STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335596	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swan Lake Nursing & Rehabilitation	25 Schoenfeld Blvd Patchogue, NY 11772

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observation, record review, and interviews conducted during the Recertification Survey initiated on 7/24/2024 and completed on 7/31/2024, the facility did not exercise reasonable care for the protection of the resident's property from loss or theft. This was identified for one (Resident #52) of one resident reviewed for grievances. Specifically, Resident #52's clothes were lost after the clothes were sent to the laundry. The facility was unable to determine the lost items because an inventory list of the resident's belongings was not maintained. The finding is: The Policy and Procedure dated 6/1/2024 for Resident's Personal Belonging documented The facility staff will take all practicable steps to safeguard residents' belongings. All resident property will be inventoried on a Resident's Personal Possessions Sheet, a copy of which will be maintained in the resident's medical record, along with the facility possessions book. The form is to be completed by facility staff upon admission/readmission or when any items are brought into the facility. It is the responsibility of the person(s) bringing in any such items, to make staff aware of these items and to bring these items to the appropriate staff: front desk receptionist, nurse, Certified Nurse Assistant. or any facility representative/designee. All clothing items will be appropriately inventoried and labeled by the facility. Resident # 52 had diagnoses that included Cerebral Palsy and Morbid (severe) Obesity. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident's Brief Interview for Mental Status (BIMS) was 12, indicating moderately impaired cognition. The Minimum Data Set assessment also documented the resident had no behaviors. A grievance form dated 7/19/2024 documented the resident was alleging lost clothing. The social worker documented there is no inventory of the resident's clothes' on file and that housekeeping will search the laundry and the clothes will be reimbursed. The grievance form indicated that the resident's Pajamas and sweatpants were not found, the resident had other clothes to wear and the facility will order Pajamas and sweatpants for the resident. The Inventory form was given to the resident to complete. (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: 335596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation of the resident's room on 7/29/2024 at 10:00 AM revealed Resident #52's clothing was being stored in the closet in their room. With the permission of the resident, the resident's closet was searched. All clothing was labeled with the resident's name except for one jersey and one sweat pants that were unlabeled. Resident #52 was interviewed on 7/29/2024 at 10:00 AM and stated their clothing was lost by the facility laundry. Some of the clothing was found; however, some of the clothing was still missing. The facility staff did not label their clothes and document them on an inventory list whenever they got new clothing. They are supposed to inventory my clothing. I came to the facility in 2018 and can not remember if they inventoried my clothes. A review of the resident's record lacked documented evidence of an inventory list indicating the resident's belongings. Social Worker # 1 was Interviewed on 7/29/2024 at 2:33 PM and stated the facility staff were still looking for the resident's lost items and that is why the resident was not reimbursed for the lost items. The staff was not able to find an inventory sheet that would indicate the amount of clothing the resident had. Social Worker #1 further stated that the resident was admitted in 2018 and the facility should have ensured an inventory sheet is maintained in the resident's record. The Director of Guest Services was interviewed on 7/29/2024 at 3:06 PM and stated Resident #52 was admitted to the facility in 2018 and the staff were not able to locate the resident's inventory sheet. The Administrator was Interviewed on 7/30/2024 at 12:40 PM and stated, we cannot explain why the resident does not have an inventory sheet. We are implementing an inventory list and ensuring it is accurate. 10 NYCRR 415.5(h)(2)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585 Based on observation, record review, and interviews conducted during the Recertification Survey and Abbreviated Survey (NY 00348285) initiated on 7/24/2024 and completed on 7/31/2024 the facility did not ensure that each resident was free from abuse. This was identified for one (Resident #68) of three residents reviewed for abuse. Specifically, Certified Nurse Assistant #4 had verbal arguments and threatened Resident #68 with physical harm. Resident #68 verbalized being scared and upset after the interaction with Certified Nursing Assistant #4. The finding is: The Policy and Procedure titled, Abuse Prevention last reviewed in 3/2024 documented that the resident has the right to be free from abuse, neglect, and misappropriation of resident property. Verbal abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include but are not limited to threats of unjustified retribution or punishment. In the event of suspicion of abuse being investigated, the staff member will be suspended until the investigation is complete. Resident # 68 was admitted with diagnoses including Morbid Severe Obesity, Anxiety disorder, and Major Depressive disorder. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented Resident #68 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The resident had no behaviors indicated during the assessment period. The Comprehensive Care Plan (CCP) for abuse initiated on 7/6/2023 and last revised on 7/24/2024 documented that Resident #68 was at risk of being a victim of abuse, neglect, and /or mistreatment. Interventions included ensuring the resident was safe by removing the alleged abuser or moving the resident to a safe and supervised area. The Accident and Incident report dated 7/12/2024 documented that at approximately 10:00 PM on July 12, 2024, the nursing supervisor was called on the first floor by the charge nurse due to an altercation between Resident #68 and Certified Nurse Assistant #4. Resident #68 stated that Certified Nurse Assistant #4 threatened them by saying You are lucky, I f with you, otherwise I would have whooped your a s outside. Sit your a s down. Certified Nurse Assistant #4 was laughing while commanding the resident to sit down. Resident #68 stated they were scared. The investigation concluded that Resident #68 was a victim of mental and psychological harm caused by the interaction between the resident and Certified Nurse Assistant #4 and there was cause to believe alleged abuse had occurred. The incident was reported to the New York State Department of Health on 7/13/2024 and to the local Police Department. A review of Certified Nurse Assistant # 4 timecard revealed they remained on duty until 7/13/2024 at 6:03 AM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Supervisor #2 was interviewed on 7/31/2024 at 11:46 AM and stated they witnessed Certified Nurse Assistant #4 loudly yelling and arguing with Resident #68. Registered Nurse Supervisor #2 stated Certified Nurse Assistant #4's behavior was not acceptable. The Registered Nurse Supervisor # 2 could not recall what words were used; however, directed Certified Nurse Assistant #4 to go to the nursing supervisor's office. Certified Nurse Assistant #4 had not gone to the supervisor's office as instructed and went to the day room instead to argue more with Resident #68. Resident # 68 was interviewed on 7/31/2024 at 3:46 PM and stated that Certified Nurse Assistant #4 yelled and cursed at them and told them You are lucky I F . with you, otherwise I would have whooped your a s outside. Resident #68 stated they were upset and scared. Registered Nurse Supervisor #2 witnessed Certified Nurse Assistant #4 being verbally abusive. When they (Resident #68) went to the day room, Certified Nurse Assistant #4 followed them into the day room and continued to curse and yell at them. Resident #68 stated Certified Nurse Assistant #4 was reassigned to a different side of the hall but remained on the unit until the end of the shift. The resident stated they were afraid that night. Certified Nurse Assistant #4 was interviewed on 7/31/2024 at 1:50 PM and stated Resident #68 started yelling at them and was making false allegations against them because they did not braid the resident's hair. Certified Nurse Assistant #4 stated they worked all night and left the unit at 6:00 AM on 7/13/2024. Certified Nurse Assistant #4 denied being loud and denied using curse words. Registered Nurse Supervisor #3 was interviewed on 7/31/2024 at 3:05 PM and stated Certified Nurse Assistant #4 and Resident #68 had a verbal argument on 7/13/2024. Registered Nurse Supervisor #3 stated they did not remove Certified Nursing Assistant #4 from the unit because it was only a verbal argument. Registered Nurse Supervisor #3 stated they did not witness the verbal argument between the resident and the Certified Nurse Assistant #4. Registered Nurse Supervisor #3 stated they chose to stay with Resident #68 because the resident was very upset after the altercation and the resident needed emotional support. The Director of Nursing Services (DNS) was interviewed on 7/31/2024 at 2:53 PM and stated Certified Nurse Assistant #4 was terminated because there were witnesses that revealed Certified Nurse Assistant #4 was verbally abusive towards Resident #68 on 7/13/2024. Certified Nurse Assistant #4 should have been immediately suspended after they threatened Resident #68 because the staff witnessed the verbal abuse. The Director of Nursing Services stated that Resident #68 was verbally abused and threatened by Certified Nursing Assistant #4. The incident was reported to the Department of Health and the local Police. 10 NYCRR 415.4(b)(1)(i)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on observation, interview, and record review, the facility failed to ensure an ongoing activities program was provided based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This was identified for one (Resident #59) of one resident reviewed for activities. Specifically, Resident #59 was observed on multiple occasions in their room without meaningful activities (activities as per resident preferences, such as stimulation/conversation, crafts and or newspaper/ magazine, television/music). Additionally, the facility did not offer evening activities for any resident. The finding is: A facility policy titled Recreation Programming, last revised 6/2024 documented the facility must provide, based on the comprehensive assessment, individualized care plan, and the preferences of each resident, an ongoing program of recreational services to support residents in their choice of activities. The recreational programs/activities are designed to meet the interests of and support the physical, cognitive, social, emotional/psychosocial, and spiritual well-being of each resident. Activities are not limited to formal activities being provided only by the recreation department. Monthly calendars of scheduled activities are posted in resident rooms and common areas. Supplies/equipment for recreational activities must be readily available for use in recreational programs/activities. Residents are reminded and/or encouraged to attend activities through verbal and written announcements (for example: overhead announcements, staff announcements in resident rooms/units, daily chronicles). Residents are escorted/transported to/from the activity as needed, prior to the scheduled start time of the activity. Track all activity participation. Resident #59 has diagnoses of Cancer, Arthritis, and Cataracts/Glaucoma or Macular Degeneration. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12 indicating moderate cognitive impairment. The resident had adequate hearing, speech, and vision. Resident #59 was dependent on activities of daily living, such as eating and transfer. The resident and or family/significant other did not participate in the assessment and goal setting. The Minimum Data Set documented that having books, newspapers, and magazines to read, being around animals such as pets, and participating in religious services or practices were not very important to Resident #59. The Minimum Data Set further documented that listening to music and keeping up with the news was somewhat important. Doing things with groups of people, and going outside to get fresh air when the weather is good was very important to Resident #59. A Physician's order initiated 11/2/2022 and renewed 7/26/2024 documented Activity: As Tolerated. A comprehensive care plan, titled Resident is an active participant in therapeutic recreation programs, effective 11/29/2023 and last reviewed/revised 7/2/2024, documented interventions including escorting the resident to activities, informing the resident of activities, inviting the resident to activities, and offering one to one visit for stimulation/conversation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A comprehensive care plan titled Recreation- Independent, effective 11/29/2023 reviewed/revised 7/2/2024, documented Resident #59 preferred independent leisure time activities and plans own day as evidenced by the selection of activities that coincide with personal interest. Interventions included but were not limited to encouraging and maintaining involvement in activities of interest, inviting, informing, and offering to escort to activities, and offering one-to-one recreation visits for socialization. A care plan review note dated 6/14/2024 documented the resident is on daily visits with recreation staff, strolling music, and pet therapy. A care plan review note dated 7/2/2024 documented the resident continues to receive and enjoy one to one visits. A Therapeutic Recreation Initial assessment dated [DATE] documented the resident's hobbies as bowling, listening to music, using of personal iPad and phone, and watching television and movies. The resident participated in activities on a regular basis including Bingo, Left-Right-Center, special events, and barbeques, and attended entertainment and socials. The resident is an active participant in large group recreation programs including special events, socials, and bingo. The resident accepts one to one visits from recreation staff, pet therapy, and strolling music. A Therapeutic Recreation assessment dated [DATE] documented Resident #59 preferred things with groups of people, go outside to get fresh air when the weather is good, listen to music, and keep up with the news. Resident #59 was observed in their room and was interviewed on 7/24/2024 at 10:31 AM. Resident #59 stated that recreation staff do not come into their room to visit them because they (Resident #59) were on enhanced barrier precautions. Resident #59 stated the facility only offers bingo on weekends. On weekdays, there are no activities scheduled after 3:00 PM. Resident #59 was observed on 7/29/2024 at 2:14 PM in their room without meaningful activity (per resident preferences, such as stimulation/conversation, crafts and or newspaper/ magazine, television/music). Resident #59 stated that no one comes to their room to provide recreational activities because of the enhanced barrier precaution sign posted outside their room. A review of the Recreation Calendar for the month of July 2024, reflected no activity programs after 3:00 PM for any day of the week. The weekend activities calendar documented the following: on Saturday a morning strolling coffee cart and a nail spa were scheduled on alternating weekends, a game of Left-Right-Center or a movie was scheduled in the afternoon, and a refreshment cart was scheduled at 3:00 PM. On Sunday, a morning strolling coffee cart was scheduled in the morning, a movie or a classic show and bingo on the first floor was scheduled in the afternoon, and refreshment care was scheduled at 3:00 PM. A review of Resident #59's attendance record for the period of 1/1/2024 through 7/31/2024, documented that the resident had limited participation in programs. The resident received only seven one to one visits, three live entertainment programs, and one resident council/food committee meeting, and the resident attended games/puzzles only nine times from 1/1/2024 through 7/31/2024. There is no documented evidence that the resident was offered or invited to activity programs and refused. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Recreation Aide #1 was interviewed on 7/30/2024 at 11:07 AM and stated they were assigned to provide activities on the second-floor unit during the day including a strolling coffee cart. Today they did craft time with the residents where they gave out coloring sheets and crayons. For residents in their rooms, they conducted a one-to-one visit and offered art supplies to the residents. Recreation Aide #1 stated that Resident #59 used to like to go outside and come to socials and was mainly out of bed in the afternoons. Recreation Aide #1 stated they were not able to provide attendance records or refusal records for activity programs for Resident #59 and were unable to explain why one to one visits were not conducted for Resident #59 as per the resident's care plan. Recreation Aide #1 stated they were aware that there are no scheduled evening activities, and that the facility is trying to hire more staff. Recreation Aide #1 stated that there are no restrictions on visiting Resident #59. The Assistant Director of Recreation was interviewed on 7/30/2024 at 2:02 PM and stated Resident #59's participation in activity programs was limited as the resident wanted to do independent things in their rooms. The Assistant Director of Recreation confirmed that there were no activities after 3:00 PM and only limited activities were offered on the weekend. The Assistant Director of Recreation was unable to explain why Resident #59 only had seven one to one visits over a seven-month period. The Administrator was interviewed on 7/31/2024 at 9:11 AM and stated that residents are brought to the main dining room around 2:00 PM for activities programs such as games, or to go outdoors. The Administrator stated they no longer have evening recreation staff and are looking to hire the evening recreation staff. 10 NYCRR 415.5(f)(1)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observations, record review, and staff interviews during the Recertification Survey initiated on 8/05/2024 and completed on 8/09/2024, the facility did not ensure that each resident received adequate supervision to prevent accidents. This was identified for one (Resident #38) of three residents reviewed for abuse. Specifically, Resident #241, with known history of peer-to-peer physical altercations and behaviors that annoy others such as yelling, crying, and wandering into other residents' rooms. Resident #241 was to be kept in the line of sight in a supervised area when out of bed as per their Comprehensive Care Plan (CCP). On 4/7/2024, the staff did not supervise Resident#241 as directed. Resident #241 wandered into Resident#38's room and threw the opened water bottle at Resident #38's face when Resident #38 asked Resident #241 to leave their room. Subsequently, both Resident #38 and Resident #241 were observed on the floor in Resident #38's room fighting with each other. The finding is: Resident # 241 was admitted to the facility with diagnoses of Vascular Dementia with agitation, restlessness, and Anxiety disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview of Mental Status score of 5, which indicated the resident had severely impaired cognition. The Minimum Data Set documented the resident had no behaviors. The Behavior Comprehensive Care Plan dated 11/5/2022 last revised on 4/2024 documented that Resident #241 had physical behavioral symptoms directed toward others as evidenced by hitting and grabbing. The care plan documented the resident also had physical behavioral symptoms not directed toward others as evidenced by pacing, rummaging, and exposing genitals. The interventions were documented to keep the resident in a supervised area when out of bed. The Peer Abuse Comprehensive Care Plan dated 4/27/2023 documented that the Resident had the potential to abuse others due to a previous history of altercations with other residents/history of abusing others, the resident expressed anger by threatening to physically strike out or break things. The resident also had the potential to be a victim of abuse due to behaviors that annoy others such as yelling, crying, and wandering into other resident's rooms. The interventions included but were not limited to keep the resident safe by removing from the area if being annoyed by another resident, close monitoring, place within a line of sight in a supervised area when awake, engage in activities that can positively channel behavior and reduce frustration, identify programs/independent activities that are a distraction for the resident. A review of the care plan progress notes revealed that Resident #241 had peer-to-peer altercations with other residents (other than Resident #38) on 4/28/2023, 5/14/2023, and 10/28/2023. Resident #38 was admitted to the facility with diagnoses of lack of coordination, Type two Diabetes Mellitus, and Essential Tremors. The Minimum Data Set, dated dated dated [DATE] documented the resident had a Brief Interview of Mental Status score of 15, which indicated the resident had intact cognition. Resident #38 had an impaired range of motion on one side of the upper extremity. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse comprehensive care plan dated 2/16/2024 documented that Resident #38 was at risk of being a victim of abuse, neglect, and/or mistreatment. The interventions included to monitor mood and provide early intervention on changes, provide emotional support and reassurance, room change, upon a report of the alleged abuse, ensure the resident is safe by removing the alleged abuser or moving the resident to a safe and supervised area. Resident #38 was interviewed on 7/24/2024 at 10:16 AM and stated they (Resident #38) were physically assaulted by Resident #241 on 4/7/2024 while they were in their (Resident #38's) bedroom. Resident #38 stated Resident #241 came into their room and started hitting and punching Resident #38, then pushed them (Resident #38) onto the floor. Resident #38 stated the staff knew Resident #241 was a threat to all residents. The Accident and Incident Report dated 4/7/2024 documented that on 4/7/2024 at approximately 9:30 AM, Certified Nursing Assistant #6 walked into Resident #38's room after they (Certified Nursing Assistant #6) heard help and observed Resident #241 and Resident #38 on the floor fighting. Resident #241 was removed from Resident #38's room and both residents were assessed. Resident #38, who was alert and oriented, reported they (Resident #38) were in the bathroom brushing their teeth when they heard somebody outside the bathroom door. Resident #38 walked out of the bathroom and saw Resident #241 standing by Resident #38's bed next to their bedside table. Resident #38 told Resident #241 to leave and Resident #241 picked up an open bottle of water and threw the bottle in Resident #38's face. Resident #38 and Resident #241 started to fight, resulting in them both on the floor. Resident #241 was not able to give any statement due to cognitive impairment; however, Resident #241 said I need to fight more. Resident #241 was last seen sitting in the day room before the incident. The incident summary documented that there must be consistent staff observation for Resident #241. The summary concluded the resident to resident altercation was unpredictable and unavoidable due to Resident #241's diagnoses of [NAME] Matter Disease and Post Traumatic Stress Disorder. Certified Nursing Assistant #6 was interviewed on 7/31/2024 at 11:16 AM and stated they were assigned to Resident #241 on 4/7/2024. Resident #241 was confused, agitated, and had a history of hitting other residents. Certified Nursing Assistant #6 stated that prior to the altercation between Resident #241 and Resident #38, Resident #241 was sitting in the day room which was supervised by Resident Assistant #2. Certified Nursing Assistant #6 stated that they went on their break and when they returned, they heard Resident #38 yelling for help. Certified Nursing Assistant #6 stated they observed Resident #38 was on the floor in Resident #38's room and Resident #241 was bending over Resident #38. Certified Nursing Assistant #6 stated that all unit staff were responsible for supervising Resident #241 while the resident was ambulating in the hallway due to their (Resident #241) physically aggressive behavior. Licensed Practical Nurse #3 was interviewed on 7/31/2024 at 11:43 AM and stated that they were the medication nurse on the unit on 4/7/2024. Licensed Practical Nurse #3 stated they were aware that Resident #241 had a history of physical altercations with other residents. Licensed Practical Nurse #3 stated Residents who needed supervision are usually placed in the day room. Resident Assistants are assigned to monitor the residents in the day room. Resident #241 was supposed to be kept in the dining room for close supervision and to keep the resident in the line of sight at all times when awake. Licensed Practical Nurse #3 stated that they did not observe Resident #241 in the hallway prior to the incident because they (Licensed Practical Nurse #3) were administering medications to other residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident Assistant #2 was interviewed on 7/31/2024 at 11:57 AM and stated they (Resident Assistant #2) are responsible for supervising the day room and answering the call bells on 4/7/2024. Resident Assistant #2 stated they are not responsible for monitoring the hallway. Resident Assistant #2 stated they were only responsible for supervising the residents who were in the day room. Resident Assistant #2 stated on 4/7/2024, Resident #241 was constantly walking in and out of the day room. When they observed Resident #241 leave the day room, they did not question or follow the resident because they did not want to agitate Resident #241. Resident Assistant #2 stated they did not alert any other staff member to supervise Resident #241 in the hallway because there was no staff present in the hallway or at the nursing station. Certified Nurse Assistant #7 was interviewed on 7/31/2024 at 12:24 PM and stated they were assigned to Resident #38 on 4/7/2024. Certified Nurse Assistant #7 stated they did not observe Resident #241 in the hallway and did not observe the altercation between Resident #241 and Resident #38 because they were off the unit for a couple of minutes. Certified Nurse Assistant # 7 stated all staff are supposed to supervise Resident #241 since Resident #241 had a history of going into other resident rooms and physically assaulting the residents. Registered Nurse Supervisor #4 was interviewed on 7/31/2024 at 12:30 PM and stated they were the unit supervisor on 4/7/2024. Registered Nurse Supervisor #4 stated they were aware Resident #241 wandered into the other resident rooms and hit other residents. Registered Nurse Supervisor #4 stated they were aware Resident #241 needed to be supervised and should remain in the line of sight at all times all the time when awake. Registered Nurse Supervisor #4 stated that they did not observe Resident #241 in the hallway or going into Resident #38's room because they (Registered Nurse Supervisor #4) were conducting rounds on the other side of the unit. Registered Nurse Supervisor #4 stated Resident Assistant #2 was assigned to supervise the day room and should have notified the nurse when Resident #241 exited the day room so the other staff could supervise the resident in the hallway. The Director of Nursing Services was interviewed on 7/31/2024 at 2:32 PM and stated the facility should have prevented the altercation between Resident #241 and Resident #38. The Director of Nursing Services stated Resident #241 should have been supervised and kept within the line of sight at all times when awake as per the resident's plan of care. The Director of Nursing Services stated that one Certified Nursing Assistant should have been dedicated to supervising Resident #241 at all times. 10 NYCRR 415.12(h)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Swan Lake Nursing & Rehabilitation	25 Schoenfeld Blvd Patchogue, NY 11772

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349 Based on observations, interviews, and record review during the recertification survey initiated on 7/24/2024 and completed on 7/31/2024, the facility did not ensure that each resident's medical record was maintained in accordance with accepted professional standards and practices. The facility did not maintain medical records for each resident that were complete and accurately documented. This was identified for one (Resident #74) of one resident reviewed for Respiratory Care. Specifically, Resident #74 was observed receiving oxygen therapy without a physician's order on multiple occasions (7/24/2024, 7/25/2024, 7/26/24 and 7/29/2024). The finding is: The facility's policy and procedure titled Respiratory Care, undated, documented to verify that there is a physician's order in place and review the physician's orders or facility protocol for oxygen administration. Resident #74 had diagnoses that included Chronic Obstructive Pulmonary Disease, Schizophrenia, and Mild Intermittent Asthma. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 9 which indicated the resident had moderate cognitive impairment. The physician's orders for July 2024 (interim and renewal orders) were reviewed and there was no documented evidence of an order for oxygen therapy. Resident #74 was observed in their room on 7/24/2024 at 10:28 AM, 7/25/2024 at 8:42 AM, and 7/26/2024 at 8:16 AM receiving oxygen therapy at 3 liters per minute. On 7/29/2024 at 10:14 AM the resident was observed in their room receiving oxygen therapy at 2 liters per minute from an oxygen concentrator via a nasal cannula. A physician's monthly medical note dated 7/19/2024 had no documented evidence that the resident was receiving oxygen therapy. A comprehensive care plan titled Alteration in Respiratory Status, effective date 4/13/2023, last reviewed 4/20/2024, documented the resident had altered respiratory status related to Chronic Obstructive Pulmonary Disease and Asthma, as evidenced by shortness of breath and the resident requires oxygen. The Licensed Practical Nurse Manager #1 was interviewed on 7/29/2024 at 10:33 AM and stated Resident #74 receives oxygen therapy daily; however, they were not able to find current physicians' orders for oxygen use for Resident #74. Nurse Practitioner #1 was interviewed on 7/29/2024 at 10:48 AM and stated Resident #74 used oxygen therapy at bedtime according to the resident. Nurse Practitioner #1 stated Resident #74 should have a physician's order for the use of oxygen therapy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335596	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024
NAME OF PROVIDER OR SUPPLIER Swan Lake Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 25 Schoenfeld Blvd Patchogue, NY 11772	

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 7/29/2024 at 11:04 AM and stated that if the resident needs oxygen therapy then a physician's order should have been obtained. Physician #2 was interviewed on 7/29/2024 at 1:42 PM and stated that with a diagnosis of Asthma or Chronic Obstructive Pulmonary Disease, a resident may sometimes need oxygen. Physician #2 stated that the oxygen order for Resident #74 was given as a verbal order and Physician #2 was unaware that Resident #74 did not have a written order for the use of oxygen therapy. 415.22(a)(1-4)