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	08/11/2025

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 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, during the Recertification Survey initiated on 07/21/2025 and completed on 08/11/2025, the facility failed to ensure that a resident requiring respiratory care is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This was identified for two (2) (Resident #74 and Resident #119) of four (4) residents reviewed for Respiratory Care. Specifically, Resident #74 with a diagnosis of Chronic Obstructive Pulmonary Disease had a physician's order for supplemental oxygen and did not receive it. On 07/25/2025, the resident was in respiratory distress and was utilizing accessory muscles, appeared pale with gray lips, and verbalized I need air. Licensed Practical Nurse #4 stated the resident's breathing difficulty was due to a panic attack and that the resident was exaggerating; and they would administer Xanax (an antianxiety medication) when available. Licensed Practical Nurse #4 did not check the resident's oxygen tank to determine oxygen availability; the oxygen tank gauge needle was observed at the red zone; and Resident #74's oxygen saturation was measured at 82% (normal range 95% to 100%). This resulted in actual harm to Resident #74 and a likelihood for serious harm to 13 other residents utilizing supplemental oxygen therapy, that is Immediate Jeopardy. The finding is:The facility's policy for Oxygen Administration, last reviewed on 01/2025, documented before administering oxygen and while the resident is receiving oxygen therapy, assess for signs or symptoms of cyanosis (blue tone to the skin and mucous membranes) and hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion). The policy included guidance regarding documentation, including the date and time that the oxygen treatment was ordered; the name and title of the individual who administers the oxygen, the rate of oxygen flow, route, and rationale, the frequency and duration of the treatment, and all assessment data obtained before, during, and after the procedure, for example oxygen saturation (a measure of how much hemoglobin in your blood is carrying oxygen) and vital signs.Resident # 74 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease and Respiratory Failure (a progressive lung disease that makes it difficult to breathe). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented that the resident required assistance with personal hygiene, transfers, and dressing. The resident received oxygen therapy during the assessment look-back period.The Comprehensive Care Plan for Altered Respiratory Status related to Chronic Obstructive Pulmonary Disease, Asthma, and Sleep Apnea (breathing repeatedly stops and starts during sleep), revised on 06/02/2025 documented interventions including monitor respiratory status, oxygen saturation, lung sounds, complaints of shortness of breath, use of accessory muscles, cyanosis and provide oxygen therapy as per the physician's orders. The physician's order dated 05/27/2025 documented to administer supplemental oxygen at two (2) liters per minute to maintain oxygen saturations above 90% every shift. During the resident council meeting on 07/21/2025 at 3:30 PM, Resident #74 stated they usually run out of [supplemental] oxygen, and it could take two (2) to three (3) hours before the oxygen tank was replaced. Resident #74 stated they have difficulty breathing when the oxygen tank is empty, and the staff do not care when they ask for (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	assistance to replace the oxygen tank.The Medication Administration Record for July 2025 documented to administer supplemental oxygen at two (2) liters per minute to maintain oxygen saturation above 90% every shift. On 07/25/2025, at 7:00 AM, the resident's oxygen saturation was documented to be at 96% by Licensed Practical Nurse #4.A Nursing progress note dated 07/25/2025 at 1:06 PM documented the resident's family member was present at the facility and expressed concerns that the resident had been jittery (restless, unable to relax) and appeared more anxious this visit than usual. The family member was informed that the resident had received a dose of Solumedrol (corticosteroid) injection the day prior and was also receiving nebulizer treatments, which could contribute to the resident feeling jittery. The Physician discussed with the resident and the family member to change the resident's Xanax dosage. The Resident and their family member were both in agreement with the plan of care.The Physician's order dated 07/25/2025, documented supplemental oxygen 2-4 Liters per minute to maintain oxygen saturation above 90% every shift and Alprazolam (Xanax) oral tablet 0.25 milligrams. Give one (1) tablet by mouth two times a day in the morning and afternoon for 14 days, and 0.5 milligrams (Alprazolam) one (1) tablet by mouth at bedtime for 14 days.During an observation on 07/25/2025 at 1:45 PM, Resident #74 was observed self-propelling themselves in a wheelchair from the dining room to the nurse' station. The resident was wearing a nasal cannula (a thin, flexible tube used to supply supplemental oxygen through the nose) that was connected to a portable oxygen tank. The resident was having difficulty breathing and was using their accessory (chest) muscles to try and breathe. The resident's color was pale with gray lips. The oxygen tank gauge needle was observed to be in the red area (indicating a low level of oxygen remaining in the tank). Licensed Practical Nurse #4 was administering medications to other residents in the hallway in front of the nurse' station. Resident #74 told Licensed Practical Nurse #4, I need air. Licensed Practical Nurse #4 told the resident they (the resident) were having a panic attack. Licensed Practical Nurse #4 stated they were waiting for Xanax to be delivered. The resident repeated, I need air. Licensed Practical Nurse #4 stated to the surveyor in the presence of the resident, The resident is exaggerating, and they (Licensed Practical Nurse #4) must finish providing medications to other residents. Resident #74 put their hands up in the air and stated, They do not care. The Director of Nursing Services was in the vicinity and intervened. The Director of Nursing Services acknowledged and confirmed that the resident's oxygen tank was empty. The Director of Nursing Services then checked the resident's oxygen saturation, which was found to be 82 % (low), and directed Licensed Practical Nurse #4 to get a full oxygen tank. The Director of Nursing Services then replaced the resident's oxygen tank. The resident's oxygen saturation went up to 94% after the oxygen tank was replaced. Resident #74 stated they felt better. Licensed Practical Nurse #4 stated the resident utilized an oxygen concentrator while in bed and an oxygen tank when out of bed. Licensed Practical Nurse #4 stated that they did not connect the resident to the oxygen tank and did not check the resident's oxygen tank during their shift. During an observation of an activity program in the dining room on 07/28/2025 at 11:00 AM, Resident #74 was again observed with an oxygen tank with the gauge needle in the red area. Resident #74 stated they were having some difficulty breathing, and there was no air flow coming out of the tubing. The resident stated they did not report having breathing difficulty to anyone because the staff usually would not do anything. At 11:08 AM, Housekeeper #1 was observed replacing Resident #74's oxygen tank. During an interview on 07/28/2025 at 11:12 AM, Housekeeper #1 stated they were told by Recreational Assistant #1 to change the resident's oxygen tank. Housekeeper #1 stated they usually changed the oxygen tanks for residents in the facility. During a re-interview on 07/28/2025 at 11:16 AM, Licensed Practical Nurse #4 stated the resident had a full oxygen tank when they last checked the resident on 07/28/2025 at 8:00 AM. Licensed Practical Nurse #4 stated they should have rechecked the resident's oxygen tank every two (2) hours; however, they were busy with the medication administration pass. The resident usually comes to the nurse and asks for the oxygen tank to be replaced. Licensed Practical Nurse #4 stated there was no problem with a housekeeper changing the resident's oxygen tank. During an (continued on next page)

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F 0695 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	interview on 07/28/2025 at 11:37 AM, Recreational Assistant #1 stated they were the only staff member in the room conducting the activity program and could not leave the dining room to notify nursing staff that Resident #74's oxygen tank was empty and needed replacement. Recreational Assistant #1 stated that normally, they would notify the Certified Nurse Assistants to get the oxygen tank or take the resident out of the room to the nurse to get a new oxygen tank. Recreational Assistant #1 stated they did not see any Certified Nurse Assistant or a nurse, so they asked Housekeeper #1 to replace the oxygen tank for Resident #74. During an interview on 07/28/2025 at 11:40 AM, Registered Nurse #3 stated a full oxygen tank that is utilized by the resident should last for three (3) to four (4) hours, depending on the oxygen flow rate, and should be monitored by the Licensed Practical Nurse at least twice a shift, at around 10:00 AM and 2:00 PM. Registered Nurse #3 stated it was okay for Certified Nurse Assistants or housekeepers to replace the resident's oxygen tanks. Registered Nurse #3 stated they were not notified until 11:40 AM on 07/28/2025 that the resident's oxygen tank was found empty, and they would go and assess the resident now. During an interview on 07/28/2025 at 2:30 PM, the Director of Nursing Services stated staff should check the resident's oxygen tank at least three (3) times per shift. They should not wait until the tank is empty and the gauge needle is in the red zone to change the oxygen tank. The Director of Nursing Services stated nurses should monitor and assess the residents at least twice per shift when the residents are receiving oxygen at three (3) liters per minute, including obtaining oxygen saturation to ensure the oxygen level is maintained within the parameters ordered by the Physician.During an interview on 07/28/2025 at 2:00 PM, Respiratory Registered Nurse #1 stated they were responsible for ensuring oxygen concentrators were properly functioning, providing respiratory treatments, and chest physical therapy. Respiratory Registered Nurse #1 stated that if the resident was receiving three (3) liters of oxygen, the oxygen tank should last up to four (4) hours, and the Licensed Practical Nurse should check the resident's oxygen tank every three (3) hours. The oxygen tank should be changed by the nurses, not a Certified Nurse Assistant or the housekeeper.During an interview on 07/29/2025 at 11:00 AM, Attending Physician #1 stated Resident #74's oxygen saturation level was down to 82% on 07/25/2025, the resident was in respiratory distress because the resident did not receive supplemental oxygen and should have received oxygen therapy as ordered by the Physician. Attending Physician #1 stated Resident #74 had Pneumonia and required oxygen therapy. Resident #119 was admitted with diagnoses of Congestive Heart Failure (heart cannot pump blood well enough to give the body a normal blood supply), Chronic Obstructive Pulmonary Disease, and Chronic Respiratory Failure with Hypoxia (low oxygen level in blood). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of six (6), which indicated the resident had severely impaired cognition. The resident utilized oxygen therapy in the assessment look-back period.The Physician's order for Resident #119, dated 07/28/2025, documented that the resident was on oxygen at two (2) liters per minute. During an observation on 08/08/2025 at 4:46 PM, Resident #119 was observed in their room holding their nasal cannula in their hand and pointing to the nasal cannula. The oxygen tank was empty with the gauge needle at zero. Certified Nurse Assistant #1 walked into the room and changed the resident's oxygen source from the oxygen tank to the oxygen concentrator and stated they were allowed to do that. The Certified Nurse Assistant then took the oxygen tank outside of the resident's room. The Director of Nursing Services was in the hallway and stated that the Certified Nurse Assistants were not allowed to change the oxygen source.Review of Licensed Practical Nurse #4's personnel file on 08/11/2025 at 11:00 AM indicated no in-service education related to caring for residents on oxygen therapy.During an interview on 08/11/2025 at 12:30 PM, the Inservice Coordinator stated there is no competency completed for the nurses related to the oxygen or respiratory care, except for tracheostomy (opening into the windpipe) care. The Inservice Coordinator stated the nurses should know to how to handle oxygen tanks and to care for residents with respiratory issues because it is a standard of practice for nurses. 10 NYCRR 415.12(k)(6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interviews, and record review conducted during the Recertification Survey, initiated on 07/21/2025 and completed on 08/11/2025, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was identified during the Kitchen Task observation. Specifically, 1) the walk-in freezer, the storage shelf in the kitchen, and the two-door reach-in freezer had one opened and undated food or food packages. 2) The cooked poultry meal temperatures were not maintained within the required range (above 135 degrees).The findings are:The facility's policy titled Food Storage documented that food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross-contamination. Food should be dated as it is placed on the shelves. Plastic containers with tight-fitting covers or sealable plastic bags must be used for storing grain products, dried vegetables, and broken lots of bulk foods or opened packages. All containers or storage bags must be legible and accurately labeled and dated. Refrigerated/frozen food storage: all foods should be covered, labeled, dated, and routinely monitored to assure that foods (including leftovers) will be consumed by the use-by dates, or frozen (where applicable) or discarded. The facility's policy titled Food Temperatures documented that the temperature of all food items will be taken and properly recorded prior to service of each meal. All hot food times must be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Hot food items may not fall below 135 degrees Fahrenheit after cooking, unless it is an item that is to be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit (for a minimum of 15 seconds) prior to serving. Temperatures should be taken periodically to ensure hot foods stay above 135 degrees Fahrenheit during the holding and plating process and until food leaves the service area. Foods sent to the units for distribution will be transported and delivered to unit storage areas to maintain temperatures at or above 135 degrees Fahrenheit for hot foods.During the Kitchen observation with the Food Service Director and the Assistant Food Service Director on 7/21/2025 at 9:43 AM, the walk-in freezer had two pans of opened packets of frozen food items (three bags of hash brown patties and a tray of waffles) that were unlabeled and undated; A storage shelf in the kitchen had multiple open packages of pasta and a package of pastina that were not labeled or dated. Below the storage shelf, there was one canister of flour that was undated and another canister with an unlabeled and undated powdered type food product; The two-door reach-in freezer had one opened, undated package of corn bread, and an unlabeled and unidentified food package.The Assistant Food Service Director was immediately interviewed after the observation on 7/21/2025 and stated that the hash brown patties and waffles should not be used as they have a potential for freezer burn and reduced quality. The Assistant Food Service Director stated that all opened food packages should be properly labeled and dated.During an observation of the tray-line for lunch meal with the Assistant Food Service Director on 7/25/2025 at 11:46 AM, the cooked chicken thigh temperature was measured at 110 degrees Fahrenheit. A second temperature check of an additional chicken thigh was immediately conducted, and the temperature was measured at 120 degrees Fahrenheit. The Assistant Food Service Director stated that the cooked chicken temperatures did not meet the standard for food safety and that the proper holding temperatures should be 135 degrees Fahrenheit to prevent food spoilage. The Food Service Director, also present, agreed with the statements of the Assistant Food Service Director.During an interview on 7/25/2025 at 12:06 PM, [NAME] #1 stated that they took the internal temperature of the cooked chicken approximately 15 minutes prior to service, and the temperature measured 165 degrees Fahrenheit. [NAME] #1 further stated that they did not recheck the holding temperature of the chicken prior to service.The review of the food temperature log dated 7/25/2025 documented the cooked chopped chicken meal's initial temperature and the temperatures at the completion of the tray at 100 degrees Fahrenheit. The Food Service Director and the Assistant (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Food Service Director stated that this was not an appropriate temperature for holding and service. The Assistant Food Service Director stated that low temperature will result in a poor-quality product as well as an increased risk for bacterial growth, which could make the residents ill. A review of the food temperature log was conducted on 7/28/2025 at 2:30 PM with the Food Service Director and the Assistant Food Service Director. The food temperature log documented two temperatures of 100 degrees Fahrenheit for the cooked chicken, indicating the temperature at the start of the tray line and at the completion of the tray line. The Assistant Food Service Director stated that the temperatures are taken and recorded by the Cooks.During an interview on 7/29/2025 at 1:09 PM, [NAME] #1 stated that on 7/25/2025, they were training a new cook. They were taking the temperatures, and the trainee was recording them. [NAME] #1 stated that the temperature recording on the log of 100 degrees Fahrenheit was a mistake, as they would never accept that as an appropriate temperature for the cooked poultry item; the temperature should have been about 165 degrees Fahrenheit. They further stated that although their name was recorded on the temperature log, they did not review what was documented.During an interview on 7/29/2025 at 12:45 PM, the Administrator stated that they knew in the past there had been issues with cold food. They stated that when they attended the Resident Council meeting, they did not recall food issues being brought up; however, they knew of the cold food issue from reading previous Resident Council meeting minutes. The Administrator stated that the 100-degree Fahrenheit temperature was not an appropriate temperature for food safety and resident satisfaction, and that it was likely an error. The Administrator further stated that foods in the freezer should have been sealed properly and dated.10 NYCRR 415.14(h)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, during the re-certification survey initiated on 07/21/2025 and completed on 08/11/2025, the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for two (2) (Resident #74 and Resident #119) of (4) four residents reviewed for Respiratory care. Specifically, the facility was not effectively administered to ensure two (2) (Resident #74 and Resident #119) of (4) four residents were monitored for respiratory care. On 07/25/2025 and 07/28/2025, Resident #74 was observed without Oxygen in their portable Oxygen tank, and on 08/08/2025, Resident # 119 was observed without oxygen in their portable Oxygen tank. Additionally, the facility policy did not provide guidance related to monitoring and handling the portable oxygen tanks to ensure residents were not left without supplemental oxygen. Cross ReferenceF 695 Respiratory careThe finding is:The facility's policy for Oxygen Administration, last reviewed on 01/2025, documented before administering oxygen and while the resident is receiving oxygen therapy, assess for signs or symptoms of cyanosis (blue tone to the skin and mucous membranes) and hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion). The policy included guidance regarding documentation, including the date and time that the oxygen treatment was ordered; the name and title of the individual who administers the oxygen, the rate of oxygen flow, route, and rationale, the frequency and duration of the treatment, and all assessment data obtained before, during, and after the procedure, for example oxygen saturation (a measure of how much hemoglobin in your blood is carrying oxygen)and vital signs. The facility policy did not provide guidance related to monitoring and handling the portable oxygen tanks to ensure residents were not left without supplemental oxygen. Resident # 74 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease and Respiratory Failure. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented that the resident required assistance with personal hygiene, transfers, and dressing. The resident received oxygen therapy during the assessment look-back period.The Physician's order dated 07/25/2025, documented supplemental oxygen 2-4 Liters per minute to maintain oxygen saturation above 90% every shift.During an observation on 07/25/2025 at 1:45 PM, Resident #74 was observed self-propelling themselves in a wheelchair from the dining room to the nurse' station. The resident was wearing a nasal cannula (a thin, flexible tube used to supply supplemental oxygen through the nose) that was connected to a portable oxygen tank. The resident was having difficulty breathing and was using their accessory (chest) muscles to try and breathe. The resident's color was pale with gray lips. The oxygen tank gauge needle was observed to be in the red area (indicating a low level of oxygen remaining in the tank). Licensed Practical Nurse #4 was administering medications to other residents in the hallway in front of the nurse' station. Resident #74 told Licensed Practical Nurse #4, I need air. Licensed Practical Nurse #4 told the resident they (the resident) were having a panic attack. Licensed Practical Nurse #4 stated they were waiting for Xanax to be delivered. The resident repeated, I need air. Licensed Practical Nurse #4 stated to the surveyor in the presence of the resident, The resident is exaggerating, and they (Licensed Practical Nurse #4) must finish providing medications to other residents. Resident #74 put their hands up in the air and stated, They do not care. The Director of Nursing Services was in the vicinity and intervened. The Director of Nursing Services acknowledged and confirmed that the resident's oxygen tank was empty. The Director of Nursing Services then checked the resident's oxygen saturation, which was found to be 82 % (low), and directed Licensed Practical Nurse #4 to get a full oxygen tank. The Director of Nursing Services then replaced the resident's oxygen tank. The resident's oxygen saturation went up to 94% after the oxygen tank was replaced. Resident #74 stated they felt better. Licensed Practical Nurse #4 stated (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident utilized an oxygen concentrator while in bed and an oxygen tank when out of bed. Licensed Practical Nurse #4 stated that they did not connect the resident to the oxygen tank and did not check the resident's oxygen tank during their shift. During an observation of an activity program in the dining room on 07/28/2025 at 11:00 AM, Resident #74 was again observed with an oxygen tank with the gauge needle in the red area. Resident #74 stated they were having some difficulty breathing, and there was no air flow coming out of the tubing. The resident stated they did not report having breathing difficulty to anyone because the staff usually would not do anything. At 11:08 AM, Housekeeper #1 was observed replacing Resident #74's oxygen tank. During an interview on 07/28/2025 at 11:12 AM, Housekeeper #1 stated they were told by Recreational Assistant #1 to change the resident's oxygen tank. Housekeeper #1 stated they usually changed the oxygen tanks for residents in the facility. During a re-interview on 07/28/2025 at 11:16 AM, Licensed Practical Nurse #4 stated the resident had a full oxygen tank when they last checked the resident on 07/28/2025 at 8:00 AM. Licensed Practical Nurse #4 stated they should have rechecked the resident's oxygen tank every two (2) hours; however, they were busy with the medication administration pass. The resident usually comes to the nurse and asks for the oxygen tank to be replaced. Licensed Practical Nurse #4 stated there was no problem with a housekeeper changing the resident's oxygen tank. During an interview on 07/28/2025 at 11:40 AM, Registered Nurse #3 stated a full oxygen tank that is utilized by the resident should last for three (3) to four (4) hours, depending on the oxygen flow rate, and should be monitored by the Licensed Practical Nurse at least twice a shift, at around 10:00 AM and 2:00 PM. Registered Nurse #3 stated it was okay for Certified Nurse Assistants or housekeepers to replace the resident's oxygen tanks. During an interview on 07/28/2025 at 2:30 PM, the Director of Nursing Services stated staff should check the resident's oxygen tank at least three (3) times per shift. They should not wait until the tank is empty and the gauge needle is in the red zone to change the oxygen tank. The Director of Nursing Services stated nurses should monitor and assess the residents at least twice per shift when the residents are receiving oxygen at three (3) liters per minute, including obtaining oxygen saturation to ensure the oxygen level is maintained within the parameters ordered by the Physician. The Director of Nursing Services stated that the facility's policy and procedures did not include how often to monitor a resident's portable oxygen tank.Resident #119 was admitted with diagnoses of Congestive Heart Failure (heart cannot pump blood well enough to give the body a normal blood supply), Chronic Obstructive Pulmonary Disease, and Chronic Respiratory Failure with Hypoxia (low oxygen level in blood). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of six (6), which indicated the resident had severely impaired cognition. The resident utilized oxygen therapy in the assessment look-back period.The Physician's order for Resident #119, dated 07/28/2025, documented that the resident was on oxygen at two (2) liters per minute. During an observation on 08/08/2025 at 4:46 PM, Resident #119 was observed in their room holding their nasal cannula in their hand and pointing to the nasal cannula. The oxygen tank was empty with the gauge needle at zero. Certified Nurse Assistant #1 walked into the room and changed the resident's oxygen source from the oxygen tank to the oxygen concentrator and stated they were allowed to do that. The Certified Nurse Assistant then took the oxygen tank outside of the resident's room. The Director of Nursing Services was in the hallway and stated that the Certified Nurse Assistants were not allowed to change the oxygen source.During an interview on 08/08/2025 at 7:30 PM, the Administrator stated that nonclinical staff should not be handling oxygen. The Administrator stated that the facility's policy and procedures did not include how often to monitor a resident's portable oxygen tank.10 NYCRR 415.26

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, during the Recertification Survey initiated on 07/21/2025 and completed on 08/11/2025, the facility did not ensure that each resident had the right to receive services in the facility with reasonable accommodation of resident needs and preferences. This was identified for one (Resident #40) of seven residents reviewed for Activities of Daily Living. Specifically, during the Resident Council meeting on 07/21/2025, Resident # 40 stated they were not getting their showers as per their preference. A review of the record documented that Resident # 40 was receiving bed baths and not receiving showers as per the resident's care plan and preference.Finding is:The facility's policy and procedure for Bathing and Shower, revised on 2/14/2025, documented that the purpose of this procedure was to promote cleanliness, provide comfort to the resident, and to observe the condition of the resident's skin.Resident # 40 was admitted with diagnoses including Multiple Sclerosis. The Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognition intact. Resident #40 required one to two persons' extensive assistance with personal hygiene, transfers, and dressing, and Resident #40 required physical help in part of the bathing activity of two persons.During the Resident Council meeting on 7/21/2025 at 3:30 PM, Resident #40 reported they did not receive their twice-weekly showers as per their preference and the plan of care. Resident #40 further stated that the Certified Nursing Assistants just document refused showers. Resident #40 stated they never refuse their showers.The Activities of Daily Living Care Plan dated 5/09/2025 documented the resident required assistance with Activities of Daily Living related to Progressive Multiple Sclerosis, impaired mobility, and impaired gait. Interventions included two-person assistance for transfers to the shower on Wednesdays and Saturdays. The Plan of Correction Response History (completed by the Certified Nurse Assistants) documentation for July 2025 indicated Resident #40 received only bed baths on 7/2/2025, 7/3/2025, 7/6/2025, 7/7/2025, 7/8/2025, 7/9/2025, 7/11/2025, 7/15/2025, 7/19/2025, 7/21/2025, and 7/23/2025. The Plan of Correction Response History (completed by the Certified Nurse Assistants) documented the resident received showers on 7/1/2025, 7/4/2025, 7/16/2025, and 7/23/2025, only 4 times in 24 days. During an interview on 7/24/2025 at 1:40 PM, Certified Nurse Assistant #5 stated they were usually assigned to Resident #40 during the 7:00 AM-3:00 PM shift. Certified Nurse Assistant #5 stated they did not give showers to Resident #40 and only provided bed baths instead, because of staffing issues. During an interview on 7/24/25 at 3:40 PM, Certified Nurse Assistant #6 stated they were regularly assigned to Resident #40 during the 3:00 PM to 11:00 PM shift. Certified Nurse Assistant #6 stated they did not give showers to Resident #40 and only provided bed baths because of staffing issues. A review of the staffing sheets for the month of July 2025 indicated no issues with staffing. During an interview on 7/24/25 at 1:47 PM, Resident #40 stated they did not get a bed bath on 7/23/2025 and only had their back cleansed. Resident #40 stated that sometimes they go without a shower for more than two weeks.During an interview on 7/24/2025 at 2:40 PM, Registered Nurse # 3 stated all residents should receive their showers as per the plan of care. The Registered Nurse # 3 further stated they were responsible for the supervision of the Certified Nursing Assistants; however, they were not aware of staffing issues and were not aware that resident # 40 had not been receiving their showers as per the plan of care. During an interview on 7/29/2025 at 2:00 PM, the Director of Nursing Services stated the Certified Nurse Assistants reported that the resident refuses their showers and was not aware that the resident wanted showers. The Director of Nursing Services stated the facility did not have staffing concerns, and if there was a call out, then the workload would be adjusted accordingly. It is not acceptable to not provide showers to residents and document on the records that the residents had a bed bath and/or refuse.10 NYCRR 415.5(e)(1)

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	335410	A. Building B. Wing	08/11/2025

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, during the Recertification Survey initiated on 07/21/2025 and completed on 08/11/2025, the facility did not ensure that services provided or arranged by the facility meet the current professional standards of quality. This was identified for two (Resident # 74 and Resident #119) of four residents during the Respiratory Care. Specifically, Licensed Practical Nurse #4 did not provide respiratory care to Resident #74 when the resident's oxygen tank was observed to be empty. The resident complained of difficulty breathing. Licensed Practical Nurse #4 dismissed the resident's complaint as a panic attack and that the resident was exaggerating their distress and proceeded to complete the medication administration to other residents. Licensed Practical Nurse #4 did not evaluate the resident until the surveyor and the Director of Nursing Services intervened. Additionally, the ancillary staff were observed changing the residents' oxygen tanks and did not notify the nurses to evaluate the residents' respiratory status.Cross Reference -F695The finding is:The facility's policy for Oxygen Administration, last reviewed on 1/2025, documented before administering oxygen and while the resident is receiving oxygen therapy, assess for signs or symptoms of cyanosis (blue tone to the skin and mucous membranes) and hypoxia (i.e., rapid breathing, rapid pulse rate, restlessness, confusion). The policy included guidance regarding documentation, including the date and time that the oxygen treatment was ordered; the name and title of the individual who administers the oxygen, the rate of oxygen flow, route, and rationale, the frequency and duration of the treatment, and all assessment data obtained before, during, and after the procedure, for example oxygen saturation (a measure of how much hemoglobin in your blood is carrying oxygen)and vital signs. The policy did not provide guidance to staff regarding which staff were responsible for changing and monitoring the oxygen tanks.Resident # 74 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease and Respiratory Failure. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented that the resident required assistance with personal hygiene, transfers, and dressing. The resident received oxygen therapy during the assessment look-back period.The Comprehensive Care Plan (CCP) for Altered Respiratory Status related to Chronic Obstructive Pulmonary Disease, Asthma, and Sleep Apnea (breathing repeatedly stops and starts during sleep), revised on 6/2/2025 documented interventions including monitor respiratory status, oxygen saturation, lung sounds, complaints of shortness of breath, use of accessory muscles, cyanosis and provide oxygen therapy as per the physician's orders.The physician's order dated 5/27/2025 documented to administer supplemental oxygen at two (2) liters per minute to maintain oxygen saturations above 90% every shift.During an observation on 7/25/2025 at 1:45 PM, Resident #74 was observed self-propelling themselves from the dining room to the nursing station. The resident was wearing a nasal cannula (a thin, flexible tube used to supply supplemental oxygen through the nose) that was connected to a portable oxygen tank. The resident was having difficulty breathing and was using their chest (accessory) muscles to try to breathe. The resident was pale with gray lips. The oxygen tank gauge needle was observed to be in the red area. Licensed Practical Nurse #4 was administering medications to other residents in the hallway in front of the nursing station. Resident #74 told Licensed Practical Nurse #4, I need air. Licensed Practical Nurse #4 told the resident they (the resident) were having a panic attack. Licensed Practical Nurse #4 stated they were waiting for Xanax to be delivered. The resident repeated, I need air. Licensed Practical Nurse #4 stated to the surveyor in the presence of the resident, The resident is exaggerating, and they (Licensed Practical Nurse #4) have to finish providing medications to other residents. Resident #74 put their hands up in the air and stated, they do not care. The Director of Nursing Services was in the vicinity and intervened. The Director of Nursing Services acknowledged and confirmed that the resident's oxygen (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tank was empty. The Director of Nursing Services then checked the resident's oxygen saturation, which was found to be 82 % (low), and directed Licensed Practical Nurse #4 to get a full oxygen tank. The Director of Nursing Services then replaced the resident's oxygen tank. The resident's oxygen saturation went up to 94 % after the oxygen tank was replaced. Resident #74 stated they feel better now. Licensed Practical Nurse #4 stated the resident utilized an oxygen concentrator while in bed and an oxygen tank when out of bed. Licensed Practical Nurse #4 stated that they did not connect the resident to the oxygen tank and did not check the resident's oxygen tank since they started their shift.Review of Licensed Practical Nurse #4's personnel file indicated no inservice education related to caring for residents on oxygen therapy. During an observation of an activity program in the dining room on 7/28/2025 at 11:00 AM, Resident #74 was again observed with an oxygen tank with the gauge needle in the red area. Resident #74 stated they were having some difficulty breathing, and there was no air flow coming out of the tubing. The resident stated they did not report having breathing difficulty to anyone because the staff usually would not do anything. At 11:08 AM, Housekeeper#1 was observed replacing Resident #74's oxygen tank. During an interview on 7/28/2025 at 11:12 AM, Housekeeper #1 stated they were told by the Recreational Assistant #1 to change the resident's oxygen tank. Housekeeper #1 stated they usually changed the oxygen tanks for residents in the facility.During a re-interview on 7/28/2025 at 11:16 AM, Licensed Practical Nurse #4 stated there was no problem with a housekeeper changing the resident's oxygen tank.During an interview on 7/28/2025 at 11:37 AM, Recreational Assistant # 1 stated they were the only one present in the room conducting the activity program and could not leave the dining room to notify the nursing staff that Resident #74's oxygen tank was empty and needed replacement. Recreational Assistant #1 stated that normally, they would notify the Certified Nurse Assistants to get the oxygen tank or take the resident out of the room to the nurse to get the new oxygen tank. Recreational Assistant # 1 stated they did not see any Certified Nurse Assistant or a nurse, so they asked Housekeeper #1 to replace the oxygen tank for Resident #74.During an interview on 7/28/2025 at 11:40 AM, Registered Nurse # 3 stated it was okay for Certified Nursing Assistants or housekeepers to replace the resident's oxygen tanks. Registered Nurse # 3 stated they were not notified until 11:40 AM on 7/28/2025 that the resident's oxygen tank was found empty, and they would go and assess the resident now. During an interview on 7/28/2025 at 2:30 PM, the Director of Nursing Services stated nurses should monitor and assess the residents at least twice per shift when the residents are receiving oxygen at three liters per minute, including obtaining oxygen saturation to ensure the oxygen level is maintained within the parameters ordered by the Physician.During an interview on 7/28/2025 at 2:00 PM, Respiratory Registered Nurse #1 stated the Licensed Practical Nurse should check the resident's oxygen tank every three (3) hours. The oxygen tank should be changed by the nurses, not a Certified Nurse Assistant or the housekeeper.Resident #119 was admitted with diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Chronic Respiratory Failure with Hypoxia (low oxygen level in blood). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of six (6), which indicated the resident had severely impaired cognition. The resident utilized oxygen therapy in the assessment look-back period.The Physician's order for Resident #119, dated 7/28/2025, documented that the resident was on oxygen at 2 liters per minute. During an observation on 8/8/2025 at 4:46 PM, Resident #119 was observed in their room holding their nasal cannula in their hand and pointing to the nasal cannula. The oxygen tank was empty with the gauge needle at zero. A Certified Nursing Assistant walked into the room and changed the resident's oxygen source from the oxygen tank to the oxygen concentrator and stated they were allowed to do that. The Certified Nursing Assistant then took the oxygen tank outside the resident's room. The Director of Nursing Services was in the hallway and stated that the Certified Nursing Assistants were not allowed to change the oxygen source.10 NYCRR 415.11(c)(3)(i)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation record review and staff interviews during the Recertification Survey initiated on 07/21/2025 and completed on 08/11/2025, the facility did not ensure that residents who are unable to carry out activities of daily living receive the necessary services to maintain good nutrition. This was identified for one (Resident #7) of five residents reviewed for Limited Range of Motion. Specifically, during an observation on 07/22/2025 at 11:20 AM, Resident #7's breakfast tray was observed unopened and untouched on the overbed table. Resident #7 required setup help and was not assisted with their breakfast meal.The finding is: The facility's policy and procedure titled Assisting the Resident With In-Room Meals, revised on 2/14/2025, documented placing the (meal) tray on the overbed table or serving area. Be sure it is adjusted to a comfortable position and height for the resident. Arrange the dishes and silverware so that they can be easily reached by the resident. Place the drinks within easy reach. Open beverage cartons as necessary. Resident #7 was admitted to the facility with diagnoses that included Malnutrition, Sepsis, and Right Femur Fracture. An admission Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score as 13, which indicated intact cognition. The resident had no behavior problems and did not reject care. The resident had impairment on one side upper extremity and required setup and clean-up help for eating. A Comprehensive care plan for activities of daily living dated 5/11/2025 documented the resident required assistance with activities of daily living related to Fractures, Pain, and Trauma. Interventions included to encourage the resident to participate to the fullest extent possible with each interaction. During an observation on 7/22/2025 at 11:20 AM, Resident #7 was observed in bed, awake and alert. The resident's breakfast tray was observed unopened and untouched on the overbed table. The resident stated they were asleep and were not aware the tray was on the table. The resident stated the staff did not wake them to inform them that their breakfast tray was there, and no one came back to check if they had eaten their breakfast meal. During an interview on 7/22/2025 at 11:45 AM, Licensed Practical Nurse #5, the medication nurse, stated the assigned Certified Nursing Assistant was responsible for checking on the resident to ensure the resident received setup help and consumed their breakfast.During an interview on 7/24/25 at 2:50 PM, Registered Nurse #1 stated that breakfast trays arrived on the unit at around 8:00 AM and the Certified Nursing Assistants should have been checking the rooms to assist with setup and encourage the resident to eat. Registered Nurse #1 stated that at around 9:00 AM, the Certified Nursing Assistants were supposed to collect the trays and check the percentage of food eaten by the residents. Registered Nurse #1 stated the resident's breakfast tray should not have been at the resident's overbed table at 11:20 AM, unopened and untouched.During an interview on 7/24/25 at 2:20 PM, Certified Nursing Assistant #7 stated Resident #7 required setup help for eating, which included opening containers on the resident's meal tray. Certified Nursing Assistant #7 stated they did not recall if they had served the resident their breakfast tray that morning; however, they did not check to see if the resident had eaten their breakfast. Certified Nursing Assistant #7 stated they were assigned to the resident and should have checked to ensure the resident had their breakfast. During an interview on 7/29/25 at 9:32 AM, the Director of Nursing Services stated the Certified Nursing Assistants were responsible for serving the meal trays, assisting with setup, and encouraging the resident to eat. The Director of Nursing Services stated that the resident's breakfast tray should not have been at the bedside, unopened and untouched, and if the resident had refused to eat that the nurse should have been notified. 10 NYCRR 415.12(a)(3)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/21/2025 and completed on 08/112025, the facility did not ensure that each resident with a Pressure Ulcer or potential for a Pressure Ulcer received the necessary treatment and service consistent with professional standards of practice to promote healing, prevent infections, and prevent new ulcers from developing. This was identified for one (Resident #112) of three residents reviewed for Pressure Ulcers. Specifically, Resident #112, with a history of Stage 4 pressure ulcer, was observed on multiple occasions in bed on an air mattress that was set to 450 pounds and had a history of pressure ulcers and currently weighs 167 pounds. The finding is:The facility's policy titled Low Air Mattress, dated 1/04/2025, documented that low air loss systems are medical devices designed to prevent and manage pressure ulcers by providing air circulation to reduce pressure and moisture on the skin. Clinical staff must document the patient's condition, any changes in pressure injury status, and the use of the low air loss system in the patient's medical record. The Unit Nurse will check each mattress at least once daily, and the completed form will be given to the Director of Nursing. The operation manual for the air mattress, undated, documented how to adjust the air mattress to a desired firmness according to the patient's weight and comfort.Resident #112 was admitted with diagnoses including Chronic Kidney Disease, Urinary Tract Infection, and Congestive Heart Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating that the resident had moderate cognitive impairment. The Minimum Data Set documented Resident #112 was at risk for Pressure Ulcers. A Skin/Wound Care Evaluation dated 7/24/2025 documented that Resident #112 had a Stage IV Pressure Ulcer that was present on admission on their right gluteus and was resolved on 07/24/2025.A physician's order dated 7/24/2025, documented checking the function and settings of the air mattress every shift and as needed. There was no physician order for the placement of the air mattress.Resident #112 had documented weights on 7/17/2025 of 167.4 pounds and 6/24/2025 of 175.0 pounds. A Comprehensive Care Plan titled Musculoskeletal Impairment, dated 5/21/2024 and revised 7/24/2025, with interventions that included checking the function and settings of the air mattress every shift. This intervention was added on 7/24/2025. During an observation on 7/21/2025 at 9:55 AM, Resident #112 was observed in bed, on an air mattress that was set to 450 pounds. Resident #112 was unable to be interviewed as the resident was lethargic and was newly diagnosed with a Urinary Tract Infection. During a second observation on 7/22/2025 at 11:10 AM, Resident #112 was observed in bed sleeping, with the air mattress observed to be set to 450 pounds.During an interview on 7/24/2025 at 12:46 PM, Certified Nursing Assistant #3 stated that maintenance staff were responsible for setting up an air mattress on a resident's bed. Certified Nursing Assistant #3 stated they do not monitor or adjust the weight setting. During an interview on 7/24/2025 at 12:50 PM, Licensed Practical Nurse #3 stated air mattress was provided by the Maintenance Department; however, they were not sure who entered the weight settings on the air mattress. Licensed Practical Nurse #3 stated they were responsible for making sure that the air mattress was in place and inflated; they do not touch the weight settings on the air mattress. During an interview on 7/24/2025 at 1:24 PM, Registered Nurse Supervisor #1 stated nurses were responsible for checking air mattress weight settings every shift. The nursing Supervisor should be notified when the air mattress weight setting is not set accurately according to the resident's weight. Registered Nurse Supervisor #1 stated they did not know that the resident did not have a Physician's order for monitoring of the air mattress and that the air mattress weight setting was not set according to the resident's weight; no one notified them. During an interview on 7/28/2025 at 9:58 AM, the Director of Maintenance stated that the maintenance staff was responsible for placing the mattress on the bed with the air mattress's default settings. Nursing staff were responsible for setting up the air mattress weight setting. During an interview on 7/29/2025 at 9:14 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, the Director of Nursing Services stated the nurses were responsible for obtaining a Physician's order for the air mattress and for monitoring the weight setting on the air mattress. The air mattress weight setting should be adjusted to match the resident's weight to provide pressure relief. If the air mattress weight setting is not set according to the resident's weight, the resident may not receive the desired pressure relief and have the potential to develop pressure ulcers. 10 NYCRR 415.12(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/21/2025 and completed on 08/11/2025, the facility did not ensure that all drugs were labeled in accordance with currently accepted professional principles, including the expiration dates. This was identified for one (Resident #66) of seven residents reviewed during medication pass observation, one (2 North medication cart) of two medication carts observed during the medication storage and labelling task, and for one (Resident #83) of three residents reviewed for Accidents. Specifically, 1) during medication pass observation, Resident #66's nebulizer treatment medication, Budesonide Inhalation, was not dated. 2) Unit 2 North medication cart was observed with a souffle cup containing three prepoured unlabeled medication tablets. 3) During an initial screening, Resident #83 was observed with two medication cups with unidentified medications on the overbed table. Resident #83 had moderately impaired cognition and there was no staff in the vicinity. The facility's policy titled “Medication Label and Storage,” dated 3/19/2025, documented that multi-dose vials that have been opened are dated with the open date and discarded according to the manufacturer's instructions. 1) Resident #66 was admitted with diagnoses that included Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and Pulmonary Embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot). The Quarterly Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 13, indicating the resident had intact cognition. A physician's order dated 6/17/2025 documented to give 0.5 milligrams per 2 milliliters of Budesonide Inhalation. Inhale 2 milliliters orally via nebulizer every 12 hours for Bronchospasms (when muscles surrounding the lungs' small airway tighten, narrowing the airways). During a medication pass observation on 7/22/2025 at 8:38 AM, Licensed Practical Nurse #1 retrieved an ampule (sealed capsule containing a liquid) of Budesonide Inhalation from an opened, undated, foil packet to administer to Resident #66. The packet included instructions: once the foil envelope is opened, use the ampules within two weeks. The package also included an area to write the date the package was opened. During an interview on 7/22/2025 at 8:38 AM, Licensed Practical Nurse #1 stated they forgot to date the Budesonide Inhalation package when they first opened the package and should have. Licensed Practical Nurse #1 stated the medications in the package should be discarded after two weeks, once the package is opened. During an interview on 7/24/2025 at 1:24 PM, Registered Nurse Supervisor #1 stated that all multi-dose pack medications should be labelled with the time and date when first opened. During an interview on 7/29/2025 at 09:14 AM, the Director of Nursing Services stated that the nursing staff must date the foil packet for Budesonide medication, indicating the date the packet was opened and the date the packet should be discarded. If a nurse encounters an open packet that is not dated, they should discard the undated packet and open a new one. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/29/2025 at 10:04 AM, the Licensed Pharmacist stated the stability of the Budesonide medication would be compromised when the foil packet is opened for longer than two weeks, as recommended by the manufacturer. 2) The facility's policy titled “Medication Label and Storage,” dated 3/19/2025, documented that medications and biologicals are stored in the packaging in which they are received. Resident #54 was admitted with diagnoses that included Cerebral Infarction, Major Depressive Disorder, and Chronic Kidney Disease. The Quarterly Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 13, indicating the resident had intact cognition. A current physician's order documented Amlodipine Besylate 10 milligrams, give one tablet by mouth once a day for Hypertension. A current physician's order documented Keppra 250 milligrams, give one tablet by mouth two times a day for Seizure disorder. A current physician's order documented Finasteride 5 milligrams, give one tablet by mouth once a day for Benign Prostatic Hyperplasia (a condition where the prostate gland enlarges but is not cancerous, causing uncomfortable urinary symptoms). During an observation of the 2 North Medication Cart with Licensed Practical Nurse #2 on 7/23/2025 at 10:08 AM, a medication soufflé cup containing three unlabeled medication tablets was observed stored in the medication cart. During an interview on 7/23/2025 at 10:08 AM, Licensed Practical Nurse #2 stated they prepared the medications for Resident #54 for administration and had to stop because they went to care for another resident. Licensed Practical Nurse #2 stated they knew they should not have stored the unlabeled medication cup in the medication cart; they should have given Resident #54 the medications or disposed of the medications before going to another resident. During an interview on 7/24/2025 at 1:24 PM, Registered Nurse Supervisor #1 stated, if the nurse was unable to deliver the medications that were poured into the medication cup promptly, those medications should be discarded. Medications must not be stored in a medication cup within the medication cart for later delivery. During an interview on 7/29/2025 at 9:14 AM, the Director of Nursing Services stated that the nurse should have discarded the medications if they were not going to administer the medications. 3) The facility's policy and procedure titled “Medication Administration,” revised 3/19/2025, documented that medications are administered in a safe and timely manner, and as prescribed. Resident #83 was admitted with diagnoses including Hypertension (elevated blood pressure) and Chronic Kidney Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented that the resident had a Brief Interview for Mental Status score of 10, indicating moderate cognitive impairment. The Minimum Data Set assessment documented that the resident did not reject medications, did not have difficulty or pain while swallowing, and was able to eat independently. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 7/21/2025 at 10:34 AM, Resident #83 was observed in their room sitting in a wheelchair. Two medication cups contained unidentified medications on the resident's overbed table. Resident #83 stated the nurse gave them their medications without any fluids to consume the medications with. During an interview on 7/21/2025 at 10:40 AM, Registered Nurse #3 stated they should not have left the resident's room without observing the resident swallow their medications. Registered Nurse #3 stated that today they were working as a charge nurse and were also responsible for administering the medications; they wanted to give medications to all residents in a timely manner. During a reinterview on 7/21/2025 at 2:00 PM, Registered Nurse #3 reviewed the July 2025 Medication Administration Record and confirmed the following medications were left at the resident's bedside on 7/21/2025 as observed at 10:34 AM: ALPRAZolam Oral Tablet 0.5 milligrams (Alprazolam), an antianxiety medication. TUMS, Antacid, Chewable 2 Tablets Carvedilol Oral Tablet 25 MG (Carvedilol), heart medication. Farxiga Oral Tablet 5 MG (Dapagliflozin Propanediol), heart medication. Ferrous Sulfate Tablet 325 (65 Fe) MG Give 1 tablet, supplement. HydrALAZINE HCl Oral Tablet 100 MG (Hydralazine HCl), an antihypertensive medication. Senna Oral Tablet 8.6 MG (Sennosides) 2 tablets, stool softener. Sodium Bicarbonate Tablet 650 MG 2 tablets, heartburn medication. Venlafaxine HCl ER Oral Capsule Extended Release 24 Hour 150 MG (Venlafaxine HCl), an antidepressant. During an interview on 7/29/2025 at 1:00 PM, the Director of Nursing Services stated Registered Nurse #3 should not have left the medications unattended with the resident and should have ensured the resident consumed medications with fluids provided by the nurse. 10 NYCRR 415.18(d)(e)(1-4)

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	08/11/2025

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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 07/21/2025 and completed on 08/11/2025, 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 (Resident #112) of one resident reviewed for infection control and one (Resident #19) of seven residents reviewed for Medication Pass Observation. Specifically, Resident #112 had a physician's order for Enhanced Barrier Precautions secondary to the use of an indwelling Foley Catheter. There was no Enhanced Barrier Precaution signage posted outside the resident's door to alert staff and visitors regarding the resident's precaution status. On 07/21/2025, two Certified Nursing Assistants were observed providing personal hygiene care to Resident #112 without wearing the proper Personal Protective Equipment. 2) Licensed Practical Nurse #1 was observed during medication pass to remove a medication tablet out of a blister pack into their bare hand, then placed the tablet in the medication cup, and attempted to administer the medication to Resident #119.The findings are:1) The facility policy titled Enhanced Barrier Precautions, dated 1/04/2025, documented that enhanced barrier precautions are used as an infection prevention and control intervention to reduce the transmission of multidrug-resistant organisms to residents. Enhanced Barrier Precautions are indicated for a resident with an indwelling medical device such as a urinary catheter. Signs are posted on the door or wall outside the resident's room indicating the precautions and protective equipment required. Gowns and gloves are applied before performing the high-contact care for the resident, such as changing briefs, changing linens, and providing hygiene. Resident #112 was admitted with diagnoses including Chronic Kidney Disease, Urinary Tract Infection, and Congestive Heart Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. The Minimum Data Set documented that the resident utilized an indwelling Catheter and was at risk for Pressure Ulcers.A physician's order dated 7/22/2025 documented, Enhanced Barrier Precautions due to a Foley Catheter, wear gown and gloves during assistance with dressing, bathing, transferring, hygiene, changing linens, briefs, toileting, and wound care.A Comprehensive Care Plan titled Enhanced Barrier Precautions related to a Foley Catheter, dated 9/26/2024, last revised on 4/25/2025, had interventions that included wearing a gown and gloves during assistance with dressing, bathing, hygiene, and transferring the resident.During an observation with Registered Nurse Supervisor #2 on 7/21/2025 at 10:46 AM, Resident #112 was lying in their bed, which was located by the door. Certified Nursing Assistant #1 and Certified Nursing Assistant #2 were observed in Resident #112's room changing the resident's clothing and performing hygiene care. An Enhanced Barrier Precaution signage was posted outside the resident's room, indicating that Resident #112's roommate, whose bed was near the window, was on Enhanced Barrier Precautions. There was no indication on the Enhanced Barrier Precautions signage that Resident #112 was on Enhanced Barrier Precautions. Registered Nurse Supervisor #2 stopped the two Certified Nursing Assistants and had them take off the gloves, wash their hands, and put on the proper Personal Protective Equipment to finish care for Resident #112. During an interview on 7/21/2025 at 10:47 AM, Registered Nurse Supervisor #2 stated that Certified Nursing Assistant #1 and Certified Nursing Assistant #2 should wear the appropriate Personal Protective Equipment when providing high contact care, such as hygiene care and changing the resident's clothing. Registered Nurse Supervisor #2 confirmed that there was no signage at the doorway indicating Resident #112 was on Enhanced Barrier Precautions. There should have been a sign indicating both Resident #112 and their roommate were on Enhanced Barrier Precautions.During an interview on 7/21/2025 at 10:56 AM, Certified Nursing Assistant #2 stated they went to help Certified Nursing Assistant #1 and did not realize Resident #112 was on Enhanced Barrier Precautions because there was no sign outside the resident's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room indicating Resident #112 was on Enhanced Barrier Precautions.During an interview on 7/21/2025 at 11:07 AM, Certified Nursing Assistant #1 stated the Enhanced Barrier Precautions Sign outside Resident #112's room indicated that the resident's roommate was on Enhanced Barrier Precautions. Certified Nursing Assistant #1 stated they should have questioned why Resident #112 was not on Enhanced Barrier Precautions because the resident had a Foley Catheter.During an interview on 7/28/2025 at 9:06 AM, the Assistant Director of Nursing/Infection Preventionist/Educator stated all staff must don (put on) and doff (take off) the appropriate personal protective equipment when providing high-contact care. The Infection Preventionist or the admitting nurse was responsible for placing the Enhanced Barrier Precautions signage outside the resident rooms when indicated, and did not know why Resident #112 did not have the Enhanced Barrier Precautions signage to alert staff and visitors to use appropriate Personal Protective Equipment and precautions. Assistant Director of Nursing/Infection Preventionist/Educator stated, even if a sign was not posted, staff should know to wear appropriate Personal Protective Equipment because the resident had a Foley Catheter and all staff were educated to know when Enhanced Barrier Precautions were required.During an interview on 7/29/2025 at 9:14 AM, the Director of Nursing Services stated that the admitting nurse was responsible for placing an Enhanced Barrier Precaution sign, updating the care plans, and obtaining the necessary physician's orders. If a resident was already in-house, the Infection Control Nurse was responsible for putting the precautions sign, obtaining the physician orders for the precautions, and updating the resident's care plans. Certified Nursing Assistants should be aware that a resident with a Foley catheter requires Enhanced Barrier Precautions. If there was no sign on the doorway for Resident #112, Certified Nursing Assistant #1 and Certified Nursing Assistant #2 should have used appropriate Personal Protective Equipment while providing care to Resident #112 and alerted the nurse that the precaution sign was not displayed at the doorway.2) The facility's policy titled Medication Administration, dated 3/19/2025, documented that staff are to follow established facility infection control procedures for administering medications (for example, handwashing, aseptic technique, gloves, and isolation precautions).Resident #19 was admitted with diagnoses including Parkinson's Disease, Seizures, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact.A physician's order dated 5/13/2025 documented Vortioxetine, give one 10 milligram tablet orally once a day for Depression.During a Medication Pass observation on 7/22/2025 at 9:00 AM, Licensed Practical Nurse #1 was observed removing the Vortioxetine Oral 10 milligram tablet from the blister pack into their bare hand and then placing the tablet in the medication cup to administer the medication to Resident #119.During an interview on 7/22/2205 at 9:00 AM, Licensed Practical Nurse #1 stated they used Purell on their hands before removing the medications from the blister pack. They stated they should not have touched the pill with their bare hand and were not aware why they touched the pill with their bare hand, as this was not their practice. Licensed Practical Nurse #1 then discarded the tablet and removed a new tablet from the blister pack without touching it. During an interview on 7/28/2025 at 8:28 AM, the Assistant Director of Nursing/Infection Preventionist/Educator stated nurses should remove the medications from the blister pack without touching them with their bare hands. If the nurse accidentally touched the tablet, then the tablet should have been discarded properly. During an interview on 7/29/2025 at 9:14 AM, the Director of Nursing stated that staff should wash their hands between attending to residents. If a nurse touches a medication tablet by accident, that tablet must be discarded and replaced with a new one.10 NYCRR 415.19 (a)(1-3)