STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335175	A. Building B. Wing	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Multicare Nursing Center	7 Route 25a Smithtown, NY 11787

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 11/19/2025 and completed on 11/25/2025 the facility did not ensure that each resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of their quality of life. This was identified for two (2) (Resident #116 and Resident #140) of seven (7) residents reviewed for Dignity. Specifically, during a lunch meal observation on 11/20/2025, Certified Nursing Assistant #2 and Registered Nurse #2 were observed standing over the residents while they fed the residents the lunch meal.The finding is: The facility policy titled Assisting with Feeding dated 01/21/2025 documented residents who cannot feed themselves will be fed with attention to safety, comfort and dignity. Staff should not stand over residents while assisting them with meals. Resident #116 was admitted with diagnoses including Alzheimer's (brain disorder that causes memory loss), Depression and seizures (sudden burst of electrical activity in the brain that can cause changes in a person's behavior, movements, feelings, and consciousness). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0, indicating the resident had severe cognitive impairment. The resident was dependent on staff members for eating and meal setup. The Comprehensive Care Plan for Nutritional status, initiated on 03/07/2023 and last revised on 10/25/2025, documented the resident was at risk for compromised nutritional status related to a mechanically altered diet and potential for dehydration. The Comprehensive Care Plan for Activities of Daily Living, initiated on 03/06/2023 and last revised on 05/13/2024, documented the resident should be provided extensive assistance with eating. Resident #140 was admitted with diagnoses including Dementia (loss of memory, language, problem-solving and other thinking abilities), Aphasia (difficulty speaking), and iron deficiency Anemia (not enough iron to make healthy red blood cells, which are needed to carry oxygen). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 0, indicating the resident had severe cognitive impairment. The resident required maximal assistance with eating their meals. The Comprehensive Care Plan for Activities of Daily Living, initiated 11/09/2023 and last revised on 07/30/2024, documented the resident was dependent on staff members for feeding. During an observation of the Diamond Unit lunch meal service on 11/20/2025 at 12:21 PM, Registered Nurse #2 was feeding Resident #116 and Certified Nursing Assistant #2 was feeding Resident #140. Registered Nurse #2 and Certified Nursing Assistant #2 were both standing while feeding the residents. During an interview on 11/20/2025 at 01:51 PM, Certified Nursing Assistant #2 stated they usually sit down when feeding a resident. Certified Nursing Assistant #2 stated they were not sitting down because there were not enough chairs available. Certified Nursing Assistant #2 stated they should have been sitting when feeding a resident. During an interview on 11/20/2025 at 01:55 PM, Registered Nurse Unit Manager #3 stated that staff members should be seated next to the resident when assisting a resident with their meal. Registered Nurse Unit Manager #3 stated staff members are expected to sit and interact with the resident to maintain the resident's dignity and quality of life. During an interview on 11/25/2025 at 08:58 AM, the Director of Nursing Services stated that staff members are expected (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to sit next to and interact with the resident while assisting with a meal. The Director of Nursing Services stated the nursing staff members should have been at eye level with the residents while feeding and observing them for chewing. The Director of Nursing Services stated the staff members should never stand while feeding a resident. 10 NYCRR 415.5(a)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews during the Recertification Survey initiated on 11/19/2025 and completed on 11/25/2025, the facility did not ensure that it provided a safe, clean, comfortable, and homelike environment. This was identified for one (1) (Broadway Unit) of seven (7) nursing units reviewed for Environment. Specifically, the ceiling in Resident #56's room had a hole that measured approximately one and half (1.5) feet by one and a half (1.5) feet. The hole had water stains along the edges and had draping plaster hanging on each side. Additionally, the wall above the window in Resident #56's room was poorly spackled and had water stains. The finding is: The facility policy titled Maintenance Requests Internal Work Orders, last revised on 01/2025, documented that anyone requesting a maintenance repair must fill out a maintenance request form. Maintenance mechanic/designee will collect all maintenance requests daily. Work orders will be prioritized and distributed to maintenance staff for completion. Time frames for work order completions will be based on the complexity of the work and the availability of materials. Completion dates will vary based on the scope of work. Resident #56 was admitted with diagnoses including Type 2 Diabetes, Acute Kidney Failure, and Bipolar Disorder (a mental health condition characterized by extreme mood swings). An Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating Resident #56 had intact cognition. During an observation on 11/19/2025 at 10:16 AM, Resident #56 was lying in their bed. The ceiling near the window of Resident #56's room had a one-and-a-half (1.5) feet by one-and-a-half (1.5) feet hole with draping plastic paper hanging on each side of the hole and the edging around the hole opening had water stains. The wall above the window in Resident #56's room was poorly spackled and had water stains. During an interview on 11/19/2025 at 10:25 AM, Resident #56 stated they told the nursing staff about the hole in the ceiling and could not remember when they reported the problem. Resident #56 stated the nursing staff were aware that the ceiling needed to be fixed. Resident #56 stated the ceiling leaks when it rains outside. Resident #56 stated their bed was not directly below the ceiling, but they were concerned about the leak. Resident #56 stated that Maintenance should have fixed the ceiling by now and they were frustrated with the condition of their room. During an observation on 11/20/2025 at 08:20 AM, Resident #56 was lying in their bed. The resident's room was in the same condition observed on 11/19/2025. A review of the maintenance request book revealed there were no requests made to repair the ceiling in Resident #56's room. During an interview on 11/20/2025 at 08:30 AM, Registered Nurse #1, the Unit Manager, stated that maintenance requests should be written in the maintenance request book. Registered Nurse #1 stated they knew that Resident #56's ceiling needed to be fixed and could not remember how long the hole has been in the ceiling. Registered Nurse #1 confirmed maintenance staff were notified about Resident #56's room condition but could not remember when. Registered Nurse #1 stated they did not know why the requested work order was not in the maintenance request book. During an interview on 11/20/2025 at 08:54 AM, the Director of Building Services stated they did not know that the ceiling in Resident #56's room needed to be fixed. The Director of Building Services stated they reviewed the maintenance request book and did not see any requests from the nursing staff to repair the ceiling in Resident #56's room. During an interview on 11/20/2025 at 09:19 AM, Maintenance staff member #1 stated they were assigned to Resident #56's room and did not know the ceiling in Resident #56's room needed to be fixed. Maintenance staff member #1 stated they did not remember if the nursing staff made a maintenance request for Resident #56's room. Maintenance staff member #1 stated they do environmental rounds everyday but did not notice the hole in the ceiling of Resident #56's room. During an interview on 11/20/2025 at 09:51 AM, Certified Nursing Assistant #1, who was regularly assigned to Resident #56, stated all the staff members were aware that Resident #56's room ceiling needed to be fixed. Certified Nursing (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant #1 stated the condition of Resident #56's room had been reported numerous times, and they did not know why a work order was not in the maintenance request book. Certified Nursing Assistant #1 stated the resident's room was in disrepair for more than two weeks. During an interview on 11/21/2025 at 11:00 AM, the Administrator stated the unit nursing staff should have entered the request in the maintenance request book as soon as they observed the hole in Resident #56's room ceiling. The Administrator stated the maintenance staff should have fixed the ceiling in Resident #56's room. 10 NYCRR 415.5(h)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews during the Recertification Survey initiated on 11/19/2025 and completed on 11/25/2025, the facility did not ensure that it implemented a comprehensive person-centered care plan to meet each resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment. This was identified for one (1) (Resident #67) of four (4) residents reviewed for Pressure Ulcers. Specifically, Resident #67 had physician's orders for bilateral elbow pads to be worn at all times and padded side rails while in bed. The resident was observed on multiple occasions wearing either one elbow pad or no elbow pads. Additionally, the side rail pads were on the floor while the resident was in bed on one occasion.The finding is: The facility policy titled Comprehensive Care Plans and Resident/Patient Meeting, Timing, and Revisions dated 02/15/2025 documented the facility develops and implements a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet the residents medical, nursing and mental and psychosocial needs that are identified in the assessment. The purpose of the assessment is to accurately communicate the resident's capability to perform daily life functions and to identify significant impairments in functional capacity and the plan suggested by the care plan team for improvement/maintenance for each of the resident's primary care issues. Resident #67 was admitted with diagnoses including Cerebral Palsy, Seizure Disorder, and Aphasia (a language disorder caused by damage to the brain that affects a person's ability to speak, write, read, and understand language). The Annual Minimum Data Set assessment dated [DATE] documented the resident had severely impaired cognitive skills for daily decision making. The resident was at risk for pressure ulcer development and currently had no pressure ulcers. A Comprehensive Care Plan titled Padded Side Rails effective 09/08/2025 was last updated on 11/21/2025. Interventions included the use of padded side rails for injury prevention during seizures due to decreased safety awareness; and to check padding regularly to ensure it is secure, intact, and free of damage. A care plan note dated 09/12/2025 documented a trial of least restrictive restraints was attempted and unsuccessful due to the resident's involuntary flailing of upper and lower extremities. A Comprehensive Care Plan titled At Risk for Pressure Ulcers effective 10/06/2018 and last updated 07/31/2025 documented the resident was at high risk for pressure ulcer development. Interventions included to provide diligent skin care. A Side Rail assessment dated [DATE] documented the side rails were applied to the resident's bed for safety due to convulsions. The assessment documented the resident could not enter or exit the bed independently. The side rails did not restrict the resident's movement and do not meet the definition of restraint. The physician's orders dated 11/10/2025 documented seizure precautions; bilateral elbow pads at all times when in bed and when in the chair for prophylactic (prevention) measures; and four one-half padded side rails while in bed secondary to unawareness of physical boundaries due to the diagnosis of Epilepsy. During an observation on 11/19/2025 at 12:25 PM, Resident #67 was lying in bed. The resident only had an elbow pad applied to their left arm. During an observation on 11/20/2025 at 10:25 AM, Resident #67 was in their room sitting in the Geri-chair with a lap tray. The resident was not wearing any elbow pads and the resident's elbows were resting on the lap tray. An elbow pad was observed on the bedside table. During an interview and observation on 11/20/2025 at 10:30AM, Certified Nursing Assistant #6 stated the resident does require elbow pads. Certified Nursing Assistant #6 was observed taking the elbow pad off the resident's bedside table and then placed it on the resident's left elbow. Certified Nursing Assistant #6 searched for another elbow pad in the closets and drawers in the room. Certified Nursing Assistant #6 found the elbow pad in a closet and placed the pad on the resident's right elbow. Certified Nursing Assistant #6 stated they forgot to place the elbow pads on the resident earlier this morning. During an interview and observation on 11/21/2025 at 08:20 AM, Resident #67 was lying in bed. The four half side rails were raised and the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side rail pads were on the floor. Certified Nursing Assistant #6 and Certified Nursing Assistant #7 were present in the room. Certified Nursing Assistant #6 stated they (Certified Nursing Assistant #6 and Certified Nursing Assistant #7) had just entered the room to provide morning care to Resident #67, and the side rail pads were on the floor when they entered the room. Certified Nursing Assistant #7 confirmed the same. Certified Nursing Assistant #7 stated the resident used to have a bed with full side rails, but the new bed has four half rails and the side rail pads in the room were for full side rail pads. Certified Nursing Assistant #7 demonstrated that the full side rail pads did not fit properly on the half side rails and would not stay in place. Certified Nursing Assistant #7 stated the nurse knows about the side rail pads not fitting the new bed. Certified Nursing Assistant #6 confirmed the same. The Certified Nursing Assistants did not know when the resident was given a new bed. During an interview on 11/21/2025 at 08:25 AM, Registered Nurse #5 (Unit Manager) stated the elbow pads should be on the resident at all times and Certified Nursing Assistant #6 would have to be re-educated. Registered Nurse #5 stated they did not know that the side rail pads did not fit the half side rails. Registered Nurse #5 stated if they had known, they would have alerted the Rehabilitation Department to provide the appropriate side rail pads. Registered Nurse #5 stated the resident used to have full side rails about a year ago. Registered Nurse #5 stated the nursing staff attempted to use less restrictive side rails including two upper side rails, but they were not appropriate because the resident had involuntary movements and did not have bed boundary awareness. The resident was provided four half side rails as the least restrictive alternative to full side rails. Registered Nurse #5 stated it is possible that the side rail pads were for the full side rails. During an interview on 11/21/2025 at 09:30 AM, the Rehabilitation Department Director #1 stated the Rehabilitation Department does not provide side rail pads. Rehabilitation Department Director #1 stated nursing and housekeeping staff provide side rails pads for the residents. During an interview on 11/21/2025 at 09:37 AM, Housekeeping Director #1 stated they did not know the side rail pads did not fit the side rails on Resident #67's bed. Housekeeping Director #1 stated the nursing staff did not report the problem to the Housekeeping Department. Housekeeping Director #1 stated they do have half side rail pads in stock and they provide the side rail pads when requested by the nursing staff. During an interview on 11/21/2025 at 12:15 PM, the Director of Nursing Services stated the resident should wear the bilateral elbow pads at all times, as indicated on the physician's order. The Director of Nursing Services stated the side rail pads should be in place when the resident is in bed and the half side rail pads should have been provided when the resident's bed was changed. 10 NYCRR 415.11(c)(1)