

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Waters Edge at Port Jefferson for Rehab and Nrsgr		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20757</b></p> <p>Based on record review and interviews during the Abbreviated Survey (NY00370917) the facility did not ensure that each resident's representative was immediately informed when a resident had a change in condition or the potential for change of condition requiring physician intervention. This was identified for one (Resident #1) of six residents reviewed for Quality of Care. Specifically, on 1/26/2025 and 1/27/2025 Resident #1 presented with fever, tachycardia (increased heart rate) hypotension (low blood pressure) and critical lab results including a HGB (hemoglobin) 4.9g/dl (normal range is 13.0-17.0g/dl). The resident's representative was not informed of the change in condition, or the interventions provided.</p> <p>The finding is:</p> <p>The facility's policy titled Change in Condition, last reviewed by the facility on 09/18/2024, documented the facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical mental condition and/or status. The policy further documented a significant change of condition is a decline in the resident's status that requires interdisciplinary review and or revision to the plan of care and impacts more than one area of the resident's health status.</p> <p>Resident #2 was an [AGE] year-old readmitted on [DATE] with diagnoses of atypical atrial flutter, heart failure with preserved ejection fraction, acute kidney injury, Altered Mental Status, abdominal distension, anemia, coronary artery disease, hemiplegia affecting right dominant side and pneumonia. Resident #2's Minimum Data Set (an assessment tool) dated 1/03/2025 documented resident had a Brief Interview for Mental Status score of 6/15 which indicated a significant cognitive impairment. Resident #2 had an advanced directive dated 12/30/2024 which included Send to hospital, when medically necessary.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician Encounter note dated 1/26/2025 at 12:00AM documented the Chief Complaint / Nature of Presenting Problem as Patient evaluated for fever, tachycardia, hypotension. Reviewed documents from 1/24/205 regarding chest x-rays with bilateral interstitial lung markings which was presumed as likely viral etiology. Patient currently on Tamiflu renal dosing since 1/25/2025. However, spiking fever with blood pressure 76/47 requires immediate fluid bolus and Tylenol 1gram versus 650milligrams. The heart rate 113, ordered EKG, fever 102.0 on repeat 101, initiating cooling measures and sepsis protocol. Patient currently on sepsis protocol. The note further documented Stat fluid bolus for blood pressure initially 76/47. Improvement after 500cc, repeat blood pressure 102/68 which is reassuring. Tachycardia improved pulse from 113 =&gt;94 status post fluid bolus. Cooling measures and Tylenol from 650 milligram to 1000 milligram every 8 hours. Ordered vancomycin 1 gram now followed by vancomycin 1 gram for 4 days for total 5-days treatment. The encounter further documents the plan is to manage at facility versus transfer.</p> <p>There is no documented evidence the provider notified the Resident Representative.</p> <p>A nursing progress Note dated 1/26/2025 at 4:09PM documented Resident #2 was noted with a temporal temperature of 101.1F, hypotensive (low blood pressure) and tachycardia. The note documented the Nurse Practitioner was made aware new order for Intravenous bolus initiated, Intravenous Meropenem 1gram, Vancomycin 1gram, labs and chest x-ray to be obtained.</p> <p>A nursing progress note dated 1/27/2025 at 3:11AM, documented the writer was called to assess resident with abnormal lung sounds; upon assessments lungs auscultated to have crackles bilaterally and only responsive to painful stimuli. Resident was suctioned, vital signs stable (no documented measurements) outside of temp of 99.9 ongoing care in progress. There is no documented evidence the resident representative was notified.</p> <p>A review of the Lab results dated 1/27/2025 documented a critical level of HGB (hemoglobin) 4.9g/dL (critically low) (normal range 13.0-17.0g/dL), HCT (hematocrit test) 17% (critically low) (normal range 39.0-50%) and Sodium 161 mmol/L (critically high) (134-145 mmol/L). There is no documented evidence the resident representative was notified.</p> <p>The Resident's Representative (primary contact) was interviewed on 2/13/2025 at 12:32 PM and stated the facility did not notify them when the resident was started on antibiotics for a sepsis protocol. They further stated they were not aware until they arrived at the funeral home that Resident #1 was experiencing symptoms of sepsis. Resident Representative stated they visited Resident #1 frequently and wanted to be notified if Resident had any changes in their medical condition. Residents Representative stated they would have demanded Resident #1 sent to the hospital if they were aware of the blood pressure readings below 90 or abnormal lung sounds.</p> <p>During an interview conducted on 2/15/2025 at 2PM with Nurse #2 they stated they were called to assess Resident #1 they observed the resident with abnormal lung sounds and not responsive to verbal or tactile stimuli. They further stated they did not notify the Resident Representative or the Physician.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 2/13/2025 at 1:24PM Registered Nurse Supervisor #1 stated on 1/27/2025 they received a call from the lab at approximately 6:30PM and was informed Resident #1's hemoglobin and hematocrit results were critically low (4.9g/dl 17%), they stated they called the Nurse Practitioner on duty and informed them of the results. They stated they did not call the resident's Representative and could not provide an answer as to why not.</p> <p>Multiple attempts were made on 2/14/2025, 2/20/2025 and 2/21/2025 to contact Physician Assistant #1 without success.</p> <p>During an interview on 2/13/2025 at 10:22 AM, the Director of Nursing Services stated the facility staff should have called the resident's representative and advised them of changes with the resident's medical condition and new interventions.</p> <p>10 NYCRR 415.3(f)(2)(ii)(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20757</b></p> <p>Based on interviews and closed record reviews , during an abbreviated survey (NY00370917), the facility failed to ensure that each resident received treatment and care in accordance with professional standards of practice for one (1) out of three (3) residents. Specifically, on [DATE] at 8:01 PM, Resident #2 was evaluated for symptoms including fever and tachycardia. Nurse Practitioner #1 was notified on [DATE] at 6:30 PM of critical lab values and ordered to send Resident #2 to the hospital for an emergent blood transfusion. Registered Nurse Supervisor #1 documented Resident #2 would be sent to the hospital in the morning. Subsequently, on [DATE] at 1:20 AM, Resident #2 was found to be unresponsive, pulseless, and without respirations. Resident #2 expired at 2:01 AM. This resulted in Immediate Jeopardy with the likelihood for serious injury, serious harm, or death for all residents.</p> <p>Findings include:</p> <p>The facility policy titled Health Care Providers Services dated [DATE] documented (3) The health care providers will perform pertinent, timely medical assessments; prescribe an appropriate medical regimen; provide adequate, timely information about the resident's condition and medical needs.</p> <p>Resident #2 was an [AGE] year-old readmitted on [DATE] with diagnoses of heart failure (a condition when the heart cannot pump enough blood and oxygen to the body), acute kidney injury (decrease in kidney function), and pneumonia. Resident #2's Minimum Data Set (an assessment tool) dated [DATE] documented resident had a Brief Interview for Mental Status score of 6 which indicated a significant cognitive deficit. Resident #2 had an advanced directive dated [DATE] which included Send to hospital, when medically necessary.</p> <p>A Physician Encounter note dated [DATE] at 12:00 AM documented the Chief Complaint / Nature of Presenting Problem as Patient evaluated for fever, tachycardia, hypotension (low blood pressure). Reviewed documents from [DATE] regarding chest x-rays with bilateral interstitial lung markings (abnormal findings on an x-ray that indicates inflammation and scarring of lung tissue) which was presumed likely viral etiology. Patient currently on an antiviral medication (used to treat the flu) renal dosing since [DATE]. However, spiking fever with blood pressure ,d+[DATE] requires immediate fluid bolus and Tylenol 1 gram versus 650 milligrams.</p> <p>A Nursing Progress Note on [DATE] at 4:09 PM documented Resident #2 was noted with a temporal (forehead) temperature of 101.1 Fahrenheit, hypotensive, and tachycardia (increased heart rate). The note documented the Nurse Practitioner was made aware with new orders for intravenous bolus, initiated intravenous antibiotics, labs and chest x-ray to be obtained.</p> <p>A Nursing Progress Note dated [DATE] at 3:11 AM, documented resident was assessed [with] abnormal lung sounds; upon assessment lungs auscultated to have crackles bilaterally and the resident was only responsive to painful stimuli. Resident was suctioned (the process of removing something by way of vacuum or pump), vital signs stable (no documented measurements) outside of temp of 99.9, ongoing care in progress.</p> <p>A Medication Administration Note, dated [DATE] at 6:50 AM, documented Resident #2 had an elevated temperature of 101.2.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>A review of the lab results dated [DATE] documented a critical low level of hemoglobin at 4.9g/dL, a critical low level of hematocrit at 17%, and a critical high level of Sodium at 161 mmol/L (normal range ,d+[DATE] mmol/L).</p> <p>A review of Resident #2's vital signs documented the following blood pressures:</p> <p>[DATE] 8:10 AM - blood pressure reading ,d+[DATE]. No documented evidence the physician was notified.</p> <p>[DATE] at 9:10 AM - blood pressure reading ,d+[DATE]. No documented evidence the physician was notified</p> <p>[DATE] at 6:19 PM - blood pressure reading of ,d+[DATE]. No documented evidence the physician was notified.</p> <p>A Nursing Progress Note dated [DATE] at 6:32 PM, documented Registered Nurse Supervisor #1 received a call from the lab that Resident #1 had a critical result including a hemoglobin of 4.9 and hematocrit of 17.0. Resident with stable vitals (no measurements documented). The note further documented Nurse Practitioner #1 was notified and ordered Resident #1 be transferred to emergency room in the morning for blood transfusion.</p> <p>An On Call Telemedicine note written by Nurse Practitioner #2 on [DATE] at 10:21 PM documented the nurse (there is no documented evidence who Nurse Practitioner #2 spoke to) called in stating that the patient's sodium is elevated. No signs or symptoms. The note further document the nurse added that the patient is going to be sent to the hospital tomorrow morning for transfusion due to critical hemoglobin level.</p> <p>A Nursing Progress Note, dated [DATE] at 2:20 AM, documented that at approximately 1:20 AM Resident #2 was found unresponsive with no pulse. Cardiopulmonary Resuscitation initiated immediately. Emergency services were called and arrived on scene at 1:31 AM. Paramedics assumed care and Resident #2 was pronounced deceased at 2:01 AM.</p> <p>During an interview with Registered Nurse Supervisor #1 on [DATE] at 3:30 PM, they stated they received a call from the lab on [DATE] at approximately 6 PM regarding critical values for Resident #2. They took vital signs and notified Nurse Practitioner #1. Registered Nurse Supervisor #1 stated they were given orders to send Resident #2 for a blood transfusion in the morning.</p> <p>During an interview with Nurse Practitioner #1 on [DATE] at 1:15 PM, they stated they recalled receiving a phone call from the Registered Nurse Supervisor #1 on [DATE] at approximately 6 PM informing them of Resident #2's critical lab result. Nurse Practitioner #1 stated to their recollection they were only given the critical hemoglobin level and speculated that the other results may not have been completed at the time of the call. Nurse Practitioner #1 stated they believed something got lost in translation on the call with the nurse. Nurse Practitioner #1 stated they did not give the nurse an order to wait until the morning to send Resident #2 to the hospital for a blood transfusion. Nurse Practitioner #1 stated if Resident #2's hemoglobin level had been a little higher, they might have been able to schedule Resident #2's transfer to the hospital for a transfusion but not in this case.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview with Physician #1 on [DATE] at 3:00 PM, they stated Resident #2 would need the blood transfusion given the critical labs but could wait until the morning if the resident's vitals were stable. The physician stated the blood pressure were not indicative of stable vital signs. The Physician further stated Resident #2 should have been sent to the hospital immediately.</p> <p>During an interview with the Medical Director on [DATE] at 2:30 PM and [DATE] at 2:00 PM, they stated the treatment of a patient with a hemoglobin below 8 would be to consider a blood transfusion. The facility has a process for acute changes to call 911. The Medical Director further stated he is not involved with direct patient care, however if a resident presented in the Emergency Department with a hemoglobin of less than 8, they would need a blood transfusion right away.</p> <p>During an interview with the Director of Nursing on [DATE] at 2:05 PM they stated if blood pressure, pulse, respiration, or temperature documented by the staff are out of range, the system provides notification to the nurse with an out-of-range alert. If the resident is to be transferred, the Nurse Practitioner or physician should say it's immediate, otherwise the transportation line is used. They further stated Resident #2 was set to have a planned transfer. A planned transfer means if the patient is stable, they would contact transport and let the hospital know the patient is coming for continuation of care. The Director of Nursing confirmed that based on the residents' blood pressure and abnormal lab results, Resident #2 was not stable.</p> <p>10 NYCRR 415.12</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20757</b></p> <p>Based on observation, interview and record review conducted during an abbreviated survey (NY00370917), the facility did not provide person-centered care and services necessary to maintain the highest practicable physical, mental, and psychosocial well-being for three of six residents (Resident #2 #3 #5) reviewed for Accidents. Specifically, (1) Resident #2 was identified as high risk for aspiration (choking) and was to be fed via percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube that allows nutrition directly through your stomach.) Resident #2 physician orders documented medications to be administered by mouth. (2) Resident #3 was evaluated by speech and deemed to be at risk for aspiration, a physician's order indicated a puree diet. Resident #3 was given a dog biscuit which Resident #3 ate and subsequently began coughing and noted with abnormal lung sounds (stridor). (3) Resident #5 was identified at risk for aspiration, Resident # 5 was evaluated by speech with recommendations for nothing by mouth (NPO). Medication administration records dated January 2025 indicated multiple medication administration by oral route.</p> <p>The findings are:</p> <p>The policy titled Accidents and Incidents Investigating and Reporting dated 5/2024 documented all accidents or incidents involving residents shall be investigated using the Report of Incident/Accident Form including the circumstances surrounding the accident or incident, the names of witnesses and their accounts, and other pertinent data as necessary or required.</p> <p>The facility policy titled Aspiration Precautions dated 5/2024 documented aspiration precautions were defined as measures taken to reduce the risk of aspiration during eating, drinking, and other activities. Nursing staff were responsible for monitoring residents for signs of aspiration risk, implementing precautions and communicating changes in condition. The Speech Language Pathologists assess swallowing function and recommend appropriate dietary modifications and interventions. Provide direct supervision for residents with high aspiration risk and observe for signs of difficulty such as coughing and choking. Documents observations in the resident's medical record.</p> <p>Resident #2 was a [AGE] year-old readmitted on [DATE] with diagnoses of atypical atrial flutter, heart failure with preserved ejection fraction, Acute Kidney Injury, Altered Mental Status, abdominal distension, anemia, Coronary Artery Disease, hemiplegia affecting right dominant side and pneumonia.</p> <p>Resident #2's Minimum Data Set (an assessment tool) dated 1/03/2025 documented resident had a Brief Interview for Mental Status score of 6/15 which indicated a significant cognitive deficit. Resident #2 had an advanced directive dated 12/30/2024 which included Send to hospital, when medically necessary.</p> <p>A review of the Patient Review Instrument dated 12/26/2025 documented (19) Eating = 5 Tube of parenteral feeding for primary intake of food. (Not just for supplemental nourishments.)</p> <p>The speech therapy evaluation dated 12/30/2024 documented resident should have nothing by mouth (NPO).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The physician orders dated 12/27/2024-1/28/2025 does not reflect a diet order or an order for nothing by mouth. The physician order recap dated 12/27/2024 to 1/28/2024 documented May crush and mix medications together unless contraindicated. Any drug which cannot be crushed, may be given whole in applesauce.</p> <p>Physician orders further document the following:</p> <p>Omeprazole Tablet Delayed Release 20 MG Give 2 tablet by mouth every 12 hours for acid indigestion for 2 Weeks. Start Date: 1/17/2025, Discharge/Death 1/28/2025</p> <p>Tamiflu Oral Capsule 30 MG (Oseltamivir Phosphate) Give 1 capsule by mouth one time a day for flu for 5 days Start Date 1/26/2025, Discharge/Death 1/28/2025</p> <p>Tylenol Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain. Start Date 1/13/2025, Discontinue 1/26/2025</p> <p>The medication administration record dated January 2025 documented signatures indicating administration of the orders as prescribed.</p> <p>Multiple attempts to reach Physician Assistant #1 on 2/14/2025, 2/20/2025 and 2/21/2025 were unsuccessful.</p> <p>(2) Resident #3 was admitted [DATE] with diagnoses of chronic obstructive pulmonary disease, atherosclerotic heart disease of native coronary artery without angina pectoris, adult failure to thrive, other specified anemias, essential primary hypertension, other obstructive and reflex uropathy, schizophrenia, and other specified depressive episodes. Resident #3's Minimum Data Set (an assessment tool) dated 11/8/2024 documented a Brief Interview for Mental Status score of 8/15 which signified a moderate cognitive deficit.</p> <p>Physician Order dated 8/7/2023 documented Regular diet puree texture thin liquid consistency, aspiration precautions-no straws.</p> <p>A Speech Language Pathology Screen dated 9/14/2023 documented discharge status and recommendations documented puree consistencies.</p> <p>A nursing progress note dated 12/25/2025 documented Resident was given dog treat (solid consistency) to feed dog and resident subsequently ingested said dog treat. The note further documented resident presents with a persistent cough with stridor (Stridor is a high-pitched, whistling or noisy sound that occurs when breathing. It is caused by an obstruction or narrowing in the upper airway).</p> <p>The physician progress note dated 12/26/2025 documented Resident #3 ate the treat with subsequent fit of coughing, stridor noted at the time but resolved.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility accident and incident report dated 12/27/2025 documented during pet therapy the resident asked if he could give the dog a treat, Resident #3 was given a dog treat to feed dog, resident ingested dog treat which was a milk bone treat, Registered Nurse Supervisor was immediately notified. Registered Nurse Supervisor completed an assessment, resident noted with a persisting cough with slight stridor noted to lungs, resident refused vital signs at the time and the physician was made aware.</p> <p>During an interview conducted with the Speech Language Pathologist on 2/13/2025 at 1 PM they stated Resident #3 would present with immediate cough and throat clear with all intakes which indicates that he is at risk for aspiration with solid foods. They further stated resident could not tolerate a solid dog biscuit.</p> <p>(3) Resident #5 was admitted to the facility with a medical diagnosis that included Acute Respiratory Failure with Hypoxia, and Schizophrenia.</p> <p>The review of the Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score- 15 indicating intact cognition for decision making, eating not attempted due to medical condition or safety concerns, feeding tube on admission, while a resident, the resident received through parenteral or tube feeding-51% or more, for the Resident.</p> <p>The review of the Order Recap Report dated 1/11/2025 documented Tube Feed diet, nothing by mouth.</p> <p>The review of the physician orders dated 1/16/2025 documented Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for 7 Days, prednisone oral tablet 20 mg give 2 tablet mouth one time a day for wheeze and cough for 7 days and Tamiflu oral capsule 75 give one capsule by mouth one time a day for flu exposure for 8 days.</p> <p>The review of the Medication Administration Record dated 2/2025 documented signatures indicating medication administrations as ordered for Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for 7 Days, prednisone oral tablet 20 mg give 2 tablet mouth one time a day for wheeze and cough for 7 days and Tamiflu oral capsule 75 give one capsule by mouth one time a day for 8 days.</p> <p>Multiple attempts to reach Physician Assistant #1 on 2/14/2025, 2/20/2025 and 2/21/2025 were unsuccessful.</p> <p>On 2/13/2025 at 2:20 PM, the Director of Nursing was interviewed and stated the nurses are aware of the residents with feeding tube. The Director of Nursing stated that Residents who are assessed to have nothing by mouth (NPO) should have orders to administer medication thru the feeding tube. They further stated staff are aware of Residents #5 feeding tube and should have notified the physician to change the order to reflect the medication be administered via the feeding tube.</p> <p>On 2/13/2025 at 1:18 PM, Medical Doctor #1 was interviewed and stated residents who are assessed to have nothing by mouth (NPO) should have orders to administer medication thru the feeding tube. They further stated Resident # 3 should not have consumed the dog biscuit.</p> <p>10 NYCRR 415.12(h)(1)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 20757</p> <p>Based on record review and interviews during an abbreviated survey (NY00370917) the facility did not ensure the physician reviewed the resident's total program of care, including treatments at each visit and a decision about the continued appropriateness of the resident's current medical regimen for 2 out of 6 residents (Resident #5, #2) reviewed for Quality of Care. Specifically, (1) Resident #2 was admitted to the facility with orders for nothing to be administered by mouth and a feeding tube the facility did not address Resident #2 ability to receive oral medication or include an order for nothing by mouth (NPO) on the admission orders. Additionally, Physician Assistant #1 ordered Tylenol 325mg by mouth every 8 hours and Tamiflu capsules 30mg daily by mouth. (2) Resident #5 was admitted with orders for nothing by mouth with a feeding tube, Resident #5 was evaluated on 1/19/2025 by Physician Assistant #1 with orders including amoxicillin tablet, prednisone tablet and Tamiflu capsules to be administered by mouth. (3) The pharmacy review for resident #5 recommended to discontinue Proscar (medication used in the treatment of benign prostate hypertrophy) and initiate Rapaflo. Nurse practitioner #1 initiated the new medication but did not discontinue the Proscar. For 30 days resident received both medications.</p> <p>The findings are:</p> <p>The facility Physician's Visit policy dated 2/1/2016 and last revised 1/2020 documented the attending physician must make visits in accordance with applicable state and federal regulations. The attending physician must perform relevant tasks at the time of each visit, including a review of the resident's total program of care and appropriate documentation.</p> <p>1)</p> <p>Resident #2 was an [AGE] year-old readmitted on [DATE] with diagnoses of atypical atrial flutter, heart failure with preserved ejection fraction, acute Kidney Injury, Altered mental Status, abdominal distension, anemia, coronary artery disease, hemiplegia affecting right dominant side and pneumonia. Resident #2's Minimum Data Set, dated dated [DATE] documented resident had a Brief Interview for Mental Status score of 6/15 which indicated a significant cognitive impairment. Resident #2 had an advanced directive dated 12/30/2024 which included Send to hospital, when medically necessary.</p> <p>A review of the Patient Review Instrument dated 12/26/2025 documented (19) Eating = 5 Tube of parenteral feeding for primary intake of food. (Not just for supplemental nourishments.)</p> <p>The speech therapy evaluation dated 12/30/2024 documented resident should have nothing by mouth (NPO).</p> <p>The physician orders dated 12/27/2024-1/28/2025 does not reflect a diet order or an order for nothing by mouth.</p> <p>The physician order recap dated 12/27/2024 to 1/28/2024 documented May crush and mix medications together unless contraindicated. Any drug which cannot be crushed, may be given whole in applesauce.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Waters Edge at Port Jefferson for Rehab and Nrsg		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Physician orders further document the following:</p> <p>Omeprazole Tablet Delayed Release 20 MG Give 2 tablet by mouth every 12 hours for acid indigestion for 2 Weeks.</p> <p>Tamiflu Oral Capsule 30 MG (Oseltamivir Phosphate) Give 1 capsule by mouth one time a day for flu for 5 days.</p> <p>Tylenol Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain.</p> <p>Medication administration record dated January 2025 documented signatures indicating administration of the orders as prescribed.</p> <p>Multiple attempts to reach Physician Assistant #1 on 2/14/2025, 2/20/2025 and 2/21/2025 were unsuccessful.</p> <p>During an interview conducted with the Medical Director on 2/12/2025 at 3PM they stated the physician/practitioner should review the recommendations from the speech pathologist for the resident's intake status. They further stated if a resident is deemed nothing by mouth (NPO) there should be physician order to reflect that, and medications should not be administered or ordered by mouth.</p> <p>2)</p> <p>Resident#5 was admitted to the facility with a medical diagnosis that included Acute Respiratory Failure with Hypoxia, and Schizophrenia.</p> <p>The review of the Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score- 15 indicating intact cognition for decision making, eating not attempted due to medical condition or safety concerns, feeding tube on admission, while a resident, the resident received through parenteral or tube feeding-51% or more, for the Resident.</p> <p>The review of the Order Recap Report dated 1/11/2025 documented Tube Feed diet, nothing by mouth.</p> <p>The review of the physician orders dated 1/16/2025 documented Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for 7 Days, prednisone oral tablet 20 milligram give 2 tablets by mouth one time a day for 7 days and Tamiflu oral capsule 75 milligram give one capsule by mouth one time a for 8 days.</p> <p>The review of the Medication Administration Record dated 2/2025 documented signatures indicating medication administrations as ordered for Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for 7 Days, prednisone oral tablet 20 mg give 2 tablet mouth one time a day for 7 days and Tamiflu oral capsule 75 give one capsule by mouth one time a day for 8 days.</p> <p>Multiple attempts to reach Physician Assistant #1 on 2/14/2025, 2/20/2025 and 2/21/2025 were unsuccessful.</p> <p>3)</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335410	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/21/2025
NAME OF PROVIDER OR SUPPLIER  Waters Edge at Port Jefferson for Rehab and Nrsng		STREET ADDRESS, CITY, STATE, ZIP CODE  150 Dark Hollow Road Port Jefferson, NY 11777	

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The medication Regimen review dated 1/10/2025 documented consultant pharmacy recommendations including currently receiving Finasteride (proscar) by PEG (feeding tube) for benign prostate hypertrophy which should not be crushed. Please consider discontinue and start Silodosin (Rapaflo) 8 Mg daily opened spinked in applesauce and given via GT.</p> <p>The physician/ prescriber response indicated Agree; Will do signed and dated by the prescriber on 1/13/2025.</p> <p>The physician order recap report dated February 21, 2025, documented; Finasteride oral tablet 5mg 1 tablet via peg-tub one time a day for urinary obstruction.</p> <p>The medication administration record dated January 2025 and February 2025 documented signatures indicating administration of silodosin 8mg once a day from January 14 thru February 13, 2025.</p> <p>The medication administration record dated January 2025 and February 2025 documented signatures indicating administration of finasteride 5 mg once a day from January 8 thru February 13, 2025.</p> <p>During an interview conducted with Nurse Practitioner #1 on 2/13/2025 at 2pm they stated they reviewed the recommendations from the pharmacy. They further stated they agreed to switch to Silodosin (Rapaflo) which could be given via the feeding tube. Nurse Practitioner #1 stated proscar should have been discontinued and it was an oversight. They stated they would do it immediately.</p> <p>10NYCRR 415.15(b)(2)(iii)</p>