STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335284	A. Building B. Wing	06/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Island Healthcare	825 Old Country Rd Plainview, NY 11803

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview during the abbreviated survey (NY00367963) the facility did not ensure that each resident receive an accurate assessment reflective of the resident's status. This was evident for one (Resident #1) resident reviewed for Minimum Data Set (MDS) Accuracy. Specifically, the Minimum Data Assessment Assessments dated 12/16/2024 with a look back period of 12/09/2024 to 12/16/2024 documents the resident had 1 (one) unstageable pressure ulcer due to coverage of wound bed by slough and eschar present on admission and 1 (one) unstageable pressure injuries presenting as deep tissue injury that were present on admission/entry (12/09/2024). The Nursing admission Progress Noted dated 12/10/2024 at 11:58PM documented redness to the sacrum no openings, bilateral heals red and dry. The finding are: The centers for Medicaid / Medicare Resident Assessment instrument manual dated 10/20/2025 documents pressure injuries must be coded in the 7-day look back period based on review of the medical records, including skin care flow sheets. For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home. Consider current and historical levels of tissue involvement. (Pg M-8) The facility policy titled Resident Assessment Instrument (MDS 3.0), effective June 15, 2011, and revised October 1, 2023, in the section titled General Information, documents information is gathered from multiple sources: the resident, resident family, significant other, and health care providers including licensed and non-licensed, physicians and therapists. Health care team members utilize various methods to obtain data including observation, interview and record review. Resident #1 was admitted to the facility on [DATE] and has diagnoses including Chronic Kidney Disease Stage 3 and Diabetes Mellitus. A Minimum Data Set assessment dated [DATE] documented a Brief Interview Mental Score of 13 indicating mild cognitive impairment. Section GG - Functional Abilities documents Resident #1 is dependent in ambulation but requires only partial / moderate assist in all other Activities of Daily Living related to mobility. Minimum Data Set further documents the resident had wounds on admission to the facility (12/9/2024) 1 (one) unstageable pressure ulcer due to coverage of wound bed by slough and eschar present on admission and 2 (two) unstageable pressure injuries presenting as deep tissue injury that were present on admission/entry. (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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing admission Progress Noted dated 12/10/2024 at 11:58PM documents in the section Presence of skin breakdown: sacrum red no openings, bilateral heals red and dry. A Nursing Progress Noted dated 12/17/2024 at 12:32PM by RN #1(Wound Care RN) documents request to see resident for suspected Deep Tissue Injury, on admission redness was noted to sacral area and now appears to have evolved. Section M identified resident is at risk of developing pressure ulcer. Nursing admission assessment dated [DATE] Section titled Nursing Braden Scale documents mild risk for skin break down. Section titled Nursing Intake and Assessment documents sacrum is red and intact, left heel is dry, red and intact, Right heel is dry, red and intact. Base Line Care Plan completed 12/12/2024 Section titled Bowel and Bladder documents skin is intact. A Comprehensive Care Plan dated effective 12/10/2024 titled Skin Integrity: At Risk for Skin Break Down include intervention for the preventions of skin break down. Interventions include completing a Pressure Ulcer Risk Assessment, using a pressure reducing cushion in wheelchair and using skin protectant / barrier when performing perineal care. Comprehensive Care Plans dated effective 12/17/2024 titled Skin Integrity: Presence of Skin Break Down Right Heel includes interventions for an air mattress, consult with wound care doctor and apply wound treatments per medical order. Comprehensive Care Plans dated effective 12/19/2024 titled Skin Integrity: Presence of Skin Break Down Left Heel includes interventions for an air mattress, consult with wound care doctor and apply wound treatments per medical order. Comprehensive Care Plans dated effective 12/19/2024 titled Skin Integrity: Presence of Skin Break Down Sacral Area includes interventions for an air mattress, consult with wound care doctor and apply wound treatments per medical order. Medical order dated 12/11/ 2024 documented, Apply A&D Ointment to sacrum twice a day. Medical order dated 12/11/ 2024 documented, Apply A&D Ointment to bilateral heels every day. Medical order dated 12/17/ 2024 documented, Cleanse sacral area with normal saline solution. Apply clean dry dressing, every day. Medical order dated 12/20/2024 Cleanse sacral area with normal saline solution. Apply Silicone boarded foam dressing every day. Medical order dated 12/26/ 2024 documented Santyl 250 unit/gram topical ointment, apply by topical route, cleanse sacral area with normal saline solution apply nickel size of Santyl cover with moisten gauze then abdominal pad and secure with boarded gauze daily. Medical order dated 12/31/2024 Paint left heel with betadine and cover with dry protective dressing daily and as needed. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/07/2025 at 2:54 PM with Minimum Data Set Coordinator. who stated the Minimum Data Set was completed on 12/26/24 and they referenced a noted dated 12/20/24 for the wound, they confirmed the look back period was 12/9-12/16/24. The MDS Coordinator stated they did not see the admission note or the admission assessment and they don't review hospital paperwork. MDS Coordinator could not provide explanation as to why she used a note outside of the look back period. 483.20 (g)(h)(i)(i)