| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335301 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| St James Rehabilitation & Healthcare Center | 275 Moriches Road<br>St James, NY 11780 |

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) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during a recertification survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that a comprehensive person-centered care plan was developed for each resident that included measurable objectives and timeframes to meet each resident's medical and nursing needs. This was identified for one (1) (Resident #24) of two (2) residents reviewed for Respiratory care. Specifically, Resident #24 has a physician's order for 2 liters of continuous oxygen therapy via nasal cannula. There was no documented evidence that a comprehensive person-centered care plan was developed related to the use of oxygen therapy. The finding is:The facility's policy titled Care Plans Comprehensive Person-Centered dated 12/01/2022 documented the comprehensive person-centered care plan includes measurable objectives and time frames. Describes the services to be furnished to attain or maintain the resident's highest practical physical, mental and psychosocial well-being.The facility's policy titled Oxygen Administration dated 08/2025 documented to verify the physician's order and review the resident's care plan.Resident #24 was admitted with diagnoses that included pneumonia, dementia, and major depressive disorder. The Minimum Data Set assessment dated [DATE] documented Resident #24 had a Brief Interview for Mental status score of 00, indicating the resident had severe cognitive impairment. The Minimum Data Set assessment documented the resident received oxygen therapy.A physician's order dated 11/18/2025 documented oxygen therapy 2 liters per minute via nasal cannula, continuously.A review of Resident #24's comprehensive care plans revealed there were no care plans developed to address the resident's use and need for the oxygen therapy. During an observation on 12/03/2025 at 10:43 AM, Resident #24 was sitting in a wheelchair in their room with a nasal cannula applied to their nose and connected to an oxygen concentrator (a medical device that provides supplemental concentrated oxygen). Resident #24 was not interviewable. During an observation on 12/08/2025 at 10:12 AM, Resident #24 was observed sitting in a wheelchair with a nasal cannula applied to their nose and connected to an oxygen concentrator.During an interview on 12/08/2025 at 10:13 AM, the Registered Nurse Manager #1 stated there should be a care plan in place for the resident's use of oxygen therapy. Registered Nurse Manager #1 stated the resident's care plan should have been created when the physician's order for oxygen therapy was entered in the electronic medical record. Registered Nurse Manager #1 stated they were responsible for updating care plans and should have updated Resident #24's care plan to address the use of oxygen therapy.During an interview on 12/09/2025 10:17 AM, the Director of Nursing Services stated the resident's care plan should have been developed when the physician's order for oxygen therapy was entered into the electronic medical record. The Director of Nursing Services stated the nurse manager, or the nurse supervisor can update the care plans. 10 NYCRR 415.11(c)(1) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews during a recertification survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (1) of seven (7) residents reviewed for Pressure Ulcers. Specifically, Certified Nursing Assistant #1, who was not qualified to provide wound care treatment, was observed providing a wound care treatment to Resident #98's stage 3 pressure ulcer during morning care on 12/03/2025. Cross reference F880 Infection Control The finding is: Resident #98 was admitted with diagnoses including non-pressure chronic ulcer of the left calf (back of the lower leg), peripheral vascular disease, and atrial fibrillation. The admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The resident was at risk for developing pressure ulcers and had one (1) Stage 2 pressure ulcer that was present upon admission. The resident was always continent of urine and was occasionally incontinent of bowel.The physician's orders dated 12/02/2025 documented to topically apply medihoney wound dressing external gel (wound dressings) to bilateral buttocks and sacral area every day and during the evening, after a normal saline cleanse followed by a silicone dressing shift for the wound healing. During an observation and interview on 12/03/2025 at 10:30 AM, Resident #98 was lying in their bed. The bed side table was observed with a four (4) inch by four (4) inch border gauze dated 12/03/2025 with a nurse's initials. The gauze was noted with a white substance on it. The resident stated the nurse left the gauze on the table for Certified Nursing Assistant #1 to apply on their (resident's) buttocks after the bed bath.During a morning care observation on 12/03/2025 from 10:48 AM to 11:10 AM, Certified Nursing Assistant #1 provided a bed bath to Resident #98. The resident's pressure ulcers to the sacrum and the buttocks did not have a cover dressing on. Certified Nurse Assistant #1 cleansed the resident's uncovered pressure ulcers with a soiled towel that was used to clean the resident's genital area.During an interview on 12/03/2025 at 11:13 AM, Certified Nursing Assistant #1 stated some nurses leave the wound care treatment on the resident's bedside table for the Certified Nursing Assistant to apply after they provide the resident with a bed bath. Certified Nursing Assistant #1 stated they were not trained to do the wound care; they were just helping the nurses.During an interview on 12/03/2025 at 11:25 AM, Licensed Practical Nurse #6 stated they completed Resident #98's wound care treatments in the morning. Licensed Practical Nurse #6 stated they do not allow Certified Nursing Assistants to apply wound treatments because Certified Nursing Assistants are not qualified to do the wound care.During an interview on 12/09/2025 at 02:00 PM, the Director of Nursing Services stated only nurses are allowed to complete the wound care treatments. The Director of Nursing Services stated nurses should handle the wound care since they are skilled in infection control and can accurately follow the physician's orders.10 NYCRR 415.11(c)(3)(i) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure each resident with pressure ulcers received necessary services consistent with standards of practices to promote healing and prevent infection. This was identified for one (1) (Resident #98) of seven (7) reviewed for pressure ulcers. Specifically, Resident #98 was admitted with a stage two pressure ulcer to right buttocks on 11/26/2025 and there was no documented evidence that wound treatment was ordered and provided to the resident's pressure ulcer until 12/02/2025.The finding is: The Facility Policy for admission assessment dated [DATE] documented to contact the attending physician to communicate and review the findings of the initial assessment and other pertinent information and obtain admission orders that are based on these findings. Notify the supervisor and the attending physician of any immediate needs that the resident may have. The Facility's Pressure Injury Overview Policy dated 03/06/2025 documented it is the responsibility of the nursing staff to monitor, provide care, manage, report, and document all wounds including the development of new wounds and/or pressure injuries. Resident #98 was admitted with diagnoses including non-pressure chronic ulcer of the left calf (back of the lower leg), peripheral vascular disease, and atrial fibrillation. The admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The resident was at risk for developing pressure ulcers and had one (1) Stage 2 pressure ulcer that was present upon admission. The resident was always continent of urine and was occasionally incontinent of bowel. The Admission/readmission Evaluation dated 11/26/2025 documented Resident #98 had a pressure ulcer to their right buttock. The resident's right buttock had loss of dermis (top layer of skin) and presented as a shallow open ulcer with a red/pink wound bed. The Care Plan dated 11/26/2025 for at risk for pressure injury development documented intervention to administer treatments and medications as ordered and monitor for effectiveness. There was no baseline care plan developed specific to the Stage 2 pressure ulcer to the right buttock. The admission physician's orders dated 11/26/2025 documented weekly skin checks.A review of the physician's orders from 11/26/2025 to 12/02/2025 revealed there were no wound care treatment orders to address the pressure ulcer identified on admission.The physician visit note dated 11/29/2025 at 13:13 documented the resident had a right buttock ulcer. The note did not indicate any treatment recommendations for the right buttock ulcer.A review of the physician's orders from 11/26/2025 to 12/02/2025 revealed there were no wound care treatment orders to address the pressure ulcer identified on admission. A review of the Treatment Administration Record from 11/26/2025 to 12/02/2025 indicated no treatments were provided to the resident's right buttock pressure ulcer. The wound care evaluation dated 12/02/2025 documented Resident #98 had a stage 3 pressure ulcer to the right buttock pressure ulcer that measured 2.3 centimeters in length 2.9 centimeters in width and 0.1 centimeters depth. The wound had 100 percent granulation with light exudate. The physician's orders dated 12/02/2025 documented to topically apply medihoney wound dressing external gel (wound dressings) to the buttocks every day and during the evening after a normal saline cleanse followed by a silicone dressing shift for wound healing. During an interview on 12/03/2025 at 11:25 AM, Licensed Practical Nurse #6 stated they did not know that Resident #98 had a pressure ulcer to the right buttocks and were not able to provide a treatment for Resident #98's pressure ulcers because there were no physician's orders. During an interview on 12/05/2025 at 11:14 AM, Wound Care Nurse #1 stated the admission nurse identified that Resident #98 had a Stage 2 pressure ulcer on the right buttock on 11/26/2025 and there was no physician's order for a treatment until they (Wound Care Nurse #1) assessed Resident #98 on 12/02/2025. Wound Care Nurse #1 stated they did not work in the facility until 12/01/2025 due to the holiday. Wound Care Nurse #1 stated the admission nurse should have notified the Physician on 11/26/2025 and obtained a treatment order for<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the identified pressure ulcer. During a wound care observation for Resident #98 on 12/08/2025 at 10:00 AM with the Wound Care Nurse #, the right buttock wound appeared to be dime size. The wound bed was noted to be pink in color with no drainage or signs of infection. The peri wound area was normal to the resident's skin tone. During an interview on 12/08/2025 at 10:54 AM, Registered Nurse Supervisor #2 stated they admitted Resident #98 on 11/26/2025; however, they were not responsible for obtaining the physician's orders. Registered Nurse Supervisor #2 stated Resident #98's had a Stage 2 pressure ulcer on the right buttock on the admission. Registered Nurse Supervisor#2 stated after they assessed the resident's buttocks, they cleansed the pressure ulcer with normal saline and covered the area with a dry protective dressing. Registered Nurse Supervisor #2 stated another nurse (name not recalled) called the Physician to obtain orders that were recommended by the hospital. Registered Nurse Supervisor #2 stated the hospital did not recommend a pressure ulcer treatment. Registered Nurse Supervisor #2 stated they did not communicate with the nurse who entered the hospital recommended physician's orders in the medical record. Registered Nurse Supervisor #2 stated the Wound Care Nurse typically evaluates the resident the next day and obtains physician orders for the appropriate treatments. Registered Nurse Supervisor #2 stated they assumed the Wound Care Nurse was going to assess the resident the following morning and would enter the treatment orders for the pressure ulcer.During an interview on 12/09/2025 at 11:07AM Nursing Supervisor #5 stated they worked on 11/26/2025 until 11:00 PM and called the Physician to obtain the admission orders for Resident #98. The Primary Physician approved all the medications that were listed in the hospital discharge papers. Nursing supervisor#5 stated they usually did not look at the admission skin assessment; however, they verbally communicate with the admission assessment nurse to see if the resident needs additional treatment orders. Nursing supervisor #5 stated on 11/26/2025 they left the facility before the admission nurse (Nursing Supervisor #2) completed the admission assessment for Resident #98 therefore they did not communicate and obtain the treatment orders for the resident's pressure ulcer.During an interview on 12/09/2025 at 12:25 PM, Primary Care Physician#1 stated that on 11/29/2025, they evaluated Resident #98 and obtained information about Resident #98's right buttock stage 2 pressure ulcer. Primary Care Physician #1 stated they do not follow the wound care evaluations and treatment orders. Primary Care Physician #1 stated they assumed there was a physician's order for the resident's wound care treatment. Primary Care Physician#1 stated at the end of the day, they were responsible for all physician orders and should have ensured there was a treatment order in place for the resident's pressure ulcer.During an interview on 12/09/2025 at 2:00PM, The Director of Nursing Services stated Resident #98 should have received wound care treatments from admission. The Director of Nursing Services stated that the resident's Physician and nurses should have ensured a treatment order was in place for the wound treatment. 10 NYCRR 415.12(c)(1) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that the medical care of each resident was supervised by a Physician. This was identified for one (1) (Resident #98) of seven (7) residents reviewed for Pressure Ulcers. Specifically, a stage 2 pressure ulcer to Resident #98's right buttocks was identified upon admission on [DATE]. The attending physician did not evaluate the wound and did not ensure that treatment orders were in place until 12/02/2025.The finding is: The facility physician services policy dated 03/06/2025 documented a Physician supervising the medical care of residents includes (but not limited to): prescribing medications and therapy, conducting routine requires visits, monitoring changes in residents' medical status, providing consultation or treatments when called by the facility, and overseeing a relevant plan of care for the residents.Resident #98 was admitted with diagnoses including non-pressure chronic ulcer of the left calf (back of the lower leg), peripheral vascular disease, and atrial fibrillation. The admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The resident was at risk for developing pressure ulcers and had one (1) Stage 2 pressure ulcer that was present upon admission. The resident was always continent of urine and was occasionally incontinent of bowel.The Admission/readmission Evaluation dated 11/26/2025 documented Resident #98 had a pressure ulcer to their right buttock. The resident's right buttock had loss of dermis (top layer of skin) and presented as a shallow open ulcer with a red/pink wound bed.The Care Plan dated 11/26/2025 for at risk for pressure injury development documented intervention to administer treatments and medications as ordered and monitor for effectiveness. There was no baseline care plan developed specific to the Stage 2 pressure ulcer to the right buttock.The admission physician's orders dated 11/26/2025 documented weekly skin checks.A review of the physician's orders from 11/26/2025 to 12/02/2025 revealed there were no wound care treatment orders to address the pressure ulcer identified on admission.The physician visit note dated 11/29/2025 at 13:13 documented the resident had a right buttock ulcer. The note did not indicate any treatment recommendations for the right buttock ulcer.A review of the physician's orders from 11/26/2025 to 12/02/2025 revealed there were no wound care treatment orders to address the pressure ulcer identified on admission.A review of the Treatment Administration Record from 11/26/2025 to 12/02/2025 indicated no treatments were provided to the resident's right buttock pressure ulcer. The wound care evaluation dated 12/02/2025 documented Resident #98 had a stage 3 pressure ulcer to the right buttock pressure ulcer that measured 2.3 centimeters in length 2.9 centimeters in width and 0.1 centimeters depth. The wound had 100 percent granulation with light exudate. The physician's orders dated 12/02/2025 documented to topically apply medihoney wound dressing external gel (wound dressings) to the buttocks every day and during the evening after a normal saline cleanse followed by a silicone dressing shift for wound healing. During an interview on 12/05/2025 at 11:14 AM, Wound Care Nurse #1 stated the admission nurse identified that Resident #98 had a stage 2 pressure ulcer on the right buttock on 11/26/2025 and there was no physician's order for a treatment until they (Wound Care Nurse #1) assessed Resident #98 on 12/02/2025.During an interview on 12/09/2025 at 12:25 PM, Primary Care Physician#1 stated that on 11/29/2025, they evaluated Resident #98 and obtained information about Resident #98's right buttock stage 2 pressure ulcer. Primary Care Physician #1 stated they do not follow the wound care evaluations and treatment orders. Primary Care Physician #1 stated they assumed there was a physician's order for the resident's wound care treatment. Primary Care Physician#1 stated at the end of the day, they were responsible for all physician orders and should have ensured there was a treatment order in place for the resident's pressure ulcer.During an interview on 12/09/2025 at 2:00PM, The Director of Nursing Services stated Resident #98 should have received wound care treatments from admission. The<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Director of Nursing Services stated that the resident's Physician and nurses should have ensured a treatment order was in place for the wound treatment. 10 NYCRR 415.15(b)(1)(i)(ii) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that Nurse Aides were able to demonstrate competency in skills and techniques necessary to care for the resident's need. This was identified for one (1) (Resident #1) of one (1) resident reviewed for Accidents. Specifically, Resident #1 reported that they sustained an injury to their left great toe to Certified Nursing Assistant #2 on 12/04/2025; however, there was no documented evidence that Certified Nursing Assistant #2 reported the resident's injury to the nurse.The finding is: The facility policy on Accidents/Incidents last revised 04/2013 documented the facility shall provide a safe and secure environment for staff and residents. Staff who witness an accident/incident shall report the incident to the nursing supervisor as soon as practicable to ensure that an appropriate assessment occurs and that medical attention is obtained, as needed.Resident #1 was admitted with diagnoses that included peripheral vascular disease (a circulatory problem where narrowed blood vessels reduce blood flow to your limbs) and diabetes mellitus. A 5-Day Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The resident had no behavioral symptoms and was dependent on staff for bed mobility and transfers. The resident was able to wheel themself 50 feet to 150 feet once seated in a wheelchair. During an observation on 12/04/2025 at 11:06 AM, Resident #1 was observed seated on the side of the bed with their feet on the floor. The resident was not wearing socks at the time of the observation. A hematoma (blood pooled under the skin) was observed on the left great toenail. Resident #1 stated that someone rolled over their toe with a wheelchair during a music program. The resident was unable to give the date and time of the incident. Resident #1 stated at the time of the incident their toe did not hurt, and they did not know the toe would become discolored.During an interview on 12/08/2025 at 9:00 AM, Certified Nursing Assistant #2 stated they cared for the resident on Wednesday 12/03/2025 and they did not see the discoloration on the resident's left big toe. Certified Nursing Assistant #2 stated on Thursday 12/04/2025, the resident showed them the discoloration on their left great toe and did not complain of pain. Certified Nursing Assistant #2 stated they did not think it was a big deal. Certified Nursing Assistant #2 stated they did not report the hematoma to anyone because the regular nurse was not on duty that day. Certified Nursing Assistant #2 stated that the resident was not complaining of pain therefore, they did not report it to the nurse. Certified Nursing Assistant #2 further stated that they should have reported the injury to the resident's toe to the nurse. A Review of the Certified Nursing Assistant Task for skin observation dated 11/25/2025-12/07/2025 was completed and there was no documentation of the discoloration to the resident's toe on 12/04/2025.During an interview on 12/08/2025 at 09:20 AM, Licensed Practical Nurse #7 stated they were not made aware of the resident's left great toe discoloration. Licensed Practical Nurse #7 stated that Certified Nursing Assistant #2 should have reported the discoloration to the nurse. During an interview on 12/09/2025 at 10:18 AM, the Director of Nursing Services stated Certified Nursing Assistant #2 should have reported the change in resident's skin condition to the nurse. The Director of Nursing Services stated that it was not the Certified Nursing Assistant's responsibility to decide what was a big deal, and that they must report any changes in the residents' in skin condition to the nurse. 10 NYCRR 415.26(c)(1)(iv) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that all medications and biologicals were stored in locked compartments. This was identified for one (1) (Unit 2 North, B medication cart) of four (4) units reviewed during the Medication Storage Task. Specifically, the medication cart for Unit 2 North (B cart) was observed with an unlabeled souffle cup containing one tablet of Januvia 25 milligrams (a medication to lower blood sugar in an adult with type 2 Diabetes Mellitus) in the top drawer. Licensed Practical Nurse #3 confirmed that Resident #49 refused their 06:00 AM Januvia 25 milligrams dose, and instead of discarding the medication, the nurse stored the medication in an unlabeled souffle cup in the medication cart.The finding is:The undated facility policy titled Medication Labeling Storage documented medications are stored in an orderly manner to prevent the possibility of mixing medications of several residents. Resident #49 was admitted with diagnoses that included type 2 diabetes mellitus, chronic obstructive pulmonary disease (a lung condition that blocks the airflow making it difficult to breath), and heart failure. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10, indicating the resident had moderately impaired cognition. A physician's order dated 05/24/2025, documented Januvia 25 milligrams oral tablet give one tablet by mouth, once a day, for Diabetes Mellitus.During an observation on 12/04/2025 at 06:16 AM, the top drawer of the B medication cart on Unit 2 North had a souffle cup containing one orange tablet. A review of the December 2025 Medication Administration Record for Resident #49 documented Resident #49 received their 06:00 AM dose of Januvia on 12/04/2025. During an interview on 12/04/2025 at 06:16 AM, Licensed Practical Nurse #3 stated they attempted to administer the Januvia tablet to Resident #49 and the resident refused the medication because they preferred to continue sleeping. Licensed Practical Nurse #3 stated they should have discarded the tablet and should not have placed the prepared medication back in the medication cart. Licensed Practical Nurse #3 stated they did not discard the tablet because they wanted to reapproach the resident when the resident woke up.During an interview on 12/04/2025 at 06:19 AM, Registered Nurse Supervisor #2 stated the medication nurse should have discarded the refused medication and should not have stored the medication in an unlabeled souffle cup in the medication cart. During an interview on 12/05/2025 at 07:35 AM, the Director of Nursing Services stated the nurses should not store prepared medication in a souffle cup in the medication cart. The Director of Nursing Services further stated the nurse should discard the refused medication and reapproach the resident when the resident is ready to take their medication.10 NYCRR 415.18 (d)(e) (1-4) |

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| | 335301 | A. Building<br>B. Wing | 12/09/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St James Rehabilitation & Healthcare Center | 275 Moriches Road<br>St James, NY 11780 |

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) |
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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that residents receive and consume foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician and/or assessed by the interdisciplinary team to support the resident's treatment, plan of care, in accordance with their goals and preferences. This was identified for one (1) (Resident #206) of seven (7) residents reviewed for Nutrition. Specifically, Resident #206 had a physician's order for thin liquids and a therapeutic no added salt diet with a mechanically altered chopped texture, related to the diagnosis of heart failure. During the breakfast and lunch meal service on 12/05/2025, Resident #206 was provided with regular diet meals with a mechanically altered chopped texture with additional salt packets on the meal trays.The finding is:The facility's undated policy titled Therapeutic Diets documented a therapeutic diet must be prescribed by the residents attending physician. Diet order must match the terminology used by the food and nutrition services department. A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietician as part of a treatment for a disease or clinical conditions.Resident #206 was admitted with diagnoses that included Heart Failure, Hypertension, and Ulcerative Colitis. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. Resident #206 was on a therapeutic diet that was mechanically altered.The current physician's order documented no added salt diet, mechanically altered chopped texture, thin liquids consistency related to heart failure.A Comprehensive Care Plan dated 10/05/2025 documented Resident #206 was at high nutrition/hydration risk related to mechanically altered diet. Interventions included to provide the resident a no added salt diet as prescribed.A dietary progress note dated 10/07/2025 documented Resident #206 was prescribed a no added salt diet.During an observation and interview on 12/03/2025 at 10:55 AM, Resident #206 was sitting in their wheelchair in their room. Resident #206 stated they are supposed to be on a no added salt diet, but they were getting the incorrect meals. Resident #206 stated sometimes they do not eat because of the salt in their meals. Resident #206 stated they told the nursing staff they were getting wrong food, but it has not changed. During an observation and interview on 12/05/2025 at 8:07 AM, Resident #206 was sitting in a wheelchair in their room eating breakfast. Resident #206 consumed the oatmeal and some of the eggs on the breakfast tray. A salt packet was observed on the meal tray. Resident #206 stated they were not supposed to have salt; they do not use the salt packets and did not know why they receive the salt packets on their meal tray.A meal ticket dated 12/05/2025 for Resident #206 documented breakfast regular-mechanically altered chopped diet, including one salt packet on the tray. During an observation on 12/05/2025 at 12:45 PM, Resident #206 was sitting in their room. The resident's lunch tray was observed on the overbed table which contained salt packets on the tray.A meal ticket dated 12/05/2025 for Resident #206 documented lunch, regular-mechanically altered chopped diet, including one salt packet on the tray. During an interview on 12/08/2025 at7:48 AM, the Registered Nurse Manager #1 stated the dietary staff transcribes the dietary orders on the meal tickets. Registered Nurse Manager #1 stated the Certified Nursing Assistants check the meal tickets for the items on the meal tray and do not check for the type of diet the resident is prescribed. Registered Nurse Manager #1 stated the Certified Nursing Assistants do not know what type of diet each resident is prescribed. During an observation and interview on 12/08/2025 at 7:54 AM, Registered Nurse Manager #1 checked Resident #206's breakfast meal tray. The breakfast meal tray contained salt packets, and the meal ticket documented regular-mechanically altered chopped meal. Registered Nurse Manager #1 stated dietary staff were responsible for entering the diet orders in the meal ticket system. Registered Nurse Manager #1 stated Resident #206 had a physician's order for a no added salt diet<br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | due to the resident's diagnosis of heart failure. Registered Nurse Manager #1 stated the breakfast meal provided was not the prescribed diet for Resident #206. During an interview on 12/08/2025 at 8:46 AM, Registered Dietician #1 stated the dieticians check the physician's orders in the meal ticket system on a quarterly basis. Registered Dietician #1 stated they were not sure why Resident #206's meal ticket did not match the physician's order for a no added salt diet. Registered Dietician #1 stated a dietician should have checked the meal ticket system and changed the resident's meal ticket to match the physician's order. Registered Dietician #1 stated nursing staff did not report the discrepancy to them. During an interview on 12/08/2025 at 10:58 AM, Primary Care Physician #1 stated the dietary staff should follow the physician's order for a no added salt diet and should not have provided the resident with a regular diet and salt packets.10 NYCRR 415.14(e) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not ensure that food was prepared, distributed, and served in accordance with professional standards for food service safety. This was identified for two (2) (Resident #09 and Resident #10) of two (2) residents reviewed for Tube Feeding and during the Kitchen task. Specifically, 1) Resident #09 and Resident #10's tube feeding formula and the water bags were unlabeled and did not indicate the resident's name, the date, and the time the tube feeding was initiated. 2) During the tray line service observation on 12/09/2025, the temperature of the prepared cold food items was observed to be above 41 degrees Fahrenheit. The findings are:<br><br>1) The facility's policy titled Enteral Feeding Tubes and Care, last revised on 01/01/2025, documented that resident who is fed by an enteral feeding tube shall receive appropriate treatment and services. Feeding solution is hung for no longer than twenty-four hours. Clinical dietary staff will calculate the amount of free water and caloric value for patients on enteral feedings. The feeding set is changed and labeled with the name of the patient, date, and time every twenty-four hours.<br><br>Resident #09 was admitted with diagnosis including dysphagia (difficulty swallowing) following cerebral infarction. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #09 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident had intact cognition. Resident #09 had a feeding tube and received an average fluid intake per day by tube feeding.<br><br>A Comprehensive Care Plan titled Tube Feeding for Nutritional Support, dated 06/28/2023 and revised on 09/25/2025, documented interventions including providing the resident with tube feeding as ordered, providing water flush as ordered and maintaining the head of the bed at 30-45 degrees during feeding.<br><br>The current physician's order documented Osmolite (a nutritional formula for tube feeding that provides calories, protein, vitamins and minerals) 1.5/1000 milliliters at 83 milliliters per hour, auto water flush per 1000 milliliters at 83 milliliters per hour. Start time at 05:00 PM until completed.<br><br>During an observation on 12/03/2025 at 10:47 AM, Resident #09 was lying in bed. An enteral tube feeding bottle and a water bag was hanging on a feeding tube stand without a label that included the resident's name and the time the tube feeding was started. The resident was not receiving the tube feeding at the time of the observation.<br><br>During an interview on 12/03/2025 at 10:58 AM, Licensed Practical Nurse #04, the Medication Nurse, stated they did not know why the enteral tube feeding bottle and the water bottle were unlabeled. Licensed Practical Nurse #04 stated that the enteral tube feeding bottle, and the water bottle were connected during the 3:00 PM to 11:00 PM shift and was started at 5:00 PM. Licensed Practical Nurse #04 stated when they came in this morning, Resident #09 was disconnected from the feeding.<br><br>During an interview on 12/03/2025 at 11:00 AM, Registered Nurse #03, the Nurse Supervisor, stated that the nurse who worked during the 3:00 PM to 11:00 PM shift should have labeled the enteral tube feeding bottle and water bottle with the resident's name and the time that the feeding was started.<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/04/2025 at 2:25 PM, Licensed Practical Nurse #05 stated that they were the medication nurse who worked during the 3:00 PM to 11:00 PM shift on 12/02/2025. Licensed Practical Nurse #05 stated they remembered putting the label on the feeding and water bottle before starting the feeding. Licensed Practical Nurse #05 stated they did not know what happened to the label after their shift.<br><br>During an interview on 12/08/2025 at 10:15 AM, the Director of Nursing Services stated the enteral tube feeding bottle and water bottle should be labeled before the start of the feeding. The Director of Nursing Services stated that the label should include the resident's name and the time the feeding started. The Director of Nursing Services stated they expect all nurses to label the feeding and water bottle.<br><br>-Resident #10 had a diagnosis of dysphagia (difficulty swallowing). Resident #10's Quarterly Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 11, indicating moderate cognitive impairment. The assessment documented the resident's primary source of nutrition and hydration was through a feeding tube.<br><br>A comprehensive care plan for tube feeding last revised 12/03/2025 documented the resident required tube feeding for nutritional support secondary to swallowing difficulty and inability to consume adequate food and fluids by mouth. Interventions included to provide tube feeding, monitor the resident's tolerance of the tube feeding, and flush as ordered.<br><br>The physician's orders dated 12/03/2025 documented tube feeding, continuous feed of Pivot (tube feeding formula) 1.5, 1400 milliliters, at 80 milliliters per hour; automatic water flush of 1000 milliliters at 80 milliliters per hour from 4:00 PM until it is completed, every shift.<br><br>During an observation on 12/03/2025 at 11:10 AM, Resident #10's tube feeding pump was connected to a tube feeding formula bag and a bag of water; both bags were unlabeled and undated.<br><br>During an interview on 12/03/2025 at 1:00 PM, Registered Nurse Supervisor #4 stated Resident #10's feeding requires two bottles of formula, so they poured the formula into a bag. Registered Nurse Supervisor #4 further stated the formula bag, and the water bag should have been labeled and dated.<br><br>2) An undated facility policy and procedure titled Food Temperatures, documented the temperatures of the food items will be taken and properly recorded for each meal. Take temperatures often to monitor for safe holding temperature ranges of at or below 41 degrees Fahrenheit for cold foods. All cold food items must be maintained and served at a temperature of 41 degrees Fahrenheit or below. Foods sent to the units for distribution (such as meals, snacks, nourishments, oral supplements) will be transported and delivered to maintain temperatures at or below 41 degrees Fahrenheit for cold foods.<br><br>During an observation of the lunch meal tray line service on 12/09/2025 at 12:08 PM, the Food Service Director measured the temperature of a 4-ounce almond milk. The temperature was noted to be 52.9 degrees Fahrenheit and the temperature of a 4-ounce container of yogurt was noted to be 59.6 degrees Fahrenheit.<br><br>During an interview on 12/09/2025 at 12:30 PM, the Food Service Director stated the temperature of the cold food items were not appropriate. The Food Service Director stated cold food items that are held at temperatures above 41 degrees Fahrenheit increases the risk for foodborne illness when (continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | consumed.<br><br>10 NYCRR 415.12(g)(2) and 415.14(h) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 12/03/2025 and completed on 12/09/2025, the facility did not maintain an infection prevention and control program to help prevent the transmission of communicable diseases and infections. This was identified for one (1) (Resident #98) of seven (7) residents reviewed for Pressure Ulcers. Specifically, Resident #98 had Stage 3 pressure ulcers on their bilateral buttocks and sacrum. During morning care on 12/03/2025, Certified Nurse Assistant #1 cleaned the resident's uncovered pressure ulcers with a soiled towel that was used to clean the resident's genital area.The finding is: The Facility Pressure Injury Overview Policy dated 03/06/2025 documented steps of dressing changes including cleaning of the wounds indicating a no touch technique. The policy did not define no touch technique. Resident #98 was admitted with diagnoses including non-pressure chronic ulcer of the left calf (back of the lower leg) , peripheral vascular disease, and atrial fibrillation. The admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The resident was at risk for developing pressure ulcers and had one (1) Stage 2 pressure ulcer that was present upon admission. The resident was always continent of urine and was occasionally incontinent of bowel. The physician's orders dated 12/02/2025 documented to topically apply Medihoney wound dressing external gel (wound dressings) to bilateral buttocks and sacral area every day and during the evening, after a normal saline cleanse followed by a silicone dressing shift for the wound healing. The wound care evaluation note dated 12/02/2025 documented Resident #98 had a stage 3 pressure ulcer to the sacrum that measured 4 centimeters in length, 1.6 centimeters in width, and 0.1 centimeter in depth. Resident #98 also had a stage 3 pressure ulcer to the left buttock that measured 1.1 centimeter in length, 1.3 centimeters in width, and 0.1 centimeters in depth. Additionally, Resident #98 had a stage 3 right buttock pressure ulcer that measured 2.3 centimeters in length, 2.9 centimeters in width and 0.1 centimeters in depth. During an observation and interview on 12/03/2025 at 10:30 AM, Resident #98 was lying in their bed. The bed side table was observed with a four (4) inch by four (4) inch border gauze dated 12/03/2025 with a nurse's initials. The gauze was noted with a white substance on it. The resident stated the nurse left the gauze on the table for Certified Nursing Assistant #1 to apply on their (resident's) buttocks after the bed bath. During a morning care observation on 12/03/2025 from 10:48 AM to 11:10 AM, Certified Nursing Assistant #1 provided a bed bath to Resident #98. The resident's pressure ulcers to the sacrum and the buttocks did not have a cover dressing on. Certified Nurse Assistant #1 cleansed the resident's uncovered pressure ulcers with a soiled towel that was used to clean the resident's genital area. During an interview on 12/03/2025 at 11:13 AM, Certified Nursing Assistant #1 stated some nurses leave the wound care treatment on the resident's bedside table for the Certified Nursing Assistant to apply after they provide the resident with a bed bath. During an interview on 12/03/2025 at 11:25 AM, Licensed Practical Nurse #6 stated they completed Resident #98's wound care treatments in the morning. Licensed Practical Nurse #6 stated they do not allow Certified Nursing Assistants to apply wound treatments because Certified Nursing Assistants are not qualified to do the wound care. During an interview on 12/05/2025 at 11:14 AM, Wound Care Nurse#1 stated only licensed nurses are allowed to provide the wound care treatments. Wound Care Nurse #1 stated it was crucial to follow the physician's order and to provide the wound care treatments properly to prevent skin deterioration and infection. Wound Care Nurse #1 stated the wound should be cleansed with normal saline to prevent infection and promote healing. Wound Care Nurse #1 stated the soiled towel used to clean the resident's perineal and genital area should not have contacted the resident's wounds. During an interview on 12/09/2025 at 02:00 PM, the Director of Nursing Services stated only nurses are allowed to complete the wound care treatments. The Director of Nursing Services stated nurses should handle the wound care since they are skilled in infection control and can accurately follow the physician's orders. 10 NYCRR 415.19(a) (1-3) |