STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335487	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnland Nursing Center Inc	395 Sunken Meadow Road Kings Park, NY 11754

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the abbreviated survey 2645588 , the facility did not ensure the residents right to be free from abuse and neglect for one (Resident #1) of three residents reviewed. Specifically, during a transfer Certified Nursing Assistant #1 needed to lower Resident #1 to the floor when their (Resident #1) legs became weak. This resulted in an injury to Resident #1's left knee requiring first aid. Certified Nursing Assistant #1 completed the transfer by themselves although the comprehensive care plan and Kiosk Nursing instructions documented Resident #1 was to have two staff member assistances with transfers.The finding is :The facility Abuse Prevention Identification Investigation and Reporting policy dated October 2016 reviewed April 2025 documented neglect defined as means failings provide timely, consistent, safe, adequate, and appropriate services, treatment, and/or care to a resident of a residential care facility, while the resident is under the supervision of the facility, including but not limited to: nutrition, medication, therapy, sanitary clothing, surroundings, and activities of daily living. Neglect may include but is not limited: Failure to carry out physician orders, medication omission, treatment omission or failure to follow the care plan or provide emergency services.Resident #1 was readmitted to the facility on [DATE] with diagnoses that include urinary tract infection (Infection in any part of the urinary system), atrial fibrillation (irregular heartbeat originating in the heart's upper chamber) hypertension (high blood pressure) chronic obstructive pulmonary disease (progressive lung disease that causes obstructed air flow).The Minimum Data Set (an assessment tool) dated 10/14/2025 documented Resident #1 had a Brief Interview for Mental status score of 13 indicating intact cognition. The Minimum Data Set (an assessment tool) dated 10/19/2025 documented Resident #1's transfer status as requiring transfer from chair to bed and toilet transfers required the assistance of two or more helpers to complete the activity.A Comprehensive Care Plan for Resident #1 dated 3/15/2025 and updated 10/14/2025 documented assist resident with Activities of Daily Living tasks as needed daily and to see the plan of care instructions on kiosk nursing instructions.The kiosk nursing Instructions audit dated 10/15/2025 at 2:56 pm documented Resident#1 had a support change from one-person physical assist to two plus persons physical assistance for transfers.An Accident and Incident report dated 10/15/2025 documented that on 10/15/2025 at 6:45 pm, Certified Nursing Assistant #1 was transferring Resident #1 using one person assist contrary to the plan of care which specified a two- person assist for all transfers involving Resident #1 from the wheelchair to the bed and Resident #1 was lowered to the floor when their legs became weak resulting in a scab being removed from the left knee requiring first aid. Resident #1 remained alert and oriented, and no other significant injury was observed.A Treatment Administration Record dated 10/15/2025 at 7:33pm documented to left knee opening, cleanse with normal saline, apply Neosporin, cover with dry protective dressing daily and as needed until healed.During an interview with Certified Nursing Assistant #1 on 2/5/2026 at 11:38 am, they stated they (continued on next page)

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

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

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were transferring Resident #1 from the wheelchair to the bed by themselves because that was their (resident #1's) status prior to their readmission on [DATE]. They stated they did not check the kiosk nursing Instructions for Resident#1's transfer status prior to transferring them. Certified Nursing Assistant #1 stated they usually do not check if they are familiar with the residents. Certified Nursing Assistant #1 also stated that when Resident #1's knees weakened during the transfer, they had to lower resident number one to the floor.During an interview with Registered Nurse #2 on 2/5/2026 at 2:00 pm, they stated Resident #1 was on the floor lying on their left side. Resident #1 denied pain, discomfort or hitting their head. Resident #1 was observed with an open area on their left knee measuring 3 centimeters by 3 centimeters by 0 centimeters. Registered Nurse #2 stated that nurse practitioner #1 ordered a treatment to the left knee opening to cleanse with normal saline, apply Neosporin, cover with dry protective dressing daily and as needed until healed.During an interview with the Director of Nursing on 2/5/2026 at 3:40 pm, they stated they expected Certified Nursing Assistant #1 to check the kiosk for Resident #1's current transfer status at the beginning of the shift prior to transferring and caring for Resident #1.415.4(b)(1)(i)