STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335636	A. Building B. Wing	01/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Nursing and Rehabilitation Care Ctr	101 Elm St Sayville, NY 11782

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 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** 20757 Based on interviews and record review during an abbreviated survey (Complaint Number: NY00344815), the facility did not ensure resident rights to be free from neglect. Specifically, one (Resident #1) of three residents reviewed for neglect. After the resident fell to the floor, the Licensed Practical Nurse #2 picked Resident #1 up off the floor and sat the Resident#1 back into the wheelchair and did not call for a Registered Nurse. This negligence resulted in Resident #1 not being assessed by the Registered Nurse to assess for injury and need for immediate intervention. The Findings are: The review of the facility policy dated 6/2019 titled accident/incident reports for the resident, documented any accident/incident must be reported by the staff member to the Registered Nurse. The Nursing Supervisor/Registered Nurse must be notified immediately. The Nursing Supervisor/Registered Nurse will assess for injury and need for immediate intervention. Resident#1, admitted to the facility on [DATE] with diagnoses that included anxiety disorder, macular degeneration, unsteadiness on feet stroke, arthritis, and depression. The review of the 14 day, Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score-13 indicating intact cognition skills for decision making, behaviors-none, sit to stand -substantial/maximal assist, for Resident#1. The Fall Risk assessment dated [DATE] documented Resident #1 at risk for falls. The review of the Comprehensive Care Plan (CCP) documented dated 3/30/2024 at risk for falls the interventions documented, remains on 30-minute safety checks. The review of the Comprehensive Care Plan (CCP) documented dated 6/8/2024 skin, resident has a skin tear the interventions updated 6/12/2024 documented, 2 cm by 1 cm skin tear to right side of forehead, 3 cm by 2 cm red purple eccymotic area to right cheek, orders for normal saline cleanse bowed by bacitracin, open to air twice a day for 7 days; The review of the Resident Profile dated 3/30/2024 documented wheelchair mobility-one person assists, high fall risk alerts, updated 5/23/2024 30-minute checks, keep in supervised areas when out of bed. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review of the Resident Progress Notes dated 6/7/2024 at 3:13PM documented continues 30-minute checks; no behavior issues, half hour safety check in progress; 6/8/2024 at 3:31PM self-wheeling within unit, yelling and screaming, able to redirect, currently in recreational activities. The review of the Resident Progress Notes dated 6/8/2024 at 10:03PM documented resident in main dining room, irate and yelling when a 2 cm laceration to forehead was noticed, cleansed with normal saline, bacitracin, Next of Kin aware. The resident was brought to the Registered Nurse Supervisor in wheelchair with a 2 cm by 2 cm skin tear to right side of forehead and a 3 cm by 2 cm red purple eccymotic area to right cheek. Resident screaming and kicking, wants to go to hospital, the Nurse Practitioner made aware, order for normal saline cleanse, neuro checks for 24 hours placed on 1:1 supervision. The review of the Nursing Home Investigative Report documented Resident#1 was interviewed by Assistant Director of Nursing and, the Administrator regarding Accident & Incident. Resident#1 stated, one person came, kept pushing me, kicked the chair and dropped me on the floor and took me off the floor. Licensed Practical Nurse#1 assigned to work on the Unit on 6/8/2024, stated, on the date of 6/8/24, they were walking down the hallway on the Unit heading towards the dining room when a resident was waving for attention in the main dining room. At this time the Licensed Practical Nurse#2 was in the hallway standing at medication cart facing the wall. When Licensed Practical Nurse#1 went into the dining room saw the resident on the floor laying on right side trying to get up. Licensed Practical Nurse#2 ran in the dining room and picked the resident up off the floor and put them in the chair. Witness interviews summarize that Resident #1 was seen on the floor on 6/8/2024, when Licensed Practical Nurse#2 ran into the Main Dining Room to assist the resident back into the wheelchair. The review of the Accident/Incident Report dated 6/8/2024 at 9:45PM the resident#1 brought to the Registered Nurse with a 2 cm skin tear to right side of forehead, bruise noted to right cheek, neurological checks, remined 1:1 until back to bed. Unwitnessed fall in the dining room, the staff was interviewed, and the Resident was assessed, The review of the Department Orientation Checklist dated 8/25/14 documented the Licensed Practical Nurse #2 signed as trained in review of the policy and procedure for reporting incident/injuries. During the telephone interview dated 6/27/2024 at 12:34PM, with the 3:00 PM -11:00 PM shift Licensed Practical Nurse (LPN) #1 who was on duty on 6/8/2024 and the Licensed Practical Nurse stated was on duty 6/8/2024 and recalls an incident with Resident#1 who self-propels wheelchair throughout the facility and is always watched for falls. The Nurse stated at a time not recalled walking in the hallway and Resident#2 was waving at the nurse, but then the Resident #2 was pointing at the floor and the Licensed Practical Nurse#1 ran into main dining room and observed resident lying on left side on the floor, bump on left forehead, left cheek and left shin and saw a little blood ,suddenly Licensed Practical Nurse#2 ran into main dining room and picked the Resident#1 up off floor and placed Resident #1 back into wheelchair. The Licensed Practical Nurse stated did not have time to say to Licensed Practical Nurse #2 we have to get the Registered Nurse Supervisor before the resident is picked up off the floor. Licensed Practical Nurse #2 was just too quick. Licensed Practical Nurse#1 wheeled the resident to the Registered Nurse Supervisor and reported the incident to the Registered Nurse. The interview dated 6/27/2024 at 3:30PM with the Assistant Director of Nursing, and they stated, the Licensed Practical Nurse #2 should not have placed the Resident back into the wheelchair from the floor and should have called for the Registered Nurse before moving the Resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the telephone interview dated 12/30/2024 at 10:55PM, with the unit 7:00 AM -3:00 PM Registered Nurse Supervisor # 5 and the Registered Nurse stated if any resident has a fall or other type of incident, the Registered Nurse must be called to assess the resident prior to picking a resident up from the floor. The Registered Nurse Supervisor #5 stated they were on duty dated 6/8/2024 and assessed the resident, who had a small laceration to right forehead and right check, ecchymosis to right knee, resident denied pain. Resident speaking incoherently, resident stated fell , hit head, and put back in the chair, not agitated or in distress. During the telephone interview with Licensed Practical Nurse#2 on duty dated 6/8/2024, 3:00PM-11:00PM and they stated was passing medications in the hall and would stand in the doorway to watch the residents in the main dining room, they stated staff is supposed to watch residents in dayroom. They stated saw Licensed Practical Nurse#1 walking into the dayroom and stated Resident #1 is on the floor and Licensed Practical Nurse#2 stopped passing medications and went to the dayroom. They stated did a bad thing and they helped resident #1 back into wheelchair but should have called the Registered Nurse to check the resident but did not do that. They stated should have left the resident on the ground until they were assessed by a Registered Nurse. 415.4 (b)