STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335294	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Island Care Center Inc	144-61 38th Ave Flushing, NY 11354

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews conducted during an abbreviated survey (2614147), the facility failed to ensure a resident's physician was notified of changes in condition. This was evident in one (1) out of five (5) residents (Resident #1) sampled. Specifically, the Medical Director was not notified of Resident #1's change in condition. A review of the Certified Nursing Assistant Accountability Record dated 08/01/2027 through 08/17/2025 documented that Resident #1 exhibited watery stool on 08/02/2025, 08/04/2025, 8/05/2025, 08/06/2025, and 08/09/2025. Record review of the medical and nursing notes revealed no documented evidence that the Medical Director was notified of Resident #1's watery stool. The findings include:The facility's policy titled, Notification of Medical Doctor of Residents Change in Condition dated 04/28/2025, documented it is the policy of the facility that the resident's primary medical doctor or designee, be made aware of any change in the resident's condition to facilitate complete and continuous quality of care to the residents and to promote optimal outcomes. Resident #1 was admitted to the facility with diagnoses including cerebral palsy, peripheral vascular disease, seizure disorder, chronic lung disease, and asthma.A review of the Minimum Data Set (a resident assessment tool) dated 07/21/2025, documented Resident #1's cognition was severely impaired.A review of the Physician's Order dated 07/24/2025, documented Lactulose 15 milliliters once daily via gastrostomy tube for constipation. Milk of Magnesia 30 milliliters as needed once daily. Dulcolax Suppository once daily as needed on the 3:00 PM - 11:00 PM shift, if no bowel movement after Milk of Magnesia.A review of the Medication Administration Record dated 08/01/2025-08/17/2025 revealed Resident #1 continued to receive Lactulose 15 milliliter daily.A review of Certified Nursing Assistant Accountability Record documented that Resident #1 had watery bowel movements on 08/02/2025, 08/04/2025, 08/05/2025, 08/06/2025, and 08/09/2025.A review of Nursing and Medical notes dated 08/01/2025 through 08/17/2025, revealed no documentation regarding Resident #1 had watery bowel movements. During an interview on 09/18/2025 at 2:24 PM, the Director of Nursing stated the Certified Nursing Assistants are responsible for reporting watery stool to the nurse. They stated the nurse would assess the resident and follow up with the Physician. They stated the Registered Charge nurse and Registered Nurse / Unit Managers are responsible for checking the accountability record daily prior to their shift and if there are any abnormality, any nurse, charge nurse, unit manager, or supervisor should report to the Medical Doctor.During an interview on 09/19/2025 at 10:41 AM, Registered Nurse Supervisor #1 stated staff usually inform them when Resident #1 has watery stool, however, they could not recall being told about Resident #1 having watery stool in the month of August. They stated when the staff informs them of the resident having watery stool they are responsible for checking the accountability record and informing the Medical Doctor. During a telephone interview on 09/18/2025 at 4:32 PM, the Medical Director stated they could not recall receiving any calls or being informed of Resident #1 having watery bowel movements. They stated they should be notified if there was a change in the resident's status, which includes watery bowel movements. They stated as the Medical Director, they expect the Physicians to monitor their residents through collaborating with staff verbally about any changes. 10 NYCRR 415.1210 NYCRR 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 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during an abbreviated survey (2614147), the facility did not ensure that a resident care plan was reviewed and revised by the interdisciplinary team to reflect a resident's bowel pattern. This was evident in two (2) of five (5) residents (Resident #1 and #2) sampled. Specifically, the Certified Nursing Assistant Accountability Record documented that Resident #1 had watery bowel movements on 08/02/2025, 08/04/2025, 08/05/2025, 08/06/2025, and 08/09/2025. Additional, Resident #2 had watery bowel movements daily from 08/01/2025-08/19/2025 and 08/22/2025-08/30/2025. According to interviews with nursing staff and Medical Doctor #1, water bowel movements are expected due to enteral feeding. This was not reflected in Resident #1 and Resident #2's plan of care. The findings include:The facility's policy titled Updating Comprehensive Care Plans dated 05/2024 documented that it is the policy of the facility to treat the Comprehensive Care Plan as personalized plan of care designed to meet the medical, nursing, rehabilitative, social, nutritional, and emotional needs of each resident. The Comprehensive Care Plan shall be updated whenever there is a change in the resident's condition or other factors that affect care. Resident #1 was admitted to the facility with diagnoses including Cerebral Palsy, Peripheral Vascular Disease, Seizure Disorder, Chronic lung disease, and Asthma.The Minimum Data Set, dated [DATE] documented Resident #1 had severely impaired cognition.A Comprehensive Care Plan related to Constipation dated 04/11/2022 had documented interventions to administer medications as per physician's orders, document bowel record, monitor and record frequency. A care plan note dated 05/25/2025 documented quarterly review. Resident #1 remains at risk for constipation due to multiple comorbidities. Bowel regimen in place and is being followed. No significant changes in bowel pattern noted at this time.A review of Certified Nursing Assistant Accountability Record dated 08/02/2025, 08/04/2025, 08/05/2025, 08/06/2025, and 08/09/2025 documented Resident #1 had watery bowel movements.There was no documented evidence the plan of care was updated to reflect on Resident #1's watery bowel movements. Resident #2 was admitted to the facility with diagnoses including Coronary Artery Disease and Cerebrovascular Accident.The Minimum Data Set, dated [DATE] documented Resident #2 had moderately impaired cognition.A review of Certified Nursing Assistant Accountability Record dated 08/01/2025-08/19/2025 and 08/22/2025-08/30/2025 documented that Resident #2 had watery bowel movements.A Comprehensive Care Plan related to Constipation dated 02/05/2025 had documented interventions to monitor bowel movements every day, notify the Medical Doctor if there are no bowel movements in two (2) days, monitor for complaints of abdominal pain, decreased bowel sounds, abdominal distention, low grade fever and administer medication as per the Medical Doctor's orders. A care plan note dated 05/11/2025 documented quarterly review. Resident #2 remained free from constipation during review. Bowel regimen in place. Plan of care to be continued. A review of Certified Nursing Assistant Accountability Record dated from 08/01/2025-08/19/2025 and 08/22/2025-08/30/2025 documented Resident #2 had daily watery bowel movements.There was no documented evidence the plan of care was updated to reflect on the watery bowel movements. During an interview on 09/18/2025 at 2:24 PM, the Director of Nursing stated the care plans are updated quarterly and as needed. They stated the unit managers and supervisors are responsible for updating the care plans. They stated Resident #1's care plan was due to be updated in August, however, Resident #1 was transferred to the hospital and did not return. During a telephone interview on 09/23/2025 at 11:11 AM, /Registered Nurse/Unit Manager #2 stated the care plans are updated every ninety days, unless there is an episodic change. They stated Resident #2's care plan was not updated in during the month of August 2025 because there were no active Unit Managers at that time. They stated when the resident is having consistent watery bowel movements, they review the medication, follow up with the Medical Doctor and document interventions in the progress note and update the care plan. They stated the Unit Managers are responsible for updating the care plans.During a telephone interview on 09/23/2025 at 11:30 AM, Registered Nurse Supervisor #5 stated the care plan is usually updated quarterly, annually and when there is a significant change. They stated if a resident is having watery stool a narrative note is documented in their chart and the care plan should be updated. They stated Resident #2's care plan should have been updated in August 2025 because Resident #2 was having consistent watery stool. They stated they do not know why the care plan was not updated.10 NYCRR 415.11(c)(1)