STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Pavilion for Rhb & Nrsg at Rockville Ctr	41 Maine Avenue Rockville Centre, NY 11570

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 - Some	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** 49245 Based on observations, record review, and interviews during the Recertification Survey initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure that each resident was treated with respect and dignity and in a manner and in an environment that promotes maintenance or enhancement of their quality of life. This was identified for three (Resident #335, Resident#283, and Resident #284) of three residents reviewed for Dignity. Specifically, Resident #335, Resident #283 and Resident #284 were not provided a privacy cover for their urinary catheter bags. Both residents' urinary catheter bags contained urine and were visible from the hallway. The findings are: The facility's policy and procedure titled Foley Catheter Care and Privacy, last revised on 10/19/2024 documented to ensure that the care of residents with Foley Catheters is conducted safely, effectively, and with respect to their privacy and dignity. To promote resident's rights and privacy, the urinary bag must be maintained in a privacy pouch. 1) Resident #335 was admitted with diagnoses including Acute Kidney Failure, Rhabdomylosis (breakdown of muscle tissue that releases a damaging protein into the blood), and Sacral (bottom of the spine) Pressure Ulcer. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #335 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #335 had an Indwelling Catheter (a thin tube inserted into the bladder to drain urine). A Physician's Order dated 1/3/2025 documented an order for a Foley catheter French 20 with 10 milliliters balloon. Change the catheter every month and as needed. Provide Foley Catheter care every shift and as needed. A Comprehensive Care Plan (CCP) dated 1/5/2025 documented Resident #335 had a Foley catheter related to urinary retention. Interventions included maintaining the Foley Catheter to a straight drain, keeping the urinary catheter bag below the level of the bladder, checking for placement and function every shift, monitoring for any kinks in the tubing, and keeping the urinary catheter drain bag covered. (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: 335297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER The Grand Pavilion for Rhb & Nrsg at Rockville Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 41 Maine Avenue Rockville Centre, NY 11570	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #335 was observed on 1/5/2025 at 10:30 AM sitting in their room in a wheelchair. The resident's urinary catheter bag and the tubing was visible from the hallway. The urinary catheter bag was half-filled with urine. During an interview on 1/5/2025 at 2:34 PM, Certified Nursing Assistant #3 stated they transferred Resident #335 from the bed to the wheelchair. They did not notice a privacy bag was attached to the wheelchair. Certified Nursing Assistant #3 stated they did not place the urinary catheter bag in the privacy bag and should have. During an interview on 1/8/2025 at 8:41 AM, Registered Nurse #3, the Unit Manager stated Certified Nursing Assistant #3 should have placed Resident #335's urinary catheter bag and tubing in the privacy bag to promote the resident's rights and privacy. During an interview on 1/8/2025 at 12:15 PM, the Director of Nursing stated staff should use a privacy bag to cover the urinary catheter drainage bag and the tubing to promote residents' rights, dignity, and privacy at all times. 48827 2) Resident #283 was admitted with diagnoses that included Benign Prostatic Hyperplasia (a noncancerous enlargement of the prostate gland), Obstructive and Reflux Uropathy (a condition that prevents urine from flowing normally through the urinary tract), and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented the Brief Interview for Mental Status score of 10, which indicated the resident had moderate cognitive impairment. The Minimum Data Set documented that Resident #283 was admitted to the facility with an indwelling catheter. A Comprehensive Care Plan was initiated on 12/19/2024 and documented the resident had a Foley catheter related to Benign Prostatic Hyperplasia and Obstructive & Reflux Uropathy. Interventions included changing the catheter monthly and as needed. The interventions did not document the use of a privacy bag for the Foley bag. A Physician's order dated 12/12/2024 documented to maintain Foley catheter 16 French, 20 cubic centimeter balloon, change every month and as needed for infection prevention. During an observation on 1/05/2025 at 9:17 AM Resident #283 was sitting in bed with a Foley bag attached to the side of the bed. The urinary catheter drainage bag was visible from the doorway, not covered, and half filled with urine. During an interview on 1/05/2025 at 9:17 AM, Resident #283 stated the Certified Nursing Assistant placed their Foley bag on the bedside. The resident stated they did not know anything about covering the urinary catheter drainage bag. During an interview on 1/05/2025 at 10:40 AM, Certified Nursing Assistant #8 stated the night shift put Resident #283 back to bed last night and did not cover the urinary drainage bag with a privacy bag. Certified Nursing Assistant #8 stated they would put the urinary catheter drainage bag in a privacy bag when they would get the resident out of bed to the wheelchair. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #284 was admitted with diagnoses that included Cerebral Infarction, Obstructive and Reflux Uropathy (a condition that prevents urine from flowing normally through the urinary tract), and Benign Prostatic Hyperplasia (a noncancerous enlargement of the prostate gland). The Minimum Data Set assessment dated [DATE] documented the Brief Interview for Mental Status score of 10, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented the resident was admitted to the facility with an indwelling catheter. A Comprehensive Care Plan was initiated on 12/21/2024 and revised on 1/06/2025, documented interventions that included positioning the urinary catheter bag and tubing below the level of the bladder and away from the entrance room door. Change Foley catheter every month. The interventions did not document the use of a privacy bag for the urinary catheter drainage bag. A Physician's order dated 12/31/2024 documented an order to change the Foley catheter as needed. During an observation on 01/05/2025 at 9:41 AM, Resident #284 was seen in bed sleeping, with a urinary catheter drainage bag hanging from the side of the bed. There was no privacy cover over the urinary catheter drainage bag. The urinary catheter drainage bag. During an interview on 1/05/2025 at 10:30 AM, Certified Nursing Assistant #8 stated the night shift put Resident #284 back to bed last night and did not cover the Foley drainage bag with a privacy bag. Certified Nursing Assistant #8 stated they would put the drainage bag in the privacy bag when they get Resident #284 out of bed to the wheelchair. During an interview on 1/05/2025 at 10:53 AM, Registered Nurse Manager #4 stated all urinary catheter drainage bags should be covered with a privacy cover. They believe they ordered new bag covers for both Resident # 283 and Resident #284 as the previous ones were soiled. A Physician's order dated 1/06/2025 documented an order to maintain the Foley catheter to a straight drain, keep the urinary catheter drainage bag below the level of the bladder, check for placement and function every shift, monitor for any kinks in the tubing, keep the urinary drain bag covered. During an interview on 1/08/2025 at 12:08 PM, the Director of Nursing Services stated all residents with a urinary catheter should have a privacy bag to cover the urinary catheter drainage bag to promote resident privacy. 10 NYCRR 415.5(a)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 45349 Based on record review and interviews during the Recertification Survey initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure that comprehensive assessments of residents were conducted within 14 calendar days after admission and not less than once every 12 months. This was identified for two (Resident #67 and Resident #37) of six residents reviewed during the Resident Assessment Task. Specifically, Resident #67 and Resident #37's annual Minimum Data Set Assessment was not completed within 14 days of the Assessment Reference date. The finding is: The facility policy titled MDS Assessments, dated 12/10/2024, documented all Minimum Data Set assessments are to be completed and submitted to Centers for Medicare and Medicaid Services as per the guidelines provided in the Resident Assessment Instrument Manual. The Minimum Data Set Coordinator will assume the leadership role to ensure that all Minimum Data Set Assessments are completed and submitted as per the guidelines. Resident #67's Annual Minimum Data Set assessment with an Assessment Reference Date of 8/30/2024 was completed on 9/20/2024. This was 7 days beyond the required time frame. Resident 37's Annual Minimum Data Set Assessment with an Assessment Reference Date of 8/22/2024 was completed on 9/11/2024. This was 6 days beyond the required time frame. During an interview on 1/10/2025 at 9:19 AM, the Minimum Data Set Director stated the Minimum Data Set should be completed 14 days from the Assessment Reference Date. The Minimum Data Set Director stated they knew that Resident #37's and Resident #67's Annual Minimum Data Set was completed late. They further stated that the Director of Nursing and Administrator were aware. During an interview on 1/10/2025 at 9:51 AM, the Director of Nursing Services stated they were aware the Minimum Data Set assessments were completed late. The Director of Nursing Services stated the late assessment completion was because of staffing turnover. 10 NYCRR 415.11

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident’s assessment is updated at least once every 3 months. 45349 Based on record review and interviews during the Recertification Survey initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure that the Quarterly Minimum Data Set assessments were completed within the prescribed time frames. This was identified for three (Resident #6, Resident#113, Resident #13) of six residents reviewed during the Resident Assessment Task. Specifically, Resident #6, Resident#113, and Resident #13 Quarterly Minimum Data assessment was not completed within 14 days of the Assessment Reference date. The finding is: The facility policy titled MDS Assessments, dated 12/10/2024, documented all Minimum Data Set assessments are to be completed and submitted to Centers for Medicare and Medicaid Services as per the guidelines provided in the Resident Assessment Instrument Manual. The Minimum Data Set Coordinator will assume the leadership role to ensure that all Minimum Data Set Assessments are completed and submitted as per the guidelines. Resident #6's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 8/23/2024, was completed on 9/9/2024. This was three days beyond the required time frame. Resident #113's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 8/2/2024, was completed on 8/21/2024. This was five days beyond the required time frame. Resident #13's Quarterly Minimum Data Set assessment, with an Assessment Reference Date of 8/30/2024, was completed on 9/17/2024. This was four days beyond the required time frame. During an interview on 1/10/2025 at 9:19 AM, the Minimum Data Set Director stated the Minimum Data Set should be completed 14 days from the Assessment Reference Date. The Minimum Data Set Director stated they knew that Resident #37's and Resident #67's Annual Minimum Data Sets were completed late. They further stated that the Director of Nursing and Administrator were aware. During an interview on 1/10/2025 at 9:51 AM, the Director of Nursing Services stated they were aware the Minimum Data Set assessments were completed late. The Director of Nursing Services stated the late assessment completion was because of staffing turnover. 10 NYCRR 415.11 (a)(4)

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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** 45349 Based on observations, record review, and staff interviews during the Recertification survey initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure that a comprehensive care plan was developed and implemented for each resident including measurable objectives and timeframe to meet each resident's medical and nursing needs. This was identified for one (Resident#233) of one resident reviewed for Hydration; one (Resident #68) of seven residents reviewed during the Medication Administration Task; and one (Resident #285) of two residents reviewed for Urinary Catheter or Urinary Tract Infection. Specifically, 1) Resident #233 had a physician's order for intravenous hydration therapy; however, there was no comprehensive care plan developed for the insertion, care, and use of the Intravenous Catheter. 2) Resident #68 was administered Calcium 500 milligrams with Vitamin D 3 instead of the Physician ordered Calcium-Vitamin D 600 milligrams-200 milligrams. 3) Resident #285 received antibiotic therapy intravenously; however, there was no comprehensive care plan developed for the insertion, care, and use of the Peripheral Intravenous Catheter. The findings are: A facility's policy titled Care Plans, Comprehensive Person-Centered, documented a comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The comprehensive person-centered care plan describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including services that would otherwise be provided. 1) Resident #233 was admitted with diagnoses including Hypertension, Diabetes Mellitus, and Depression. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated the resident was cognitively intact. A physician's order dated 1/4/2025 documented to intravenously administer Sodium Chloride Solution 0.9 percent at 100 milliliters per hour every shift for Hydration for two days. A nursing progress note dated 1/6/2025 documented the resident was started on Sodium Chloride Solution 0. 9 percent at 100 milliliters per hour intravenously, every shift for hydration until 1/7/2025. There was no documented evidence that a comprehensive care plan was developed for the use of intravenous fluids. During an interview on 1/8/2025 at 9:49 AM, Registered Nurse Unit Manager #2 stated Resident #233 received intravenous fluids related to their elevated blood sugar levels starting 1/4/2024 for two days. Registered Nurse Unit Manager #2 further stated that whoever picked up the Physician's order should have started a comprehensive care plan. During an interview on 1/10/2025 at 10:06 AM, the Director of Nursing Services stated there should have been a care plan developed for the use of intravenous fluids. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	49245 2) The facility's policy and procedure titled Medication Administration, last revised on 10/18/2024 documented that medications are administered in accordance with the prescriber's orders, including the required time frame. Resident #68 was admitted with diagnoses including Vitamin D Deficiency, Hemiplegia (paralysis on one side of the body), and Seizures. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #68 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #68 had no Osteoporosis (bones become weak and brittle) or Arthritis (joint inflammation). A Comprehensive Care Plan (CCP) dated 10/19/2024 documented Resident #68 was at risk for pain related to contractures (when muscles, tendons, joints, or other tissues tighten or shorten causing deformity). The intervention included administering medication as ordered by the Physician. A Physician's order dated 10/12/2023 documented Calcium with Vitamin D tablet 600 milligrams-200 International Unit (unit of measurement for a substance biological effect or activity) one tablet by mouth daily for supplement. Resident #68 was observed in their room on 1/5/2025 at 9:10 AM. Licensed Practical Nurse #2 was observed during the Medication Administration Task administering two tablets of Calcium 250 milligrams with Vitamin D3 (3.1 micrograms) to Resident #68. The resident refused to take the medications. During an interview on 1/5/2025 at 9:12 AM, Licensed Practical Nurse #2 stated they did not have the Calcium with Vitamin D 600 milligrams-200 International Unit available in their medication cart. Licensed Practical Nurse #2 stated the Calcium 250 milligrams with Vitamin D3 (3.1 micrograms) was the closest dose they had in their medication cart. Licensed Practical Nurse #2 stated they would have documented in Resident #68's Electronic Medication Administration Record (EMAR) that a partial medication dose was administered if Resident #68 did not refuse the medications. During an interview on 1/5/2025 at 11:33 AM, Registered Nurse #3, the Unit Manager stated that Licensed Practical Nurse #2 should never have given a different dose of Calcium with Vitamin D to the resident. Registered Nurse #3 stated that Licensed Practical Nurse #2 should have checked with Central Supply for the medication availability. Licensed Practical Nurse #2 should have also called the Physician to get a different order if Calcium with Vitamin D 600 milligrams-200 International Unit was not available. During an interview on 1/8/2025 at 12:34 PM, the Director of Nursing Services stated Resident #68 should not have been given any medication except for what the Physician had ordered. The Director of Nursing Services stated Nursing staff should follow the orders given by the Physician. 48827 3) Resident #285 had diagnoses that included Urinary Tract infection, Chronic Kidney Disease, and Obstructive and Reflux Uropathy (a condition that prevents urine from flowing normally through the urinary tract). The Minimum Data Set assessment dated [DATE] documented Resident #285 had a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order dated 1/02/2025 documented the insertion of an Intravenous Midline Catheter. A Physician's order dated 1/02/2025 documented an order for Ceftriaxone Sodium (antibiotic) Solution 1 gram reconstituted intravenously every 12 hours for 7 days for infection. There was no documented evidence of a Comprehensive Care Plan for an Intravenous Midline Catheter use. Additionally, while there was a Comprehensive Care Plan for a Urinary Tract Infection dated 12/28/2024, the care plan did not include interventions related to the placement or care of an Intravenous Midline Catheter. During an observation on 1/5/2025 at 9:35 AM, Resident #285 was observed in bed with an Intravenous Catheter in their right arm. During an observation on 1/7/2025 at 10:51 AM, Resident #285 was in bed with the Intravenous Catheter in their right arm. During an interview on 1/7/2025 at 10:24 AM, Registered Nurse Unit Manager #4 stated a Care Plan should be developed for the Intravenous Midline Catheter when the peripheral intravenous catheter was ordered and placed. During an interview on 1/8/2025 at 12:01 PM, the Director of Nursing Services stated staff is expected to confirm that a physician's order for the placement of an Intravenous Midline Catheter is obtained and a care plan for the Intravenous Midline Catheter is initiated. 10 NYCRR 415.11(c)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This was identified for one (Resident #94) of one resident reviewed for Activities of Daily Living. Specifically, Resident #94 was observed on multiple occasions with long, untrimmed fingernails on both hands. Resident #94 stated they were unable to trim their fingernails on their own and wanted them trimmed. The finding is: The facility's policy titled Activities of Daily Living Care, dated 10/2024, documented the nursing home shall provide Activities of Daily Living care that promote and maintains residents' health, safety, independence, and dignity. Activities of Daily Living care include assistance with tasks such as bathing, dressing, grooming, eating, toileting, mobility, and transferring. Assist with grooming tasks such as shaving, hair care, oral hygiene, and nail care. Resident #94 was admitted with diagnoses including Cancer, Vertebra Fracture, and Muscle Weakness. The 11/26/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident was dependent on facility staff for personal hygiene. A Comprehensive Care titled Resident requires assist with activities of daily living related to bladder cancer with metastasis to spine, initiated 11/20/2024, documented personal hygiene: dependent on one staff member. The KARDEX (Certified Nursing Assistant care instructions), as of 1/5/2025, documented that the resident was dependent on one staff member for personal hygiene. Resident #94 was observed in bed on 1/5/2025 at 9:58 AM. Their fingernails on both hands were long and untrimmed. The resident stated they would like their fingernails trimmed, but they cannot trim the fingernails themselves because their hands are numb. Resident #94 was observed in bed on 1/6/2025 at 8:20 AM and their fingernails had not been trimmed yet. During an interview on 1/6/2025 at 8:25 AM, Certified Nursing Assistant #1 stated they were not the regularly assigned Certified Nursing Assistant and had not worked with Resident #94 before. Certified Nursing Assistant #1 observed Resident #94's fingernails and stated the nails were long and needed to be trimmed. Certified Nursing Assistant #1 stated they were not sure if the Certified Nursing Assistants were allowed to trim fingernails. During an interview on 1/6/2025 at 8:30 AM, Licensed Practical Nurse #1 stated if the resident is diabetic, the Certified Nursing Assistant can file the resident's fingernails and if the resident is not a diabetic, then the Certified Nursing Assistant can cut the fingernails. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 1/6/2025 at 12:28 PM, written by Registered Nurse #2, documented fingernails cut/trimmed/filed this morning. During an interview on 1/7/2025 at 10:41 AM, the Registered Nurse Staff Educator stated the Activities of Daily Living care include keeping fingernails clean. The Certified Nursing Assistants are allowed to cut the resident's fingernails. During an interview on 1/8/2025 at 10:40 AM, the Director of Nursing Services stated that Certified Nursing Assistants are expected to trim and clean the resident's fingernails. 10 NYCRR 415.12(a)(3)

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

34798

Based on observation, record review, and interviews during the Recertification Survey, initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, for one (Resident #234) of four residents reviewed for Pressure Ulcers. Specifically, Resident #234 had a physician's order for a positioning triangle wedge for pressure relief due to the resident having a Stage 3 pressure ulcer (full-thickness tissue loss; a deep wound extending through all layers of the skin into the fatty tissue beneath, indicating significant tissue damage) to the sacrum (a large, triangular bone at the base of the spine). On 1/5/2025 while the resident was in bed, the wedge cushion was observed against the bed's side rail and was not being used for providing pressure relief. The direct care staff were unaware of the reasons for the positioning wedge cushion use.

The finding is:

The facility's policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, revised 11/13/2024 documented that the nurse shall describe and document/report the following: full assessment of pressure sore, including location, stage, length, width and depth, presence of exudate or necrotic tissue; pain assessment; resident mobility status; current treatments, including support surfaces, and all active diagnoses. The Physician will order pertinent wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings, and application of topical treatments.

1) Resident #234 was admitted with diagnoses including Cellulitis of the Left Lower Limb, Muscle Weakness, and Difficulty Walking. The 10/22/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 6, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented that the resident was dependent on staff for bed mobility and transfers, had no pressure ulcers, was at risk for pressure ulcer development, and required pressure-reducing devices for the bed and chair.

The Braden score (a scale for predicting pressure ulcer risk) dated 10/15/2024, documented a score of 16, indicating the resident was at mild risk for developing pressure ulcers.

A nursing progress note dated 12/18/2024, written by Registered Nurse Unit Manager #2, documented the assigned Certified Nursing Assistant reported an open area to the resident's right buttocks. Wound Care Registered Nurse #1 determined the area as a Stage 3 pressure ulcer. Treatment was initiated.

A physician's order dated 12/31/2024 documented to apply Santyl External Ointment 250 unit/gram (an enzymatic debriding agent), apply to sacral wound topically every day shift for wound healing; cleanse with normal saline, apply Santyl and cover with dry dressing every day.

A physician's order dated 1/3/2024 documented Adaptive Device: Positioning triangle wedge to be placed on right/left side of trunk/hips when in bed. Reposition every 2 hours for pressure relief.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Pavilion for Rhb & Nrsg at Rockville Ctr	41 Maine Avenue Rockville Centre, NY 11570

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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 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

A progress note dated 1/3/2025, written by Physical Therapist #1, documented the resident was provided with a positioning wedge for pressure relief, to be placed on the right/left side of the trunk/hips while in bed. Reposition the resident every 2 hours. The Certified Nursing Assistant assigned to the resident was informed and educated.

A Comprehensive Care Plan titled Open Area to Right Buttock, Retitled to Sacral Stage 3, initiated on 12/18/2024 and last updated on 1/5/2025, documented an intervention to administer treatments/medications as ordered and monitor for effectiveness; the care plan did not include an intervention for the Positioning Triangle Wedge.

A review of the Certified Nursing Assistant Accountability Record for January 2025 revealed that Certified Nursing Assistants started using the triangle wedge on 1/6/2025.

During an observation on 1/7/2025 at 8:45 AM, Resident #234 was observed in their room with facial grimacing and was complaining in profane language that their buttocks were hurting and they wanted to die. The resident was lying flat on their back. The positioning wedge was observed against the side rail and did not provide pressure relief to the resident. Registered Nurse Unit Manager #2 entered the resident's room and stated the positioning wedge was to prevent the resident from falling out of bed. Registered Nurse Unit Manager #2 stated they had to check with the Rehabilitation Department to see if the positioning wedge was meant to provide pressure relief.

During an observation and interview on 1/7/2025 at 9:00 AM, Registered Nurse Unit Manager #2 returned to Resident #234's room and stated they spoke to the Rehabilitation Department and stated the positioning wedge was meant to offload the sacral area and to provide pressure relief. Registered Nurse Unit Manager #2 and Licensed Practical Nurse #1 (who was also in the room to administer medication to the resident) then left the resident's room without repositioning the resident or placing the positioning wedge under the resident. The resident continued with facial grimacing and complaints of pain in the buttock area.

During an observation and interview on 1/7/2025 at 9:04 AM, Certified Nursing Assistant #5 (assigned to Resident #234) entered the resident's room after being alerted of the resident's pain complaints. The resident was complaining in profane language of pain in the buttock area. Certified Nursing Assistant #5 repositioned a pillow under the resident and stated the positioning wedge was to keep the resident safe.

During an interview on 1/7/2025 at 09:14 AM, the Rehabilitation Department Director stated the triangular positioning wedge was meant for pressure relief for Resident #234 and should be placed under the resident's hip to offload the wound. The positioning wedge is not used to prevent the resident from falling out of bed.

During an interview on 1/7/2025 at 1:53 PM, Physical Therapist #1 stated the positioning triangle wedge was meant to be placed on either side of the resident's hips/trunk and switched every 2 hours for pressure relief and was meant to keep the resident off their back. Physical Therapist #1 stated they spoke to the Certified Nursing Assistant assigned to the resident (could not recall the name) and to the Registered Nurse Unit manager #2.

During an interview on 1/8/2025 at 9:37 AM, Registered Nurse Unit Manager #2 stated they did not recall Physical Therapist #1 telling them about the positioning wedge.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/8/2025 at 02:27 PM, the Director of Nursing Services stated the nursing staff taking care of Resident #234 should have known what the positioning wedge was for and should have utilized the wedge cushion to offload the would area. 10 NYCRR 415.12(c)(1)

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F 0692

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide enough food/fluids to maintain a resident's health.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48827

Based on observations, record review, and interviews during the Recertification Survey initiated on 01/05/2025 and completed on 01/10/2025, the facility did not ensure that each resident was offered a therapeutic diet when there is a nutritional problem, and the healthcare provider ordered a therapeutic diet. This was identified for one (Resident #54) of six residents reviewed for Nutrition. Specifically, Resident #54 experienced a 10% weight loss over one month, decreasing from 99 pounds on November 5, 2024, to 89 pounds by December 12, 2024. Registered Dietician #1 recommended weekly weights; however, there was no documented evidence the resident's weights were obtained weekly to monitor further weight loss. Subsequently, Resident #54 had an additional 7% weight loss from 12/12/2024 to 1/7/2024.

The finding is:

The facility's policy titled Management and Prevention of Significant Weight Loss, revised on 11/01/2023 documented that the Clinical Dietitian will place the resident on a weekly weight if a resident's weight [loss/gain] is unplanned or undesirable. The Physician will be notified of any weekly or monthly significant weight changes or as needed. Care plans will be under continuous revisions to meet the resident's needs with the goal of achieving the desired outcome. Communicate with the Physician and Charge Nurse about any nutritional recommendations based on assessment. Monitor resident's progress and document weekly or sooner in the medical record until weight status resolves.

Resident #54 was admitted with diagnoses including Alzheimer's Disease, Atrial Fibrillation, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview could not be completed due to Resident #54's severe cognitive impairment. Resident #54 was on a mechanically altered therapeutic diet and required supervision or touching assistance (the helper provides verbal cues and/or touching/steadying and/or contact guard assistance as the resident completes the activity. Assistance may be provided throughout the activity or intermittently) for eating. The resident's height was 60 inches and weight was 99 pounds. The resident did not have a weight gain or weight loss of 5% in one month or 10% in six months of the assessment period.

The Comprehensive Care Plan effective 8/05/2024 last reviewed 11/19/2024 documented the resident had a high nutritional risk secondary to chewing difficulty. The interventions included monitoring weights monthly/weekly and monitoring oral intake of food and fluids.

A Physician's order dated 8/05/2024 and revised on 10/30/2024 with an end date of 1/7/2025 documented a puree texture, Nectar Thickened Liquids consistency diet, for the Planned Weight Gain Regimen.

A Physician's order dated 08/05/2024 and revised on 10/30/2024 with an end date of 1/6/2025 documented Ensure Clear (a high-calorie drink) two times a day by mouth, thickened to nectar thick consistency, Aspiration Precautions, and planned weight gain regimen.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Dietician progress note dated 11/05/2024 documented Quarterly nutritional assessment. The resident was on a no-salt added diet with puree consistency and nectar thick liquids and was on weekly weights. The resident's weights were: on 8/3/2024 the resident weighed 105.2 pounds; on 10/7/2024 the resident's weight was 99.2 pounds; on 10/23/2024 the resident weighed 98 pounds; and on 11/5/2024 the resident weighed 99 pounds. The resident's weight increased by one pound in 2 weeks and was stable in 30 days; however, there was a 6.2 pounds (5.8%) weight loss in 90 days. The weight loss was not desirable. The resident was receiving additional food items for weight stability/weight gain. The recommendation was to monitor weights and oral intake. The Weights and Vitals Sign Summary documented on 11/17/2024 the resident weighed 132 pounds; however, the weight was crossed off and no reweigh was documented for November 2025. On 12/12/2024 the resident weighed 89 pounds which was a 10% weight loss in one month since 11/5/2024. The resident's weight on 1/07/2024 was recorded as 83 pounds which was an additional 7% weight loss since 12/12/2024. A dietary progress note dated 12/16/2024, written by Registered Dietitian #1, documented the resident's weight decreased by 10 pounds in 30 days (10%). Registered Dietitian #1 documented they observed the resident on meal rounds. The resident was consuming only a few bites of lunch and a few sips of nectar thick liquids. The plan was to continue monitoring the weekly weights, oral intake, and tolerance of supplements. The medical record lacked documented evidence of weekly weights in November and December 2024. A physician progress note dated 12/16/2024, written by Primary Physician #1, documented Resident #54 was seen and examined. The resident's weight was 89 pounds on 12/12/2024. The resident was at risk for Malnutrition. A Physician's order dated 12/19/2024 Infuvite Adult Intravenous Injectable (Multiple Vitamin) intravenously one time a day for Vitamin Insufficiency for 3 Days. Administer into a 500-milliliter bag of normal saline daily for 3 days. A physician's progress note dated 1/03/2025, written by Nurse Practitioner #1 documented staff requested to evaluate Resident #54 for poor appetite. A Calorie Count was ordered for 3 days. The resident would continue to receive Ensure supplement. Nurse Practitioner #1 documented they will reevaluate the resident at the end of the calorie count and will discuss the goals of care with the family. The Calorie Count was not initiated until 1/6/2025. The Certified Nursing Assistant Accountability Record for Resident #54's meal intake in December 2024 documented that Resident #54 consumed 0-75% of their meals. For January 2025, Resident #54 consumed 25-75% of their meals. During an observation and interview on 1/08/2025 at 11:52 AM, Resident #54 was observed sitting in a Geri chair. Certified Nursing Assistant #2 was feeding Resident #54 their lunch meal. The resident fell asleep during the meal and ate less than 25% of their lunch. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Grand Pavilion for Rhb & Nrsg at Rockville Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE: 41 Maine Avenue, Rockville Centre, NY 11570	

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/07/2025 at 2:59 PM, Registered Dietician #1 stated Resident #54 had a 10% weight loss in one month in December 2024. Registered Dietician #1 stated the resident was diagnosed with COVID-19 infection in December 2024 and they thought the weight loss was related to COVID-19 infection. Registered Dietician #1 stated the resident lost 10 % of weight in one month; however, they did not change the resident's plan of care. They stated they should have changed the Ensure Clear from twice a day to three times a day on 12/12/2024 when they first identified the weight loss. Registered Dietician #1 stated the Dieticians are responsible for monitoring the resident's weight, assessing the resident for weight loss, notifying the Physician, and providing nutritional interventions to prevent further weight loss. During an interview on 1/07/2025 at 3:40 PM, Chief Dietician #1 stated Resident #54 had a significant weight loss in December 2024. Registered Dietician #1 was expected to make changes to the resident's nutritional plan of care and should have provided increased protein and calories. Resident #54's weekly weights should have been obtained as recommended by Registered Dietician #1. During an interview on 1/10/2025 at 9:24 AM, Primary Physician #1 stated they stated, they were made aware of Resident #54's weight loss. Resident #54 had a COVID-19 infection and was treated with intravenous fluids and intravenous antibiotics. Primary Physician #1 stated they follow the the Dietician's recommendations to increases and decreases the diet and supplements. Primary Physician #1 stated stated they did not documented a weight change in their notes; however, they provided orders to administer intravenous fluids to Resident #54 for hydration. 10 NYCRR 415.12(i)(1)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and staff interviews during the Recertification Survey initiated on 1/5/2025 and completed on 1/10/2025 the facility did not ensure Intravenous antibiotics were administered consistent with professional standard of practice and in accordance with physician's orders and the comprehensive person-centered care plan. This was identified for two (Resident #336 and Resident #285) of two residents reviewed for Urinary Tract Infection. Specifically, 1) Resident #336 had a Midline Intravenous Catheter (a type of peripheral intravenous access, flexible tube inserted into a vein in the upper arm) on the left arm. There were no physician orders for monitoring and flushing the Midline Intravenous Catheter. 2) Resident #285 was observed with a peripheral intravenous catheter (Midline Intravenous Catheter) in their right arm. There were no physician orders for monitoring and flushing of the Midline Intravenous Catheter. The findings are: The facility's policy titled Intravenous Infusion, last revised on 12/10/2024 documented that intravenous sites are checked every four hours and as needed for signs and symptoms of infection or inflammation. The Nurse will assess associated risks due to intravenous fluid administration such as infiltration (when fluids leak out into the tissue under the skin) and infection. The intravenous documentation is recorded in the Nurses' notes and/or Medication Administration Records. Flush vascular access device with normal saline. Resident #336 was admitted with diagnoses including Urinary Tract Infection, non-Hodgkin lymphoma (a type of cancer that develops in the lymph nodes), and Fracture of the Right Pubis (front portion of the hip bone). The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severely impaired cognition. The Minimum Data Set (MDS) assessment documented Resident #336 was incontinent of urine. A Physician's order dated 12/31/2024 documented Unasyn Injection Solution (an antibiotic that treats bacterial infection) three grams intravenously every eight hours for Urinary Tract Infection for seven days. There were no documented Physician's Orders to monitor and flush the Midline Intravenous Catheter until 1/8/2025. There was no Physician's Order to insert the Midline Intravenous Catheter and Midline Intravenous Catheter site dressing until 1/13/2025. A review of Resident #336's Electronic Medical Administration Record (EMAR) revealed there was no documentation that Resident #336's Midline Intravenous Catheter site was assessed for infiltration (when some of the fluid leaks out into the tissues under the skin where the tube has been put into the vein) and flushed with saline before 1/8/2025 per the facility policy. A review of Resident #336's Progress notes from 12/31/2024 to 1/7/2025 revealed that the Medication Nurses were not consistently documenting that Resident #336's left arm Midline Intravenous Catheter site was assessed for any infiltration and signs of infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan (CCP) dated 12/31/2024 and revised on 1/8/2025 documented that Resident #336 had a Midline Intravenous Catheter on the left arm. The intervention included an assessment of the Midline Insertion site for redness, tenderness, and swelling. Resident #336 was observed on 1/5/2025 at 9:45 AM in bed. Resident #336 was receiving medication intravenously via the left arm Midline Intravenous Catheter. There was no redness or swelling around the Midline Intravenous Catheter site. During an interview on 1/8/2025 at 8:48 AM, Registered Nurse #3, Unit Supervisor stated they forgot to obtain an order to assess and flush Resident #336's Midline Intravenous Catheter. Registered Nurse #3 stated there should have been an order for the assessment and saline flush for Resident #336's Midline Intravenous Catheter. During an interview on 1/8/2025 at 12:00 PM, Licensed Practical Nurse #3 stated there should have been an order for the assessment of the intravenous site which included redness, swelling, and inflammation. Licensed Practical Nurse #3 stated they (Licensed Practical Nurse #3) must have forgotten to document the assessment in Resident #336's Progress Notes. During an interview on 1/8/2025 at 12:08 PM, the Director of Nursing Services stated an intravenous catheter site should be assessed for signs of infiltration and signs of infection every shift as per facility policy. The Director of Nursing Services stated they expected the nurses to document the assessment in the resident's Progress Note every shift while the resident was receiving intravenous fluids or intravenous antibiotics. 48827 2) Resident #285 had diagnoses that included Urinary Tract infection, Chronic Kidney Disease, and Obstructive and Reflux Uropathy ((a condition that prevents urine from flowing normally through the urinary tract)). The Minimum Data Set assessment dated [DATE] documented Resident #285 had a Brief Interview for Mental Status score of 4, indicating severe cognitive impairment. The Minimum Data Set did not document that Resident #285 was admitted to the facility with an intravenous catheter. A Physician's order dated 1/02/2025 documented Midline Intravenous Catheter insertion. A Physician's order dated 1/02/2025 documented Ceftriaxone Sodium Solution (antibiotic) 1 gram intravenously every 12 hours for 7 days for infection. The Medication Administration Record for January 2025 documented the resident received intravenous antibiotics. There was no documentation regarding the assessment, monitoring, or flushing of the Midline Intravenous Catheter. The Treatment Administration Record for January 2025 did not include documentation related to an assessment monitoring, or flushing of the Midline Intravenous Catheter. During an observation on 1/5/2025 at 9:35 AM, Resident #285 was sleeping in bed with a Midline Intravenous Catheter in their right arm. The site appeared clean and dry. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 1/7/2025 at 10:51 AM, Resident #285 was sleeping in their bed with the midline intravenous catheter in their right arm. The site appeared clean and dry. During an interview on 1/7/2025 at 10:24 AM, Registered Nurse Unit Manager #4 stated the nurses were expected to assess the Midline Intravenous Catheter site and flush the catheter before and after administering intravenous medication each shift and document their findings in the medical record. Registered Nurse Unit Manager #4 stated there should be physician's orders to assess the site and to flush the intravenous catheter before and after intravenous medication administration. During an interview on 1/08/2025 at 12:01 PM, the Director of Nursing Services stated they expected nursing staff to ensure a physician's order for placement and the assessment of the intravenous catheter was present for residents with intravenous catheters in place. The Director of Nursing Services stated nurses on all shifts must assess the intravenous catheter site including flushing of the intravenous catheter and document in a progress note or the Medication Administration Record or the Treatment Administration Record. 10 NYCRR 415.12(k)(2)

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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 - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34798 Based on observations, record review, and interviews during the Recertification Survey, initiated on 1/5/2025 and completed on 1/10/2025, the facility did not ensure that pain management was provided to each resident who requires such services, consistent with professional standards of practice, and the comprehensive person-centered care plan. This was identified for one (1) (Resident #234) of four (4) residents reviewed for Pressure Ulcers. Specifically, Resident #234 had a Stage 3 pressure ulcer to the sacrum (a large, triangular bone at the base of the spine). The resident was heard from the hallway loudly complaining of pain and they wanted to die. The resident did not have a physician's order for pain medications. Interviews with the facility staff revealed the resident complained of pain since they developed a pressure ulcer. This resulted in actual harm that is not Immediate Jeopardy. The finding is: The facility's policy titled Pain Management, dated 10/2024, defined pain management as the process of alleviating the resident's pain based on their clinical condition and established treatment goals. Possible behavioral signs of pain include negative verbalizations and vocalizations such as groaning, crying, and screaming; facial expressions such as grimacing, frowning, clenching of the jaw; behavior changes such as resisting care, irritability, depressed mood; be aware the resident may avoid the term pain and use other descriptors such as throbbing, aching, hurting, cramping, numbness, or tingling; monitor the resident for presence of pain and need for further assessment when there is change in condition; assess the resident whenever there is a suspicion of new pain or worsening existing pain; review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including pressure, venous, or arterial ulcers; identify any situations where an increase in pain may be identified, such as treatment for wound care or dressing changes. Assessing pain includes the medical conditions and pain medications, the resident's goal for pain management, and their satisfaction with the current level of pain control. The medication regimen is implemented as ordered. The results of the interventions are documented and communicated directly to the provider when appropriate. Ongoing communication between the prescriber and staff is necessary for the optimal and judicious use of pain medications. Contact the prescriber immediately if the resident's pain or medication side effects are not adequately controlled. If pain has not been adequately controlled, the multidisciplinary team, including the Physician, shall reconsider approaches and make adjustments as indicated. The facility's policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol, dated 11/13/2024 documented the nurse shall document and report pain assessment; the physician will help identify medical interventions related to managing pain related to the wound or wound treatment. Resident #234 was admitted with diagnoses including cellulitis (skin infection) of the left lower leg, muscle weakness, Malnutrition, and difficulty walking. The 10/22/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 6, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented the resident had occasional, moderate pain and had received scheduled and as needed pain medications. The resident was able to make self understood and understands. The resident was dependent on staff for bed mobility and transfers and had no pressure ulcers. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A Comprehensive Care Plan titled, at risk for pain related to a decrease in mobility, recent hospitalization , effective 10/15/2024, documented to monitor, record, and report to the nurse any signs and symptoms of non-verbal pain including but not limited to vocalizations (grunting, moans, yelling out, silence), mood and behavior changes, more irritable, restless, aggressive, squirmy, constant motion, sad face, crying, worried, scared, grimacing, and thrashing, etc.; and to administer medications as ordered by the Physician. The physician's order dated 10/15/2024 documented to administer Oxycodone (pain medication) 5 milligrams, one tablet every 6 hours as needed for pain (location not specified) for seven days. The order was discontinued on 10/22/2024. A nursing progress note dated 12/18/2024, written by Registered Nurse #2 (the Unit Manager), documented the assigned Certified Nursing Assistant reported an open area to the resident's right buttocks. The resident was assessed by the wound nurse (Wound Care Registered Nurse #1) as a Stage 3 pressure ulcer-(full-thickness tissue loss indicating significant damage to the underlying tissue beneath the skin) to the right buttocks. Treatment was initiated. A Comprehensive Care Plan titled Open Area to Right Buttock, (Retitled to Sacral Stage 3), initiated on 12/18/2024, and last updated on 1/5/2025, documented an intervention to administer treatments/medications as ordered and to monitor for effectiveness. There was no documented evidence the resident was assessed for pain or was provided pain management related to the wound. A progress note dated 12/19/2024, written by Occupational Therapist #1, documented the resident was issued a pressure relieving cushion for the wheelchair to prevent skin breakdown and help alleviate pain from the wound on the right buttocks. A review of the Comprehensive Care Plan for the Sacral Wound revealed the pressure relieving cushion was not included. Nurse Practitioner #1's progress note dated 12/31/2024 documented the resident was seen for a medical follow-up. The resident was complaining that their buttocks burn. The resident had a sacral wound and was being managed by the wound care team and the plan was to continue Oxycodone for pain management. A review of the medical record revealed there was no current order on 12/31/2024 for Oxycodone. A physician's order dated 1/3/2024 documented Adaptive Device: Positioning triangle wedge to be placed on right/left side of trunk/hips when in bed. Reposition every 2 hours for pressure relief. During an initial tour observation on 1/5/2025 at 10:39 AM, Resident #234 was in their room and was heard from the hallway complaining in profane language that their buttocks hurt and saying, I want to die. During an interview on 1/5/2025 at 10:40 AM, Certified Nursing Assistant #4 stated Resident #234 complained of pain because of the wound. The resident also verbalized that the wound burns when the nurse puts the dressing on it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Pavilion for Rhb & Nrsg at Rockville Ctr	41 Maine Avenue Rockville Centre, NY 11570

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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 - Actual harm Residents Affected - Few	A physician's order dated 1/5/2025 at 10:44 AM, (received by Registered Nurse #2) documented to obtain a Psychiatry consult related to resident yelling on/off, and constant banging on their table. There was no documented evidence the physician was aware of the resident's complaint of pain. The pain level documented in the Medication Administration Record for the 7:00 AM-3:00 PM shift on 1/5/2025 was 0 (no pain). The Medication Administration Record did not indicate a specific time when the pain assessment was completed. A physician's order dated 1/6/2025 documented to administer Tylenol Oral Tablet 325 milligrams, two tablets by mouth half an hour before treatment, for pain. During an observation on 1/7/2025 at 8:45 AM, Resident #234 was observed in their room with facial grimacing and was complaining in profane language that their buttocks was hurting and they wanted to die. The resident was lying flat on their back. The positioning wedge was observed against the side rail and did not provide pressure relief to the resident. Registered Nurse Unit Manager #2 entered the resident's room and stated the positioning wedge was to prevent the resident from falling out of bed. Registered Nurse Unit Manager #2 stated they had to check with the Rehabilitation Department to see if the positioning wedge was meant to provide pressure relief. During an observation on 1/7/2025 at 8:57 AM, Licensed Practical Nurse #1 (the medication nurse) entered the room and administered two tablets to Resident #234. Licensed Practical Nurse #1 stated the tablets were 325 milligrams of Tylenol each. Licensed Practical Nurse #1 stated the positioning wedge was in place to prevent the resident from falling out of bed. Licensed Practical Nurse #1 did not ask the resident about their level of pain prior to providing the Tylenol and there was no documented follow up if the Tylenol was effective. During an observation and interview on 1/7/2025 at 9:00 AM, Registered Nurse Unit Manager #2 returned to Resident #234's room and stated they spoke to the Rehabilitation Department and the positioning wedge was meant to offload the sacral area and to provide pressure relief. Registered Nurse Unit Manager #2 and Licensed Practical Nurse #1 then left the resident's room without repositioning the resident or placing the positioning wedge under the resident. The resident continued with facial grimacing and complaints of pain in their buttock area. A review of the medical record indicated no documented follow-up regarding the resident's pain level after the Tylenol was administered on 1/7/2025 at 8:57 AM. The pain level documented on the Medication Administration Record, by Licensed Practical Nurse #1, for the 7:00 AM-3:00 PM shift on 1/7/2025 was 5 out of a scale of 10, with 0 being no pain and 10 being the worst possible pain. The Medication Administration Record did not indicate a specific time when the pain assessment was completed. During an observation and interview on 1/7/2025 at 9:04 AM, Certified Nursing Assistant #5 (assigned to Resident #234) entered the resident's room after being alerted of the resident's pain complaints. The resident was complaining in profane language of pain in the buttock area. Certified Nursing Assistant #5 repositioned a pillow under the resident and stated the positioning wedge was to keep the resident safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/10/2025
NAME OF PROVIDER OR SUPPLIER The Grand Pavilion for Rhb & Nrsg at Rockville Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 41 Maine Avenue Rockville Centre, NY 11570	

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an interview on 1/7/2025 at 2:10 PM, Occupational Therapist #1 stated during their therapy session with the resident on 12/19/2024, the resident was expressing pain and stated in profane language that their buttocks hurt. Occupational Therapist #1 stated they notified Registered Nurse Unit Manager #2 of the resident's complaint of pain. A nursing progress note, written by Registered Nurse Unit manager #2 , dated 1/7/2025 at 3:20 PM documented resident's family visited the resident and insisted on having stronger pain medication. A telephone order was received from the Physician for Tramadol (a narcotic pain reliever) 50 milligrams every 12 hours and Tylenol 650 milligrams by mouth every 6 hours. Review of the January 2025 Medication Administration Record revealed that a one-time dose of Tramadol 50 milligrams was ordered and administered on 1/7/2025 at 2:46 PM. The first standing dose was administered on 1/7/2025 at 9:00 PM. During an interview on 1/8/2025 at 9:26 AM, Certified Nursing Assistants #4 and #6 stated the resident always says in profane language that their buttocks hurt. The resident has been complaining of pain since they were admitted . Certified Nursing Assistants #4 and #6 stated the nurses and the supervisor were aware because they provided wound care and medications to the resident. During an interview on 1/8/2025 at 9:37 AM, Registered Nurse Unit Manager #2 stated the Certified Nursing Assistants never told them that Resident #234 was having pain. Occupational Therapist #1 ordered the pressure relieving cushion for Resident #234; however, they were not informed the resident was having pain. During a re-interview on 1/8/2025 at 10:19 AM, Wound Care Registered Nurse #1 stated Resident #234 did not have orders for pain medication before the treatment changes until 1/6/2025 Wound Care Registered Nurse #1 stated they assessed Resident #234 when the resident was first identified with a Stage 3 pressure ulcer on 12/18/2024; however, they did not get an order for pain management, because it was the charge nurse's responsibility. Wound Care Registered Nurse #1 could not recall if the resident was complaining of pain. Wound Care Registered Nurse #1 stated residents with a Stage 3 or Stage 4 pressure ulcer should have orders for pain medications to be administered before a wound care treatment. A Pressure Injury Investigation and Audit Form dated 12/18/2024 prepared by Wound Care Registered Nurse #1 documented no entry for Date of Last Pain Evaluation and no entry for Was there any immobility related to pain status? During an interview on 1/8/2025 at 11:05 AM, Certified Nursing Assistant #7 stated the resident always verbalized that they were always in pain. Resident #234 often stated they want to die and help me. A review of the December 2024 Medication Administration Record revealed the resident's pain level ranged from 0 (no pain) to 2 (mild pain) out of 10 on a pain scale (a score of 0 indicating no pain and a score of 10 indicating the highest amount of pain one can experience). The Medication Administration Record did not indicate a specific time when the pain assessment was completed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Actual harm Residents Affected - Few	During Resident #234's wound care observation on 1/8/2025 at 1:15 PM, Licensed Practical Nurse #5 performed the wound care and they were assisted by Wound Care Registered Nurse #1. When Licensed Practical Nurse #1 started the sacral wound care treatment, Resident #234 appeared very sensitive to touch. The resident flinched, grimaced, pulled their body away from the nurse, and stated the treatment hurt. The resident was yelling You are burning me when the wound was touched and cleansed. The resident was saying they wanted to die. The nurses stopped the treatment because of the resident's discomfort. Licensed Practical Nurse #5 stated they gave the resident Tylenol at 12:30 PM. Wound Care Registered Nurse #1 stated they would have to call the Physician for additional pain medication. A review of the Medication Administration Record for 1/8/2025 for the 7:00 AM - 3:00 PM shift revealed a pain level of 2 out of 10 entered by Licensed Practical Nurse #5. The Medication Administration Record did not indicate a specific time when the pain assessment was completed. A nursing progress note written by Wound Care Registered Nurse #1 dated 1/8/2025 at 3:09 PM documented the resident was seen today for a dressing change at 1:15 PM; they were premedicated with pain medication (Tylenol), 30 minutes before the dressing change. The resident complained of pain during repositioning and repeatedly stated I want to die. During the dressing change, the resident complained of burning when [the wound was] cleansed with normal saline and repeated, I want to die. The treatment was stopped, and the Physician was notified that the resident was complaining of pain during positioning and burning during the treatment change. Tramadol immediate dose was ordered and given. The resident was revisited at 2:35 PM for a dressing change; they still complained of burning during treatment. Treatment was completed. During an interview on 1/8/2025 at 1:47 PM, Nurse Practitioner #1 stated they saw the resident for a medical follow-up on 12/31/2024. The resident complained of pain to their buttocks area. Nurse Practitioner #1 stated at the time of the assessment they did not realize the Oxycodone order was discontinued and that the resident did not have any other pain medication orders. The resident should have had pain medication management because they had pain per their assessment. Nurse Practitioner #1 further stated the resident had a Stage 3 pressure ulcer and should be medicated prior to wound treatment, as per the facility protocol. During an interview on 1/8/2025 at 2:27 PM, the Director of Nursing Services stated the nursing staff should have reported the resident's pain to the Nurse Manager, who should then have called the Physician for pain medication orders. Additionally, the staff should have utilized the positioning wedge to offload the wound as per the Rehabilitation Department's recommendation to minimize pain. The Director of Nursing Services stated the medical provider should have initiated pain medication orders when the wound was first identified, and the nurses should assess for pain prior to providing treatment and routinely due to the Stage 3 sacral ulcer. During an interview on 1/10/2024 at 9:24, Physician #2 (the resident's Attending Physician) stated when a resident expresses verbal or non-verbal complaints of pain, the medical provider should have ensured the pain medication orders were put in place and the facility staff should have reported the resident's pain complaints to the Physician. 10 NYCRR 415.12