STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335410	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waters Edge at Port Jefferson for Rehab and Nrsg	150 Dark Hollow Road Port Jefferson, NY 11777

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observations, record review, and staff interviews during the Abbreviated Survey case #NY00369007 and initiated on 1/21/2025, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan. This was identified for six (Resident #1, Resident #2, and Resident #3, Resident #4, Resident #5, and Resident #6) of eighteen residents reviewed for Quality of Care and Treatment. Specifically, 1) Resident #1 had no documented bowel movement for eight consecutive days. 2) Resident #2 had no documented bowel movement for five consecutive days. 3) Resident #3 had no documented bowel movement for five consecutive days. The finding is: The facility's policy titled, Bowel Protocol dated 12/23/2024 documented the nurses shall assess and document/report the following: vital signs, quantitative and qualitative description of diarrhea (how many episodes in what period of time, amount and consistency, etc.); change in mental status or level of consciousness; presence of fecal impaction, signs of dehydration (altered level of consciousness, lethargy, dizziness, recent change in mental status, dry mucous membranes, decreased urine output); abdominal assessment; digital rectal examination; onset, duration, frequency, severity of signs and symptoms; all current medications; all active diagnoses; and recent labs. The was no documented evidence that the Bowel Protocol policy included a procedure for constipation. 1) Resident #1 had diagnoses including fracture of the pelvis, Type 1 Diabetes Mellitus with Diabetic Chronic Kidney Disease, and Iron Deficiency Anemia. Resident #1's Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of 15 indicating intact cognition. A nursing admission note for Resident #1 dated 12/27/2024 documented that Resident #1's last bowel movement was two days ago on 12/25/2024 while in the hospital. Resident #1's bowel records revealed no documented evidence that Resident #1 had a bowel movement since admission on 12/27/2024 until 1/5/2025. Resident #1 had eight consecutive days of no bowel movement. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1's Comprehensive Care Plan dated 12/27/2024 documented that Resident #1 had constipation related to decreased mobility. The Comprehensive Care Plan documented an intervention as follows: that the resident will have a normal bowel movement at least every three days through the review and follow the facility bowel protocol for bowel management. The Physician should be informed of any problems. A Physician Assistant progress note dated 1/4/2025 documented that Resident #1 was evaluated for complaints of constipation and muscle pain. Physician Assistant #1 documented that the resident's abdomen was assessed and had positive bowel sounds, and that the abdomen was soft and non-distended. Physician Assistant #1 documented that Resident #1 had a change in stool habits and had chronic constipation. The recommendation was to continue Senna (a bowel laxative)1-tablet by mouth two times per day. Physician Assistant #1 also documented to initiate MiraLAX (bowel laxative), if there was no improvement in the next 24 hours. Resident #1's Medication Administration Records for December 2024 and January 2025 were reviewed and there was no documented evidence that the facility's bowel protocol was initiated. Resident # 1 was discharged to the hospital on 1/7/2025. 2) Resident #2 had diagnoses that included Heart Failure, Chronic Kidney Disease Stage 3, and Cardiomyopathy. Resident #2's Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of 15 indicating intact cognition. Resident #2's bowel records revealed no documented evidence that Resident #2 had a bowel movement from 1/18/2025 to 1/22/2025. Resident #2 had five consecutive days of no bowel movement. Resident #2's Medication Administration Record for January 2025 was reviewed and there was no documented evidence that the facility's bowel protocol was initiated until 1/22/2025 at 12:05 PM. 3) Resident #3 had diagnoses that included Lower Back Pain, Osteoarthritis of the Right Knee, and Morbid Obesity. Resident #3's Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of 15 indicating intact cognition. Resident #3's bowel records revealed no documented evidence that Resident #3 had a bowel movement from 1/17/2025 to 1/21/2025. Resident #3 had five consecutive days of no bowel movement. Resident #3's Medication Administration Record for January 2025 was reviewed and there was no documented evidence that the facility's bowel protocol was initiated until 1/21/2025 at 3:52 PM. During an interview with Registered Nurse #1 on 1/21/2025 at 2:32 PM they stated they recalled Resident #1 but did not recall any specific information on the resident. Registered Nurse #1 stated that the bowel protocol procedure was that the medication nurse reported concerns about bowel movements to the charge nurse. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Doctor of Osteopathic Medicine on 1/21/2025 at 3:23 PM they stated if Resident #1 did not have a bowel movement for three days the bowel protocol should have been started and that Sorbitol (a non-stimulating laxative to promote bowel activity) should have been started on day three. The Doctor of Osteopathic Medicine stated if Resident #1 did not have a bowel movement after receiving the Sorbitol, then a rectal suppository laxative would be administered and if there was no bowel movement then further diagnostic testing would be ordered to determine if further interventions were necessary. During an interview with Physician Assistant #1 on 1/21/2025 at 4:39 PM they stated they saw Resident #1 on 1/4/2025 for muscle pain and bowel habit complaints. Physician Assistant #1 ordered Sorbitol (a non-stimulating laxative to promote bowel activity) because they did not want to do any aggressive treatment for the resident. Physician Assistant #1 stated that the resident could start having a lot of loose stools and does not recall the exact date of the resident's last bowel movement. Physician Assistant #1 also stated that they only reviewed the first page of the resident's bowel form because they were unaware that the form included three pages. During an interview with Licensed Practical Nurse #1, on 1/22/2025 at 11:37 AM they stated that when they logged in to the Electronic Medical Record a bowel alert was triggered on the any resident's clinical dashboard if the resident did not have a bowel movement for two days. Licensed Practical Nurse #1 could not recall if they received an alert for Resident #1, they are responsible for thirty residents on the unit and did not recall specifics regarding Resident #1. During an interview with Nurse Practitioner #1 on 1/22/2025 at 1:05 PM they stated they assessed Resident #1 on 12/30/2024 and 1/2/2025. Nurse Practitioner #1 stated that they only looked at one page of the bowel record and did not know there were three pages. Nurse Practitioner #1 stated they thought that the resident had a bowel movement after reviewing page one of the bowel record. During an interview with the Director of Nursing Services on 1/22/2025 at 2:25 PM the Director of Nursing Services stated that if a resident does not have a bowel movement for three days that the bowel protocol should be initiated. The bowel protocol was that when the medication nurse logs into the electronic medical record, an Alert will pop up with a specific resident's name to indicate that the resident had not had a bowel movement in three days. The Director of Nursing Services stated that the Licensed Practical Nurse, the Medication Nurse should check the alert and then inform the unit's Registered Nurse Supervisor, or that the Licensed Practical Nurse can also notify a medical provider. The Director of Nursing Services stated a medical provider is in the facility every day from 8:30AM to 5:00 PM. The Director of Nursing Services reviewed Resident #1's medical record and stated that there was no documented evidence Resident #1 had a bowel movement for ten days or that a Physician was notified. The Director of Nurses reviewed the facility policy on bowel movements and stated that the policy did not document that if a resident does not have a bowel movement in three days what protocol should be initiated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Medical Director on 1/22/2025 at 4:00 PM they stated if a resident does not have a bowel movement for two days, then the facility's bowel protocol should be initiated. The Medical Director stated that if the bowel protocol does not produce a bowel movement, then the resident would be evaluated by a medical provider to determine why the resident did not have a bowel movement. The Medical Director stated the resident may need further diagnostic testing such as an abdominal x-ray. The Medical Director stated they were not informed that Resident #1 did not have a bowel movement for eight days. The Medical Director stated that implications of an eight-day period without a bowel movement could be abdominal pain and intestinal obstruction. 10 NYCRR 415.12