Resident #117's comprehensive care plan. The Director of Nursing Services stated that Nurses should be aware that care plans are updated with any changes because the care plan reflects the total care of the resident.10 New York Code Rules and Regulations 415.11(c)(2)(iii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during survey the facility failed to ensure that pain management was provided to each resident consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This was identified for one (Resident #148) of one resident reviewed for pain management. Specifically, Resident #148 was admitted to the facility with chronic bilateral elbow pain; however, there was no pain medication ordered. In addition, when the resident reported sever pain rating of 8 out of a scale of 0-10 (a scale used to measure pain intensity, where 0 equals no pain and 10 represents the worst imaginable pain) to a Registered Nurse Supervisor, the resident did not receive pain medication for more than two hours.The findings include:The facility policy titled Pain Assessment, dated September 2025, documented pain is difficult to define because of multidimensional aspects. All residents admitted for care management will be assessed for pain. This assessment is done on admission, readmission, quarterly, annually, and with any significant change in the resident's condition. The physician and licensed nurse assess for pain management; the physician prescribes appropriate medications and dosage; the physician/licensed nurse review medication regimen, monitor increase/decrease and change in medication; and the licensed nurse assesses the medications for effectiveness in management of pain, dosage, and administration intervals.Resident #148 was admitted with diagnoses including cerebrovascular accident, Parkinson's disease, and radiculopathy lumbar region (a condition caused by compression or irritation of spinal nerve roots in the lower back, leading to radiating pain, numbness, or weakness in the legs). The 05/03/2026 Minimum Data Set assessment documented a Brief Interview for Mental Status score of 9, indicating the resident had moderate cognitive impairment; and there was no pain indicated.A Comprehensive Care Plan effective 04/29/2026 titled Pain Management, documented Alteration in comfort: pain related to (undefined); interventions included administering medications as ordered by physician and discuss with resident pain management. There were no further updates or notes.The Nursing admission assessment dated [DATE] documented that the resident had mild joint pain with activities and exhibited facial grimaces; the pain was described as a dull ache with grimacing and verbal complaints; the pain intensity was one (1) out of a scale of five (5), indicating mild pain.The Physician History and Physical dated 04/28/2026 documented no pain related to a surgical site; there was no line item related to pain at a non-surgical site.An Occupational Therapy assessment dated [DATE] documented the resident had pain that interfered with functional activity to bilateral elbows and right knee; nursing was made aware.A review of the medical record revealed no documented assessment of the pain identified by Occupational Therapy.The physician orders dated 04/29/2026 documented cleanse right and left elbows with normal saline, apply skin prep, and cover with dry dressing for Stage 1 pressure ulcers.A review of the medical record revealed that there was no pain medication ordered upon the resident's admission on [DATE] until 05/05/2026. During an observation on 05/05/2026 at 8:45 AM, Resident #148 was in bed. Registered Nurse Supervisor #5 was present at the bedside. The resident was complaining of pain in both elbows. The resident did not have the ordered dressings on the elbows. The resident stated the pain was 8 (severe) out of a scale of 10 when asked by the nurse to rate the pain. Registered Nurse Supervisor #5 stated they would call the physician regarding a pain medication. Registered Nurse Supervisor #5 did not address the missing dressings on the elbows, how long the resident has had pain, was there any incident that caused the pain, or what makes it feel better or worse, and the type of pain.During an observation on 05/05/2026 at 10:47 AM, Resident #148 was in their room in a wheelchair. The resident stated they still have pain in their elbows; it feels like when you hit your funny bone, but all the time, both elbows, There was no dressing present on either elbow.During an interview on 05/05/2026 at 10:52 AM Registered Nurse Supervisor #5 stated the resident did not have an order for the pain medication; but the physician assistant was alerted, and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they are waiting for them to assess the resident. Pain medication was not given right away because the physician assistant wanted to see the resident first because this was a new pain complaint.A physician's order dated 05/05/2026 at 11:30 AM documented Tylenol 325 milligram tablet, give two tablets (650 milligram) by oral route now for one dose. The Tylenol was administered to Resident #148 at 11:18 AM on 05/05/2026, after approximately two hours after the resident had complaint of pain level of 8 out of 10 on the pain scale indicating severe pain.A progress note written by Physician Assistant #3 on 05/05/2026 at 8:35 PM documented patient was seen today for chronic bilateral upper extremity pain. The resident reported persistent nagging pain in bilateral elbows and shoulders since a fall several months ago. The pain level was rated to be 4 out of 10 on the pain scale. There were no signs of associated swelling, redness, or skin changes. The Plan: Chronic bilateral upper extremity pain, likely musculoskeletal in nature given the chronicity and absence of any acute findings. There were no signs of an acute injury or inflammation upon examination. Initiate intravenous acetaminophen (Tylenol) 1,000 milligram every 8 hours for improved pain control. Monitor response to therapy. Consider further evaluation if pain persists or worsens.A physician's order dated 05/05/2026 documented Ofirmev 1,000 milligrams/100 milliliter (acetaminophen) intravenous solution, infuse 100 milliliters (1,000 milligrams) by intravenous route three times a day for five days.During an interview on 05/07/2026 at 9:36 AM, Physician Assistant #3 stated Registered Nurse Supervisor #5 called them about Resident #148's elbow pain. Physician Assistant #3 stated they directed the nurse to give oral Tylenol until they saw the resident. Physician Assistant #3 stated they saw the resident at about 10:30 AM-11:00 AM on 05/05/2026. The resident reported a nagging pain in both elbows for quite a long time and intravenous acetaminophen was ordered as it provides much better pain control than the oral Tylenol.During an interview on 05/07/2026 at 10:24 AM, the Director of Nursing Services stated if a resident has pain, something should be done immediately for the pain. The nurse should get a STAT (immediate) order for pain medication until the doctor can see the resident.During an interview on 05/07/2026 at 10:51 AM, Registered Nurse #8 (the admission nurse) stated they completed the admission assessment for Resident #148, and a pain medication should have been ordered because the resident did complain of pain upon admission and were not sure why the pain medications were not ordered. Registered Nurse #8 stated they think another nurse (could not recall name) was handling the medication orders as part of the admission process.During an interview on 05/07/2026 at 11:05 AM, Occupational Therapist #1 stated they conducted the initial occupational therapy assessment for Resident #148 on 04/29/2026 and the resident did complain of pain during the assessment. Occupational Therapist #1 stated they notified the nursing staff about the resident's pain but were unable to recall who they had notified. During an interview on 05/07/2026 at 11:32 AM, Physician #2 stated they were not sure if the nurses had notified them about Resident #148's complaint of pain. If they were notified, they would have ordered the as needed Tylenol for pain control. A resident with pain level of 8 out of 10 on the pain scale should be medicated with pain medication as soon as possible. 10 New York Code Rules and Regulations 415.12

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review and interviews during the survey the facility failed to ensure it provided pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for one (Resident #146) of five (5) residents observed during the medication administration task. Specifically, during the medication administration observation for Resident#146, Licensed Practical Nurse #5 crushed an extended-release (designed to slowly release the medication) potassium chloride tablet. The blister pack for the extended-release potassium chloride tablet had a direction sticker that read do not crush.The findings include:The facility policy titled Medication Administration: General Policies and Practices, dated 12/01/2025, documented prior to administering medications, the staff nurse: reads the order carefully in its entirety, noting the name, dosage, route, and time of administration, making certain the dosages, frequency and schedules correspond with the physician's orders in the electronic medical record; reads the label before removing medication from the cart, before pouring the medication, and before placing the medication back in the drawer; reviews the electronic medication administration record for accuracy after medications have been prepared; and carefully checks the accuracy of the resident's screen.Resident # 146 was admitted with diagnoses including cancer, diabetes mellitus, and osteomyelitis (bone infection). The 05/06/2026 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact.A physician's order dated 04/30/2026 documented may crush appropriate medications, unless contraindicated, to facilitate administration.A physician's order dated 04/30/2026 documented potassium chloride extended release, 10 milliequivalent tablet, give one tablet by oral route once daily at 9:00 AM, for a diagnosis of hypokalemia (low potassium).During the medication administration observation for Resident#146 on 05/05/2026 at 8:17 AM, Licensed Practical Nurse #5 crushed the extended-release potassium-chloride tablet, mixed the medication in apple sauce, and administered the medication to the resident.During an interview on 05/05/2026 at 9:45 AM, Licensed Practical Nurse #5 and the surveyor observed the potassium chloride blister pack. The label documented: give tablet by oral route once daily, do not crush, whole tablet may be dissolved in four ounces of water prior to administration (allow two minutes to dissolve). There was an additional yellow sticker placed on the blister pack documenting Do Not Crush. Licensed Practical Nurse #5 stated they did not realize the medication label documented that the medication should not be crushed and that they should not have crushed the medication tablet.During an interview on 05/05/2026 at 11:45 AM, Pharmacist #1 stated the extended-release potassium chloride tablet was created to reduce the potential for gastrointestinal pain because with potassium chloride there is the potential for gut lining irritation; therefore, the extended-release potassium chloride tablets should not be crushed.During an interview on 05/06/2026 at 8:45 AM, Nursing Educator #1 stated the nurse should never crush an extended-release medication; this is part of the seven rights of medication administration (right medication, right resident, right dose, right time, right route, right reason, right documentation).During an interview on 05/07/2026 at 10:08 AM, the Director of Nursing Services stated the nurse must read the label on the blister pack prior to medication administration and follow the facility policy to appropriately and safely administer medications to the residents.10 New York Code Rules and Regulation 415.18(b)(1)(2)(3)

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	335161	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daleview Care Center	574 Fulton Street East Farmingdale, NY 11735

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F 0761 Level of Harm - Minimal harm or potential for actual harm 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. Based on observations, record review and staff interviews, the facility failed to ensure that all drugs and biologicals were stored and labeled in accordance with currently accepted professional principles. This was identified for one (1) (unit 3) of three (3) units observed during the initial tour and for one (1) (medication cart for Unit 2) of three (3) medication carts reviewed during the medication storage and labeling task. Specifically, 1) Unit Three (3) shower room had unlabeled cream on the ledge in the shower room. 2) Unit Two (2) medication cart was observed with an insulin pen, and an eye drop bottle without a date to indicate when the medications were first opened to determine when the medications should be discarded.The findings include:The facility policy and procedure titled, Medications: Storage and Handling last revised on 12/12/2025 documented that medications and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Medications and biologicals past their expiration dates are removed from storage and usage and properly disposed of after such date.1) During an observation on 05/04/2026 at 10:46 AM, an unlabeled open tube of one (1) percent Hydrocortisone cream (a topical steroid), was observed in the Unit three (3) shower room.During an interview on 05/04/2026 at 10:35 AM, Licensed Practical Nurse #4, the charge nurse stated that no medication should be left in the shower rooms. Licensed Practical Nurse #4 stated they did not know who had left the unlabeled Hydrocortisone (topical steroid) one (1) percent tube in the shower room. Licensed Practical Nurse #4 stated that medications including the treatment creams should be stored in the medication or treatment carts.2) During an observation on Unit two (2) on 05/04/2026 at 1:12 PM, the medication cart was observed with an undated, opened Lantus Solostar insulin pen (a long-acting insulin medication used to control high blood sugars in adults and children with diabetes) and a bottle of an undated, opened latanoprost solution eye drops (a prescription medication used to reduce high pressure inside the eye).During an interview on 05/04/2026 at 1:16 PM, Licensed Practical Nurse #1, the medication nurse, stated they were not aware of the Lantus insulin pen and latanoprost eye drops were missing the opened date. Licensed Practical Nurse #1 stated that both the medications were administered during the 3:00 PM-11:00 PM shift. Licensed Practical Nurse #1 stated that the opened date should have been written on the insulin pen and the eye drop bottle to determine when the medications should be discarded. Licensed Practical Nurse #1stated they were not sure after how many days the insulin pen or the eye drop medication be discarded after the first opened date.During an interview on 05/04/2026 at 2:01 PM, Registered Nurse #1, the unit manager stated that to identify the discard date, the Lantus insulin pen and latanoprost eye drops should have been labeled with an opened date indicating when the medications were first opened. Registered Nurse #1 stated the insulin must be discarded 28 days after the opened date.During an interview on 05/05/2026 at 10:25 AM, the Pharmacist stated that the Lantus insulin pen must be discarded 28 days after opening. The Pharmacist stated that the Latanoprost eye drops must be discarded 42 days after opening. The Pharmacist stated that the medications should be discarded after the expiration date.During an interview on 05/06/2026 at 9:40 AM, Licensed Practical Nurse #3, Medication Nurse for 3:00-11:00 PM stated that they could not recall how they missed the Lantus insulin pen and latanoprost not having an opening date. Licensed Practical Nurse #3 stated that they are aware that Lantus insulin pen should be discarded 28 days after it is first opened. Licensed Practical Nurse #3 stated they were not aware that the latanoprost eye drops had an expiration day after the medication bottle was first opened.During an interview on 05/07/2026 at 10:14 AM, the Director of Nursing Services stated that nurses should always document the opened date on medication bottles or pens that have a certain expiration date including insulins and eye drops. The Director of Nursing Services stated that all medications should be properly labeled and locked in the medication or treatment carts.10NYCRR 415.18(e) (1-4)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the survey, the facility failed to maintain medical records that are complete and accurately documented. This was identified for one (1) (Resident #28) of three (3) residents reviewed for catheter. Specifically, Resident #28's contact precautions were discontinued on 04/21/2026; however, the resident's medical record was not updated to reflect discontinuation of the contact precautions in Resident #28's electronic medical record (EMR).The findings include: The facility's policy titled Charting and Documentation dated 09/2025 documented all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Resident #28 was admitted with diagnoses including neurogenic bladder (disrupts communication between the brain and bladder causing poor bladder control), diabetes (high blood sugar), and hemiplegia (total or partial loss of movement on one side of the body). A significant change in status Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated that Resident #28 had intact cognition. The Minimum Data Set (MDS) documented that Resident #28 had an indwelling catheter (a flexible tube inserted into the bladder to drain urine) and was on isolation or quarantine for active infectious disease while a resident. A Comprehensive Care Plan (CCP) titled, Contact Isolation Precautions dated 03/12/2026 documented interventions including maintaining contact isolation, applying contact isolation equipment upon entry to the room and discussing with the resident and the resident's family the importance of handwashing. A Physician's Order dated 03/21/2026 renewed on 04/27/2026 documented Contact Isolation for Vancomycin-Resistant Enterococci (bacteria that developed resistance to vancomycin, an antibiotic to treat infection), Klebsiella (bacteria found in human intestines and environment transmitted through person-to-person contact) and Pseudomonas (a highly resistive bacteria to many antibiotics) in the wound. During an observation on 05/04/2026 at 10:20 AM, Resident #28 was in their room lying in bed. An Enhanced Barrier Precaution (EBP) signage was posted outside Resident #28's door. Resident #28 did not have a contact isolation signage outside their door. During an observation on 05/04/2026 at 1:23 PM, Resident #28 was in their room lying in bed. An Enhanced Barrier Precaution signage was posted outside the door. Resident #28 did not have contact signage outside the door. During an observation on 05/05/2026 at 8:05 AM, Resident #28 was in their room. An Enhanced Barrier Precaution signage was posted outside the door. Resident #28 did not have contact signage outside the door. During an interview on 05/05/2026 at 11:26 AM, the Infection Preventionist stated that Resident #28 should have a signage for contact isolation precautions outside their (Resident #28) room. The Infection Preventionist stated that there are wandering residents who must have taken the signage down. A review of Resident #28's medical progress note dated 04/21/2026 did not document to discontinue the contact isolation precautions for Resident #28. A review of Resident #28's Electronic Medical Record revealed no documented evidence that the contact isolation was discontinued until 05/05/2026. During an interview on 05/06/2026 at 8:52 AM, Registered Nurse #1, Unit Manager stated that Resident #28's contact isolation precautions order was discontinued on 04/21/2026 when Physician Assistant#1 discontinued the intravenous antibiotic for Resident #28. Registered Nurse #1 stated that they received a verbal order from Physician Assistant #1 to discontinue the contact isolation precautions. Registered Nurse #1 stated that they took down the signage but forgot to discontinue the order, notify the infection preventionist, and write a nursing progress note. During an interview on 05/06/2026 at 9:30 AM, Physician Assistant #1 stated that they discontinued the intravenous antibiotic order on 04/21/2026 for Resident #28 and told Registered Nurse #1 to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinue the contact isolation precautions order for Resident #28. Physician Assistant #1 stated they should have documented in the medical progress note and should have written an order to discontinue the contact isolation precautions for Resident #28. During an interview on 05/07/2026 at 10:08 AM, the Director of Nursing Services stated that nurses can take verbal orders, but they are expected to document and update any changes in the medical record. 10 New York Code Rules and Regulations 415.22(a) (1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews during the survey, the facility failed to ensure it maintained an infection prevention and control program designed to help prevent the development and transmission of communicable disease and infections. This was identified for one (Resident #43) of two residents reviewed for skin conditions and for one (1) (Unit 2 medication cart) of three (3) medication carts reviewed during the medication storage and labeling task. Specifically, 1) during the wound care observation for Resident #43, Licensed Practical Nurse #6 did not sanitize the overbed table before placing the wound care supplies on top of the table. Additionally, Licensed Practical Nurse #6 did not sanitize their hands after removing the dirty dressings from the foot wounds and prior to applying the clean treatments. 2) Licensed Practical Nurse #1 did not use an Environmental Protection Agency (EPA) approved cleaning agent to sanitize the glucometer (a handheld device used to measure the concentration of sugars in the blood) machine after using the machine for each resident.The findings include: The facility policy titled Rehabilitation Nursing: Dressing-Non-Sterile, dated 12/12/2025, documented nursing staff will use a clean dressing technique to apply dressings which will provide a therapeutic environment for wounds that do not require sterile handling. Steps in the process for the licensed nurse include preparing a clean field and preparing necessary equipment that will be needed for dressing change using aseptic (to prevent contamination and the spread of pathogens) technique; washing hands, putting on gloves, removing old dressings, disposing old dressings in garbage, removing gloves and washing hands; placing clean gloves on, cleansing the wound, and then discarding gloves and washing hands before putting on new gloves and applying the ordered treatment. The facility policy and procedure titled, Blood Glucose Measurement Using a Glucose Testing System last revised on 12/01/2025 documented that Licensed Nursing staff may perform a measurement of the resident's blood glucose using a Glucose Testing system that includes glucose test strips, lancets, alcohol swab, germicidal wipes, gloves, and sharp container with instruction to clean and disinfect the Blood Glucose Machine with a germicidal wipes. 1) Resident #43 was admitted with diagnoses including diabetes mellitus, peripheral vascular disease, and cerebrovascular accident. The 04/16/2026 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 10, indicating the resident had moderate cognitive impairment, and the resident had diabetic ulcers. A Comprehensive Care Plan effective 04/13/2026 titled Skin Integrity: Presence of Skin Breakdown Right Heel Diabetic Foot Ulcer; interventions included to monitor signs and symptoms of infection and apply local treatments as ordered by the physician. A Comprehensive Care Plan effective 04/13/2026 titled Skin Integrity, Presence of Skin Breakdown, left 5th tow diabetic foot ulcer. Interventions included to monitor signs and symptoms of infection and apply local treatments as ordered by the physician. A physician's order dated 04/13/2026 documented cleanse left 5th toe diabetic foot ulcer with normal saline, apply betadine, cover with dry dressing. A physician's order dated 04/27/2026 documented right heel diabetic foot ulcer, cleanse with normal saline, apply skin prep, and cover with dry dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound consultation dated 04/27/2026 documented the right heel diabetic foot ulcer was resolved. The area remains tender. Cleanse with normal saline apply skin prep and cover with dry dressing. Left 5th toe diabetic foot ulcer, 0.4 centimeters by 0.4 centimeters by 0.1 centimeters; cleanse with normal saline, apply betadine, and cover with dry dressing. The resident remains at increased risk for wound deterioration due to immobility and underlying medical comorbidities. Comprehensive wound care plan implemented offloading, protective measures, and close monitoring for progression or infection. During Resident #43's wound care treatment observation, performed by Licensed Practical Nurse #6 on 05/06/2026 at 11:05 AM, Licensed Practical Nurse #6 set up the wound care supplies in the resident's room on the resident's overbed table by placing the supplies on a small paper towel. Some of the supplies did not fit on the paper towel and were directly touching the table. The nurse did not clean the table or set up a clean field that covered the table. Adjacent to the wound care supplies there was a television remote control and a compression knee sleeve on the table. Licensed Practical Nurse #6 set up a barrier under the resident's feet and then removed the right heel dressing and left toe dressings. The resident then rested their feet on the barrier; after removing the dressings, the nurse put on clean gloves but did not wash hands. Licensed Practical Nurse #6 cleansed the right heel with normal saline and then the resident's heel came to rest on the barrier. The nurse then applied the skin prep and the dry dressing to the heel wound without changing gloves or sanitizing their hands. Licensed Practical Nurse #6 stated they should have set up a clean field on the overbed table before placing the wound care supplies on top of the table and would get another staff member to assist them with the wound care and would restart the wound care. During an interview on 05/07/2026 at 8:02 AM, Registered Nurse #6 (the wound care nurse) stated the nurses should change gloves and wash hands after cleaning the wound; should have cleaned the overbed table to prepare a clean field. Registered Nurse #6 stated that Licensed practical Nuse #6 should have gotten assistance when performing the wound care. During an interview on 05/07/2026 at 8:18 AM, the Nursing Educator stated when performing wound care the nurses need to set up a clean field because the table may not be clean and a dirty table compromises the cleanliness of the supplies and increases the potential for infection. The nurses must sanitize hands and change gloves after each step of the wound care process During an interview on 05/07/2026 at 8:30 AM, the Infection Preventionist/Assistant Director of Nursing stated the nurses cannot wash their hands enough; the table should be sanitized with a barrier; after cleansing a wound and removing old dressings, the nurse must change gloves and wash hands before applying the new dressing/treatment. During an interview on 05/07/2026 at 10:19 AM, the Director of Nursing Services stated the nurses must sanitize hands and change gloves after each step of the wound care treatment process; and they must sanitize the overbed table and set up a clean field for wound care supplies. 2)A review of the blood glucose machine cleaning and disinfecting manual documented the meter should be cleaned and disinfected after use on each resident. The disinfection procedure is needed to prevent the transmission of blood-borne pathogens. A variety of the most used Environmental Protection Agency (EPA) registered wipes were tested and approved for cleaning and disinfecting the blood glucose monitoring system. A review of the facility's Material Safety Data Sheet (MSDS) for Instant Hand Sanitizing wipes revealed that the product cleanses and sanitizes hands. Instant Hand Sanitizing wipes is a flammable (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solid and can cause serious eye damage. A review of the facility's Material Safety Data Sheet (MSDS) for alcohol prep pads revealed that the product contains 70 percent isopropyl alcohol (a colorless, flammable, chemical compound used as disinfectant). The alcohol prep pads are for antiseptic purposes and used for preparation of skin prior to injection. A review of the facility's Material Safety Data Sheet (MSDS) for Germicidal wipes revealed that the product is used as a disinfectant for hard, non-porous surfaces (substances or areas that do not allow liquids, air, or bacteria to pass through or be absorbed because they lack pores). During an observation for the medication storage and labeling task on 05/04/2026 at 1:07 PM, Licensed Practical Nurse #1 stated they use the alcohol prep pads to wipe the glucometer machine between each resident. Licensed Practical Nurse #1 stated they also use the instant hand sanitizing wipes after wiping the glucometer machine with the alcohol prep pad. Licensed Practical Nurse #1 demonstrated how they clean the glucometer using two alcohol prep pad and instant hand sanitizing wipes. During an interview on 05/04/2026 at 1:12 PM, Licensed Practical Nurse #1, Medication Nurse stated that the alcohol prep pads, and the instant hand wipes were readily available on their cart to clean the glucometer. Licensed Practical Nurse #1 stated that the nurses were not allowed to keep the Environmental Protection Agency (EPA) approved germicidal wipes with the purple top on their medication carts. Licensed Practical Nurse #1 stated that the Environmental Protection Agency (EPA) approved germicidal wipes are kept at the nurses' station. Licensed Practical Nurse #1 stated that the glucometer test strips used for collecting blood on the machine use only a small amount of blood and the blood do not even touch the glucometer machine. Licensed Practical Nurse#1 stated they thought using the alcohol prep pads and the instant hand wipes was sufficient to clean the glucometer. During an interview on 05/04/2026 at 2:01 PM, Registered Nurse #1, the unit manager, stated that glucometer machine should be cleaned with an Environmental Protection Agency (EPA) approved germicidal wipes after each resident use. Registered Nurse#1 stated that Licensed Practical Nurse #1 should have cleansed the glucometer with the Environmental Protection Agency (EPA) approved germicidal wipes and not the alcohol pads and hand wipes. During an interview on 05/05/2026 at 8:50 AM, the Nursing Educator stated that Licensed Practical Nurse #1 should not have used the alcohol prep pads and hand wipes to clean the glucometer machine. The Nursing Educator stated that alcohol prep pads and handwipes are not effective cleaning agents for glucometers. The Nursing Educator stated that the facility protocol for cleaning the glucometer is with the Environmental Protection Agency (EPA) approved germicidal wipes to eliminate any blood borne pathogen. During an interview on 05/05/2026 at 11:26 AM, the Infection Preventionist stated that the facility uses the Environmental Protection Agency (EPA) approved germicidal wipes to clean the glucometers. The Infection Preventionist stated that the Environmental Protection Agency (EPA) approved germicidal wipes are accessible to all nurses and are kept on the nurses' station only medications should be stored in the medication carts. The Environmental Protection Agency (EPA) approved germicidal wipes are considered cleaning agents and not medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/2026 at 9:56 AM, the Director of Nursing Services stated that the glucometer machine must be cleaned with the Environmental Protection Agency (EPA) approved germicidal wipes, after each resident use. The Director of Nursing Services stated that it is not appropriate that Licensed Practical Nurse #1 used alcohol prep pads and hand wipes to clean the glucometer machine. The Director of Nursing Services stated that the facility was guided by their pharmacy consultant that Environmental Protection Agency (EPA) approved germicidal wipes should not be kept in the medication cart due to possible spillage and contact with other medications. 10 New York Code Rules Regulations 415.19(a) (1-3)