STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335568	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Manor Ctr for Nursing and Rehabilitation	1325 Brentwood Road Bay Shore, NY 11706

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to ensure that medications were administered in accordance with physician orders and in accordance with the facility's medication administration policy for one (1) of three (3) residents reviewed for a medication error (Resident #1). Specifically, the facility administered Vimpat (lacosamide), a controlled anti-seizure medication, at a dose of 200 milligram by mouth for four (4) doses when the medication administration record reflected an order for 50 mg by mouth twice daily.Findings Include:Resident #1 was admitted on [DATE] with diagnosis that include Cerebellar stroke syndrome, Conversion disorder with seizures or convulsions, and depression. On 12/23/2025 a Minimum Data Set Brief Interview of Mental Status was completed for Resident #1 and documented a score of 00 indicating severe cognitive impairment.Review of the facility policy titled Administering Medications dated 12/2025 required staff to: Verify there is a physician's medication order; Check the medication label against the Medication Administration Record; Confirm the medication name and dose prior to administration.Hospital Discharge Medication Orders for Resident #1 dated 10/27/2025 documented Resident #1 was ordered Vimpat (Lacosamide) 50 milligram twice a day by oral route. Medical Doctor Orders for Resident #1 dated 11/01/2025 documented an order for Vimpat (Lacosamide) tablet 50 milligram twice a day. The E-Script order dated 11/03/2025 documented an order for Vimpat (Lacosamide) 200 Milligrams 1 tablet by mouth twice daily. The pharmacy delivery receipt dated 11/03/2025 documented Vimpat (Lacosamide) 200 milligrams was delivered to the facility and signed. Medication Administration Record for Resident #1 documented Vimpat 50mg was ordered and signed for by Licensed Practical Nurse #1 on 11/03/2025, Vimpat 50 milligrams was ordered and signed for by Licensed Practical Nurse #2 on 11/04/2025, Vimpat 50 milligrams was ordered and signed for by Licensed Practical Nurse #3 on 11/04/2025, and Vimpat 50 milligrams was ordered and signed for by Licensed Practical Nurse #4 on 11/05/2025A review of the medication card for Vimpat 200 milligrams reflected 4 missing tablets. A Review of the Narcotic Count Sheet dated 11/03/2025 reflected 4 signatures indicating Vimpat 200 milligrams was administered. Review of a Facility Reported Incident dated 11/07/2025 documented that Resident #1 received Vimpat (Lacosamide) 200 mg by mouth for four (4) doses despite an active electronic medication administration record order for Vimpat 50 mg by mouth twice daily. The report documented no identified adverse physical or psychological outcomes. Neurological status and vital signs remained within baseline. The medication was discontinued upon discovery of the error. Review of the facility's five-day investigative report dated 11/13/2025 documented that four licensed practical nurses administered the incorrect dose. The report further documented counseling, retraining, and competency validation of involved staff and re-education of licensed nursing staff on medication administration procedures.The Medication Error report dated 11/5/20205 document resident received 200mg on 11/03/2025 during the 3-11PM shift, 11/04/2025 twice 7-3AM & 3-11PM and on 11/5/2025 the7AM-3PM shift During an interview on 02/10/2026 at 11:31AM, the Director of Nursing stated that Medical Doctor #1 entered an incorrect dose of Vimpat 200 milligram twice daily into the electronic prescribing system. The pharmacy processed the order and delivered 200 milligram tablets to the unit. Four nurses administered the 200-milligram dose despite the electronic medication administration (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record reflecting 50 milligram.During a subsequent interview on 03/03/2026 the Director of Nursing stated the current electronic medical record is not linked to the pharmacy for narcotics. When ordering narcotics the physician must go into another system called e-script to enter the order for narcotics, which then goes to the pharmacy for delivery. The pharmacy stated they filled the e-script order because the prescription is coming from the doctor and does not reconcile with the physician order in the resident's chart. There is no process in place to reconcile the narcotic order with the physician order in the chart. During telephonic interview on 02/10/2026 at 01:55 PM, Medical Doctor #1 confirmed the incorrect prescribing of Vimpat 200 milligrams instead of 50 milligrams. The physician stated no adverse effects occurred and the resident required no hospitalization.415.12(m)(2)