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	10/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** Based on observations, record review, and staff interviews during the Recertification survey initiated on 09/25/2025 and completed on 10/01/2025, the facility failed to ensure that the resident's environment remained free of accident hazards. This was identified for one (1) (Resident #39) of six (6) residents reviewed for Accidents. Specifically, Resident #39, who had a diagnosis of Schizophrenia and had moderately impaired cognition with behaviors including requesting excessively hot water to wash their clothing in their bathroom sink. On multiple observations on 09/29/2025, Resident #39's bathroom sink water temperature was found to be 136.2 degrees Fahrenheit, 123 degrees Fahrenheit, and 127 degrees Fahrenheit. This resulted in a likelihood for serious injury and harm to Resident #39, that is Immediate Jeopardy. The finding is: 42 CFR 483.470 (d)(3) PART 483-REQUIREMENTS FOR STATES AND LONG-TERM CARE FACILITIES 483.470 Condition of Participation: Physical environment. (d) Standard: Client bathrooms. The facility must ensure: (3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 Fahrenheit. The facility policy entitled Accident and Supervision, revised on 08/20/2025, documented resident's environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. All staff, including Professional, Administrative, and Maintenance staff, are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. The facility policy entitled Legionella in potable Water sampling and management plan, revised on 12/13/2024, the facility's hot water (150 degrees) main is branched into two. There are no storage tanks occupied. One of the branches supplies the hot water to the kitchen and laundry room at 150 degrees Fahrenheit. The second hot water main branch is fed into a tempering valve at 150 degrees Fahrenheit, which automatically adds cold water to a set discharge temperature of 110 degrees Fahrenheit. The 110-degree Fahrenheit hot water is then supplied to all the resident areas, such as taps, showers, and sinks. Resident #39 was admitted with diagnoses of schizophrenia, schizoaffective disorder, and post-traumatic stress disorder. The Quarterly Minimum Data Set (a resident assessment tool) dated 07/27/2025 documented a Brief Interview of Mental Status of nine (9), which indicated the resident had moderately impaired cognition. The Quarterly Minimum Data Set documented that Resident #39 required substantial (helper does more than half the effort) assistance for toileting, supervision or touching assistance for personal hygiene, and substantial assistance with toilet transfers. Resident #39 was always continent with bowel and bladder. The behavior care plan initiated on 04/26/2024, documented Resident #39 displayed the following behaviors: puts inappropriate items in the toilet, which has resulted in flooding in the room, screams, talks very loudly, and refuses care. The interventions included, but were not limited to, psychiatric evaluation and follow-up as needed, and psychological evaluation and follow-up as needed.The Psychiatric Nurse Practitioner progress note dated 08/29/2025 documented the resident had paranoia with auditory hallucinations (hears voices when not present). The resident had a significant history of (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	schizophrenia with past treatments. The resident has erratic and unpredictable triggers that vary based on the resident's perception. The facility staff reported the resident exhibited persistent behaviors of using other peers' toilets to wash their clothes and attempting to flush items in the toilet. The resident was agitated with poor impulse control and denied the behavior of using peers' toilets to wash clothes. During an interview on 09/29/2025 at 9:45 AM, the Director of Social Work stated that Resident #39 had a behavior of washing their clothes in their bathroom sink and flushing the clothes in the toilet bowl. The Director of Social Work stated the resident's behavior continued despite redirections. During an observation and interview on 09/29/2025 at 10:20 AM, Resident #39 was sitting on the edge of their bed. A wet pair of pants and a wet shirt were placed on the nightstand. The water was dripping from the wet clothes. Resident #39 stated they washed their own clothes in the bathroom and pointed to the bathroom in their room.During an observation on 09/29/2025 at 10:22 AM, the surveyor checked the bathroom sink's hot water by placing their hand under the water. The water was hot, and the surveyor had to quickly remove their hand from under the water. During an interview on 09/29/2025 at 10:40 AM, the Director of Environmental Services stated that Resident #39 requested the water in their room to be at 125 degrees Fahrenheit to wash their clothing in the bathroom sink. The Director of Environmental Services stated if the water temperature was not to the resident's liking, the resident would make a big scene, yell, scream, and throw self on the floor. The Director of Environmental Services stated they accommodated the resident's request by increasing the water temperature. There is no documented evidence the comprehensive care plan included the resident's behavior of washing their clothes in the bathroom sink and requesting hotter water. During an observation on 09/29/2025 at 10:45 AM, the Director of Environmental Services tested the water temperature in Resident #39's bathroom with an infrared laser thermometer. The water temperature was found to be at 136.2 degrees Fahrenheit. After obtaining the water temperature, the Director of Environmental Services placed their hand under the sink water and quickly pulled their hand out and stated, too hot." During an interview and observation on 09/29/2025 at 10:50 AM, the Director of Environmental Services stated the temperature reading of 136.2 degrees Fahrenheit is too hot and above the regulatory requirement. The water temperature was supposed to be at 110 degrees Fahrenheit for resident sinks and shower rooms. The Director of Environmental Services stated they had to go to the boiler room to adjust the water temperature and then quickly left to go to the second-floor elevator despite the surveyor's request to measure the water temperature of other rooms on the unit. The Director of Environmental Services was observed adjusting the mixing valves in the basement. The Director of Environmental Services stated they check Resident #39's sink water temperature every day and document their findings on a log sheet. They keep two (2) separate logs, one (1) for the facility and one (1) for Resident #39's room. They pick random rooms to check the water temperature to document on the facility water temperature log. The Director of Environmental Services stated the water temperature for Resident #39's room was already checked this morning; however, they could not recall the temperature readings for that morning and would look for the temperature logs to verify. The facility was unable to provide documented water temperature logs for September 2025 for the entire facility upon multiple requests made on 09/29/2025. Resident #39's water temperature logs were not made available on 09/29/2025. During an observation on 09/29/2025 at 1:05 PM, in the presence of the Director of Environmental Services, Resident #39's bathroom sink temperature was found to be at 123 degrees Fahrenheit utilizing the original infrared thermometer that was used at 10:50 AM. The Director of Environmental Services stated that the thermometer was broken, and they were going to utilize another thermometer. The Director of Environmental Services used two (2) other thermometers to measure the water temperature in Resident #39's bathroom sink, which read 127 degrees Fahrenheit with both thermometers. The Director of Environmental Services stated that it appeared all three (3) infrared thermometers were broken. During an observation on 09/29/2025 at 1:30 PM, the Director of Environmental Services tested water temperatures for two (2) additional room sinks. room [ROOM NUMBER]'s sink water (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	temperature was 117 degrees Fahrenheit, and room [ROOM NUMBER]'s sink water temperature was114 degrees Fahrenheit.During an interview on 09/29/2025 at 2:15 PM, Certified Nursing Assistant #4 stated Resident #39 had behaviors of washing their clothes in their bathroom. The resident was not on specific monitoring for their behavior. During an interview on 09/29/2025 at 2:22 PM, Certified Nursing Assistant #5 stated Resident #39 had a behavior of washing their clothes in the toilet in their bathroom. Certified Nursing Assistant #5 stated Resident #39 required one-person assistance for toileting. Certified Nursing Assistant #5 stated the water in the bathroom sink comes out too hot, so they have to remind the resident that the water gets hot, and they have to adjust the water temperature by turning on the cold water. They stated we adjust the water with the handles on the sink. During an interview on 09/29/2025 2:34 PM, Licensed Practical Nurse #1 stated the resident had behaviors such as refusing showers and washing their clothes in the bathroom sink in their room. Licensed Practical Nurse #1 stated they try to monitor the resident's behavior. During an interview on 09/30/2025 at 1:17 PM, Medical Doctor #1 stated they were aware of Resident #39's behavior of washing clothes in the bathroom sink. They stated they did not know that the resident was requesting hotter water for washing clothes. Medical Doctor #1 stated that a temperature of 136.2 degrees Fahrenheit is too hot and could cause significant burns. The Daily Domestic Hot Water Temperature Log Reading for Resident #39's room for September 2025 was provided on 09/30/2025 at 04:45 PM. The log indicated the water temperature ranged from 114 degrees Fahrenheit to 116 degrees Fahrenheit. The log did not include water temperatures for 09/13/2025, 09/14/2025, 09/16/2025, 09/17/2025, 09/19/2025, 09/20/2025, 09/21/2025, 09/25/2025, 09/27/2025, 09/28/2025, 09/29/2025 and 09/30/2025. The log indicated that the automatic faucet not working properly 09/27/2025.During an interview on 10/01/2025 at 10:27 AM, Certified Nursing Assistant #1 stated they were regularly assigned to Resident #39 during the 7:00 AM - 3:00 PM shift. Certified Nursing Assistant #1 stated Resident #39 washed their clothes in the bathroom sink and flushed the clothing in the toilet bowl. This caused a flood, and because of that, Environmental Services disabled the flushing system and put a commode in the resident's room. Certified Nurse Assistant #1 stated when they provide care to the resident in the room, Resident #39's bathroom sink water gets really hot, but they adjust the water temperature by turning on the cold water and the hot water at the same time to make sure the resident does not burn their hands. Certified Nurse Assistant #1 stated Resident #39 was not aware of what is hot and what is cold, and they had to warn Resident #39 that the sink water was hot and for them to be careful. Certified Nurse Assistant #1 stated they reported to the Director of the Environmental Services about the sink water being too hot but could not recall when. During an interview on 10/01/2025 at 12:15 PM, Licensed Practical Nurse Unit Manager #1 stated they knew that Resident #39 washed their clothes in the bathroom sink and rinsed them in the toilet bowl; however, they did not know that Resident #39 preferred hotter water. They assumed everyone was monitoring Resident #39's behavior of washing their clothes in the bathroom. Licensed Practical Nurse Unit Manager #1 stated they did not know that the water temperature in the resident's room was too hot. During an interview on 10/01/2025 at 12:33 PM, the Administrator stated Resident #39 was not coherent to demand the water temperature of at least 125 degrees Fahrenheit. The Administrator stated they were not made aware of Resident #39's preferred water temperature; however, they knew that the resident was washing their clothes in the bathroom sink and that Resident #39 had the right to do so. The Administrator stated the nurses and Certified Nursing Assistants were supposed to monitor the resident for safety. The Administrator stated the Environmental Services department was supposed to monitor the water temperature and ensure the temperature was within regulatory guidelines. During an interview on 10/01/2025 at 3:00 PM, the Director of Nursing Services stated they have been working at the facility for less than two (2) months and were not aware of Resident #39's preference regarding the hotter water to wash their clothes in the bathroom. The Director of Nursing Services stated that Resident #39 had impaired cognitive function and could not verbalize the need for water temperature of 125 degrees Fahrenheit (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	to wash their clothes. The Director of Nursing Services stated a water temperature of 136.2 degrees Fahrenheit was too hot and was not acceptable. 10NYCRR 415.12(h)(2)

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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 - Some	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. Based on observations, record review, and interviews during the Recertification Survey initiated on 09/25/2025 and completed on 10/01/2025, the facility did not ensure that each resident had a right to a clean, comfortable, and homelike environment. This was identified for one (1) (Second floor) of two nursing floors; and for three (Resident#88, Resident#101, Resident#35) of five residents reviewed during the environmental facility task. Specifically, during the Resident Council meeting on 09/25/2025, two (2) (Resident#88, Resident#101) of the eight (8) residents in attendance complained about dirty shower rooms on the second floor. During observation, the second-floor shower room was found to be unsanitary, and the privacy curtains were in disrepair. The shower room also had a strong, foul odor. Additionally, Resident #39's bathroom was observed with a strong foul odor. The toilet bowl and portable commode in the bathroom contained urine and feces. The toilet's flushing mechanism was also non-functional.The finding is:The facility's policy titled Quality of Life-Homelike Environment, revised on 07/2024, documented that residents are provided with a safe, clean, comfortable, and homelike environment and are encouraged to use their personal belongings to the extent possible. The characteristics of the facility that reflect a personalized, home-like setting, including cleanliness and pleasant neutral scents.The Facility's policy titled Cleaning and Disinfecting of Environmental Surfaces, revised on 07/2024, documented that environmental surfaces will be cleaned and disinfected according to the current Centers for Disease Control recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration's bloodborne pathogen standards. The policy documented that Resident Shower rooms must be cleaned three times daily and as needed. Resident rooms and personal bathrooms must be cleaned daily and as needed.During the Resident Council Meeting on 09/25/2025 at 11:30 AM, two (Resident #101, Resident #88) of eight residents in attendance complained about dirty shower rooms. A review of the Resident Council Meeting minutes for 06/25/2025 and 07/30/2025 documented resident complaints regarding the shower rooms not being cleaned. During an observation on 09/29/2025 at 6:39 AM, the second-floor shower room was found to be unsanitary. Conditions included: a dirty floor, dirty gloves on the floor, a hairbrush in the sink, and an incontinent brief on the sink counter. The used garbage can did not have a liner, two toilet bowls contained urine, and three privacy curtain rod clips were broken. The room also had a strong, foul odor.During multiple observations on 09/29/2025 at 10:22 AM, 10:45 AM, and 01:04 PM, Resident #39's room and bathroom had a strong, foul, feces and urine odor. The portable commode and the toilet were filled with feces and urine. During an interview and observation on 09/29/2025 at 10:45 AM, the Director of Environmental Services stated the flushing mechanism for Resident #39's bathroom toilet was disabled due to the resident's behavior of flushing their clothes, which would cause flooding in the room. The Director of Environmental Services stated the condition of the resident's bathroom was disgusting, and they had to get out of the bathroom to breathe due to the unbearable odor. The Director of Environmental Services stated that no one ever reported to them that the resident was utilizing the toilet in their room after the flushing mechanism was disabled. The Director of Environmental Services stated that the condition of the resident's toilet was disgusting, and it should have been cleaned. During an interview on 10/01/2025 at 10:27 AM, Certified Nursing Assistant #1 stated Resident #39 flushed their clothes in the toilet and caused flooding in the room. Certified Nursing Assistant #1 stated that the Director of Environmental Services disabled the flushing mechanism in Resident #39's bathroom toilet to prevent flooding. Certified Nursing Assistant #1 stated that the feces and urine in the portable commode and the toilet cause a strong foul odor in the resident's room. Certified Nursing Assistant #1 stated they clean the commode as much as they can and throw the fecal material in other resident rooms and sometimes in the unit shower room. Certified Nursing Assistant #1 stated the Environmental Services Staff knew that the resident was utilizing the toilet with the disabled flushing mechanism and did nothing about it. During (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an interview on 10/01/2025 at 12:15 PM, Licensed Practical Nurse Unit Manager #1 stated, Certified Nurses Assistants are responsible for making sure the shower rooms are clean after they finish providing the shower to the residents. Licensed Practical Nurse Unit Manager #1 stated they checked the shower room at 6:40 AM on 09/29/2025, and the shower room was clean. Licensed Practical Nurse Unit Manager #1 stated Resident#39's toilet flushing system was disabled due to Resident#39's behavior of flushing clothes in the toilet, which caused flooding. During an Interview on 10/01/2025 at 12:25 PM, the Administrator stated they added a full time 3:00 PM to 11:00 PM shift housekeeper staff due to the complaints brought up during the resident council meeting. The Administrator stated there have been no complaints after the full time evening housekeeping staff was hired. The Administrator stated the maintenance department should make sure all shower curtains are working properly. The Administrator stated that the Director of Environmental Services disabled the toilet flushing mechanism, and the resident was provided a portable commode. The Administrator stated they were not notified that Resident #39 was still using the disabled toilet. The Administrator stated the Housekeepers should flush and clean the resident's toilet regularly every day and as needed to maintain the resident's dignity.During an interview on 10/01/2025 at 12:56 PM, Housekeeper #1 stated that shower rooms were cleaned three times a day. Housekeeper #1 stated there were housekeepers scheduled to work seven (7) days a week during the 7:00 AM to 3:00 PM and 3:00 PM to 11:00 PM shifts, and there should be no reason the shower rooms were dirty. They stated the Maintenance Department was responsible for fixing the shower curtains. They stated they did not realize the second-floor shower curtain clips were broken.During an interview on 10/01/2025 at 3:00 PM, the Director of Nursing Services stated the resident's bathroom should be cleaned regularly to maintain the resident's dignity. 10 NYCRR 415.5(h)(2)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/25/2025 and completed on 10/01/2025, the facility did not ensure that each resident was treated with respect and dignity and cared for in a manner that promoted maintenance or enhancement of their quality of life. This was identified for one (1) (Resident #39) of two (2) residents reviewed for Dignity. Specifically, Resident #39 had a diagnosis of Schizophrenia and moderately impaired cognition, with behaviors including flushing their clothing in the toilet bowl, resulting in flooding in the room. After the resident caused flooding in their room, the flush mechanism in the resident's bathroom toilet was disabled, and the resident was provided with a portable commode. During observation, the resident's toilet and commode were found in an unsanitary condition, filled with fecal material. Additionally, the Director of Environmental Services was observed entering Resident #39's bathroom without knocking on the door while Resident #39 was using the bathroom.The finding is:The facility's dignity policy, revised on 11/12/2024, documented all residents will be treated with privacy and confidentiality. The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. All residents have the right to personal privacy and confidentiality of his or her personal clinical records. This includes, but is not limited to, accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and residents' groups. The Facility's policy titled Cleaning and Disinfecting of Environmental Surfaces, revised on 07/2024, documented that environmental surfaces will be cleaned and disinfected according to the current Centers for Disease Control recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration's bloodborne pathogen standards. The policy documented that Resident Shower rooms must be cleaned three times daily and as needed. Resident rooms and personal bathrooms must be cleaned daily and as needed.The resident was admitted with diagnoses of Schizophrenia, Schizoaffective disorder, and Post-Traumatic Stress Disorder. The Quarterly Minimum Data Set, dated [DATE] documented a Brief Interview of Mental Status score of nine (9), which indicated the resident had moderately impaired cognition. The Quarterly Minimum Data Set documented that Resident #39 required substantial (helper does more than half the effort) assistance for toileting, supervision or touching assistance for personal hygiene, and substantial assistance with toilet transfers. Resident #39 was always continent with bowel and bladder. The behavior care plan initiated on 04/26/2024 documented Resident #39 displayed the following behaviors: puts inappropriate items in the toilet, which has resulted in flooding in the room, screams, talks very loudly, and refuses care. The interventions included, but were not limited to, psychiatric evaluation and follow-up as needed, and psychological evaluation and follow-up as needed.The Psychiatric Nurse Practitioner progress note dated 08/29/2025 documented the resident had paranoia with auditory hallucinations (hears voices when not present). The resident had a significant history of Schizophrenia with past treatments. The resident has erratic and unpredictable triggers that vary based on the resident's perception. The facility staff reported the resident exhibited persistent behaviors of using other peers' toilets to wash their clothes and attempting to flush items in the toilet. The resident was agitated with poor impulse control and denied the behavior of using the peers' toilet to wash clothes. During an observation on 09/29/2025 at 10:22 AM, Resident #39's room and bathroom had a strong foul feces and urine odor. The portable commode and the toilet were filled with feces and urine. The resident was sitting on the bed. The resident was wearing pants that were long and were soiled with brownish material. During an interview and observation on 09/29/2025 at 10:45 AM, the Director of Environmental Services stated the flushing mechanism for Resident #39's bathroom toilet was disabled due to the resident's behavior of flushing their clothes, which would (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cause flooding in the room. The Director of Environmental Services stated the condition of the resident's bathroom was disgusting, and they had to get out of the bathroom to breathe due to the unbearable odor. The Director of Environmental Services stated no one ever reported to them that the resident was utilizing the toilet in their room after the flushing mechanism was disabled. The Director of Environmental Services stated that the condition of the resident's toilet was disgusting, and it should have been cleaned. During an observation on 09/29/2025 at 1:04 PM, the Director of Environmental Services entered Resident #39's bathroom without knocking on the door. The resident was in the bathroom and shouted at the Director of Environmental Services. During an interview on 10/01/2025 at 10:27 AM, Certified Nursing Assistant #1 stated Resident #39 flushed their clothes in the toilet and caused flooding in the room. Certified Nursing Assistant #1 stated that the Director of Environmental Services disabled the flushing mechanism in Resident #39's bathroom toilet to prevent flooding. Certified Nursing Assistant #1 stated that the feces and urine in the portable commode and the toilet cause a strong foul odor in the resident's room. Certified Nursing Assistant #1 stated they clean the commode as much as they can and throw the fecal material in other resident rooms and sometimes in the unit shower room. Certified Nursing Assistant #1 stated the Environmental Services Staff knew that the resident was utilizing the toilet with the disabled flushing mechanism and did nothing about it. During an interview on 10/01/2025 at 12:15 PM, Licensed Practical Nurse Unit Manager #1 stated they knew the flushing mechanism in the resident's toilet was disabled by the Director of Environmental Services to prevent flooding. Licensed Practical Nurse Unit Manager #1 stated there was a portable commode in Resident #39's bathroom for Resident #39's toileting needs, and Certified Nurse Assistants were responsible for cleaning the portable commode. Licensed Practical Nurse Unit Manager #1 stated they did not know Resident #39 continued to utilize the toilet while it was disabled. During an interview on 10/01/2025 at 12:33 PM, the Administrator stated they were made aware that Resident #39 caused a flood in their room due to flushing their clothing in the toilet. The Administrator stated that the Director of Environmental Services disabled the toilet flushing mechanism, and the resident was provided a portable commode. The Administrator stated they were not notified that Resident #39 was still using the disabled toilet. The Administrator stated the Housekeepers should flush and clean the resident's toilet regularly every day and as needed to maintain the resident's dignity. During an interview on 10/01/2025 at 12:56 PM, Housekeeper #1 stated they did not know the resident was using the disabled toilet in their room. Housekeeper #1 stated they thought the resident was not using the toilet and could not remember when they last cleaned the bathroom before 09/29/2025 because the nurses and the Certified Nursing Assistants were responsible for cleaning Resident #39's portable commode. During an interview on 10/01/2025 at 3:00 PM, the Director of Nursing Services stated the resident's bathroom should be cleaned regularly to maintain the resident's dignity. 10 NYCRR 415.3(d)(1)(i)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 05/13/2025 and completed on 05/19/2025, the facility did not ensure that comprehensive care plans were reviewed and revised by the interdisciplinary team to reflect each resident's preferences and status after each assessment. This was identified for one (Resident #24) of six residents reviewed for Accidents. Specifically, Resident #24 was identified as having a behavior of rolling out of bed onto the floor mat. The comprehensive care plan and the Certified Nursing Assistant Accountability Record were not updated to include the use of the floor mats as an intervention.The finding is:The facility policy titled Behaviors, dated 08/20/2025, documented that appropriate interventions may include environmental modifications, and all interventions will be documented and incorporated into the resident's individualized care plan.The facility policy titled Care Plans, dated 07/02/2025, documented that the care plan shall be reviewed and revised as changes in the resident's needs, strengths, and goals change, but not less than quarterly. The care plans, as appropriate, shall be revised to enhance interventions as residents' conditions change. This can include, but is not limited to, behavior changes, falls, changing conditions, warranting review of medications and treatments.The undated facility policy titled Fall Prevention documented that residents identified for falls will be assessed for protective devices, which include but are not limited to anti-skid mats, floor mats, and low beds.Resident #24 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease (damage to the airways and other parts of the lungs, which leads to inflammation that blocks airflow and makes it hard to breathe), Cerebral Infarction (a medical condition where a portion of the brain tissue dies due to a lack of blood flow), Bipolar Disorder(a mental condition marked by alternating periods of elation and depression). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 5, indicating the resident had severe cognitive impairment. The Minimum Data Set further documented that the resident had one fall since admission/reentry without injury.A Comprehensive Care Plan titled Behavior, dated 08/12/2024, and last reviewed 09/23/2025, documented that Resident #24 had physical behavior of rolling onto the floor mat when they needed to be changed and then refused care from the staff. There was no documented evidence that the use of the floor mats was included as an intervention. A Comprehensive Care Plan titled Fall/Injury, dated 08/12/2024 and last reviewed 08/16/2025, documented that the resident had a fall from their wheelchair in the bathroom without injury on 07/01/2025. There was no documented evidence that the use of the floor mats was included as an intervention. The Fall Risk assessment dated [DATE] documented that Resident #24 was a high risk for falls.The Kardex (Certified Nursing Assistant instructions to care for Resident #24) did not document the use of floor mats.During an observation and interview on 09/25/2025 at 11:28 AM, Resident #24 was lying in bed and pointed to the floor mat at the bedside and stated they did not want it there, but the staff would not take it away. The resident denied ever falling out of bed.During an observation on 09/29/2025 at 1:09 PM, Resident #24 was not in their room, but a floor mat was observed lying against the wall.During an observation on 09/30/2025 at 7:15 AM, Resident #24 was observed in bed, sleeping. A floor mat was placed on the floor by the bed.During an interview on 09/30/2025 at 7:36 AM, Certified Nursing Assistant #2 stated the resident was on fall precautions and utilized a floor mat. Certified Nursing Assistant #2 stated the resident was incontinent of bladder, but at times, asked to be taken to the bathroom.During an interview on 09/30/2025 at 7:45 AM, Licensed Practical Nurse Manager #1 stated resident #24 had a behavior of throwing themselves on the floor when they did not want care. Licensed Practical Nurse Manager #1 stated there was no intervention added to the care plan for the use of the floor mat. There should be an intervention in the falls care plan for the use of the floor mat. Putting a floor mat on the floor by the bed is a nursing intervention. They were not sure why this was (continued on next page)

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	10/01/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not added to the care plan. During an interview on 10/01/2025 at 10:20 AM, Certified Nursing Assistant #1 stated that floor mats were being used for Resident #24 when the resident was in bed and were removed when the resident was ready to get out of bed in the morning. During an interview on 10/01/2025 at 3:03 PM, the Assistant Director of Nursing Services stated that the floor mats are a nursing intervention, and it would be documented in the fall or injury as an intervention. The Nurses were responsible for updating the care plans and should have updated Resident #24's care plan to indicate the use of the floor mats.10 NYCRR 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the Recertification Survey initiated on 09/25/2025 and completed on 10/01/2025, the facility did not ensure that a resident who needed respiratory care was provided such care consistent with professional standards of practice. This was identified for one (1) (Resident #10) of one (1) resident reviewed for Respiratory Care. Specifically, Resident #10 had a physician's order to receive two liters of supplemental oxygen continuously via a nasal cannula; however, during an observation, the resident was receiving supplemental oxygen at four liters per minute.The finding is:The undated facility policy titled Oxygen Policy documented that nursing staff are to initiate and monitor oxygen therapy, perform assessments, document, and escalate concerns as applicable.The undated facility policy titled Chronic Obstructive Pulmonary Disease documented that oxygen is a medication and must be administered only with a licensed provider's order.Resident #10 was admitted with diagnoses that included Chronic Obstructive Pulmonary Disease (damage to the airways and other parts of the lungs, which leads to inflammation that blocks airflow and makes it hard to breathe), Hemiplegia (paralysis or severe weakness on one side of the body) affecting the right dominant side, and Heart Failure. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderate cognitive impairment. The Minimum Data Set further documented that the resident received oxygen therapy.A comprehensive care plan for respiratory status related to Chronic Obstructive Pulmonary Disease was initiated on 07/29/2024. The interventions included administering supplemental oxygen as per the physician's order.A physician's order renewed on 09/15/2025 and discontinued on 09/25/2025 at 2:45 PM documented supplemental oxygen at a rate of two liters per minute via nasal canula continuously for shortness of breath and dyspnea on exertion (shortness of breath or difficulty breathing during physical activity).The Treatment Administration Record for September 2025 documented the daily use of supplemental oxygen at a rate of two liters per minute via nasal canula, and continuous monitoring of the oxygen saturation for each shift.During an observation on 09/25/2025 at 1:38 PM, Resident #10 was observed sleeping in bed and receiving four liters of oxygen per minute via a nasal cannula.During an interview on 09/25/2025 at 1:47 PM, the Licensed Practical Nurse Unit Manager stated the nurse on duty was responsible for checking the oxygen setting for the residents utilizing supplemental oxygen.A physician's order initiated on 09/25/2025 at 2:45 PM documented to administer two to four liters of oxygen via nasal canula continuously for shortness of breath and dyspnea on exertion (shortness of breath or difficulty breathing during physical activity).During an observation on 09/29/2025 at 10:46 AM, Resident #10 was observed sleeping in a Geri chair in the hallway outside their bedroom. The resident was receiving supplemental oxygen at a rate of three liters per minute via nasal canula.During a re-interview on 09/30/2025 at 7:56 AM, the Licensed Practical Nurse Unit Manager stated that they should have been made aware that the resident required an increase in oxygen. Resident #10 was not able to change the oxygen flow rate themself. During an interview on 10/01/2025 at 3:00 PM, the Assistant Director of Nursing stated Resident #10, who has Chronic Obstructive Pulmonary Disease, should have supplemental oxygen administered as ordered by the Physician. The Registered Nurse on duty should assess the resident, and if the oxygen needs to be increased, the Physician should be notified.10 NYCRR 415.12(k)(6)