STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335401	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momentum at South Bay for Rehab and Nursing	340 East Montauk Highway East Islip, NY 11730

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey, initiated on 09/02/2025 and completed on 09/09/2025, the facility did not ensure a comprehensive person-centered care plan was implemented for each resident to meet the resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. This was identified for one (1) (Resident #57) of twelve (12) residents reviewed for Infection Control. Specifically, Resident #57 had a physician's order for Contact Precautions dated 08/12/2025; however, there was no Comprehensive Care Plan developed for Contact Precautions with measurable goals and interventions. The finding is:The facility's policy titled Comprehensive Care Plans and Resident meeting dated 04/28/2025 documented that a Comprehensive Care Plan for the resident's needs should be developed by 14 days of admission and no later than 21 days. Within fourteen days of the resident's admission, a comprehensive assessment of the resident's needs will be prepared and developed by the interdisciplinary team.Resident #57 was admitted with diagnoses including Enterocolitis (inflammation of the colon) due to Clostridium difficile, Benign Prostatic Hyperplasia (a condition in which the prostate gland is enlarged), and Bacteremia (bacteria in the bloodstream). The 5-day admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating the resident is cognitively intact.A Baseline Care Plan dated 08/11/2025 documented contact isolation with interventions that included infection control per protocol.A physician's order dated 08/12/2025 documented that Resident #57 requires strict isolation contact precautions. This order was discontinued on 08/27/2025.A physician's order dated 08/27/2025 documented contact precautions.A review of the Comprehensive Care Plan revealed there was no documented evidence that a Comprehensive Care Plan with measurable goals and interventions for Contact Isolation was developed by 14 days of admission and no later than 21 days.During an observation on 09/02/2025 at 12:04 PM, Resident #57's room door had signage that documented Contact Enteric Precautions; doctors and staff must [put on] a gown and gloves at the door. Everyone must wash their hands with soap and water before and after care. The resident was not in the room and was unavailable for an interview.During an observation on 09/03/2025 at 8:40 AM, the precautions signage was still present on the doorway and documented Contact Enteric Precautions; doctors and staff must [put on] a gown and gloves at the door.During an interview on 09/08/2025 at 1:10 PM, Registered Nurse Manager #3 stated Resident #57 should have had a Comprehensive Care Plan developed for contact precautions.During an interview on 09/09/2025 at 8:48 AM, the Director of Nursing Services stated that a Comprehensive Care Plan should have been developed when the resident was placed on contact precautions. The admission nurse initiates a baseline care plan for contact precautions. The Infection Preventionist, Nurse Manager, or Nurse Supervisor is responsible for creating a Comprehensive Care Plan.10 NYCRR415.11(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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record review, and interviews during the Recertification Survey, initiated on 09/02/2025 and completed on 09/09/2025, the facility did not ensure a comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team to reflect the resident's current status. This was identified for one (1)(Resident #1) (1)of one resident reviewed for Pressure Ulcers. Specifically, Resident #1's Comprehensive Care Plan was not updated to indicate the changes in the interventions related to offloading the resident's heels (both extremities). The finding is: The facility's policy, titled Pressure Ulcer Prevention and Care, dated 10/30/2024, documented to Avoid positioning the resident on a pressure injury. If unavoidable, attempt to limit the duration of the pressure on these areas. Resident #1 was admitted with diagnoses including Down Syndrome and Peripheral Vascular Disease (blood does not flow properly in the veins of the lower extremities). The 07/01/2025 admission Minimum Data Set assessment documented that the resident had severely impaired cognitive skills for daily decision making. The resident was dependent on facility staff for bed mobility and had one Stage 3 (full thickness loss of skin) pressure ulcer. A Comprehensive Care Plan titled Impaired Skin Integrity Right Heel, effective 07/13/2025, documented that the resident has a right heel pressure ulcer measuring 1.0-centimeter X 1.0-centimeter X 0.1 centimeter with 100% Pale Granulation tissue. Interventions included to float the resident's heels on a pillow. A review of the Certified Nursing Assistant care guide for September 2025 revealed there were no instructions to float the resident's heels on a pillow. The Care guide instructed the Certified Nursing Assistant that there is a right heel wound. A wound note dated 08/29/2025 documented on 08/27/2025 the resident's right heel pressure ulcer measured 0.2-centimeter x 0.2-centimeter x 0.1 centimeter and had 100% pink, minimal serous exudate, peri-wound dry skin. The treatment plan for the right heel Stage 3 pressure injury included to cleanse with normal saline, followed by honey gel and dry clean dressing daily, and as needed. The recommendations were to float the resident's heels with a pillow. During an observation on 09/02/2025 at 11:00 AM, Resident #1 was in their room in their bed without a pillow to offload their right heel. The resident was observed wearing bilateral heel booties with heels resting directly on the bed. During an observation of the wound care treatment to the resident's right heel on 09/04/2025 at 11:00 AM, the resident was observed again in heel booties without a pillow to offload the heels. Licensed Practical Nurse # 4 and Wound Care Registered Nurse # 3 performed the treatment. During the treatment, the resident was observed without restlessness. Wound Care Registered Nurse #3 was interviewed on 09/04/2025 at 11:05 AM and stated the resident does not use the pillow to offload their heels because the resident has restless legs. Wound Care Registered Nurse #3 stated they developed the care plan and initially implemented the intervention to float the heels with pillows; however, the resident had restlessness to their lower extremities, and the intervention to use the pillow to offload the heels should have been discontinued. During an interview on 09/04/2025 at 2:15 PM, Certified Nursing Assistant # 2 stated they were never instructed to put a pillow under the resident's legs. Certified Nursing Assistant # 2 stated they only applied the heel booties and had never seen the resident with a pillow under their legs while in bed. Certified Nursing Assistant # 2 stated, The resident does not move around much, and their legs are not restless. During an interview on 09/5/2025 at 12:35 PM, the Director of Nursing Services stated the Comprehensive Care Plan interventions included to float the resident's heels. The Director of Nursing Services stated the resident should have had a pillow under their heels to prevent further breakdown or skin deterioration, and the care plan should reflect the resident's current needs and interventions. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, during the Recertification Survey and Abbreviated Survey (800725) initiated on 09/02/2025 and completed on 09/09/2025, the facility did not ensure that pain management was provided to residents who required such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This was identified for one (1) (Resident # 92) of three (3) residents reviewed for Pain Management. Specifically, Resident #92 had a diagnosis of Spinal and Hip Fractures and had a physician's order for Acetaminophen (pain reliever) for 14 days on 08/05/2025. The pain medication order was not renewed after 14 days. The resident was evaluated by Pain Management Nurse Practitioner #2 on 09/07/2025 and recommended to continue Acetaminophen for pain management without reviewing the resident's physician's orders. The resident complained of a pain level of four (4) out of ten (10) on the morning of 09/09/2025 to the Rehabilitation staff. The resident was observed receiving therapy at 11:48 AM and complained of a pain level of six (6) out of ten (10) on the pain scale. The finding is:The facility's Pain Management Policy, effective November 2024, documented that the overall goals of care for residents with pain included identifying and assessing pain, monitoring treatment efficacy and side effects, reviewing active medication orders to ensure interventions were carried out as planned, and ensuring that pain interventions were consistent with the resident's plan of care. Resident # 92 was admitted with a Spinal, Hip, and Pelvic Fracture. The admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 14, demonstrating that the resident was cognitively intact. The Minimum Data Set documented that the resident experienced moderate occasional pain and that the resident was on a pain management program. The Comprehensive Care plan for pain and Right Hip Fracture, dated 08/01/2025 and 08/02/2025, respectively, included the interventions for monitoring for signs and symptoms of pain such as verbal complaints, facial grimacing, increased agitation, and moaning.The admission physician's order dated 08/01/2025 documented Acetaminophen 325 milligrams (pain reliever), two tablets (650 milligrams) every six hours as needed, and pain management consultation as needed. This order was discontinued on 08/05/2025. The physician's order dated 08/01/2025 documented to monitor for pain every shift. The pain management consult dated 08/05/2025 documented the resident's complaint of neck pain. The resident was on daily therapy and tolerated well. The assessment included muscle wasting, difficulty walking, and neck pain. Recommendations included changing the Acetaminophen order from as needed to 1000 every eight (8) hours. The physician's order dated 08/05/2025 documented to change Acetaminophen to 500 milligrams, two tablets (1000 milligrams) every eight hours for 14 days. This order was completed on 08/19/2025 and was not renewed. The Medication Administration Record for the period of 08/19/2025 to 09/07/2025 documented monitoring for pain every shift with a consistent score of 0 for each shift, signifying no presence of pain. The Nephrology consult dated 08/22/2025 documented no complaint of joint pain. The Surgery and Vascular consultation dated 08/26/2025 documented that the resident reported right hip pain and denied pain at rest. The recommendations included continuing with the current medical management.The Electronic Medical Record did not include other medical progress notes until 09/07/2025. The medical progress note dated 09/07/2025, written by the Pain Management Nurse Practitioner, documented a plan to continue Acetaminophen 1000 milligrams every eight hours for 14 days and management of pain progression with rehab [rehabilitation]. The note included no complaint of muscle pain. The assessment included neck pain. There was no indication of the severity of the pain level. The Physical Therapy note dated 09/09/2025 documented that the resident reported a pain level of four (4) out of ten (10) on a pain scale (where zero (0) is no pain and ten (10) is the highest amount of pain) lying in bed that morning. During an observation and interview on 09/09/2025 at 11:48 AM, the resident was observed in the Rehabilitation Therapy room receiving (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapy with occupational and physical therapy staff. The resident stated they had pain in their right hip, and the pain level was six (6) out of ten (10) on a pain scale. The physician's order dated 09/09/2025 documented Acetaminophen 500 milligrams, two tablets (1000 milligrams) every eight hours.During an interview on 09/09/2025 at 11:50 AM, Occupational Therapist #1 stated, the resident has had occasional pain the past few weeks, but usually the pain improved after therapy, as reported by the resident. A review of the Occupational Therapy treatment encounter notes from 08/19/2025 to 09/09/2025 revealed no documentation regarding the resident's pain level, except for 09/09/2025, when the note indicated the resident had no pain. During an interview on 09/09/2025 at 11:52 AM, Physical Therapist #1 stated the resident has had complaints of pain off and on over the past few weeks, but the pain usually goes away after the therapy session, as per the resident. Physical Therapist #1 stated they usually notify nursing staff when the resident complained of a pain level above two (2) out of ten (10). A review of the Physical Therapy treatment encounter notes from 08/19/2025 to 09/08/2025 revealed no documentation regarding the resident's pain level. During an interview on 09/09/2025 at 12:35 PM, Registered Nurse Manager #2 stated Resident #92 was alert and oriented and was able to verbalize their needs. Registered Nurse Manager #2 stated they interacted with the resident regularly and asked the resident about their pain level; however, the resident did not report any pain to them, and the staff did not report the resident's complaint of pain. Registered Nurse Manager #2 stated they did not realize the Acetaminophen order was discontinued for Resident #92 on 08/19/2025 and was not reordered until 09/09/2025. During an interview on 09/09/2025 at 1:00 PM, Pain Management Nurse Practitioner #2 stated, I was not aware the Acetaminophen order ended on August 19. I usually review the medication administration records, but I do not always look at the administration of non-narcotic medications like Acetaminophen. When I saw the resident on September 7, I thought they were still on Acetaminophen and recommended it be continued. During an interview on 09/09/2025 at 1:10 PM, Certified Nursing Aide #3 stated that they are the regular nursing aide for the resident. They couldn't recall the resident ever complaining of pain and claim that they ask the resident if they are in pain on a routine basis. During an interview on 09/09/2025 at 1:30 PM, Licensed Practical Nurse #5 stated they were the medication nurse, and the resident reported their pain level was five (5) out of ten (10) today and was administered Acetaminophen as per the physician's orders. Licensed Practical Nurse #5 stated they did not recall the resident complaining of pain before. During an interview on 09/09/2025 2:21 PM, the attending Primary Physician #2 stated they ordered the pain medications for 14 days. They relied on staff to notify them of the resident's complaint of pain for them to reorder the pain medications. The attending Primary Physician #2 stated they were not notified of Resident #92's complaints of pain and were also not notified of the recommendations provided by Pain Management Nurse Practitioner #2 to continue the pain medication for the resident. During an interview on 09/09/2025 at 3:00 PM, the Medical Director stated the pain management consultant should have reviewed the resident's Medication Administration Record and communicated their recommendations to the attending physician.During an interview on 09/09/2025 at 3:30 PM, the Director of Nursing Services stated, Pain Management Nurse Practitioner #2 should have reviewed the resident's Medication orders to know the resident's current medications. Pain Management Nurse Practitioner #2 should have also communicated their recommendations to continue the pain medication for Resident #92 to the nursing supervisor, who then should have informed the Physician. 10 NYCRR 415.12

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, during the Recertification Survey and Abbreviated Survey (800725) initiated on 09/02/2025 and completed on 09/09/2025, the facility did not ensure that the medical care of each resident was supervised by a Physician, including monitoring changes in the resident's status and the need for changes in the treatment. This was identified for one (1) (Resident #92) of three (3) residents reviewed for Pain Management. Specifically, Resident #92 had a diagnosis of Spinal and Hip Fractures and had a physician's order for Acetaminophen (pain reliever) for 14 days on 08/05/2025. The pain medication order was not renewed after 14 days. The resident was evaluated by Pain Management Nurse Practitioner #2 on 09/07/2025 and recommended to continue Acetaminophen for pain management without reviewing the resident's physician's orders. Cross Reference- F697The finding is:The facility's Pain Management Policy, effective November 2024, documented that the overall goals of care for residents with pain included identifying and assessing pain, monitoring treatment efficacy and side effects, reviewing active medication orders to ensure interventions were carried out as planned, and ensuring that pain interventions were consistent with the resident's plan of care. Resident # 92 was admitted with a Spinal, Hip, and Pelvic Fracture. The admission Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 14, demonstrating that the resident was cognitively intact. The Minimum Data Set documented that the resident experienced moderate occasional pain and that the resident was on a pain management program. The Comprehensive Care plan for pain and Right Hip Fracture, dated 08/01/2025 and 08/02/2025, respectively, included the interventions for monitoring for signs and symptoms of pain such as verbal complaints, facial grimacing, increased agitation, and moaning.The admission physician's order dated 08/01/2025 documented Acetaminophen 325 milligrams (pain reliever), two tablets (650 milligrams) every six hours as needed, and pain management consultation as needed. This order was discontinued on 08/05/2025. The physician's order dated 08/01/2025 documented to monitor for pain every shift. The pain management consult dated 08/05/2025 documented the resident's complaint of neck pain. The resident was on daily therapy and tolerated well. The assessment included muscle wasting, difficulty walking, and neck pain. Recommendations included changing the Acetaminophen order from as needed to 1000 milligrams, every eight (8) hours. The physician's order dated 08/05/2025 documented to change Acetaminophen to 500 milligrams, two tablets (1000 milligrams) every eight hours for 14 days. This order was completed on 08/19/2025 and was not renewed. The medical progress note dated 09/07/2025, written by the Pain Management Nurse Practitioner, documented a plan to continue Acetaminophen 1000 milligrams every eight hours for 14 days and management of pain progression with rehab [rehabilitation]. The note included no complaint of muscle pain. The assessment included neck pain. There was no indication of the severity of the pain level. The Physical Therapy note dated 09/09/2025 documented that the resident reported a pain level of four (4) out of ten (10) on a pain scale (where zero (0) is no pain and ten (10) is the highest amount of pain) lying in bed that morning. During an observation and interview on 09/09/2025 at 11:48 AM, the resident was observed in the Rehabilitation Therapy room receiving therapy with occupational and physical therapy staff. The resident stated they had pain in their right hip, and the pain level was six (6) out of ten (10) on a pain scale. The physician's order dated 09/09/2025 documented Acetaminophen 500 milligrams, two tablets (1000 milligrams) every eight hours.During an interview on 09/09/2025 at 1:00 PM, Pain Management Nurse Practitioner #2 stated, I was not aware the Acetaminophen order ended on August 19. I usually review the medication administration records, but I do not always look at the administration of non-narcotic medications like Acetaminophen. When I saw the resident on September 7, I thought they were still on Acetaminophen and recommended it be continued. During an interview on 09/09/2025 2:21 PM, the attending Primary Physician #2 stated they ordered the pain (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications for 14 days. They relied on staff to notify them of the resident's complaint of pain for them to reorder the pain medications. The attending Primary Physician #2 stated they were not notified of Resident #92's complaints of pain and were also not notified of the recommendations provided by Pain Management Nurse Practitioner #2 to continue the pain medication for the resident. During an interview on 09/09/2025 at 3:00 PM, the Medical Director stated the pain management consultant should have reviewed the resident's Medication Administration Record and communicated their recommendations to the attending physician.10 NYCRR 415.15 (b)(1)(i)(ii)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/02/2025 and completed on 09/09/2025, the facility did not ensure it maintained an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. This was identified for one (1) (Resident #57) of twelve (12) residents reviewed for Infection Control, and two (2) (Resident #19 and Resident #156) of two (2) residents reviewed during the Medication Storage task. Specifically, 1) Resident #57 had a physician's order for Contact Precautions due to Clostridium Difficile (a bacterium that causes severe diarrhea and intestinal inflammation) infection. Certified Nursing Assistant #4 was observed entering and exiting Resident #57's room without putting on and removing Personal Protective Equipment. 2) During the Medication Storage task, Licensed Practical Nurse #6 stated they clean the shared glucometer device with an alcohol wipe after each resident's use; however, the facility's infection control policy required the use of an Environmental Protection Agency (EPA) approved disinfectant to disinfect the shared glucometer device. The findings are:1) The facility policy titled Transmission-Based Precautions, dated 09/11/2024, documented that Transmission-Based Precautions will be initiated by a licensed nurse as per the physician's order. Contact Precautions will be used when there is evidence of multidrug-resistant organisms, including but not limited to Clostridium Difficile. Residents on contact precautions will have signage posted outside the resident's room. Resident #57 was admitted with diagnoses including Enterocolitis (inflammation of the colon) due to Clostridium difficile, Benign Prostatic Hyperplasia (a condition in which the prostate gland is enlarged), and Bacteremia (bacteria in the bloodstream). The 5-day admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating the resident is cognitively intact. A Baseline Care Plan dated 08/11/202 documented contact Isolation with interventions that included infection control as per protocol. A physician's order dated 08/12/2025 documented that Resident #57 requires strict isolation contact precautions. This order was discontinued on 08/27/2025. A physician's order dated 08/27/2025 documented contact precautions.During an observation on 09/02/2025 at 12:04 PM, Resident #57's room door had signage that documented Contact Enteric Precautions; doctors and staff must [put on] a gown and gloves at the door. Everyone must wash their hands with soap and water before and after care. The resident was not in the room and was unavailable for an interview.During an observation on 09/03/2025 at 8:40 AM, Certified Nursing Assistant #4 sanitized their hands and proceeded to walk into Resident #57's room without putting on Personal Protective Equipment, including a gown and gloves. Certified Nursing Assistant #4 was subsequently observed walking out of the room a minute later and was carrying an empty breakfast tray to the food truck that was located right outside the resident's room. The signage was still present on the doorway and documented Contact Enteric Precautions; doctors and staff must [put on] a gown and gloves at the door. During an interview on 09/03/2025 at 8:48 AM, Certified Nursing Assistant #4 stated they did not put on Personal Protective Equipment because they were not going to touch the resident, and they did not think they needed to wear personal protective equipment.During an interview on 09/04/2025 at 11:37 AM, Registered Nurse Manager #3 stated every staff member needs to wear Personal Protective Equipment when going into a resident's room who is on contact isolation precautions, including when picking up or dropping off a meal tray.During an interview on 09/08/2025 at 8:47 AM, the Registered Nurse Infection Preventionist/Inservice Coordinator stated that contact precautions signage is displayed on the door with instructions to use the Personal Protective Equipment available outside the resident's room. The Registered Nurse Infection Preventionist/Inservice Coordinator stated that staff should put on the appropriate Personal Protective Equipment prior to entering the room, including when picking up a meal tray from inside the resident's room. During an interview on 09/09/2025 at 8:45 AM, the Director of Nursing Services (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they expect staff to follow the facility's infection control policy. The Director of Nursing Services stated that all staff should wear appropriate Personal Protective Equipment before entering a resident's room who is on contact precautions. 2) The facility policy titled Blood Glucose Monitoring, dated 06/04/2025, documented that the glucometer (used to measure how much glucose (sugar) is present in the bloodstream at a given moment in time) should be cleaned and disinfected between each resident test. Equipment needed to clean the machine included: The Environmental Protection Agency registered germicidal or bleach wipes must be approved for use in healthcare settings and for surface cleaning. The wipes must be effective against Human Immunodeficiency Virus, Hepatitis B Virus, and Hepatitis C Virus (purple top Sani wipe). Resident #19 was admitted with diagnoses including Type 2 Diabetes Mellitus, Arthritis, and Cerebral Ischemia (blood flow to the brain is reduced). The Minimum Data Set assessment, dated 06/21/2025, documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set documented the resident received insulin one (1) of the seven (7) days in the assessment look-back period. A physician's order dated 06/18/2025 and renewed on 08/26/2025 documented inject insulin Lispro 100 units/per milliliter subcutaneously every day at 06:30 AM, 11:30 AM, 04:30 PM, and 09:00 PM. Monitor Blood Sugar, use sliding scale, if Blood Sugar is 181-240 milligrams per deciliter, give 4 units, if Blood Sugar is 241-280 milligrams per deciliter, give 6 units, if Blood Sugar is 281-320 milligrams per deciliter, give 8 units, greater than 320 or lower than 80 milligrams per deciliter, call the Physician.Resident #156 was admitted with diagnoses including Type 2 Diabetes Mellitus, Chronic Respiratory Failure, and Acute Kidney Failure. The Quarterly Minimum Data Set assessment, dated 06/22/2025, documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A physician's order for Resident #156 dated 08/16/2025, and renewed on 09/04/2025, documented to check blood glucose twice a day at 06:00 AM and 09:00 PM; call the physician if the blood sugar levels are less than 60 milligrams per deciliter, or greater than 400 milligrams per deciliter. During the Medication Storage task on 09/04/2025 at 11:11 AM, the medication cart for Unit 2 F hall was observed with Licensed Practical Nurse #6. Licensed Practical Nurse #6 stated they clean the glucometer device with the alcohol pads before and after using the glucometer device for each resident who required blood glucose monitoring. Licensed Practical Nurse #6 stated they clean the Blood Pressure cuff with the purple germicidal wipe and the glucometer with an alcohol pad. Licensed Practical Nurse #6 stated they were educated to use different methods to clean the two items. Licensed Practical Nurse #6 then demonstrated that they clean the glucometer with an alcohol pad. Licensed Practical Nurse #6 stated they have the germicidal wipes on the medication cart, but only use them to clean the Blood Pressure cuff. Licensed Practical Nurse #6 stated there were only two residents in the unit who required blood sugar monitoring, Resident #19 and Resident #156. During an interview on 09/04/2025 at 11:32 AM, Registered Nurse Manager #3 stated that they also use alcohol pads to clean the glucometer device. Registered Nurse Manager #3 returned on 09/04/2025 at 2:27 PM and stated they wanted to clarify that the facility uses the germicidal wipes to clean the glucometer after each resident's use, not the alcohol wipes. During an interview on 09/08/2025 at 8:49 AM, Registered Nurse Infection Prevention/Inservice Coordinator stated the facility policy directs staff to use the germicidal wipes to disinfect glucometer devices after each use, not the alcohol pads. Registered Nurse Infection Prevention/Inservice Coordinator stated the alcohol pad would not disinfect the glucometer device from infectious organisms. Registered Nurse Infection Prevention/Inservice Coordinator stated staff should not use alcohol pads to clean the glucometer, and only germicidal wipes are acceptable. During an interview on 09/09/2025 at 8:45 AM, the Director of Nursing Services stated that staff members are required to sanitize the glucometer device using a germicidal wipe after each use. The Director of Nursing Services stated nurses must adhere to the facility's infection control policy and should not use an alcohol pad to clean the glucometer device. The Director of Nursing Services stated that the alcohol pad would not disinfect everything. 10 NYCRR 415.19(a)(1-3)