STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335571	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockaway Care Center	353 Beach 48th Street Far Rockaway, NY 11691

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Number of residents sampled: 5Number of residents cited: 5 Based on observation, record review, and interviews conducted during the Recertification survey, the facility did not ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist. This was evident for five (5) of (5) residents (Resident #4, #10, #7, #6, and #221) reviewed for Unnecessary Medications out of 41 sampled residents. Specifically, there was no documented evidence in the clinical records of Residents #4, #10, #7, #6, and #221 that monthly Medication Regimen Reviews were completed. The findings include but are not limited to: The facility policy titled 'Medication Regimen Review' dated 12/31/2023 stated the Consultant Pharmacist will perform Medication Regimen Reviews for each resident at least monthly and for all newly admitted residents. The policy also stated the Consulting Pharmacist will document in the resident's medical record that the monthly Drug Regimen Review and whether there are any recommendations in the electronic medical record. 1.Resident #4 was admitted to the facility with diagnoses that included Alzheimer's Disease and Depression. Upon request, as part of the Medication Regimen Review documentation, the facility provided a document titled 'Unit 6 Census Detail Report' which was stamped 'Drug Regimen Review-PharmD' and dated 04/26/2025, 05/2025, 06/27/2025, and 07/2025. The facility also provided a document titled 'Point Click Care' Pharmacist-Drug Regimen Review which was dated 9/25 and listed all active residents including Resident #4. There was no signed and dated statement, by the pharmacist, in Resident #4's medical record that no irregularities were identified during the monthly reviews. 2. Resident #10 was admitted to the facility with diagnoses that included Diabetes Mellitus, Bell's Palsy, and Hypertension. Upon request, the facility provided Medication Regimen Reviews titled Census Detail Report dated 04/20/2025, 05/19/2025, 06/18/2025, 07/16/2025, 08/20/2025, and 09/15/2025. This four-page report listed all active residents including Resident #10. Affixed at the top of every page was the pharmacist's initials and a date. There was no signed and dated statement, by the pharmacist, in Resident #10's medical record that no irregularities were identified during the monthly reviews. 3. Resident #7 was admitted to the facility with diagnoses including Schizophrenia and Bipolar (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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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Disorder. A review of census lists for Unit 5 was provided by the facility and dated 04/2025, 06/2025, 08/2025, and 09/2025. The lists were stamped, signed and dated by the Pharmacy Consultant. There was no signed and dated statement, by the pharmacist, in Resident #7's medical record that no irregularities were identified during the monthly reviews. On 09/29/2025 at 3:13 PM the Director of Nursing was interviewed and stated the Pharmacist Consultant comes and sees all the residents, but the practice is that the Pharmacist consultants do not document in the electronic medical records. The Director of Nursing also stated if there were any recommendations, the Pharmacy consultants would email the Director of Nursing and the Administrator about the recommendations, otherwise they would send a checklist on which residents' charts were reviewed without recommendations. The Director of Nursing further stated there was no other documentation which stated residents medications were reviewed by the Pharmacy Consultants. On 09/29/2025 at 2:34 PM, an interview was conducted with the Pharmacy Consultant who stated that that they review medical records monthly and send irregularities to the Director of Nursing and the Administrator. The Pharmacy Consultant also stated the Medical Director is not included on the email chain. The Pharmacy Consultant further stated they do not document in each resident's medical records every month, however, they print out the census on each unit of residents with no irregularities, and they usually will stamp, sign and date the census printout and did not think any other documentation was necessary as they assumed the Director of Nursing would know. On 09/30/2025 at 3:35 PM, an interview was conducted with the Administrator who stated they receive the pharmacy recommendations by email on a monthly basis, and the Director of Nursing and the Medical Director are included on the email chain. The Administrator also stated the Pharmacy Consultant also sends a list of residents that have no irregularity and put their stamp, date and signature on them, and they do not act on those ones. The Director of Nursing then reviews recommendations with the physicians and acts on them. The Administrator stated they have a plan to change the current Pharmacy Consultant because they are not following the facility's policy on Medication Regimen Reviews, and they have discussed with them often that pharmacy records are missing, but the Pharmacy Consultant does things in their own way. 10 NYCRR 415.18(c)(2)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification conducted from 09/24/2025 to 10/01/2025, the facility did not ensure sufficient nursing staff was consistently provided to meet the residents' needs in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care. Specifically, 1). Residents reported the facility was short staffed with Certified Nursing Assistants, especially on weekends both days and nights, which resulted in a lack of timely staff response to call bells and delays in performing Activities of Daily Living and personal care. 2). The facility Payroll Based Journal for Quarter 3 (April 1 - June 30) also revealed an excessively low weekend staffing, and 3). Review of the actual staffing schedules dated from 04/01/2025 to 06/30/2025 revealed that staffing assignments were consistently less than the projected staffing needs specified in the Facility Assessment.The findings are: The facility's policy and procedure titled 'Staffing, Hiring, Application, Process, Training', last reviewed 02/06/2025, documented that it is the policy to assure that there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet the needs safely and in a manner that promotes each resident's rights, physical, mental and emotional wellbeing. Sufficient staffing for all personnel on a Twenty-Four (24) hour basis will be determined by number of residents, acuity and facility assessment. Twenty-Four (24) hour qualified staffing will be provided. 1.Resident #8 was admitted to the facility with diagnoses that included Anxiety Disorder, Depression, and Quadriplegia. The Minimum Data Set (an assessment tool) dated 09/29/2025 documented Resident #8 had intact cognition, and they required dependent assistance for toileting and showering. On 09/25/2025 at 12:55 PM, an interview was conducted with Resident #8 who stated that the facility is short staffed especially on weekends, and at nights. Resident #8 also stated it takes a longer time for staff to respond after they ring the call bell, and this happens very often. Resident #168 was admitted to the facility with diagnoses include Cerebrovascular Accident, Hemiplegia, and Hyperlipidemia. The Minimum Data Set, dated [DATE] documented Resident #168 had intact cognition, and they required dependent assistance for toileting, showering, upper/lower body dressing, and putting on footwear. On 10/01/2025 at 11:19 AM, an interview was conducted with Resident #168 who stated they have to wait a long time for staff to clean and change their incontinence brief when staffing is short on the unit. 2. The Payroll Based Journal Staffing Data Report for the 2nd quarter of 2025 (04/01/2025 - 06/31/2025) documented that low weekend staffing was triggered. The Facility Assessment, last updated August 2025 documented the facility has 6 units, with a 228-bed capacity, and each unit has a capacity of 42-47 beds. Ventilator dependent residents reside (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on the 3rd floor. The section of the Facility Assessment titled 'Daily Staffing Report by unit Monday to Friday' documented the following staffing pattern: 7:00 AM - 3:00 PM: 2nd Floor: 2 Licensed Practical Nurses, 4 Certified Nursing Assistants 3rd Floor: 2 Registered Nurses, 2 Licensed Practical Nurses, 4 Certified Nursing Assistants 4th Floor: 2 Licensed Practical Nurses, 4 Certified Nursing Assistants 5th Floor: 1 Licensed Practical Nurse, 4 Certified Nursing Assistants 6th Floor: 1 Licensed Nurse, 4 Certified Nursing Assistants 3:00 PM - 11:00 PM: 2nd Floor: 1 Registered Nurse, 1 Licensed Practical Nurse, 4 Certified Nursing Assistants 3rd Floor: 1 Registered Nurse,1 Practical, 4 Certified Nursing Assistants 4th Floor: 2 Licensed Practical Nurses, 4 Certified Nursing Assistants 5th Floor: 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 6th Floor: 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 11:00 PM - 7:00 AM: 2nd Floor: 1 Registered Nurse, 3 Certified Nursing Assistants 3rd Floor: 1 Registered Nurse, 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 4th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants 5th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants 6th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants The section of the Facility Assessment titled 'Staffing Report Weekends/Holidays' documented the following staffing pattern: 7:00 AM - 3:00 PM: 2nd Floor: 2 Licensed Practical Nurses, 3 Certified Nursing Assistants 3rd Floor: 2 Registered Nurses, 1 Licensed Practical Nurses, 4 Certified Nursing Assistants (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4th Floor: 1 Licensed Practical Nurses, 3 Certified Nursing Assistants 5th Floor: 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 6th Floor: 1 Licensed Nurse, 3 Certified Nursing Assistants 3:00 PM - 11:00 PM: 2nd Floor: 2 Licensed Practical Nurses, 3 Certified Nursing Assistants 3rd Floor: 1 Registered Nurse,1 Practical, 4 Certified Nursing Assistants 4th Floor: 2 Licensed Practical Nurses, 3 Certified Nursing Assistants 5th Floor: 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 6th Floor: 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 11:00 PM - 7:00 AM: 2nd Floor: 1 Registered Nurse, 3 Certified Nursing Assistants 3rd Floor: 1 Registered Nurse, 1 Licensed Practical Nurse, 3 Certified Nursing Assistants 4th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants 5th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants 6th Floor: 1 Licensed Practical Nurse, 2 Certified Nursing Assistants The Weekend /Holiday staffing reflected 6 fewer Certified Nursing Assistants, and 1 less Registered Nurse and Licensed Practical nurse despite the census remaining the same for weekdays and weekends. 3. A review of the facility's 'Daily Staffing Sheet for weekend staffing from April 2025 to June 2025 included but was not limited to the following: 04/05/2025 (Saturday) 7:00 AM-3:00 PM Shortage of 1 Licensed Practical Nurse on 2nd and 4th Floor, and 1 Certified Nursing Assistant for 2nd, 3rd, 5th and 6 th Floor units. 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 6th floor. 11 AM-7 PM (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Shortage of 1 Certified Nursing Assistant 4th and 6th floor units. 04/06/2025 (Sunday) 7:00 AM-3:00 PM Shortage of 2 Certified Nursing Assistants on the 6th floor. 04/13/2025 (Sunday) 7:00 AM-3:00 PM Shortage of 1 Certified Nursing Assistant on the 6th floor. 04/19/2025 (Saturday) 7:00 AM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 3rd floor. 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant 3rd and 6th floor units. 04/20/2025 (Sunday) 7:00 AM-3:00 PM Shortage of 1 Certified Nursing Assistant on the 2nd Floor, and 2 Certified Nursing Assistants on the 6th floor units. 3:00 PM-11:00 PM Shortage of 1 Licensed Practical Nurse on the 4th Floor, and 1 Certified Nursing Assistant on the 6th floor units. 11:00 PM-7:00 AM Shortage of 2 Certified Nursing Assistants on the 2nd Floor, and 1 Certified Nursing Assistant on the 4th and 6th Floor units. 04/26/2025 (Sunday) 11:00 PM-7:00 AM Shortage of 1 Certified Nursing Assistant on the 5th Floor, and 2 Certified Nursing Assistants on the 6th Floor units. 05/04/2025 (Sunday) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7:00 AM-3:00 PM Shortage of 1 Certified Nursing Assistant on the 4th floor. 05/10/2025 (Saturday) 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 4th floor. 05/11/2025 (Sunday) 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 3rd, 4th, 5th, and 6th Floor units. 05/18/2025 (Sunday) 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 5th Floor. 05/24/2025 (Saturday) 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 3rd Floor. 05/25/2025 (Sunday) 3:00 PM-11:00 PM Shortage of 1 Certified Nursing Assistant on the 3rd Floor and 4th floor units. 05/31/2025 (Sunday) 7:00 AM – 3:00 PM Shortage of 1 Certified Nursing Assistant on the 4th and 6th floor. 3:00 PM – 11:00 PM Shortage of 2 Certified Nursing Assistant on the 2nd floor. 11:00 PM-7:00 AM Shortage of 1 Certified Nursing Assistant on the 2nd floor and 3rd floor units. 06/07/2025 (Saturday) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7:00 AM – 3:00 PM Shortage of 1 Registered Nurses 3rd floor unit. 3:00 PM – 11:00 PM Shortage of 1 Licensed Practical Nurse on the 2nd floor unit. Shortage of 1 Certified Nursing Assistant on the 4th floor, 5th floor, and 6th floor units. 06/08/2025 (Sunday) 7:00 AM – 3:00 PM Shortage of 1 Certified Nursing Assistant on the 2nd, 3rd, 4th, 5th, and 6th floor units. 3:00 PM – 11:00 PM Shortage of 1 Certified Nursing Assistant 2nd, 4th, 5th and 6th floor units. 11:00 PM – 7:00 AM Shortage of 1 Certified Nursing Assistant 2nd, and 3rd floor units. 06/28/2025 (Saturday) 11:00 PM – 7:00 AM Shortage of 1Certified Nursing Assistant on the 3rd, 5th, and 6th floor units. 06/29/2025 (Sunday) 7:00 AM – 3:00 PM Shortage of 1 Certified Nursing Assistant on the 2nd, 3rd, 4th, and 6th floor units. 3:00 PM -11:00 PM Shortage of 1 Certified Nursing Assistant 2nd, and 3rd floors units. On 10/01/2025 at 11:47 AM, an Interview was performed with Certified Nursing Assistant #10, who stated certified nursing assistant staffing is always low especially on the weekends, and at times there are only two (2) certified nursing assistants to care for 40-45 residents on the unit. Certified Nursing Assistant #10 also stated when the staffing is low, the two (2) Certified Nursing Assistants team up and provide care for all the residents. Certified Nursing Assistant #10 further stated residents who are scheduled for showers may not receive showers on that day, so quick bed baths are given instead. On 09/26/2025 at 11:44 AM, an interview was performed with the Director of Respiratory Services (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who stated the ventilator unit currently has eleven (11) ventilator dependent residents nine (9) residents with tracheostomies, and the others are step-down respiratory residents who were weaned. The Director of Respiratory Services also stated they are working as the respiratory therapist for the floor, and that today's other staff on the unit include one (1) Licensed Practical Nurse and three (3) Registered Nurses but usually, the unit is staffed with two (2) Registered Nurses and one (1) Licensed Practical Nurse. The Director of Respiratory Services further stated when the unit is staffed with three (3) nurses, normally one (1) is floated to another unit. On 09/30/2025 at 9:17 AM, the Director of Nursing stated the Staffing Coordinator was not available for interview as they were currently travelling out of the country. On 09/30/2025 at 9:20 AM, an interview was performed with the Director of Nursing who stated staffing is the responsibility of the coordinator and the Director of Nursing. The Director of Nursing also stated they ask the staffing coordinator daily about staffing every morning and the coordinator shows them the schedule which includes staff call outs and no shows. Internal staff and long-term agency staff are called to work in times of shortages and there a fifty-fifty success rate. The Director of Nursing further stated when Certified Nursing Assistant staffing is low, a plan is created for certified nursing assistants to buddy up and complete the floor assignment together. If facility has low nurse staffing, the nursing supervisors will assist with treatments, picking up orders and supplies. The Director of Nursing stated the facility is using 3 staffing agencies and offering staff overtime as well, but it is still difficult to meet the required staffing levels on the weekend. On 09/30/2025 at 8:47:00 AM, an interview was performed with the Facility Administrator who stated the facility assessment was last reviewed August 25, 2025, and is an overview of the residents and the care they provide and documents the staffing and structure. The Facility Administrator also stated staffing was adjusted in August 2025, because after meeting consistently with the staffing coordinator there was a difference in the ability to staff the weekends based on the levels needed and the facility is working toward meeting these levels. The Facility Administrator further stated they are aware the Payroll Based Journal report for Quarter Two (2) 2025 triggered due to excessively low weekend staffing, and in response a full-time recruiter was hired, and they noticed a change in March 2025. The Facility Administrator stated there was a 10% increase in staffing for Quarter Two (2) 2025 but the facility was still not meeting the staffing levels for the weekend, so the facility has increased contracts with agencies to hire specifically for the weekend and is seeing some improvement. 10 NYCRR 415.13(a)(1) (i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview, and record reviews conducted during the Recertification survey, the facility did not ensure a performance review of every nurse aide was completed at least once every 12 months, and regular in-service education was based on the outcome of these reviews. This was evident during a review of Sufficient and Competent Nursing Staffing task. Specifically, six (6) of six (6) Certified Nursing Assistant personnel files contained no evidence of yearly performance evaluations and in-services based on the results of performance evaluations. The findings are:The facility policy and procedure titled ?Staffing, Hiring, Application Process and Training' last reviewed 02/06/2024, stated it is the policy of the facility to assure there is sufficient qualified nursing staff available at all times to provide nursing and related services to meet the needs safely and in a manner that promotes each residents rights, physical, mental and psychosocial well- being. 24 hour qualified staffing will be provided and staff replaced based on evaluation and review. Annual performance reviews will be completed annually for each staff member. Specific in-service education will be completed based on the outcome of the annual performance review.Upon review of personnel records of Certified Nursing Assistant #8, #9, #10, #11, #12, and #13, there was no documented evidence of annual performance reviews, and no in-service education completed based on the outcome of those annual performance reviews.On 10/01/2025 at 9:15 AM, an interview was conducted with the Director of Human Resources who stated it is their responsibility and that of the Director of Nursing to ensure staff performance reviews are completed yearly. The Director of Human Resources also stated they have been employed in their role for two (2) years and had not reviewed the older files of employees for compliance, as their focus had been on new hires and recruiting staff. The Director of Human Resources further stated the annual performance reviews should have been completed. On 10/01/2025 at 10:23 AM, an interview was conducted with the Director of Nursing who stated it is important performance reviews are completed, and competencies are performed as staff errors and performance issues can be identified, and then staff can be reeducated. The Director of Nursing also stated the performance reviews are forwarded to them from the Human Resources department and the nursing supervisors then complete the evaluations. The Director of Nursing further stated they have been employed as Director of Nursing in the facility since May 2025 and had not receive any request to complete performance evaluations.On 10/01/2025 at 09:50 AM, an interview was conducted with the Facility Administrator who stated performance evaluations should have been performed yearly and as needed. The Facility Administrator also stated there have been many changes made in every department in terms of leadership, and they were not focused on completing performance evaluations. The Facility Administrator further stated they take full accountability for the annual performance evaluations not being completed as the facility was onboarding at a fast pace, working on the personnel files for new hires, and ensuring those files were up to date and reviewed. 10 NYCRR 415.26(c)(2)(iii)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, and interviews conducted during the Recertification survey, the facility did not ensure the medication error rate was less than 5 percent. This was evident for 2 of 32 medications observed during the Medication Administration task. Specifically, Resident #180 was given the wrong dose of Lopressor 25 mg tablets and, Zyprexa 35 mg was also administered at the wrong time. This resulted in a medication error rate of 6.5%.The findings are:The facility policy titled ?Medication Administration' dated 9/20/2021 stated each resident will be provided with medication administration as ordered by the primary medical doctor. The policy also stated Licensed Nurses will have a medication competency done yearly as needed to ensure compliance with safe medication administration.A Medication Administration competency dated 8/18/25 for Registered Nurse #3 documented general guidelines which includes compares each medication label to medication administration record, ensures each order is correct for: medication, strength, route and time prior to pouring med.Resident #180 was admitted to the facility with diagnoses which included Hypertension and Schizophrenia.The Physician Orders dated 05/12/2025, last renewed 07/15/2025, documented Resident #180's was prescribed medications which included Metoprolol Succinate 25milligram tablets: 3 tablets orally one time a day, Olanzapine 15 milligram tablet, (part of 35 milligram dose): 1 tablet orally at bedtime and Olanzapine 20milligram tablets: give 1 tablet orally at bedtime for Schizophrenia. On 09/29/2025 at 9:44 AM, during the Medication Administration task, Registered Nurse #3 was observed administering medications Metoprolol Succinate 25 milligrams 1 tablet instead of Metoprolol Succinate 25 milligram 3 tablets, as ordered by the Physician to Resident #180. Registered Nurse #3 was also observed administering Olanzapine 35 milligram tablets to Resident #180 at 9:44 AM, when the medication was ordered to be given at bedtime.On 09/29/2025 at 10:45 AM, Registered Nurse #3 was interviewed and stated they were taught to check the five rights, and to check against the Medication Administration Record, never touch the medication, and to make sure the blister matches the Medication Administration Record. Registered Nurse #3 also stated they checked the blister pack which contained the medication but did not see it properly.On 10/01/2025 at 10:35 AM, the Infection Preventionist/ Educator was interviewed and stated all Licensed Nurses were in serviced and received orientation, and the process for medication administration involves going through a checklist which includes checking the blister packs and checking the right medications. The Infection Preventionist/ Educator also stated Registered Nurse #3 was hired in August 2025 and they completed the competencies for medication administration. The Infection Preventionist/ Educator further stated they monitor the nurses by doing spot checks and observing from a distance to see if they are following the procedure The Infection Preventionist/ Educator stated that they speak about any concerns at the Quality Assurance Performance Improvement meetings. On 10/01/2025 at 2:57 PM, the Director of Nursing was interviewed and stated in-service education for Licensed Nurses are done by the Educator, and initial education is done on Orientation and annually thereafter. The Director of Nursing also stated they have been doing in services and competencies were done which included medication administration and if there are any occurrences of noncompliance in these areas, they educate and discipline the staff. 10 NYCRR 415.12(m)(1)

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	335571	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockaway Care Center	353 Beach 48th Street Far Rockaway, NY 11691

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, record review, and interviews conducted during the Recertification survey, the facility did not ensure garbage and refuse were disposed of properly. Specifically, the garbage was not properly contained outside of the facility to prevent the harborage and feeding of pests. The findings are:The facility's policy and procedure titled ?Handling, Transporting and Disposing of Trash' reviewed 9/24/2025 stated trash must be stored in refuse containers that are seamless and constructed of easily cleanable material equipped with a tight-fitting lid.On 09/26/2025 at 12:19 PM, Dietary Worker #1 was observed taking garbage from the kitchen to the garbage disposal area located outside of the building. The compactor was observed without a door and exposed piled garbage bags. Multiple flies were observed on the garbage bags and around the opening of the compactor. A door was detached and observed next to the compactor.On 09/29/2025 at 10:45 AM, the compactor was observed again without a door and with door on the ground next to it. Multiple flies were noted on the garbage inside the compactor and near the opening of the compactor.On 10/01/2025 at 10:32 AM and 10:50 AM, multiple observations of the outside area revealed a black wheeled cart contained multiple bags of garbage which was uncovered and had multiple flies around it. On 09/26/2025 at 12: 35 PM, Dietary Worker #1 was interviewed and stated they are supposed to close the compactor door prior to activating the compactor but the door appears to be broken. Dietary Worker #1 also stated they did not know when the door broke and how long it has been like this.On 09/26/2025 at 12:40 PM, the Regional Food Service Director was interviewed and stated door was noticed to be broken the morning of 09/25/2025 so they immediately informed the Administrator and Maintenance Director. The Regional Food Service Director also stated they were told the company was called, and compactor would be replaced as soon as possible.On 09/29/2025 at 12:41 PM, the Food Service Director was interviewed and stated the compactor is used and closed after usage, but they noticed the latch broken sometime last week. The Food Service Director also stated they are still waiting for the company to repair the compactor, which remains currently out of order.On 10/01/2025 at 2:41 PM, the Director of Maintenance was interviewed and stated the Regional Food Service Director informed them the compactor door was broken and was not able to be closed six days ago, but they were not sure how long it had been broken. The Director of Maintenance also stated a technician from the carting company came on the same day but stated the compactor was not repairable, and the compactor was finally picked up for repairs two nights ago. The Director of Maintenance further stated the facility has a dumpster for interim use so staff should have place garbage in the dumpster and closed it and not have left it outside uncovered in a black trash cart.On 10/01/2025 at 3:00 PM, the Administrator was interviewed and stated they were notified by the storeroom staff six days ago that the compactor area was unkempt, and the compactor door latch was broken. The Administrator also stated the compactor company was notified and came to pick up the compactor two days ago on 09/29/2025. The Administrator further stated they were not aware the garbage was left outside uncovered today. 10 NYCRR 415.14(h)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interviews and record review conducted during the Recertification survey, the facility did not ensure the facility-wide assessment was updated to include and address the total resident population and resources that were necessary to care for those residents. This was evident during a review of Sufficient and Competent Nursing Staffing. Specifically, 1). the Facility Assessment did not identify or address care for ventilator dependent residents in the total population of services offered including respiratory therapist personnel required to meet that populations daily staffing needs, and 2). on-site hemodialysis treatment was listed as a service provided and the facility did not have a certified dialysis unit.The findings are:The facility policy and procedure titled ?Facility Assessment' last reviewed 07/15/2025, stated the facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including night and weekends) and emergencies. The policy also stated the Facility Assessment will address/include resident population which includes the number of residents and resident capacity, the care required by the resident population: using evidence based, data driven methods that consider the type of disease, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity and other pertinent facts that are present within the population, the staff competencies: necessary to provide the level and types of care needed for the resident population, and the physical environment, equipment, services and other physical plant operations that are necessary to care for this population. The policy further stated the Facility Assessment will address/include the facility's resources, including equipment (medical and non-medical), services provided, all personnel, both employees and those who provide services under contract. 1.The Resident Matrix (CMS-802) for Unit 3 documented 11 (eleven) ventilator residents resided on the unit.The Long-Term Care Facility Application for Medicare and Medicare form (Form CMS-671) dated 09/24/2025, documented under Dedicated Special Care Units there were twenty (20) Ventilator/Respiratory care beds and zero (0) Dialysis beds.The Facility Assessment, dated August 2025, documented in Facility Characteristics/Resident Profile a total bed capacity of two hundred twenty-eight (228). The Facility Assessment also documented resident care provided includes Hospice Care, Palliative Care, Respite Care, Long-Term Care, Subacute Rehabilitation, Hemodialysis, Bariatric, Dementia, Traumatic Brain Injury, PASSR Level Two (2), Cancer Treatments, Substance Use Disorders. The Facility Assessment did not include ventilator dependent residents or the staff competencies necessary to provide the level and types of care needed for the population, the ventilator equipment, associated services and other physical plant operations that are necessary to care for this population or all personnel required including the respiratory therapist.The document titled Employee Contact List documented five (5) respiratory therapist as current personnel.On 09/26/2025 at 11:44 AM, an interview was conducted with the Director of Respiratory Services who stated Unit 3 currently houses 11 ventilator-dependent residents. The Director of Respiratory Services also stated they are currently working as a full-time Respiratory Therapist on Unit 3. 2. The Facility Assessment documented onsite hemodialysis treatment was provided however the facility did not have a certified dialysis unit.On 09/30/2025 at 8:47 AM, an interview was conducted with the Facility Administrator who stated the Facility Assessment is an overview of the residents and the care provided and was last reviewed on 08/25/2025. The Facility Administrator also stated the current Facility Assessment includes all care services currently provided for the residents including ventilator services which have been provided in the facility for a decade. The Facility Administrator further stated the facility does not provide on-site hemodialysis services. Upon review of the Facility Assessment the Facility Administrator stated they did not realize that ventilator services were not listed as a service provided to the resident population and that hemodialysis was erroneously listed as a service provided. 10 NYCRR 415.26

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Number of residents sampled: 7Number of residents cited: 1 Based on observation, record review, and interviews conducted during the Recertification survey, the facility did not ensure infection control practices and procedures were maintained. This was observed during medication administration for one (1) of seven (7) residents (Resident #187) observed. Specifically, Enhanced Barrier Precautions were not used when Registered Nurse #5 administered medications to Resident #187 via the gastrostomy tube.The findings are:The facility's policy titled Enhanced Barrier Precautions with a review date of 12/12/2023, stated it is the policy of this facility to adhere to the Centers for Disease Control and Prevention guidelines as related to Enhanced Barrier Precautions in order to prevent the transmission of multidrug-resistant organisms amongst residents and healthcare workers. The policy also stated the facility will implement enhanced barrier precautions during high-contact resident care with examples of high-contact resident care activities to include device care or use - central line, urinary catheter, feeding tube, and tracheostomy/ventilator.Resident #269 was admitted to the facility with diagnoses that include Multiple Sclerosis and Dysphagia.The Physician's orders dated 07/01/2025 documented orders for Enhanced Barrier Precautions Reason: G-tube/Peg tube.On 09/29/2025 at 10:17 AM, Registered Nurse #3 was observed administering medication via a Gastrostomy Tube. Registered Nurse #3 entered Resident #187's room, washed their hands, donned gloves, and prepared the medications to be administered. Registered Nurse #3 placed the medications on Resident#187's bedside table, then proceeded to administer the medications via the gastrostomy tube and flushed the tubing with water when completed. Registered Nurse #3 then discarded the containers, cleaned the bed side table, washed their hands and left Resident #187's room. At no time was Registered Nurse #3 observed wearing gown, gloves and mask as per the Enhanced Barrier Precautions.On 09/29/2025 at 10:38 AM, Registered Nurse #3 was interviewed and stated they were taught during their orientation in August 2025, that Enhanced Barrier Precautions should be used during medication administration via gastrostomy tubes. Registered Nurse #3 stated they were aware but somehow forgot to use it.On 10/01/2025 at 10:35 AM, the Infection Preventionist/Educator was interviewed and stated all Licensed Nurses were in serviced on Enhanced Barrier Precautions and Registered Nurse #3 was in serviced during their orientation in August 2025. The Infection Preventionist/Educator also stated the signage was posted on Resident #187's door indicating Enhanced Barrier Precautions were to be utilized, and this includes residents who receive medications via a feeding tube. The Infection Preventionist/Educator further stated they make rounds on the units to monitor if staff is using Enhanced Barrier Precautions and if there were any deficient practice, they would pull the nurses aside and give them an in-service on the issue.On 10/01/2025 at 2:57 PM, the Director of Nursing was interviewed and stated in-service education for Licensed Nurses are done by the Educator, and initial education is done on Orientation and annually thereafter. The Director of Nursing also stated they have been doing in-service on Enhanced Barrier Precautions and they teach the nurses Enhanced Barrier Precautions are to be maintained for residents with foley catheters, tube feedings and tracheostomies. The Director of Nursing further stated Registered Nurse #3 had a considerable number of in-services on Enhanced Barrier Precautions and should have used it during medication administration. 10 NYCRR 415.19(a)(1-3)

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	335571	A. Building B. Wing	12/10/2025

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review conducted during the Recertification survey, the facility did not ensure a building elevator was maintained in a safe working condition. This was observed in one (1) of three (3) elevators (Elevator #2) observed. Specifically, Elevator #2 was broken and out of service for over 10 months, causing delays and restricting resident movement around the facility, including attending medical appointments. The findings are: Observations conducted from 09/24/2025 to 10/01/2025 between the hours of 10:00 AM and 3:00 PM revealed Elevator #2 was not in good working condition. A security staff was positioned inside Elevator #2 to move passengers from floor to floor and the unit staff were observed paging the front door security staff to send Elevator #2 to various units when needed. Facility is a six floored building with 3 elevators located near the lobby. There were 2 passenger elevators (Elevator #1 and #2, and Elevator #3 was designated as a service elevator and used primarily for transporting goods, equipment, and staff only. On 09/26/2025 at 2:30 PM, during the Resident Council meeting six out of eight residents in attendance verbalized they have had concerns about the broken elevator for over 10 months. These residents stated only Elevator #2 is not in working condition and this prevented them from attending programs in the facility. Resident #35 stated they were stuck inside Elevator #2 a while back and it took the facility more than 30 minutes to get them out, and the situation with the elevator has still not been resolved. On 09/26/2025 at 03:10 PM, an interview was conducted with the Director of Recreation who stated they were aware of the broken elevator, however, residents or family had not complained to them. The Director of Recreation also stated they experience delays moving residents around in the facility and they just have to wait or page for the elevator where they need it. On 09/30/2025 at 11:34 AM, an interview was conducted with the Director of Maintenance Services who stated there are three elevators in the facility, Elevator #1 is for the kitchen and emergencies, Elevator #2 has been damaged for over 10 months, and Elevator #3 is currently working without problems. The Director of Maintenance Services also stated they have had some complaints from residents, family members, and staff and they were all assured it will be fixed soon. The Director of Maintenance Services further stated the Administrator was aware of the issues with the elevator and was working on it. The Director of Maintenance Services stated the part needed to repair the elevator is hard to get, and they are working on it but are not able to tell when it will be fixed. On 09/30/2025 at 04:01 PM, an interview was conducted with the Administrator who confirmed Elevator #2 was broken and out of service for over 10 months. The Administrator also stated Elevator #1 is used for emergency and to move items around and can be used when they have events at the facility like birthday parties. The Administrator further stated Elevator #2 has been out of service since November 2024 and it takes 6 to 8 months to get the piston that is broken at the base of the elevator. The Administrator stated they have been receiving complaints about the elevators, and they try to accommodate residents and family members as much as possible by having someone operate Elevator #3 and cover all of the units. The Administrator concluded the elevator is under repair now and should be fixed in 60 days. 10 NYCRR 415.29

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Number of residents sampled: 2Number of residents cited: 1 Based on observation and staff interviews conducted during the Recertification survey, the facility did not ensure that a resident was cared for in a manner that maintained or enhanced dignity. This was evident for one (1) of two (2) residents (Resident #12) reviewed for Catheter out of a sample of 41 residents. Specifically, Resident #12's foley catheter drainage bag and tubing were not covered with a privacy bag.The findings are:The facility policy titled ?Indwelling Foley Catheters' last reviewed 09/02/2022 stated a drainage bag cover should be utilized to maintain resident dignity.The facility policy titled 'Resident Right to Privacy and Dignity', last reviewed 01/2025 stated that residents are treated in a dignified manner and their privacy rights are upheld as outlined in the Resident [NAME] of rights.Resident #12 was admitted to the facility with diagnoses which include Obstructive uropathy, Seizure Disorder, and Acute kidney failure.The admission Minimum Data Set (an assessment tool) dated 08/06/2025 documented Resident #12 had severely impaired cognitive skills for daily decision making, and they required extensive assistance of 2 staff members for bed mobility, transfer, dressing, toilet use, and personal hygiene, and had an indwelling catheter.The Physician order dated 08/13/2025 documented foley catheter care every shift, monitor urine output and document amount in every shift for neuromuscular dysfunction of bladder. During multiple observations on 09/24/2025 at 10:54 AM, and 09/25/2025 at 1:06 PM, Resident #12 was observed lying in bed. Resident #12's foley catheter drainage bag and catheter tubing were observed with amber urine draining into the bag which was visible from the hallway as it was not contained in a privacy bag.On 09/26/2025 at 11:59 AM, Registered Nurse #2 was interviewed and stated they were not aware Resident #12's foley drainage bag had no cover. Registered Nurse #2 also stated Resident #12 is the only resident on the unit that has a foley catheter, and they should have put the cover, but it was an oversight.On 10/01/2025 at 11:56 AM, Licensed Practical Nurse #4 was interviewed and stated they were not aware there was no privacy cover on the foley bag, and the bag must be covered at all times because it preserves a resident's dignity. On 10/01/2025 at 2:46 PM, the Director of Nursing was interviewed and stated they were not aware Resident #12's foley had no privacy cover. The Director of Nursing also stated it is the responsibility of the staff on the unit, especially the nurse, to make sure foley catheters have privacy cover for dignity concern. 10 NYCRR 415.5(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interviews conducted during the Abbreviated (459994) and Recertification survey, the facility did not ensure the services provided or arranged by the facility as outlined by the comprehensive care plan, met professional standards of quality. This was evident for one (1) of two (2) residents (Resident #229) reviewed for Hydration out of a total of 41 sampled Residents. Specifically, a Comprehensive Metabolic Panel laboratory test was ordered for Resident #229 on 04/09/2025, there was no documented evidence that blood test was performed. The findings are: The facility policy titled 'Laboratory and Diagnostic Test' reviewed 04/01/2025, stated it is the policy of the facility that all diagnostic interventions will be provided as ordered by the physician. The physician/designee will identify, and order laboratory testing based on the resident's monitoring needs. The license nursing staff will process test requisitions. The laboratory providers will report test to the facility. The results of diagnostic testing will be reviewed by the nursing and medical staff and changes will be made to the Resident's plan of care as indicated. The registered nurse supervisor or designee reviewing laboratory results every shift will ensure that the laboratory specimen has been collected, completed with results, reviewed on the dashboard, and then the order discontinued once completed. The registered nurse supervisor or designee will run a report on a regular basis to ensure no outstanding labs are identified. Resident #229 was admitted to the facility with active diagnoses of Hypernatremia and Hyperosmolality.A Physician Order initiated on 02/06/2025 and renewed on 04/09/2025 documented a laboratory test order for a Comprehensive Metabolic Panel and Complete Blood Count testing.A Comprehensive Metabolic Panel Laboratory Result dated 02/07/2025, documented an abnormal/high Sodium Value of 146 millimole/liter with a reference range of 136-145 millimole/liter and an abnormal/high Calculated Osmolality of 304.81 milliosmoles/liter with a reference range of 275.00-295.00 milliosmoles/liter.There was no documented evidence that the Comprehensive Metabolic Panel and Complete Blood Count laboratory tests ordered on 4/9/2025 were performed.There was no documented evidence that the licensed nurses, physician, or the nurse practitioner followed up on the Comprehensive Metabolic Panel and Complete Blood Count testing that were ordered on 4/9/2025.Nursing Progress Notes dated 5/3/2025 and 5/5/2025, documented Resident #229 was awake with confusion and refused breakfast and lunch.A Physician Laboratory Order initiated on 05/05/2025, documented an immediate (STAT) one time order for Comprehensive Metabolic Panel and Complete Blood Count. laboratory testsA Comprehensive Metabolic Panel Laboratory Final Result dated 05/05/2025 documented an abnormal/high Sodium Value of 170 millimole/liter with a reference range of 136-145 millimole/liter and an abnormal/high Calculated Osmolality of 364.72 milliosmoles/liter with a reference range of 275.00-295.00 milliosmoles/liter.A Nursing Progress Note dated 05/06/2025 documented Resident #229 had a sodium level elevated at 170mEq/L and the Nurse Practitioner was made aware of the results.A Physician Order initiated on 05/08/2025, documented a medication order for an infusion of intravenous fluid of Dextrose five percent (5%) in water (D5W) at one hundred twenty-five cubic centimeters per hour for two days (125cc/hr. x 2 days).A Nursing Progress Note dated 05/06/2025, documented the administration of intravenous fluids, Dextrose five percent (5%) in water (D5W), was started for Hyperosmolality and Hypernatremia.A Physician Transfer Order initiated on 05/07/2025, documented transfer Resident #229 to the hospital. Reason: Hypernatremia and Acute Kidney Injury.On 09/30/2025 at 4:45 PM, an interview was performed with the Medical Director who stated the laboratory tests ordered in February for Resident #229 were slightly elevated and at that level there should not have been a two month wait to repeat the laboratory tests. The Medical Director also stated if laboratory test were ordered in April, when the resident was seen by the provider the next month, the provider should have been able to determine from reviewing the record that the laboratory tests previously ordered were not performed. The Medical Director further stated follow up on the test results should have been performed and that the nurse practitioner who ordered the laboratory tests in April and did not follow (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up on the results is no longer employed by the facility. On 10/01/2025 at 12:16 PM, an interview was performed with the Director of Nursing who stated the process for follow up on laboratory testing includes receipt of an order by the provider. The nursing supervisor enters the order in the electronic medical record, and a laboratory requisition is created, printed and placed in the lab book for the laboratory technician to pick up, remove the requisition from the laboratory book and obtain the specimen. The Director of Nursing also stated that in the daily twenty-four (24) hour report meeting, the need for laboratory tests and a possible change in condition should be reported and the nursing staff and the provider should be following up to ensure the laboratory tests were performed and the results obtained. The Director of Nursing further stated that laboratory tests to measure sodium and Osmolality levels for Resident #229 were ordered on 04/09/2025 but the laboratory specimen were not obtained. 10 NYCRR 415.11(c)(3)(i)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 1 Based on observation, record review, and interviews during the Recertification survey, the facility did not ensure the resident is offered a therapeutic diet when there is a nutritional problem, and the health care provider orders a therapeutic diet. This was evident for one (1) of two (2) residents (Resident #225) reviewed for Hydration out of 41 total sampled residents. Specifically, Resident #225, who had a physician's order for thickened liquid, was observed drinking coffee and water without a thickener.The findings are:The facility's policy titled ?Aspiration Precautions' reviewed on 5/31/23 stated it is the policy of this facility to identify residents who are at potential risk for aspiration and to implement interventions that will prevent aspiration and easily alert staff of who those residents are. The policy also stated the resident's meal tickets will be updated by the Food Service Director/Dietitian to indicate the diet texture, thicken liquid consistency order, if indicated.Resident #229 was admitted to the facility with diagnoses that include Altered Mental Status, Cerebral Vascular Accident, and Dementia.The Physician's Orders dated 09/22/2025 documented Resident #225's was prescribed a Carb Consistent/Heart Healthy diet, Pureed 4 texture, Nectar/Slightly Thick 1 consistency, aspirations precautions The Comprehensive Care Plan Titled Nutrition, created 09/19/2025, documented Resident requiring therapeutic diet of consistent carbohydrate, heart healthy puree consistency, nectar thickened liquids. Goals included resident will tolerate diet as ordered through review date. Interventions include provide and serve diet as ordered. A Speech Language Pathology Evaluation and Plan of Treatment dated 9/22/25 documented treatment of swallowing dysfunction and /or oral function for feeding, 3 to 5 times a week, duration of 4 weeks. Recommendation includes diet recommendations- liquids nectar thick liquids, solid=pureed consistency, and supervision for oral intake- occasional supervision. An Initial Dietary assessment dated [DATE] documented Resident #225 was receiving a consistent carbohydrate heart healthy diet, pureed diet consistency, mildly thick fluid consistency. The assessment also documented Resident #225 complained of difficulty or pain when swallowing. The assessment further documented Resident #225 was admitted on consistent carbohydrate, heart healthy diet regimen puree diet consistency with nectar thick liquids. Self-fed after tray prep with encouragement given to ensure meal completion.During a dining observation on 09/24/2025 at 12:50 PM, Resident #225's meal tray ticket documented nectar thick liquids, carb consistent/no added salt-puree. Two (2) packets of unopened thickener, one (1) cup of non-thickened coffee and one (1) cup non thickened water were observed on the tray. There was no staff observed adding thickener to Resident #225's coffee and water. Resident #225 was observed holding their cup and took three sips of coffee with no thickener added.On 10/01/2025 at10:40 AM, Registered Nurse #3 was interviewed and stated for residents with aspiration precautions who require thickened liquids, the thickener package comes up from dietary and it is the Certified Nursing Assistants' responsibility to add thickener to the residents' drink. Registered Nurse #3 also stated Certified Nursing Assistants know how much thickener to use, and the nurses would verify it. The Registered Nurse #3 further stated they monitor the Certified Nursing Assistants at different times to ensure compliance by doing rounds and giving shift reports.On 10/01/2025 at 10:45 AM, Registered Dietician #1 was interviewed and stated they did the initial assessment of Resident #225 who is on a pureed diet with nectar thick liquids. Registered Dietician #1 also stated Resident #225 gets thickened juices and water on their tray, and the thickened packet is for the coffee and the tea. The Certified Nursing Assistants and the Licensed Nurses are responsible for thickening those liquids for residents who need it. Registered Dietician #1 further stated they do periodic rounding to ensure the residents' foods are consistent with their diet, but they are not responsible for any in-services related to the thickener or aspiration precautions.On 10/01/2025 at 2:45 PM, Licensed Practical Nurse #5, who was in the dining room at the time of the observation, stated certified nursing assistants are responsible for thickening the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335571	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockaway Care Center	353 Beach 48th Street Far Rockaway, NY 11691

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	liquids for residents who require thickened liquids, and whomever prepares the residents' tray would add the thickener. Licensed Practical Nurse #5 also stated they did not know who prepared Resident #225's lunch tray on 09/24/2025. Licensed Practical Nurse #5 further stated the certified nursing assistants report to them, and they make round and is in the dining room during meals to see what is going on at mealtimes.On 10/01/2025 at 2:57 PM, the Director of Nursing was interviewed and stated Certified Nursing Assistants are responsible for adding the thickener in the residents' drink when they serve the resident's meal tray. The Director of Nursing also stated all Certified Nursing Assistants received in-service education and were trained that if there was a thickener on the tray, then it was supposed to be added to the liquids on the tray. 10 NYCRR 415.12(i)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interviews conducted during the Recertification survey, the facility did not ensure residents who needed respiratory care were provided care that was consistent with professional standards of practice. This was evident for one (1) of two (2) residents (Resident #78) reviewed for Respiratory Care out of a total sample of 41 residents. Specifically, Resident #78 was observed with an undated oxygen nasal cannula and an undated nebulizer mask and tubing. The findings are:The facility policy titled 'Oxygen Therapy' reviewed on 07/30/2021 stated residents will be provided with oxygen therapy as ordered by the Medical Doctor. When a resident uses oxygen on an as needed basis, the tubing will be labeled and placed in a zip locked bag until needed for use. When a resident has nasal cannula tubing for the concentrator, and a 2nd for use the oxygen tank, the tubing not in use must be secured in a plastic bag (dated and changed weekly). The 11-7 nurse will change and date all oxygen delivery equipment on Sunday.Resident #78 was admitted to the facility with diagnoses that include Chronic Obstructive Pulmonary Disease and Respiratory Failure.The Quarterly Minimum Data Set (an assessment tool) dated 08/11/2025, documented Resident #78 had moderately impaired cognition for daily decision making, shortness of breath or trouble breathing when sitting at rest and when lying flat, and required oxygen administration while a resident at the facility.A Physician Order dated 07/10/2025 documented Oxygen administration via nasal cannula, four (4) liters per minute continuously.A Physician Order dated 07/15/2025 documented change and label oxygen tubing on concentrator once a week every night shift every Tuesday.On 09/25/2025 at 11:35 AM, Resident #73 was observed with nasal cannula tubing connected to an oxygen concentrator, and no date was noted on the tubing.On 09/26/2025 at 3:28 PM, an observation of Resident #78 was performed with Licensed Practical Nurse #7. Resident #78 was observed resting in bed, receiving oxygen through an undated nasal cannula. The Medication Administration Record dated September 2025, documented change and label oxygen tubing on concentrator once a week. Entries were documented on 09/02/2025, 09/09/2025 and 09/23/2025, however there was no entry for 09/16/2025.On 09/26/2025 at 3:30 PM, an interview was conducted with Licensed Practical Nurse #7 who stated the oxygen nasal cannula should be dated weekly by the night nurses, but all shifts should make sure the tubing is dated. On 09/26/2025 at 2:55 PM, an interview was conducted with Registered Nurse #5, the nursing supervisor, who stated all nursing staff and nursing supervisors who round, should be looking at the oxygen tubing dates for compliance on all shifts.On 09/26/2025 at 3:17 PM, an interview was conducted with the Director of Nursing who stated all oxygen tubing should be changed and dated every Wednesday night. The Director of Nursing also stated the nurses on all shifts, including the nursing supervisors who perform rounds, should be observing the tubing to ensure compliance with weekly changing and dating of the tubing. 10 NYCRR 415.12(k)(6)

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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, record review, and interviews conducted during the Recertification survey, the facility did not ensure a Quality Assurance and Performance Improvement program identified and prioritized problems and opportunities that reflect organizational process, functions, and services provided to residents. Specifically, 1.) the facility had pattern deficiencies in the areas of Resident Rights, Sufficient Nursing Staff, Pharmacy Services, Administration, Infection Control and Physical Environment, and 2). There were repeated deficiencies from the last survey conducted from 07/20/2023 through 07/27/2023. (Refer to F604 and F880)The findings are:The facility's Quality Assurance and Performance Improvement Plan with a revision date of 07/08/25 documented the plan was designed to provide guidance in assessing and improving overall quality of care and quality of resident life. Focus areas will include all systems that affect resident and family satisfaction, quality of services and care provided, and all areas that affect the quality of people living and working in the organization. The Administrator will ensure the Quality Assurance and Performance Improvement Plan is reviewed minimally on an annual basis.1. For pattern deficiencies, cross refer to F725, F759, F838, F880 and F908.2. For repeated deficiencies, cross refer to F604 and F880.On 09/29/2025 at 03:18 PM, an interview was conducted with the Director of Nursing who stated the staff reports physical environment, care issues, and other issues to them. The Director of Nursing also stated the Quality Assurance and Performance Improvement committee is working to identify issues and to get them resolved and ensures compliance with regulations and enhance the quality of care to residents. The Director of Nursing further stated the Quality Assurance and Performance Improvement committee ensured the corrective measures for physical restraint was successful based on the audit they did periodically, however their focus was on bed rails, not on hand mittens. The Director of Nursing the issue that was identified on infection control last survey was also different from the current concern identified on this survey. On 10/01/2025 at 03:23 PM, an interview was conducted with the Administrator who stated the Quality Assurance and Performance Improvement committee meets monthly and as needed to identify problems in the facility through Resident Council meetings, family complaints, accidents, and incidents. The Quality Assurance and Performance Improvement committee analyzes what could have led to the problem and then make the necessary corrections. The Administrator also stated staffing was a big concern, but it had gotten better recently. The Administrator further stated they have multiple online partners with whom they post job postings, and they offer bonuses to those who make referrals, and they saw a big change when they started improving the rates. The Administrator stated they have an ongoing audit every month regarding physical restraints, but the facility never had issues with hand mittens. The Administrator also stated the pharmacy consultant is not willing to document in the medical records and was not in favor of utilizing the electronic medical record for documentation. When the facility would call the pharmacy consultant for clarification, they would not respond and since the pharmacy consultant was not willing to adjust their policy practice, they secured a new contract with another company. The Administrator further stated the facility tracks performance by bringing it to the team and move on if effective, if not effective then they continue to do Quality Assurance and Performance Improvement until compliance. The Administrator concluded that the issues with physical restraints and infection control are a huge task, and they need to continue to train new staff and continue the ongoing efforts in this regard.10 NYCRR 415.27 (a-c)