

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335402	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/19/2024
NAME OF PROVIDER OR SUPPLIER  Oasis Rehabilitation and Nursing, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  6 Frowein Road Center Moriches, NY 11934	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245</b></p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/19/2024, the facility did not ensure that each resident was provided with a safe, clean, comfortable, and homelike environment. This was identified on one (Starboard Unit) of two units observed during the Environmental Task. Specifically, Resident #292 was using a ripped, inverted (turned inside out) fitted bed sheet on three separate observations.</p> <p>The finding is:</p> <p>The facility's policy titled; Homelike Environment last revised on 7/1/2017 documented that the facility will ensure that residents live in an environment that is clean and neat, with appropriate furnishings in a state of good repair. The housekeeping and nursing staff would observe the environment for needed repairs including but not limited to ripped/torn soiled curtains, damaged furniture, etc.</p> <p>Resident #292 was admitted with diagnoses including Atrial Fibrillation, Congestive Heart Failure, and Type 2 Diabetes Mellitus. Resident #292's Minimum Data Set (MDS) assessment had not been completed because they were recently admitted to the facility.</p> <p>A Nursing Admission assessment dated [DATE] documented that Resident #292 was alert, friendly, and cooperative. Resident #292 was oriented to time, place, and person.</p> <p>Resident #292 was observed on 12/15/2024 at 10:15 AM, lying in bed with an inverted (inside out) and ripped fitted bed sheet that was covering the resident's mattress.</p> <p>Resident #292 was observed on 12/16/2024 at 10:33 AM, sitting in a wheelchair. An inverted and ripped fitted bed sheet was covering the resident's mattress.</p> <p>Resident #292 was observed on 12/17/2024 at 8:30 AM lying in bed with an inverted fitted bed sheet that was ripped.</p> <p>During an interview on 12/17/2024 at 8:30 AM, Registered Nurse #1 (Unit Manager) stated that Resident #292 was recently admitted to the facility, and the room was set up by the Housekeeping Department. Registered Nurse #1 stated Certified Nursing Assistant (CNA) assigned to Resident #292 did not report any issues with the bed sheet.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/17/2024 at 8:43 AM, Certified Nursing Assistant #1 stated they were focused on Resident #292's care and did not notice the fitted sheet on the mattress. Certified Nursing Assistant #1 stated if they had seen the ripped bed sheet, they would have changed the sheet with a new one.</p> <p>During an interview on 12/17/2024 at 11:00 AM, the Housekeeping Director stated they did not know who cleaned the room before Resident #292's admission. The Housekeeping Director stated they expected the housekeeping staff to use linens that are in good condition.</p> <p>During an interview on 12/19/2024 at 12:31 PM, the Director of Nursing Services stated the resident's bed sheets are changed during the resident's shower days, and when visibly soiled. The Director of Nursing Services stated that Certified Assistant #1 should have changed the torn bed sheet.</p> <p>10 NYCRR 415.5(h)(3)</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>48827</p> <p>Based on record review and interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/19/2024, the facility did not ensure its Facility Assessment considered specific staffing needs for each resident unit. This was identified for two (Starboard Unit and Port Unit) of two units reviewed during the Sufficient Staffing Task. Specifically, the Facility Assessment, last updated in October 2024, did not include a breakdown of the staffing needs for each resident unit. Additionally, the Facility Assessment did not indicate the use of staffing agencies to meet the staffing needs of the facility.</p> <p>The finding is:</p> <p>The facility's policy, titled Facility Assessment reviewed and revised 7/09/2024, documented the facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>The Facility Assessment, last updated in October 2024 did not include a breakdown of staffing needs for each of the facility's two units. The Facility Assessment documented that the facility required 11-12 Certified Nursing Assistants for the day shift; 7-9 Certified Nursing Assistants for the evening shift; 3-5 Certified Nursing Assistants for the night shift; 3-4 Licensed Nurses on the day and evening shift; 1-2 Licensed Nurses on the night shift. The Facility Assessment did not include the use of staffing agencies to meet its staffing needs.</p> <p>During an interview on 12/19/2024 at 12:23 PM, the Administrator and the Director of Nursing Services both stated they had updated the Facility Assessment in October 2024. The Director of Nursing Services stated the facility uses a staffing agency for Licensed Practical Nurses approximately four to five times a month. The Director of Nursing Services stated the resident acuity is not the same in each unit. The Starboard unit has 54 beds and the Port unit has 46 beds, and the staffing needs are different on both units. The Administrator stated the Facility Assessment did not include a breakdown of staffing needs for each unit. The Administrator stated the Facility Assessment does not include the use of the staffing agency for its staffing needs.</p> <p>10 NYCRR 415.26</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34798</p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 12/15/2024 and completed on 12/19/2024, the facility did not ensure it established and 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 (Port unit) of two nursing units. Specifically, 1) Resident #79 was identified with a COVID-19 infection and was observed with a Transmission Based Precautions signage outside their room. On 12/16/2024, Housekeeper #1 was cleaning Resident #79's room wearing Personal Protective Equipment including gloves. Housekeeper #1 handed a surgical mask to Resident #20, who was passing by the room in their wheelchair, from the housekeeping cart while wearing the same gloves used to clean Resident #79's room and 2) Appropriate Transmission-Based Precautions signage was not posted when Resident #36 tested positive for COVID-19 infection on 12/15/2024. Additionally, a visitor was observed not wearing appropriate Personal Protective Equipment while visiting Resident #36 on 12/15/2024.</p> <p>The finding is:</p> <p>The facility's policy titled Transmission-Based Precautions (Isolation Precautions), dated August 2024, documented the facility will use Transmission-Based Precautions to manage specific, highly transmissible, or epidemiologically important pathogens based on the mode of transmission: contact, droplet, and airborne. The facility will implement Transmission-Based Precautions when the resident is known or suspected to be infected based on the route of transmission of the infectious agent. Residents on Transmission-Based Precaution will have isolation signage posted outside the resident's room. Residents who tested positive for Coronavirus disease (COVID-19) will have blue droplet/contact precaution signage posted. Residents who were exposed to positive Coronavirus disease (COVID-19) residents or whose swab test results were pending will have an orange droplet/contact precaution signage posted. The Infection Preventionist will follow up with the Housekeeping Director to ensure housekeeping readiness to work in isolation conditions, compliance with different requirements of Transmission-Based Precautions, and disposal of cleaning products and supplies to reduce the risk of room-to-room transmission. Housekeepers will put on appropriate Personal Protective Equipment when entering the resident's room and remove all Personal Protective Equipment before exiting the resident's room. Nursing staff will post appropriate isolation signage outside the resident's room.</p> <p>1) During an interview on 12/15/2024 at 9:59 AM, the Administrator and Director of Nursing Services stated the facility was experiencing a COVID-19 infection outbreak among residents and there were currently eight positive COVID-19 residents who were placed in rooms in the COVID-19 designated area of the Starboard unit.</p> <p>A Social Work progress note dated 12/16/2024 at 8:11 AM documented Resident #79 was moving (to the COVID-19 isolation area on the Starboard unit) as the resident was positive for COVID-19 infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/16/2024 at 11:55 AM, Resident #79 was observed sitting in a wheelchair in their room on the Port unit awaiting transfer to the Starboard unit isolation area. Resident #79 was wearing a surgical mask. There was contact/droplet isolation signage at the room doorway. The signage documented N95 mask; providers and staff must put on gloves before room entry; discard gloves before room exit; put on a gown before room entry; discard the gown before room exit; make sure eyes, nose, and mouth are fully covered before room entry with an N95 mask covered with a blue surgical mask and a face shield; remove the blue surgical mask face protection before room exit. Housekeeper #1 was observed in the room coming in contact with the resident environment and was observed mopping the floor. Housekeeper #1 was wearing a gown, gloves, an N95 mask, and goggles; however, the housekeeper did not have a surgical mask over the N95 mask or a face shield.</p> <p>On 12/16/2024 at 12:05 PM, Resident #79 was transferred out of their room to their new room on the Starboard unit by a staff member. Housekeeper #1 was still in the room cleaning. The Housekeeping Supervisor was standing outside of the room in the hallway.</p> <p>On 12/16/2024 at 12:10 PM Housekeeper #1 was still in the same room cleaning when Resident #20 was observed self-propelling their wheelchair passing the room that was being cleaned by Housekeeper #1. Housekeeper #1 was observed reaching for a surgical mask from their housekeeping cart that was outside the room. Housekeeper #1 was wearing the same gloves that were used for cleaning the room, to retrieve the mask, and then handed the surgical mask to Resident #20. Resident #20 took the surgical mask. The surveyor immediately informed Licensed Practical Nurse #1 and Registered Nurse #2 (unit manager) of the observation. Licensed Practical Nurse #1 immediately took Resident #20 into the bathroom to wash the resident's hands. Registered Nurse #2 stated Housekeeper #1 should have been wearing a surgical mask over the N95 mask and will have to be re-educated about infection control.</p> <p>During an interview on 12/16/2024 at 1:58 PM, Housekeeper #1 stated they were cleaning the room and placing all of the dirty linens in a bag because residents in the room were being moved. Housekeeper #1 stated they made a mistake when they gave Resident #20 the surgical mask with the same gloves that were used for cleaning. Housekeeper #1 stated they knew what the signage at the doorway instructed and they should have had a covering over the N95 mask.</p> <p>During an interview on 12/17/2024 at 1:47 PM, the Housekeeping Director stated the housekeepers are expected to follow directions on the isolation signage. The Housekeeping Director stated it was an infection control breach when Housekeeper #1 handed the surgical mask to Resident #20 while wearing gloves that were used to clean Resident #79's room.</p> <p>During an interview on 12/18/2024 at 8:39 AM, the Infection Preventionist stated the facility had a COVID-19 outbreak. Resident #79 tested positive for COVID-19 infection on the morning of 12/16/2024. The Infection Preventionist stated Housekeeper #1 should have been wearing a surgical mask to protect the N95 mask. The Infection Preventionist stated Housekeeper #1 breached infection control protocols when they handed the surgical mask to Resident #20 with the same gloves that were used to clean a COVID-19 room.</p> <p>During an interview on 12/18/2024 at 1:00 PM, the Director of Nursing Services stated Housekeeper #1 was nervous and thought they were doing the right thing by handing a surgical mask to Resident #20, but that was a breach of infection control protocol. Additionally, Housekeeper #1 was expected to follow the isolation signage at the doorway and cover the N95 mask with a surgical mask.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>44963</p> <p>Resident #36 was admitted with diagnoses of Cough, Chronic Obstruction Pulmonary Disease, and Asthma. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 5, which indicated Resident #36 had severely impaired cognition.</p> <p>A physician's order dated 12/15/2024 at 11:33 AM documented to implement Droplet/Contact Precautions.</p> <p>A review of the nursing progress note dated 12/15/2024 at 11:39 AM documented that Resident #36 had an elevated body temperature of 100.3 degrees Fahrenheit, sore throat/hoarseness, cough, congestion, and complaint of overall not feeling well. Resident #36 was provided a rapid Coronavirus (COVID-19) swab test and the result was positive. The Physician Assistant was notified and had a new order to begin the Coronavirus disease (COVID-19) protocol. Droplet/Contact precautions were in place.</p> <p>The Comprehensive Care Plan titled Contact/Droplet/Isolation Precaution, dated 12/15/2024 documented Resident #36 was positive for Coronavirus disease (COVID-19) infection. Interventions included but were not limited to maintaining Transmission-Based Precautions per the physician's orders and maintaining strict single-room isolation for positive Coronavirus Disease (COVID-19) residents.</p> <p>Resident #41 was admitted with diagnoses of Anemia, Stage 4 Chronic Kidney Disease, and Chronic Atrial Fibrillation. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated Resident #41 had intact cognition.</p> <p>A physician's order dated 12/7/2024 documented Contact Precautions for Extended Spectrum Beta-Lactamase in urine (people with ESBL could be resistant to some antibiotic treatment).</p> <p>The Comprehensive Care Plan titled Contact/Droplet/Isolation Precaution dated 12/7/2024 documented the resident had Extended Spectrum Beta-Lactamase in urine and Coronavirus (COVID-19) infection Exposure. Interventions included but were not limited to maintaining precautions per the physician's order and wearing proper Personal Protective Equipment.</p> <p>The Comprehensive Care Plan titled Coronavirus (COVID-19), effective 11/14/2024 and last revised 12/16/2024, documented the resident was exposed to Coronavirus (COVID-19) on 12/15/2024. Contact/Droplet precautions were in place per the physician's orders.</p> <p>A physician's order dated 12/15/2024 documented Contact/Droplet Precautions for [COVID-19 infection] Exposure.</p> <p>During an observation on 12/15/2024 at 10:02 AM, a Contact Precaution signage was observed posted at the doorway where Resident #36 and Resident #41 resided.</p> <p>During an interview on 12/15/2024 at 10:02 AM, Licensed Practical Nurse #1 stated that the Contact Precaution signage observed at the doorway was for Resident # 41 who had bacteria in their urine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/15/2024 at 12:45 PM, a Contact Precaution signage was observed posted at the doorway where Resident #36 and Resident #41 resided. Both residents were observed in the room. Resident #41 was out of bed with no mask. Resident #36's behind the privacy curtains that were drawn. A visitor was observed at Resident #36's bedside and was wearing a surgical mask. The visitor was not wearing a gown, gloves, or eye protection while interacting with Resident #36.</p> <p>During an interview on 12/15/2024 at 12:46 PM, Resident #36's visitor, who was wearing a blue surgical mask stated that Resident #36 just tested positive for Coronavirus (COVID-19) infection this morning and the resident was waiting to be moved to another room. Resident #36's visitor stated that Resident #36 has been symptomatic since Friday (12/13/2024), but tested negative for Coronavirus (COVID-19) on Friday (12/13/2024).</p> <p>During an observation on 12/15/2024 at 12:54 PM, a Contact Precaution signage was observed posted at the doorway where Resident #36 and Resident #41 resided. Both residents were observed in the room. Resident #41 was out of bed by their bedside and wore a blue surgical mask. Resident #36 was observed in their bed and did not wear a mask. Resident #36's visitor remained in the room and was wearing a blue surgical mask and no other Personal Protective Equipment.</p> <p>During an interview on 12/15/2024 at 12:55 PM, Licensed Practical Nurse #1 stated this morning they were aware that Resident #36 was being moved out of their room due to a newly positive test result for Coronavirus (COVID-19) infection. Licensed Practical Nurse #1 stated that Resident #41, who is Resident #36's roommate, is now considered exposed and would either be placed with other exposed residents or remain in the room by themselves.</p> <p>During an interview on 12/15/2024 at 1:00 PM, the Infection Preventionist stated both Resident #36 and Resident #41 were tested for Coronavirus (COVID-19) infection today (12/15/2024) and Resident #36's test results came back positive. The Infection Preventionist stated both residents should be placed on Droplet Precautions because Resident #36 tested positive for Coronavirus (COVID-19) Infection and should be placed on Droplet Precautions as per the facility policy. The Infection Preventionist stated that Resident #36 will be moved to another room for isolation. The Infection Preventionist stated that the correct Transmission-Based Precaution signage was not yet posted but staff and family members were notified about the resident's positive COVID-19 infection results.</p> <p>During an additional interview on 12/15/2024 at 1:53 PM, the Infection Preventionist stated they were responsible for keeping track of all residents who required to be placed on Isolation Precautions. The Infection Preventionist stated Resident #36 should have a blue Droplet and Contact precaution signage at the doorway to indicate positive Coronavirus (COVID-19) infection status and Resident #41 should have an orange Droplet/Contact precaution signage to indicate their exposure to a positive Coronavirus (COVID-19) infection resident. The Infection Preventionist stated they expected the appropriate signage to be posted once the residents completed their move to their designated rooms. The Infection Preventionist stated that the signage was not posted at the door of the room where both residents stayed while waiting for a room change to eliminate confusion.</p> <p>During an interview on 12/16/2024 at 2:21 PM, Registered Nurse #2, the unit manager, stated that primarily the Infection Preventionist was responsible for posting isolation precaution signage. Registered Nurse #2 stated they were aware Resident #36 tested positive for Coronavirus (COVID-19) infection and that Resident #41 was exposed to Resident #36. Registered Nurse #2 did not post the updated Transmission-Based Precautions signage after Resident #36 tested positive for COVID-19 infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/18/2024 at 12:57 PM, the Director of Nursing Services stated there should be a blue Droplet and Contact precaution signage for residents who tested positive for Coronavirus (COVID-19) infection and an orange Droplet and Contact precautions signage for residents who were exposed to a positive resident Coronavirus (COVID-19) infection.</p> <p>10 NYCRR 415.19(a) (1-3)</p>