

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335539	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/11/2026
NAME OF PROVIDER OR SUPPLIER Our Lady of Consolation Nursing and Rehab Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Beach Drive West Islip, NY 11795	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during a survey, the facility failed to ensure that alleged violations involving abuse, neglect, exploitation, or mistreatment were reported immediately but no later than two (2) hours to the New York State Department of Health. This was identified for seven (7) residents of seven (7) residents: Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7 reviewed for abuse. Specifically, 1) Resident #1's Designated Representative alleged Resident #1 stated to them that their (Resident #1's) arm was twisted. 2) Resident #2 alleged that a certified nursing assistant was rough during care, violated their dignity and did not follow their plan of care during their transfer. 3) Resident #3 alleged that a certified nursing assistant was rough with them (and tossed them around during care. There was no documented evidence that the abuse allegations for Resident #1, Resident #2 or Resident #3 were reported to the New York State Department of Health within two (2) hours as required. This resulted in Substandard Quality of Care that was Immediate Jeopardy with the likelihood for serious adverse outcome. The findings are: The facility policy titled, Abuse Prohibition dated August 2024, documented that all alleged cases of abuse, neglect, or mistreatment will be reported to the Department of Health or any other agency as appropriate by the Administrator, and/or the [NAME] President of Clinical Services. Based upon the results of an investigation, alleged cases of abuse must be reported within five (5) days. In confirmed cases of abuse, this must be reported immediately. 1) Resident #1 was admitted with diagnoses that included atrial fibrillation (an abnormal heartbeat), respiratory failure (a lung condition that causes breathing difficulties), and dementia. Resident #1's Minimum Data Set (a resident assessment tool) dated 12/31/2025 documented Resident #1 had a moderate cognitive impairment. A facility document titled, Grievance/Complaint Form dated 01/20/2026 documented the facility received an email from Resident #1's Designated Representative addressed to Social Worker #1 and Registered Nurse Unit Manager #1. The email was forwarded from Social Worker #1 to the Director of Social Work on 01/20/2026. The email documented Resident #1 stated to the Designated Representative someone twisted my arm this morning. There was no documented evidence that the allegation of abuse was reported to the New York State Department of Health. During an interview on 03/02/2026 at 11:41 AM, the Director of Social Work/Grievance Official stated they read the email from Resident #1's Designated Representative and it was forwarded to the nursing because the concerns were related to resident care. The Director of Social work/Grievance Official stated they did not investigate or report the allegation of Resident #1's arm being twisted because they believed it was a figure of speech. The Director of Social Work/Grievance Official stated it was their responsibility to review grievances and forward them to the designated department. When they received a grievance related to the provision of care or an allegation that care was rough, it was forwarded to nursing for investigation. The Director of Social Work/Grievance Official stated it was not their responsibility to report abuse to the New York State Department of Health. During an interview on 03/02/2026 at 12:09 PM, Social Worker #1 stated they received the email from Resident #1's Designated Representative on 01/20/2026 and they read someone twisted Resident #1's arm as a figure of speech regarding (continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #1 being asked to take their medication. Social Worker #1 stated they did not speak with the Designated Representative or Resident #1 about the arm being twisted because they believed it was a figure of speech. Social Worker #1 stated if they believed Resident #1's arm was physically twisted they would file a grievance and inform the Registered Nurse Unit Manager that a grievance was being filed so that the Registered Nurse Unit Manager could investigate the allegation. Social Worker #1 stated abuse must be reported to the New York State Department of Health within 24-48 hours. During an interview on 03/02/2026 at 12:26 PM, Registered Nurse Unit Manager #1 stated they received the email from Resident #1's Designated Representative and they read someone twisted Resident #1's arm as a figure of speech and did not believe it meant a staff person physically twisted Resident #1's arm. Registered Nurse Unit Manager #1 stated because they believed it was a figure of speech; they did not question the Designated Representative or Resident #1 regarding the statement. Registered Nurse, Unit Manager #1 stated they interviewed Resident #1 and the Designated Representative about the concerns identified in the email, but they did not document the interview, and they did not ask about Resident #1's arm being twisted because they believed it was a figure of speech. Registered Nurse Unit Manager #1 stated they reported allegations of abuse to the Assistant Director of Nursing and the Director of Nursing as it was their responsibility to report abuse to the New York State Department of Health within 24 hours of the occurrence. Registered Nurse Unit Manager#1 stated they did not report the alleged abuse of Resident #1 to the Assistant Director of Nursing or the Director of Nursing. During an interview on 03/02/2026 at 1:34 PM, the Director of Nursing stated they read the email from Resident #1's Designated Representative and they read someone twisted Resident #1's arm as a figure of speech and they did not believe it meant a staff person physically twisted Resident #1's arm. The Director of Nursing stated they did not know if the Designated Representative or Resident #1 were asked to clarify the statement because there was no documented interview related to Resident #1's allegation that their arm was twisted. During an interview on 03/02/2026 at 2:11 PM, the Administrator stated allegations of abuse were reported to New York State Department of Health within two (2) hours if the allegation was substantiated. The Administrator stated that they believed Resident #1's arm being twisted was a figure of speech and not a physical act it was not investigated or reported to the New York State Department of Health. 2) Resident #2 was admitted with diagnoses that included Cerebral infarction (a stroke), Hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or reduced motor function on one side of the body), and Type 2 Diabetes. Resident #2's Minimum Data Set, dated [DATE] documented Resident #1 had an intact cognition. A facility document titled, Grievance/Complaint Form dated 10/23/2025 documented Resident #2 reported that Certified Nursing Assistant #1 was rough and even hurt them at times during care and they felt their dignity had not been respected because Certified Nursing Assistant #1 left them unclothed for extended periods of time and in the presence of guests. Resident #2 also reported that Certified Nursing Assistant #1 transferred them without assistance even though they required two (2) persons transfer with a mechanical lift. A facility document titled Grievance/Complaint Investigation Form documented to see statement and the investigative summary. The attached investigative summary dated 10/24/2025 documented there was credible evidence that this allegation was credible. There was no evidence of abuse or mistreatment. Certified Nursing Assistant #1 will no longer be assigned to Resident #2 There was no documented evidence that the allegation of abuse was reported to the New York State Department of Health. During a follow-up interview on 03/11/2026 at 2:25 PM, the Director of Nursing stated they were assigned to Resident #2's grievance. They stated they conducted an interview with Certified Nursing Assistant #1 on 10/24/2025 via telephone with the Assistant Director of Nursing present. The Director of Nursing stated they completed the investigative summary dated 10/24/2025 after they spoke with Certified Nursing Assistant #1. The Director of Nursing stated based on Resident #2's interview with Social Worker #2, Certified Nursing Assistant #1's statement and a review of Certified Nursing Assistant #1's personnel folder in which there were no disciplinary actions related to care, they had no reason (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>to conclude that Certified Nursing Assistant #1 abused Resident #2. They stated they did not interview Resident #2. The Director of Nursing stated the statement in the investigative summary, there was credible evidence that this allegation was credible was written in error and should have read, there was no credible evidence that this allegation was credible. The Director of Nursing stated at the time of the allegation, they only reported allegations of abuse to New York State Department of Health within two (2) hours of the occurrence if they found evidence of willful harm to a resident. 3) Resident #3 was admitted with diagnoses that included urinary tract infection, hereditary hemorrhagic telangiectasia (a genetic disorder causing malformed blood vessels) and transient cerebral ischemic attack (a mini stroke). Resident #3's Minimum Data Set, dated [DATE] documented Resident #3 had a moderate cognitive impairment. A facility document titled, Grievance/Complaint Form dated 09/19/2025 documented Resident #3 stated a Certified Nursing Assistant was rough with me, tossed me around, and had a nasty disposition. A facility document titled, Grievance/Complaint Investigation Form documented the outcome of the investigation was: Resident #3 was interviewed and stated the Certified Nursing Assistant #3 was rough removing their pants, a statement was taken from the assigned Certified Nursing Assistant #3, and the Certified Nursing Assistant #3 was removed from the assignment. There was no documented evidence that the allegation was reported to the New York State Department of Health. During an interview on 03/02/2026 at 12:26 PM, the Registered Nurse Unit Manager #1 stated they did not report the alleged abuse of Resident #3 to the Assistant Director of Nursing or the Director of Nursing because they did not think that the allegation was abuse. During an interview on 03/02/2026 at 12:48 PM, the Assistant Director of Nursing stated abuse was documented as a grievance, an investigation was completed and if they felt abuse occurred then it was reported to the New York State Department of Health within two (2) hours. During an interview on 03/02/2026 at 1:34 PM with the Director of Nursing, they stated they would report an allegation of abuse to New York State Department of Health within two (2) hours of the occurrence if they found evidence of willful harm to a resident. During an interview on 03/02/2026 at 2:11 PM, the Administrator stated allegations of abuse were reported to New York State Department of Health within two (2) hours if the allegation was substantiated. During an interview on 03/02/2026 at 3:13 PM, the Medical Director stated they did not know the difference between grievance and an allegation of abuse/incident. The Medical Director stated they did not know if an allegation of abuse should be reported to New York State Department of Health. The Medical Director stated he was not aware of any allegations of abuse. 10 New York Codes, Rules, and Regulations 415.4(b)(2)(3)(4) Immediate Jeopardy was identified on 03/05/2026 and was lifted on 03/10/2026 when the facility showed substantial evidence that all staff were educated on abuse and updated their policy on Abuse reporting and investigating.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews during the Abbreviated Complaint Survey (Intake ID 2702583), the facility did not ensure that all alleged violations involving abuse, mistreatment, or neglect were thoroughly investigated. This was identified for seven (7) residents of seven (7) residents: Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, Resident #6, and Resident #7 reviewed for abuse. Specifically, 1) Resident #1's Designated Representative alleged Resident #1 stated their (Resident #1's) arm was twisted and the allegation and the allegation was not thoroughly investigated. 2) Resident #2 alleged that a Certified Nursing Assistant was rough during care, violated their dignity and did not follow their plan of care during transfer and the allegation was not thoroughly investigated. 3) Resident #3 alleged that a Certified Nursing Assistant was rough with them (Resident #3) and tossed them (Resident #3) around during care and the allegation was not thoroughly investigated. The findings are: The facility policy titled, Investigation Process for Alleged Abuse dated August 2024 documented that Skilled Nursing Facilities are required by Centers for Medicare and Medicaid Services to investigate allegations of abuse, neglect, or mistreatment and complaints related to care and quality of life. 1) Resident #1 was admitted with diagnoses that included Atrial fibrillation (an abnormal heartbeat), Respiratory failure (a lung condition that causes breathing difficulties), and Dementia. Resident #1's Minimum Data Set assessment dated [DATE] documented Resident #1 had a moderate cognitive impairment, had no upper or lower extremity impairment, and was independent with bed mobility and transfer. A facility document titled, Grievance/Complaint Form dated 01/20/2026 documented the facility received an email from Resident #1's Designated Representative addressed to Social Worker #1 and Registered Nurse Unit Manager #1. The email was forwarded from Social Worker #1 to the Director of Social Work on 1/20/2026. The email documented Resident #1 stated to the Designated Representative someone twisted my arm this morning. A facility document titled, Grievance/Complaint Investigation Form with a date of occurrence as 01/17/2026 was attached to Grievance/Complaint Form dated 01/20/2026 and documented an investigation related to skin tears sustained on 01/17/2026. There was no documented evidence that an investigation related to the Resident #1 statement that someone twisted their arm this morning. There was no documented evidence that the allegation of Resident #1's arm being twisted was investigated. During an interview on 03/02/2026 at 11:41 AM, the Director of Social Work/Grievance Official stated they read the email from Resident #1's Designated Representative and it was forwarded to nursing because the concerns were related to resident care. The Director of Social Work/Grievance Official stated they did not recall reading Resident #1's arm being twisted in the email. The Director of Social Work/Grievance Official stated if they received a grievance with a resident's arm being allegedly twisted, they would report the incident to the Registered Nurse Unit Manager for investigation. During an interview on 03/02/2026 at 1:34 PM with the Director of Nursing stated they read the email from Resident #1's Designated Representative and they read someone twisted Resident #1's arm as a figure of speech and did not believe it meant a staff person physically twisted Resident #1's arm. The Director of Nursing stated investigations regarding care were completed as part of the grievance process and interviews were conducted with the residents making the allegation, the accused staff person, and any witnesses. The Director of Nursing Services stated because they believed Resident #1's arm being twisted was a figure of speech it was not investigated. 2) Resident #2 was admitted with diagnoses that included Cerebral infarction (a stroke), Hemiplegia (paralysis of one side of the body) and hemiparesis (weakness or reduced motor function on one side of the body), and Type 2 Diabetes. Resident #2's Minimum Data Set assessment dated [DATE] documented Resident #1 had an intact cognition, had a upper and lower extremity impairment on one side, used a wheelchair for mobility, and was dependent (helper did all of the effort, resident did none of the effort to complete the activity, or the assistance of two [2] or more helpers was required for the resident to complete (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the activity) for bed mobility and chair/bed-to-chair transfer. Resident #2's Comprehensive Care Plan for Activities of Daily Living Functional Status/Rehabilitation Potential created on 09/10/2025 documented transfer with extensive assistance of two (2) via mechanical lift. A facility document titled, Grievance/Complaint Form completed by Physical Therapist #1 dated 10/23/2025 documented Resident #2 reported that Certified Nursing Assistant #2 was rough, and even hurt them at times during care and they (Resident #2) felt their dignity had not been respected because Certified Nursing Assistant #2 left them unclothed for extended periods of time in the presence of guests. Resident #2 also reported that Certified Nursing Assistant #2 transferred them (Resident #2) without assistance even though they (Resident #2) required a two person transfer with a mechanical lift. A facility document dated 10/23/2025 and signed by Social Worker #1 documented an interview was conducted with Resident #2 and during the interview Resident #2 stated they did not want to report anything, but acknowledged Certified Nursing Assistant #2 sometimes left them (Resident #2) exposed. A facility documented titled, Grievance/Complaint Investigation Form documented to see statement and the investigative summary. The attached investigative summary dated 10/24/2025 documented there is credible evidence that this allegation is credible. There is no evidence of abuse or mistreatment. Certified Nursing Assistant #2 will no longer be assigned to Resident #1. The summary did not include a statement regarding not following the plan of care for a two-person transfer. A written statement dated 10/25/2025 from Certified Nursing Assistant #2 documented they did not leave Resident #2 exposed at any time. The statement documented they (Certified Nursing Assistant #2) never hurt or harmed Resident #2. The statement documented they (Certified Nursing Assistant #2) would wash Resident #2 in bed and get them out of bed with the mechanical lift. The statement did not address the allegation of not following the plan of care related to the two-person transfer. There was no documented evidence that the allegations were thoroughly investigated. During an interview on 03/02/2026 at 1:34 PM, Social Worker #2 stated they interviewed Resident #2 on 10/23/2025 related to the allegations brought forward by Occupational Therapist #1 and Physical Therapist #1. Social Worker #2 stated during the interview Resident #2 stated they did not want to report anything. Social Worker #2 stated Resident #2 only acknowledged that Certified Nursing Assistant #2 had left them exposed in front of guests. During an interview on 03/02/2026 at 3:13 PM, the Medical Director stated they did not know the difference between a grievance and an allegation of abuse/incident. The Medical Director stated they did not know if rough handling was considered abuse. The Medical Director stated the registered nurse should complete a physical assessment of the resident if they reported rough handling. During an interview on 03/3/2026 at 12:06 PM, Certified Nursing Assistant #2 stated they wrote a statement related to the allegations Resident #2 made. Certified Nursing Assistant #2 stated they never completed a one person transfer with a mechanical lift with Resident #2 because the mechanical lift required a two (2) person assist. Certified Nursing Assistant #2 stated they were never rough while providing Resident #2 with care and they never hurt Resident #2. During an interview on 03/11/2026 at 12:40 PM, Occupational Therapist #1 stated Resident #2 made the accusations about Certified Nursing Assistant #2 while they were working with Resident #2. Occupational Therapist #1 stated Physical Therapist #1 was present at the time. Occupational Therapist #1 stated Resident #2 stated Certified Nursing Assistant #2 was rough during care, left them unclothed while their privacy curtain was not pulled, and transferred them from their wheelchair to their bed without the assistance of an additional staff person as was required by their plan of care. Occupational Therapist #1 stated they reported Resident #2's statements to the Director of Rehabilitation. During an interview on 03/11/2026 at 12:46 PM, Physical Therapist #1 stated Resident #2 made the accusations about Certified Nursing Assistant #2 while they were working with Resident #2. Physical Therapist #1 stated Occupational Therapist #1 was present at the time. Physical Therapist #1 stated Resident #2 stated Certified Nursing Assistant #2 was rough during care, left them unclothed while their privacy curtain was not pulled, and transferred them from their wheelchair to their bed without the assistance of an additional staff person as was required by their plan of care. (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physical Therapist #1 stated they reported Resident #2's statements to the Director of Rehabilitation, they brought the accusations to Social Worker #2 and Registered Nurse Unit Manager #2 on Resident #2's unit. Physical Therapist #1 stated they documented the concerns in an email, on a grievance form and they verbally reviewed Resident #2's concerns with the Director of Nursing on 10/23/2025. During an interview on 03/11/2026 at 2:25 PM, the Director of Nursing stated they were assigned the grievance for Resident #2. The Director of Nursing stated they were made aware of the allegation in the afternoon on 10/23/2025 and Certified Nursing Assistant #2 had already left for the day and were not due back to work until 10/25/2025. The Director of Nursing stated they conducted an interview with Certified Nursing Assistant #2 on 10/24/2025 via telephone with the Assistant Director of Nursing present. The Director of Nursing stated they completed the investigative summary dated 10/24/2025 after they spoke with Certified Nursing Assistant #2. The Director of Nursing stated they did not document they completed a telephone interview with Certified Nursing Assistant #2 on 10/24/2025. The Director of Nursing stated Certified Nursing Assistant #2 wrote a statement on 10/25/2025 when they returned to work. The Director of Nursing stated based on Resident #2's interview with Social Worker #2, Certified Nursing Assistant #2's statement and a review of Certified Nursing Assistant #2's personnel folder in which there were no disciplinary actions related to care they had no reason to conclude that Certified Nursing Assistant #2 abused Resident #2. The Director of Nursing Stated the statement in the investigative summary, there was credible evidence that this allegation was credible was a typo and should have read, there was no credible evidence that this allegation was credible. The Director of Nursing stated they did not document anything related to the allegation that Certified Nursing Assistant #2 completed transfers without a second person assisting as directed by Resident #2's plan of care. The Director of Nursing stated they were not aware that Certified Nursing Assistant #2's written statement did not include a statement related to not following Resident #2's plan of care when transferring Resident #2. The Director of Nursing stated they should have documented a statement from Certified Nursing Assistant #2 related to allegation of not following Resident #2's plan of care for transfers. The Director of Nursing stated they did not conduct interviews with other residents who received care from Certified Nursing Assistant #2 because that was not part of their investigative process. 3) Resident #3 was admitted with diagnoses that included Urinary tract infection, Hereditary hemorrhagic telangiectasia (a genetic disorder causing malformed blood vessels) and Transient cerebral ischemic attack (a mini stroke). Resident #3's Minimum Data Set assessment dated [DATE] documented Resident #3 had a moderate cognitive impairment, had no upper or lower extremity impairment, and was dependent (helper did all of the effort, resident did none of the effort to complete the activity, or the assistance of two [2] or more helpers was required for the resident to complete the activity) for bed mobility and chair/bed-to-chair transfer. A facility document titled, Grievance/Complaint Form dated 09/19/2025 documented Resident #3 stated Certified Nursing Assistant #3 was rough with them, tossed them around, and had a nasty disposition. A facility document titled, Grievance/Complaint Investigation Form documented the outcome of the investigation was, Resident #1 was interviewed and stated Certified Nursing Assistant #3 was rough removing their (Resident #3's) pants, a statement was taken from Certified Nursing Assistant #3, and Certified Nursing Assistant #3 was removed from the assignment. A statement dated 09/19/2026 from Certified Nursing Assistant #3 documented, they (Certified Nursing Assistant #3) were not rough and did not have an attitude with Resident #3. A Nurses Progress Note dated 09/19/2025 documented Resident #3 was a two (2) person approach due to accusatory behavior. There was no documented evidence that the allegation was thoroughly investigated. Certified Nursing Assistant #3 was unavailable for interview. During an interview on 03/02/2026 at 11:41 AM, the Director of Social Work/Grievance Official stated they reviewed all facility grievances and all grievances related to resident care were forwarded to nursing for investigation if needed. During an interview on 03/02/2026 at 12:26 PM, the Registered Nurse Unit Manager #1 stated they were assigned to the grievance Resident #3 filed on 09/19/2025. The Registered Nurse Unit Manager #1 stated they (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>interviewed Resident #3 and the accused Certified Nursing Assistant #3 who Resident #3 stated worked the 3:00 PM to 11:00 PM shift on 09/18/2025 and assisted them with care. The Registered Nurse Unit Manager #1 stated Certified Nursing Assistant #3 wrote a statement on the date of the allegation and denied any rough treatment and they (Registered Nurse Unit Manager #1) removed Resident #3 from Certified Nursing Assistant #3's assignment. The Registered Nurse Unit Manager #1 stated they did not conduct any other interviews. During an interview on 03/02/2026 at 12:48 PM, the Assistant Director of Nursing stated a grievance was any concern brought forward by a resident or a resident's family representative. The Assistant Director of Nursing stated an issue such as alleged rough treatment would be looked into on a case by case basis and because Resident #3 stated they were tossed around we completed an internal investigation which included an interview with the resident and Certified Nursing Assistant #3 since Resident #3 named a particular staff person. The Assistant Director of Nursing stated a thorough investigation was conducted because interviews were conducted with Resident #3 and a statement was completed by the accused Certified Nursing Assistant #3. During an interview on 03/02/2026 at 1:34 PM, the Director of Nursing stated investigations were completed as part of the grievance process and interviews were conducted with the residents making the allegation, the accused staff person, and any witnesses. During an interview on 03/02/2026 at 2:11 PM, the Administrator stated they defined abuse as a willful action to cause harm and an allegation of abuse was investigated as a care related grievance. The Administrator stated an investigation would include a review of the resident's medical record, an interview with the resident reporting rough handling, and an interview and statement from the accused staff person. The Administrator stated a physical assessment of the resident was not always completed unless there was an obvious sign of injury such as a visible bruise and they would not notify the medical doctor unless there was physical evidence of abuse. During an interview on 03/02/2026 at 3:13 PM, the Medical Director stated they did not know the difference between a grievance and an allegation of abuse/incident. The Medical Director stated they did not know if rough handling was considered abuse. the registered nurse should had completed a physical assessment of the resident if they reported rough handling. During an interview on 03/11/2026 at 2:25 PM, the Director of Nursing stated they did not conduct interviews with other residents who received care from the accused staff person because that was not part of their investigative process. 10 NYCRR 415.4(b)</p>		

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NAME OF PROVIDER OR SUPPLIER Our Lady of Consolation Nursing and Rehab Care Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Beach Drive West Islip, NY 11795	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during an Abbreviated Survey (Intake ID 2702583), the facility did not ensure each resident was served food and drink that was palatable, attractive, and at a safe and appetizing temperature. This was identified for two (2) of nine (9) residents, Resident #1 and Resident #8 who identified hot foods being served cold. Specifically, on 02/27/2026 during the lunch meal service on one unit (DePorres Unit) the lunch entree and vegetable were not served at a safe and appetizing temperature. The finding is: The facility's policy titled, Food Temperatures with a review date of February 2025 documented all hot foods must be cooked to appropriate internal temperatures, held and served at a temperature of at least 140 degrees Fahrenheit. A complaint intake (Intake ID 2702583) dated 12/29/2025 documented since admission all of Resident #1's meals were served cold. Resident #1 was discharged and was not available for interview. During an interview on 02/26/2026 at 11:08 AM Resident #8 stated they preferred to eat meals in their room, and the food was often served cold. Resident #1 was admitted with diagnoses that included Atrial fibrillation (an abnormal heartbeat), Respiratory failure (a lung condition that causes breathing difficulties), and Dementia. Resident #1's Minimum Data Set assessment dated [DATE] documented Resident #1 had a moderate cognitive impairment. Resident #8 was admitted with diagnoses that included Muscle wasting and atrophy (the loss of muscle mass resulting in reduced strength and reduced limb size), Parkinson's disease (a neurological disorder), and Syncope and collapse (fainting and falling). Resident #8's Minimum Data Set assessment dated [DATE] documented Resident #8 had an intact cognition. On 02/27/2026 during the lunch meal service, food temperatures were conducted on the DePorres Unit. During a kitchen observation on 02/27/2026 with the Food Service Director the steam table pans for the DePorres Unit were prepared and placed in the DePorres Unit warming box at 11:46 AM and left the kitchen. The warming box arrived on the DePorres Unit at 11:50 AM. The pans were placed on the steam table and meal plating began at 11:55 AM. The last lunch tray was served at 12:28 PM. The test tray temperatures were taken at 12:29 PM in the presence of Registered Nurse #5 using the facility's food thermometer. The temperature reading for the protein entree, salmon Teriyaki was 81 degrees Fahrenheit and the temperature reading for the vegetable, carrots was 100 degrees Fahrenheit. During an interview on 02/27/2026 at 12:37 PM, the Dietary Ambassador stated when the warming box arrived on the unit the steam trays were placed on the steam table. The Dietary Ambassador stated they took the food's temperature before they began serving and the salmon was 145 degrees Fahrenheit and the carrots were 140 degrees Fahrenheit. The Dietary Ambassador stated that the salmon and carrots should have been served at a minimum of 140 degrees Fahrenheit. During an interview on 02/27/2026 at 2:00 PM, the Food Service Director stated hot food should be served at a minimum of 140 degrees Fahrenheit. The Food Service Director stated residents should not receive hot food that are cold. 415.14(d)(1)(2)</p>		