

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Little Neck Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 19 Nassau Boulevard Little Neck, NY 11362	
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 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on record review and interview, the facility did not ensure the Binding Arbitration Agreement provides for the selection of a neutral arbitrator agreed upon by both parties and the agreement provides for the selection of a venue that is convenient to both parties. This was evident in three (3) (Residents #17, #57, and #117) of 28 total sampled residents. Specifically, the Binding Arbitration Agreement signed by Residents #17, #57, and #117 had no documented evidence the agreement addresses the selection of a neutral arbitrator agreed upon by both parties and the selection of a venue that is convenient to both parties. The findings are: There was no facility policy related to Binding Arbitration Agreement. The signed Binding Arbitration Agreements for Residents #17, #57, and #117 were reviewed and documented that the arbitration shall take place in Vvv County, New York. There was no documented evidence that the Arbitration Agreement provided a selection of a neutral arbitrator agreed upon by both parties and a selection of a venue that is convenient to both parties. On 06/01/2026 at 1:47PM, the Director of Admissions was interviewed and stated they thought by the resident or their representative signing the Binding Arbitration Agreement they were acknowledging their understanding related to Medicaid, Medicare, or the Medicaid Health Maintenance Organization benefit coverage. They were unaware that residents and their representatives were supposed to be provided an opportunity to select a neutral arbitrator or to select a convenient venue in the binding arbitration agreement. On 06/01/2026 at 1:50 PM, the Administrator was interviewed and stated they were under the assumption that the facility did not offer an arbitration agreement. The Administrator also stated they had no idea of the required language that should be included in the agreement or why it was in the admission packet. 10 New York Codes, Rules, and Regulations 415.30		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 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, record review, and interviews, the facility did not ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. This was evident during the kitchen and food service observations. Specifically, 19 vanilla puddings and 21 chocolate puddings in 4-ounce containers dated 05/22/2026 were stored in the kitchen refrigerator and ready to be served that were dated passed 72 hours from the time they were prepared. The findings include: The facility policy titled, Dating Food Items with a review date of 01/2026 documented all food prepared for daily use, example, all desserts, tuna salads, egg salads including cooked meats, and chicken, and fish are to be used within 72 hours (3 days) after date prepared. All food items will be discarded past 72 hours. During kitchen observation with Dietary Manager on 05/26/2026 between 09:20 AM through 09:44 AM, it was observed that 19 vanilla puddings and 21 chocolate puddings in 4-ounce containers dated 05/22/2026 were stored in the kitchen refrigerator and ready to be served that were passed 72 hours from the time they were prepared. On 05/26/2026 at 12: 20 PM, the lunch meal was observed in the second-floor unit dining room. Residents were properly positioned, trays were being distributed in an organized manner, and meal tickets were being read by staff before given to residents. Residents #3, #66, #93, and #108 were observed to have vanilla pudding on their tray. On 05/26/2026 at 12:30 PM, the Food Service Director was interviewed and stated that pudding dated 05/22/2026 that was observed by State surveyor at 9:30 AM should have been discarded the day before and it was an oversight that it was still there. They further stated the kitchen staff were told that after 3 days all food items from the date they were prepared must be discarded because it is the facility policy, and therefore they did not know why the expired food was still there. On 05/27/2026 at 9:35 AM, the Dietary Manager was interviewed and stated the expired pudding needs to be discarded because they were passed 72 hours. On 05/28/2026 at 11 AM, Dietary Aide #1 was interviewed and stated they know after 72 hours from the time food was prepared, that it must be discarded. They did not know why the puddings were not discarded. On 05/29/2026 at 12:15 PM, the Administrator was interviewed and stated it was brought to their attention that expired pudding was still in the refrigerator and that they should have been discarded. On 06/01/2026 at 2:01 PM, the Dietary Supervisor was interviewed and stated on 05/26/2026 about 7 residents had a diet order for pudding. They also stated on second floor unit Residents #3, # 66, #93, #108 were given pudding on their tray because they have preferences to have pudding on their trays. 10 New York Code Rules and Regulation 415.14 (h)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain the residents' rights to a safe, comfortable, and homelike environment. This was evident in Unit Three (3). Specifically, residents' rooms were observed with missing and/or peeling wallpaper, missing baseboards, and missing wood on closet door. The findings include: The undated facility policy titled, Housekeeping Procedures in Residential Care Settings, documented that the resident has a right to a safe, clean, comfortable, and homelike environment. On 05/27/2026 at 9:43 AM a tour of Unit Three was conducted. The following was observed: In room [ROOM NUMBER], paint scraped and peeling behind bed A; baseboards behind beds have scraped away and have chipped wood. Closet doors have scratches where wood has been worn away. The door of room [ROOM NUMBER] is chipped exposing chipped wood. Inside room [ROOM NUMBER], there is peeled wallpaper and wood missing from base molding behind bed B. In room [ROOM NUMBER], the pink wall has been patched and painted white. Doorways to multiple rooms throughout the unit have multiple layers of chipped away paint. room [ROOM NUMBER] was observed with peeling wallpaper and loose baseboards. Blue painters' tape on the floor on either side of the doorways between rooms [ROOM NUMBERS]. The closet doors in room [ROOM NUMBER] were observed with chipped/missing wood. The resident shower room was noted with mismatched tiles. The dayroom was noted with peeling wallpaper and loose baseboard On 05/27/2026 at 12:19 PM, during lunchtime observation in the Unit 3 dining room, the wall hand sanitizer dispensing unit repeatedly opened without dispensing hand sanitizer when staff tried to get hand sanitizer. On 05/29/2026 at 11:41 AM, Housekeeping Aide #1 was interviewed and stated their responsibilities included cleaning the bathroom, replenishing supplies, cleaning tables, and lights. They stated they are not responsible for the hallways and that the floor porter is responsible for hallways. They stated they just clean the bathrooms. They further stated that if anything is broken, they would write it in the book on the floor for it to be fixed, and engineering/maintenance is responsible for checking the (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	book and fixing it. Housekeeping Aide #1 stated they are fairly new to the facility and had only been working there for less than a year. They also stated the other floors don't look like this unit, but that the unit has looked the same since they started. On 06/01/2026 at 9:30 AM, Housekeeper #1 was interviewed and stated they are the porter. Their responsibilities include mainly to take out garbage, clean the floors, sweep, mop, buff, and if the other housekeeper is not here, they would do their responsibilities as well. Housekeeper #1 stated that the other housekeeper would perform wiping and dusting of the walls. When items are in disrepair, then it will be written in the book. They further stated that all the other floors have been renovated. They stated the wallpaper needs to be fixed. They stated they had been working here for 14 years, and the other floor were renovated by a contractor a while ago. On 06/01/2026 at 10:11 AM, the Director of Maintenance was interviewed and stated they had been here for six years. They further stated when they had started the first-floor renovation was completed and the contract for the second-floor renovation was already signed. The Director of Maintenance stated that the third-floor renovation is planned in-house versus being contracted out. They stated that they are starting with the common areas, and plan to do the rooms a section at a time by moving the residents out of the rooms to renovate. The Director of Maintenance stated that the worker they have for the renovation works per diem, and therefore the renovation is very slow. They stated that given the limited number of workers available, there is no planned end date for the renovation. They further stated that the environment as it is now does not provide a homelike environment for the residents but that they are trying to do the best they can with what they have. 10 New York Code Rules and Regulations 415.5 (h)(2)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure all alleged violations involving abuse were reported immediately to the New York State Department of Health no later than 2 hours after the alleged occurrence. This was evident for 1 (Resident # 9) of 3 residents reviewed for Abuse out of 28 total sampled residents. Specifically, Resident # 9 had an allegation of injury of unknown origin that was not reported in a timely manner. The findings are: The facility policy titled, Abuse Prevention and Reporting, dated effective 07/01/2006 and last reviewed 05/01/2026, documented the facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to all the proper authorities within prescribed timeframes. Alleged violations involving abuse, neglect, exploitation mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #9 had diagnoses that include Alzheimer's Disease, Depression and Muscle weakness. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #9 has severely impaired cognition, and required substantial assistance of 1 person to assist with Activities of Daily Living. The facility's investigation documented on an Accident/Incident Report that occurred on 01/07/2026 at 1:25 PM documented Resident #9 had an injury of unknown origin specifically, bruising on neck, chin and jaw area and both hands. The facility's Director of Nursing reported to Department of Health of an occurrence on 01/08/2026 at 10:52 AM. Resident #9 was examined on 01/08/2026 by the physician who diagnosed resident with Non-thrombocytopenic purpura. The facility concluded on their investigation that the injury might have been from facial shaving administered by a Certified Nurse Assistant and did not report the injury to state agency. On 05/26/2026 at 10:05 AM, the personal and work profile of Certified Nurse Assistant #11 was reviewed and found no deficient work practice nor disciplinary measure documented. On 05/26/2026 at 10:33 AM, Resident #9 was observed in bed with Geri sleeves on both arms. Resident's face was noted with no skin discoloration on neck, chin, or jaw area. no discoloration was noted on hands or wrist area either. On 05/27/2026 at 12:36 PM, Resident #9 was observed with spouse visiting. Appeared to be with no complaint, no observed pain or discomfort. On 05/28/2026 at 10:37 AM, Certified Nursing Assistant #11 was interviewed and stated they had been working in the facility for 3 years and remembered a supervisor taking a statement last January regarding Resident #9 who had bruising on the chin, neck, and jaw area. They stated shaving was done as always on this resident and resident did not sustain any bruising or cuts while shaving. They state they always put moisturizer first before shaving Resident #9. On 05/28/2026 at 10:43 AM, Registered Nurse # 1 was interviewed stated when a resident has injury of unknown origin, the director of nursing investigates and must report to Department of Health immediately. On 05/29/2026 at 10:55 AM, the Director of Nursing was interviewed and stated they did a full investigation of Resident #9's bruises and did not report to Department of Health timely because they concluded the bruises were from facial shaving. On 05/29 /2026 11:18 AM, Administrator was interviewed and stated they did not report the facial bruising to the Department of Health timely because they investigated the cause and thought it was from facial shaving. They stated that the resident has behavioral issues as well. They further stated that they are aware that in the last two state surveys they did not ensure injury of unknown origin were reported timely. Audits were done as per plan of correction then and yet they still had this issue. 10 New York Code Rules and Regulation 415.4(b)(2)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident. This was evident for one (1) of one (1) resident investigated for Anticoagulant out of a total of 28 sampled residents. Specifically, Resident #67 did not a comprehensive care plan for anticoagulant therapy. The findings include: The facility policy titled, Comprehensive Care Plan/Baseline Care Plan, last reviewed 09/2025, documented than an individual comprehensive care plan will be developed for each problem, strength, or need with the intention of maintaining a culture of person-centered care throughout the facility, with the focus on the resident as the locus of control over their own daily lives. The comprehensive care plan will be initiated immediately upon admission, and appropriate care plans will be in place within 48 hours of admission. The team is to develop comprehensive care plans upon review of resident's problems, needs and strengths in conjunction with resident assessments. Problems will be identified from the Minimum Data Set 3.0 triggers and Care Area Assessment Summary, resident assessment, interview with resident/healthcare proxy/resident representative, direct observation, and registered nurse interview of certified nursing assistant. Each problem, need or strength is to be addressed on its own comprehensive care plan. The Comprehensive Care Plan Library listed long-term problems/needs including Anticoagulant. The facility policy title, Anticoagulant Therapy Policy and Procedure, last revised 11/2025, documented that the facility shall ensure the safe prescribing, administration, monitoring and management of anticoagulant medications for all residents receiving anticoagulant therapy. The policy also documented that nursing staff shall assess for signs and symptoms of bleeding each shift. Resident #67 was admitted to the facility with diagnoses including atrial fibrillation (abnormal heart rhythm), hypertension (high blood pressure), and overactive bladder. The Minimum Data Set Quarterly assessment dated [DATE] documented that Resident #67 had moderate cognitive impairment, could use a walker and wheelchair, and was receiving anticoagulant medication. On 05/26/2026 at 11:20 AM, Resident #67 was interviewed and stated they did not know their medications and could not explain what a blood thinner does or that they needed one. In reference to care planning, Resident #67 stated that they have meetings with the staff but could not provide any other details about their care plan. A physician's order, originated on 11/18/2024 and renewed 05/24/2026, documented Eliquis 2.5 milligram tablet, one (1) tablet by oral route two times a day for presence of automatic/implantable cardiac defibrillator and longstanding persistent atrial fibrillation. A care plan titled, Cardiac Diseases: Atrial Fibrillation/Automatic Implantable Cardiac Defibrillator/Hypertension, dated effective 11/16/2024 and last reviewed 04/24/2026, documented a focus of high risk for injury related to cardiovascular complications of atrial fibrillation with automatic implantable cardiac defibrillator with history of hypertension and congestive heart failure. Goals included that the resident would maintain pulse within normal limits. Interventions included to administer atrial fibrillation medication(s) as prescribed by MD. There was no documented evidence of monitoring in regard to the risk of bleeding. The electronic medical record was reviewed. There was no documented evidence that a care plan was initiated or implemented for anticoagulant or for the risk of bleeding. On 05/29/2026 at 10:08 AM, Licensed Practical Nurse #2 was interviewed and stated it is the responsibility of the nursing supervisor to initiate and update the care plan. They further stated that residents on anticoagulant therapy should have an anticoagulant therapy or risk of bleeding care plan. Licensed Practical Nurse #2 stated that Resident #67 has been receiving anticoagulant therapy (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since admission. On 05/29/2026 at 10:30 AM, Registered Nurse #3, who is also a nursing supervisor, was interviewed and stated that the night shift nurse is responsible for entering admission care plans, but also any registered nurse who receives a new order can initiate a care plan. Registered Nurse #3 further stated that orders, new problems, and medications would need a care plan. They stated that a resident on anticoagulant therapy would have an, Anticoagulation Therapy: Potential for Bleeding, care plan in place with the purpose to ensure monitoring is done for the resident. The electronic medical record for Resident #67 was reviewed with Registered Nurse #3 and the care plan for anticoagulation therapy was not found. Registered Nurse #3 could not provide an explanation why the care plan was not initiated. On 05/29/2026 at 12:24 PM, the Assistant Director of Nursing, who also serves as a nursing supervisor for Unit Three (3), was interviewed and stated that upon admission, care plans are initiated by the night supervisor. They further stated that care plans are developed based on diagnoses. The Assistant Director of Nursing stated that goals to be included for residents on anticoagulant therapy should include monitoring the resident for abnormal signs of bruising or discoloration. The electronic medical record was reviewed with Assistant Director of Nursing who confirmed that there was no documented evidence that the risk of bleeding due to anticoagulation use was included in Resident #67's care plans. On 06/01/2026 at 8:45 AM, the Medical Doctor was interviewed and stated that when a resident is receiving anticoagulant therapy, they must be monitored for the risk of bruising and bleeding. They further stated that typically this monitoring would be written into the resident's care plan. The Medical Doctor stated there would be no reason that a resident on anticoagulant therapy would not have a care plan for it or for the risk of bleeding. 10 New York Code Rules and Regulation 415.11(c)(1)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interviews and record review, the facility failed to ensure that the physician reviews the resident's total program of care, including medications and treatments, at each visit. This was evident for one (1) of two (2) residents investigated for Antibiotic Use out of a total of 28 sampled residents. Specifically, physician progress notes for Resident #59 failed to reflect a review of the resident's total program of care and current condition and the physician's decision about the continued appropriateness of the resident's medical regimen, specifically the rationale for continued use of an antibiotic, Ceftriaxone. The findings include: The American College of Physicians' Best Practice Advice, published in the Annals of Internal Medicine in 2021, included that an extension of antibiotic therapy should be guided by validated measures of clinical stability. Resident #59 was admitted to the facility with diagnoses including acute pyelonephritis (urinary tract infection with kidney involvement), septicemia (serious blood stream infection), and unspecified purulent endophthalmitis of the right eye (inflammation and infection of the fluids of the eye). The hospital discharge summary physician's note, dated 03/22/2026, documented the treatment plan for Resident #59 to include ceftriaxone 2 grams daily for the rest of the antibiotic course with no planned end date. Resident #59 would need repeat imaging and follow up with Infectious Disease and Pulmonology, with a plan for repeat Computed Tomography of Abdomen/Pelvis with contrast or Magnetic Resonance Imaging (MRI) with contrast two weeks from last imaging dated 03/24/2026. The plan would be to continue intravenous antibiotics until decided by follow up with the Infectious Disease Team. A physician's order dated 03/24/2026 and renewed 05/18/2026, documented resident is on enhanced barrier precaution secondary to mid-line. A physician's order dated 03/24/2026, documented Ceftriaxone two grams in 100 milliliters of Normal Saline to be infused intravenously once daily for 22 days. A physician's order dated 04/15/2026, documented a follow up appointment with the Infectious Disease doctor for 05/13/2026, and noted that the facility must call the office for the appointment time. The order was discontinued on 04/20/2026 with no documented rationale. A physician's order dated 04/16/2026 documented Ceftriaxone two (2) grams in one hundred (100) milliliters of Normal Saline to be given by intravenous route once daily for forty-five (45) days. Initial lab results dated 03/24/2026 documented that the white blood cell count was within normal limits. There was no documented evidence of subsequent lab results to trend white blood cell counts having been completed. The electronic medical record was reviewed. There was no documented evidence that a computed tomography of abdomen/pelvis and computed tomography of chest with contrast was completed. Urinalysis completed 05/23/2026 revealed small presence of leukocyte esterase but was negative for urine bacteria. The consultation report for Infectious Disease Consultation completed on 4/15/2026 documented that the resident is stable from a systemic perspective. The report further documented instructions to obtain computed tomography of abdomen/pelvic and chest with contrast and to continue ceftriaxone two grams every 24 hours pending imaging. The plan included to follow up with the infectious disease doctor on 05/13/2026 in the morning. No end date for ceftriaxone therapy was documented on the consultation report. The new admission note signed by the nurse practitioner on 03/24/2026, documented to continue ceftriaxone for 22 more days and to have Infectious Disease Consult as needed. The physician's admission note dated 03/25/2026 documented that that infectious disease recommended intravenous antibiotics and serial imaging. Repeat imaging was recommended in three to four weeks. Plan included ceftriaxone two grams once daily for 22 days. A medical progress note dated 03/27/2026 documented that lab results for 03/24/2026 were reviewed, (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and white blood cell count was within normal limits. Plan included to continue ceftriaxone for 22 more days and to trend white blood cell counts. Subsequent medical progress notes date 04/1/2026, 04/03/2026, 04/13/2026, and 04/24/2026 all documented that lab results from 03/24/2026 were reviewed, to continue ceftriaxone for 22 more days, and to trend white blood cell counts as needed. Medical progress note date 05/04/2026 documented that lab results from 3/24/2026 were reviewed, white blood cell count was within normal limits, vital signs were stable, and resident was afebrile. Plan included to continue ceftriaxone as per hospital recommendation, to repeat complete blood count as needed to evaluate. The consultation report for Infectious Disease Consultation completed on 4/15/2026 documented that the resident is stable from a systemic perspective. The report further documented instructions to obtain computed tomography of abdomen/pelvic and chest with contrast and to continue ceftriaxone two grams every 24 hours pending imaging. The plan included to follow up with the infectious disease doctor on 05/13/2026 in the morning. No end date for ceftriaxone therapy was documented on the consultation report. A progress note dated 04/15/2026 documented that Resident #59 returned from Infectious Disease appointment; instructions to obtain computed tomography of abdomen/pelvis and computed tomography of chest with contrast were included. Resident was to continue Ceftriaxone two grams every 24 hours until 05/31/2026, and to follow up on 05/13/2026. The note also documented that the information was endorsed to the charge nurse. A medical doctor's monthly progress note dated 4/21/2026 documented that the monthly assessment and evaluation was only for chronic medical conditions. There was no evidence that the resident was evaluated for current antibiotic therapy. Labs, including complete blood count, was recommended. A monthly assessment note date 05/18/2026 documented that lab results from 3/24/2026 were reviewed and white blood cell count was within normal limits. Plan included to continue ceftriaxone for 45 more days and infectious disease consult as needed. On 05/29/2026 at 9:16 AM, Registered Nurse #4, who was a float to the unit, was interviewed and stated that they believed Resident #59 was receiving intravenous ceftriaxone for an infection of the eye. They also stated that they believed that Resident #59 was close to the end of therapy as the duration was to be for about 40 days. Usually, the registered nurse would make the doctor aware that medication orders were scheduled to fall off, and the doctor or nurse practitioner would either renew the order or give further instructions. On 06/01/2026 at 8:38 AM, the Medical Doctor was interviewed and stated that regardless of the consultation report, it is up to the medical providers of the facility to determine the necessity of medications for the residents. The Medical Doctor stated that they were unfamiliar with the treatment plan for Resident #59, but that if the resident was stable, then the medical providers of the facility should have determined if continuing treatment was necessary. They further stated that if the resident was determined to be clinically stable, then it is very possible that the intravenous medication could have been discontinued if not downgraded to oral antibiotic therapy. The Nurse Practitioner was unable for interview as they had been on vacation. On 06/01/2026 at 2:32 PM, the Medical Director was interviewed and stated that they did not think the best practice of medicine was to use the lowest effective dose for the shortest duration necessary. They further stated that if a resident simply does not look good then they would continue an antibiotic. The Medical Director stated that following imaging and lab results was not necessary to determine duration of antibiotic therapy and that because a mid-line may be kept in a resident for six months to a year, there is minimal risk in keeping them on intravenous therapy. The Medical Director stated that regardless of consultation recommendations, it is up to the facility provider to determine whether or not to continue an antibiotic. They also stated that given the complexity of Resident #59's infection, the antibiotic should be continued until the medical providers in the facility determine when it should (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Little Neck Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 19 Nassau Boulevard Little Neck, NY 11362	
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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	end. They included that factors to determine duration included when the resident looks good or when the provider feels it is appropriate. On 06/01/2026 at 3:19 PM, the Infection Preventionist was interviewed and stated that residents on antibiotic therapy are follow by the facility's Antibiotic Stewardship Program. They stated that antibiotics are usually initiated depending on labs and/or imaging. Residents are initiated on care plans according to their infection and the antibiotic course would be reviewed with the medical provider. In reference to Resident #59, the Infection Preventionist stated that Resident #59 is followed by an outside Infectious Disease Physician. Upon return from consults, the in-house medical provider reviews the recommendations, and the treatment course is adjusted as necessary. They further stated that typically labs are completed once a month for resident on long-term antibiotic therapy. The Infection Preventionist did not know why labs were not repeated for Resident #59 or why imaging was not completed in a timely manner. They also did not recall the last time Resident #59's case was reviewed for antibiotic stewardship. On 06/01/2026 at 3:30 PM, in a subsequent interview the Infection Preventionist stated that if the resident received imaging, repeat labs, and was followed adequately, antibiotic therapy may have been discontinued sooner, leading to a decreased risk of adverse effect and antimicrobial resistance. 10 New York Code Rules and REgulation 415.15(b)(2)(iii)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interviews and record review, the facility failed to ensure that the resident's drug regimen was free from unnecessary drugs. This was evident for one (1) of two (2) residents investigated for Antibiotic Use out of a total of 28 sampled residents. Specifically, the facility failed to adequately review whether the infection had resolved, and there was no documented evidence of rationale for continued use, leading to a duration of ceftriaxone therapy of 67 days. The findings include: The Centers for Disease Control and Prevention's Be Antibiotics Aware Toolkit, published on 09/17/2025, documented that healthcare providers should optimize antibiotic selection and use the shortest effective duration of therapy as each additional day of antibiotic therapy increases the risk of adverse events and antimicrobial resistance. The American College of Physicians' Best Practice Advice, published in the Annals of Internal Medicine in 2021, included that an extension of antibiotic therapy should be guided by validated measures of clinical stability. Resident #59 was admitted to the facility with diagnoses including acute pyelonephritis (urinary tract infection with kidney involvement), septicemia (serious blood stream infection), and unspecified purulent endophthalmitis of the right eye (inflammation and infection of the fluids of the eye). The hospital discharge summary physician's note, dated 03/22/2026, documented the treatment plan for Resident #59 to include ceftriaxone 2 grams daily for the rest of the antibiotic course with no planned end date. Resident #59 would need repeat imaging and follow up with Infectious Disease and Pulmonology, with a plan for repeat Computed Tomography of Abdomen/Pelvis with contrast or Magnetic Resonance Imaging (MRI) with contrast two weeks from last imaging dated 03/24/2026. The plan would be to continue intravenous antibiotics until decided by follow up with the Infectious Disease Team. A physician's order dated 03/24/2026 and renewed 05/18/2026, documented resident is on enhanced barrier precaution secondary to mid-line. A physician's order dated 03/24/2026, documented Ceftriaxone two grams in 100 milliliters of Normal Saline to be infused intravenously once daily for 22 days. A physician's order dated 04/15/2026, documented a follow up appointment with the Infectious Disease doctor for 05/13/2026, and noted that the facility must call the office for the appointment time. The order was discontinued on 04/20/2026. A physician's order dated 04/16/2026 documented Ceftriaxone two (2) grams in one hundred (100) milliliters of Normal Saline to be given by intravenous route once daily for forty-five (45) days. Initial lab results dated 03/24/2026 documented that the white blood cell count was within normal limits. There was no documented evidence of subsequent lab results to trend white blood cell counts having been completed. The electronic medical record was reviewed. There was no documented evidence that a computed tomography of abdomen/pelvis and computed tomography of chest with contrast was completed. Urinalysis completed 05/23/2026 revealed small presence of leukocyte esterase but was negative for urine bacteria. The consultation report for Infectious Disease Consultation completed on 4/15/2026 documented that the resident is stable from a systemic perspective. The report further documented instructions to obtain computed tomography of abdomen/pelvic and chest with contrast and to continue ceftriaxone two grams every 24 hours pending imaging. The plan included to follow up with the infectious disease doctor on 05/13/2026 in the morning. No end date for ceftriaxone therapy was documented on the consultation report. The new admission note signed by the nurse practitioner on 03/24/2026, documented to continue ceftriaxone for 22 more days and to have Infectious Disease Consult as needed. The physician's admission note dated 03/25/2026 documented that that infectious disease recommended intravenous antibiotics and serial imaging. Repeat imaging was recommended in three to four weeks. Plan included ceftriaxone two grams once daily for 22 days. A medical progress note dated 03/27/2026 documented that lab (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	results for 03/24/2026 were reviewed, and white blood cell count was within normal limits. Plan included to continue ceftriaxone for 22 more days and to trend white blood cell counts. Subsequent medical progress notes date 04/1/2026, 04/03/2026, 04/13/2026, and 04/24/2026 all documented that lab results from 03/24/2026 were reviewed, to continue ceftriaxone for 22 more days, and to trend white blood cell counts as needed. Medical progress note date 05/04/2026 documented that lab results from 3/24/2026 were reviewed, white blood cell count was within normal limits, vital signs were stable, and resident was afebrile. Plan included to continue ceftriaxone as per hospital recommendation, to repeat complete blood count as needed to evaluate. The consultation report for Infectious Disease Consultation completed on 4/15/2026 documented that the resident is stable from a systemic perspective. The report further documented instructions to obtain computed tomography of abdomen/pelvic and chest with contrast and to continue ceftriaxone two grams every 24 hours pending imaging. The plan included to follow up with the infectious disease doctor on 05/13/2026 in the morning. No end date for ceftriaxone therapy was documented on the consultation report. A progress note dated 04/15/2026 documented that Resident #59 returned from Infectious Disease appointment; instructions to obtain computed tomography of abdomen/pelvis and computed tomography of chest with contrast were included. Resident was to continue Ceftriaxone two grams every 24 hours until 05/31/2026, and to follow up on 05/13/2026. The note also documented that the information was endorsed to the charge nurse. A medical doctor's monthly progress note dated 4/21/2026 documented that the monthly assessment and evaluation was only for chronic medical conditions. There was no evidence that the resident was evaluated for current antibiotic therapy. Labs, including complete blood count, was recommended. A monthly assessment note date 05/18/2026 documented that lab results from 3/24/2026 were reviewed and white blood cell count was within normal limits. Plan included to continue ceftriaxone for 45 more days and infectious disease consult as needed. The care plan titled, Infection: Pyelonephritis/Bacteremia, effective 03/24/2026 and last updated 04/15/2026, documented a goal of resident will adhere to medication regiment prescribed to treat underlying infection for 22 days. Interventions included monitor labs as ordered and administer antibiotic therapy as ordered and monitor for adverse reaction to medication. On 05/29/2026 at 9:16 AM, Registered Nurse #4, who was a float to the unit, was interviewed and stated that they believed Resident #59 was receiving intravenous ceftriaxone for an infection of the eye. They also stated that they believed that Resident #59 was close to the end of therapy as the duration was to be for about 40 days. Usually, the registered nurse would make the doctor aware that medication orders were scheduled to fall off, and the doctor or nurse practitioner would either renew the order or give further instructions. Registered Nurse #4 stated that a computed tomography scan (CT/CAT Scan) is an appointment that would be scheduled through the nursing office. Typically, when a resident returns from an appointment, the registered nurse would give the documentation to the nursing office for them to schedule. Registered Nurse #4 also stated that the nurses on the floor may schedule labs and X-rays. On 05/29/2026 at 10:48 AM, Registered Nurse #3, who serves as the Nursing Supervisor for Unit One, was interviewed and stated if the consult instructs for a computed tomography scan (CT/CAT Scan) to be done, the registered nurse on the floor can schedule it and put in the order for the provider to sign in the electronic medical record. For Resident #59, appointments are done outside the facility. The electronic medical record was reviewed with Registered Nurse #3. There was no documented evidence of a CT scan of Chest/Abdomen/Pelvis having been ordered and completed. Registered Nurse #3 stated they would have to look into why it wasn't done. On 05/29/2026 at 12:29 PM, the Assistant Director of Nursing, was interviewed and stated that imaging orders are sometimes scheduled by the doctors themselves, but also some outside offices will call (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility to schedule appointments for the residents. Additionally, the Assistant Director of Nursing stated that the registered nurse that received the resident upon return from appointment was responsible for scheduling the follow-up appointment but failed to do so. The Assistant Director of Nursing stated that after they had been made aware of the issue that morning, they had reached out to the infectious disease doctor's office and that the office stated that the imaging company would call the facility to make the appointment. On 06/01/2026 at 8:38 AM, the Medical Doctor was interviewed and stated that usually the nurses schedule the imaging. The Medical Doctor suggested that the imaging could have been delayed due to the need for a prior authorization, or the process was delayed at another point. The Medical Doctor stated that regardless of the consult, it is up to the medical providers of the facility to determine the necessity of medications for the residents. The Medical Doctor stated that they were unfamiliar with the treatment plan for Resident #59, but that if the resident was stable, then the medical providers of the facility should have determined if continuing treatment was necessary. They further stated that if the resident was determined to be clinically stable, then it is very possible that the intravenous medication could have been discontinued if not downgraded to oral antibiotic therapy. The Nurse Practitioner was unable for interview as they had been on vacation. On 06/01/2026 at 2:32 PM, the Medical Director was interviewed and stated that they did not think the best practice of medicine was to use the lowest effective dose for the shortest duration necessary. They further stated that if a resident simply does not look good then they would continue an antibiotic. The Medical Director stated that following imaging and lab results was not necessary to determine duration of antibiotic therapy and that because a mid-line may be kept in a resident for six months to a year, there is minimal risk in keeping them on intravenous therapy. The Medical Director stated that regardless of consultation recommendations, it is up to the facility provider to determine whether or not to continue an antibiotic. They also stated that given the complexity of Resident #59's infection, the antibiotic should be continued until the medical providers in the facility determine when it should end. They included that factors to determine duration included when the resident looks good or when the provider feels it is appropriate. On 06/01/2026 at 3:19 PM, the Infection Preventionist was interviewed and stated that residents on antibiotic therapy are followed by the facility's Antibiotic Stewardship Program. They stated that antibiotics are usually initiated depending on labs and/or imaging. Residents are initiated on care plans according to their infection and the antibiotic course would be reviewed with the medical provider. In reference to Resident #59, the Infection Preventionist stated that Resident #59 is followed by an outside Infectious Disease Physician. Upon return from consults, the in-house medical provider reviews the recommendations, and the treatment course is adjusted as necessary. They further stated that typically labs are completed once a month for resident on long-term antibiotic therapy. The Infection Preventionist did not know why labs were not repeated for Resident #59 or why imaging was not completed in a timely manner. They also did not recall the last time Resident #59's case was reviewed for antibiotic stewardship. On 06/01/2026 at 3:30 PM, in a subsequent interview the Infection Preventionist stated that Resident #59 was scheduled for imaging that day and that the antibiotic was continued until the imaging could be done. They stated that the doctor's office should have scheduled the imaging and follow up but also stated that when the follow up was not done, the antibiotic stewardship team should have noticed and followed up with the office. 10 New York Code Rules and Regulation 415.12(l)(1)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, records review, and interviews, the facility did not ensure a quality assurance and performance improvement (QAPI) program that put forth good faith attempts to identify and correct quality deficiencies were in place. Specifically, the facility had repeat deficiencies from the previous recertification surveys (from August 21/2024 to August/28/ 2024) in the areas of infection control prevention (F880), reporting of unwitnessed fall on time (F609) and posted nurse staffing information not in an accessible area for visitors to see (F732). There was no evidence there was a QAPI plan in place to meet the specific needs of the facility. The findings include: The facility policy and procedure titled, Quality Assessment and Performance Improvement Plan last reviewed in November 2025 documented that the vision of the facility is to create a homelike environment where the individualized needs of all residents will be addressed by a competent, highly skilled and compassionate staff. the mission is that the staff in the facility are committed to enhancing the quality of life of each resident in order to achieve their optimal level of wellness. As per the Quality Assessment and Performance Improvement Statement, the purpose is to study, plan, analyze and validate specific areas of improvement for positive resident care outcomes. There was no documented evidence that a Quality Assessment and Performance Improvement plan was in place to address the previous deficient practices. On 06/01/2026 8:57 AM, the Director of nursing was interviewed and stated that re-education will be done on all repeated deficiencies in a daily routine such as morning report, staff rounds. The Quality Assessment Performance Improvement team will identify any issues and meet monthly to discuss and make improvement in the identified issues. After each lesson plan, they are going to do audit. On 6/1/2026 at 9:16 AM, the Assistant Director of Nursing was interviewed and stated that for all negative outcomes, all Registered Nurses and Registered nurses' supervisors are going to be educated on repeated citations. On 6/1/2026 at 9:32 AM, the Administrator was interviewed and stated that all staff will be re-educated as well as the Quality Assessment Performance Improvement Team, to make sure that no deficiency is repeated. 10 New York Code Rules and Regulation 415.27 (a-c)		

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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. Based on observation and staff interviews, the facility did not ensure that it established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was identified specifically, when Licensed Practical Nurse #1 did not follow the manufacturer's instructions and did not use the appropriate Environmental Protection Agency (EPA) approved disinfectant to clean and disinfect the shared blood glucose meter. The findings are: The facility's policy titled, Blood Glucose-Capillary (Finger Sticks) dated 10/2025, documented to use approved EPA registered disinfectant for cleaning of sampling device. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses and clean and disinfect Glucometer with Germicidal Wipes. During a medication administration observation on 05/28/2026 at 3:51PM Licensed Practical Nurse #1 was observed performing a fingerstick for Resident #121. The glucometer was a multi-use blood glucose meter for the unit. Licensed Practical Nurse #1 was observed using an alcohol wipe (70 % Isopropyl Alcohol) to clean the blood glucose meter. When finished the Glucometer was placed on medication cart without disinfecting the device. During an interview 05/28/2026 4:54 PM Licensed Practical Nurse #1 stated they used the alcohol because they had cleaned the Glucometer before with the purple wipes. Licensed Practical Nurse #1 stated they believe the Glucometer is to be cleaned in-between residents with alcohol. Then Licensed Practical Nurse #1 stated they forgot to clean the Glucometer. Licensed Practical Nurse #1 further stated that the Glucometer is to be cleaned with the wipes in the purple container between residents and after using. During an interview on 05/29/2026 10:03 AM, the Infection Preventionist stated they were not sure which wipes are used to clean the Glucometer. The Infection Preventionist stated they think this facility uses alcohol wipes to clean the Glucometer. When asked what the purple topped container wipes are used for, they stated when those are used to clean the Glucometer and that it has to air dry. The Infection Preventionist stated they think the wipes in the container with the purple top says according to the manufacturer to air dry for 2-3 minutes. The Infection Preventionist stated once the nurse uses the glucometer, they clean it again and put it away. When asked about the Glucometer policy the Infection Preventionist stated they were not sure of the facility policy. The Infection Preventionist stated the staff are trained on facility policy once a year (unable to state a specific date) for training. The Infection Preventionist stated the Glucometer in-service is done once a year in-person and on the computer. The Infection Preventionist stated they could not recall when last in-service training was done. The Infection Preventionist stated they do not in-service the staff. During an interview 05/29/2026 11:06 AM, Assisted Director of Nursing stated they conduct staff education. The Assisted Director of Nursing stated there are also other registered nurses who provide in-services. The Assisted Director of Nursing stated they provide in-service on patient care, abuse, wound care, and educate staff on blood glucose monitoring and Glucometer use. The Assisted Director of Nursing stated the in-service for the blood glucometer monitor teaches the nurses to wash their hands and then don gloves. It also instructs to use the purple wipes to clean the glucometer and let it air dry for 3 minutes. The nurse is to check the medication administration record, use a lancet to get a specimen, then dispose of lancet and use gloves to clean Glucometer with purple top wipes. The Assistant Director of Nursing stated alcohol pads are not used to clean the Glucometer, and nurses were not educated to use alcohol pads. The Assistant Director of Nursing stated that they have not had the staff demonstrate cleaning of the glucometer. Assisted Director of Nursing stated clinical competency glucose testing is done on orientation, then as needed. 10 New York Code Rules and Regulation 415.19(a) (1-3)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to provide a safe, functional, sanitary and comfortable environment for residents, staff and the public. This was evident for one unit (Unit 3) of three units observed during the Environmental Task. Specific findings include but are not limited to, the hallway wallpaper was chipped, stained, and stapled, hallway base boards were either stained or not present, and the nurses' station was found to have mismatched paint or chipped paint. The findings include: The undated facility policy titled, Housekeeping Procedures in Residential Care Settings, documented that the resident has a right to a safe, clean, comfortable, and homelike environment. On 05/27/2026 at 9:43 AM a tour of Unit Three was conducted. The following was observed: Wallpaper chipped between the elevators. Wallpaper chipped throughout hallway. Blue baseboards throughout hallways are stained brown. Yellow stains on wallpaper next to resident shower room. Between room [ROOM NUMBER] and 303 wall is covered in staples with left over scraps of paper stapled to the wall. Doorway to nurses' station has several patches of white paint. Wallpaper in the hallway by the resident shower room is chipped and peeling in addition to having a patched up white painted section. Baseboard is missing in the hallway between rooms [ROOM NUMBERS]. Blue painters' tape on the floor on either side of the doorways between rooms [ROOM NUMBERS]. Nurses' station has chipped paint down the side of the counter. The Chart holder in the nurses' station was observed to have dark, rust-like stains. The inner room of nurses' station is painted green but has several patches of white paint. Nurses station drawers attached to table are chipped with exposed sharp edge. (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/27/2026 at 12:19 PM, during lunchtime observation in the Unit 3 dining room, the wall hand sanitizer dispensing unit repeatedly opened without dispensing hand sanitizer when staff tried to get hand sanitizer. On 05/29/2026 at 11:41 AM, Housekeeping Aide #1 was interviewed and stated their responsibilities included cleaning the bathroom, replenishing supplies, cleaning tables, and lights. They stated they are not responsible for the hallways and that the floor porter is responsible for hallways. They stated they just the clean the bathrooms. They further stated that if anything is broken, they would write it in the book on the floor for it to be fixed, and engineering/maintenance is responsible for checking the book and fixing it. Housekeeping Aide #1 stated they are fairly new to the facility and had only been working there for less than a year. They also stated the other floors don't look like this unit, but that the unit has looked the same since they started. On 06/01/2026 at 9:30 AM, Housekeeper #1 was interviewed and stated they are the porter. Their responsibilities include mainly to take out garbage, clean the floors, sweep, mop, buff, and if the other housekeeper is not here, they would do their responsibilities as well. Housekeeper #1 stated that the other housekeeper would perform wiping and dusting of the walls. When items are in disrepair, then it will be written in the book. They further stated that all the other floors have been renovated. They stated the wallpaper needs to be fixed. They stated they had been working here for 14 years, and the other floor were renovated by a contractor a while ago. On 06/01/2026 at 10:11 AM, the Director of Maintenance was interviewed and stated they had been here for six years. They further stated when they had started the first-floor renovation was completed and the contract for the second-floor renovation was already signed. The Director of Maintenance stated that the third-floor renovation is planned in-house versus being contracted out. They stated that they are starting with the common areas, and plan to do the rooms a section at a time by moving the residents out of the rooms to renovate. The Director of Maintenance stated that the worker they have for the renovation works per diem, and therefore the renovation is very slow. They stated that given the limited number of workers available, there is no planned end date for the renovation. They further stated that the environment as it is now does not provide a homelike environment for the residents but that they are trying to do the best they can with what they have. 10 New York Code, Rules and Regulation 415.29		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and record review, the facility did not ensure that results of the most recent recertification survey, as well as any complaint investigations from the preceding three years, were available and accessible to all residents and visitors. Specifically, upon review of the Department of Health survey binder located at the front desk, it did not contain the recertification survey result from 2024 and any complaint investigations since the last complaint investigation found in the binder dated 07/11/2023. The findings are: The facility's policy and procedure titled Required Postings and Signage reviewed 11/2025 documented that the Administrator shall conduct period audits to ensure compliance in posting of the most recent New York State Department of Health Survey Results, Statement of Deficiencies if required, and that they must be publicly accessible to residents, staff and visitors. During the observation conducted on 05/26/2026 at 02:05PM and another observation on 05/27/2026 at 12:15PM, the New York State Department of Health Survey Findings Binder was observed near the front entrance desk area. The binder contained Recertification, Life Safety survey results from 2022, complaint investigations findings with last completion dated 07/11/2023. The binder did not contain any complaint investigations findings since the last completion dated 07/11/2023 and it also lacked previous Recertification, Life Safety survey results from 2024. On 05/27/2026 at 12:30PM, Administrator was interviewed who stated they are responsible for ensuring residents and visitors that they can access the Department of Health survey results from previous visits and also updating the information in the binder located near the front desk. Administrator was asked to locate the last recertification survey findings from 2024 and complaint investigation findings received in the last three years in the survey binder. Administrator stated they could not locate them in the binder. Administrator stated they thought they updated/placed the information in the binder and did not know that they were not found in the binder. Administrator acknowledged for not having the information updated in the binder and stated they will update the binder as soon as possible. 10 New York Code Rules and Regulations 415.3(d)(1)(vi)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335434	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Little Neck Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 260 19 Nassau Boulevard Little Neck, NY 11362	
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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record review, the facility did not ensure that Nurse Staffing Information was posted in a prominent place readily accessible to residents and visitors. Specifically, the staffing information was posted on the glass window of nursing office located on the main floor, not in a prominent area, readily accessible to all residents and visitors. Additionally, the staffing information did not indicate the actual hours worked by staff. The findings are: The facility's policy and procedure titled Required Postings and Signage reviewed 11/2025 documented that the Administrator shall conduct period audits to ensure compliance in posting of daily nursing staffing information including Registered Nurse/Licensed Practical Nurse/Certified Nursing Assistant staffing levels and required staffing summaries, and that they must be publicly accessible to residents, staff and visitors. The facility's policy and procedure titled Daily Staffing reviewed 12/2025 documented the facility will maintain adequate staff in order to provide appropriate care to the residents in accordance with their diagnoses and prevailing medical conditions. A copy of Daily Nursing Schedule shall be posted outside of the nursing supervisor's office for maximum visibility. During the observations conducted from 05/26/2026 at 09:00AM to 05/29/2026 at 11:30AM, the daily nursing staffing information was observed posted on the glass window of nursing office on the main floor, which is not in a prominent area accessible to residents and visitors. Additionally, the staffing information did not indicate the actual hours worked by staff. Specifically, on 05/26/2026 at 01:37 PM, the posting titled Census of Nursing dated 05/26/2026 for 7AM to 3PM shift was observed posted and it documented total number of three (3) Registered Nurses = 22.5 hours, three (3) Licensed Practical Nurses = 21.75 hours, and fifteen (15) Certified Nursing Assistants = 108.75 hours worked during 7AM to 3PM shift. However, upon reviewing of the Actual Staffing Assignment and staff timecard report dated 05/26/2026 for 7AM to 3PM shift, revealed three (3) Registered Nurses, three (3) Licensed Practical Nurses, fourteen (14) Certified Nursing Assistants worked on 05/26/2026 from 7AM to 3PM shift. Certified Nursing Assistant #11 did not work as scheduled for 7AM to 3PM shift. The posting of staffing information did not match the actual number/hours worked by staff as per actual staffing assignment/timecard report dated 05/26/2026 for 7AM to 3PM shift. On 05/29/2026 at 11:10AM, Assistant Director of Nursing stated Staffing Coordinator is on sick leave since April 2026. The Director of Nursing and Assistant Director of Nursing are covering staffing coordinator's responsibilities in the meantime. Assistant Director of Nursing stated they are posting the staffing information on the glass window by the nursing office which was relocated from previous location near the employee time clock. Assistant Director of Nursing stated the plan of correction was to ensure the posting was visible for the public. The posting for staffing is updated every shift at the beginning of the shift. Assistant Director of Nursing stated they were not aware of any call out on 05/26/2026 for 7AM to 3PM shift so they did not know that the staffing information posted on 05/26/2026 for 7 AM to 3PM shift, was not accurately reflecting the actual number and hours worked. On 06/01/2026 at 11:56 AM, Director of Nursing stated that they had a deficiency for staffing posting on the last recertification survey because it was not posted in a highly visible area. It is now posted by the nursing office which they believed to be a highly visible area. Director of Nursing stated the required posting for staffing should reflect the actual number and hours worked; however, they were not aware that actual number/hours were not reflected on the posted staffing information. On 06/01/2026 at 12:54PM, Administrator stated the posting of staffing information is currently on the glass window by the nursing office which they believed to be visible area for the public. Administrator stated that location was approved for corrective action plan; however, they didn't realize that visitors (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	generally do not go or pass by the nursing office upon entering the facility.10 New York Codes, Rules and Regulations 415.13		