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	03/19/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observations, record review, and interviews during the Recertification Survey initiated on 3/16/2025 and completed on 3/19/2025, the facility did not ensure each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (Resident # 73) of two residents reviewed for Skin Conditions. Specifically, Resident #73 was observed with a dressing on the left forearm that had dried blood from an open purpura (Purpura happens when small blood vessels burst). There was no documented evidence that a skin assessment was completed, the Physician was not notified of the resident's skin tear, and a treatment order was not obtained before applying the dressing to the resident's left forearm. The finding is: The facility's policy titled Change in Skin Condition dated 3/1/2024 documented the facility will assess and accurately document any skin impairment that occurs and provide the necessary care and treatment indicated. In the event a staff member notices a change in skin integrity such as skin tear, laceration, abrasion, open area, pressure injury, or ecchymosis: immediately notify a registered nurse for an assessment. Notify the attending Physician /designee, notify the designated representative, provide treatment as ordered, and investigate the cause. If the cause cannot be identified, the Registered Nurse is to initiate an accident and incident report, [and obtain] witness statements. Assess skin impairment upon notification, order wound consult if warranted, and administer a review of all documentation to ensure completion, accuracy, and accountability. Resident #73 was admitted with diagnoses including Anxiety Disorder and Atherosclerotic Heart Disease. The Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of seven (7) which indicated the resident had severely impaired cognition. The Minimum Data Set documented the resident was at risk for developing skin pressure ulcers/injuries. The comprehensive care plan dated 10/25/2024 documented that Resident #73 had the potential for skin tears, open purpura, and abrasions related to Antiplatelet (medications that prevent blood clotting) medication use. The interventions included observing skin daily during care and reporting any concerns or changes. The physician's orders dated 3/3/2025 documented Aspirin tablet chewable 81 milligrams, 1 tablet once a day, and Plavix 75 milligrams, 1 tablet once a day for Atherosclerotic Heart Disease. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 3/16/2025 at 7:39 AM, Resident #73 was observed lying in bed with an undated gauze dressing to the left forearm. There was a moderate amount of dried blood on the dressing. The resident stated they are on blood thinners and often get skin tears. A review of Resident #73's medical record as of 3/16/2025 revealed no skin assessment that addressed the resident's open purpura to the left forearm; no treatment orders for the left forearm; and no documented evidence that the Physician was notified of the open purpura. During an interview on 3/17/2025 at 10:17 AM, Licensed Practical Nurse #3 stated Resident #73 was on Plavix and Aspirin (anticoagulant medications) which causes prolonged bleeding in the event of skin tear. Licensed Practical Nurse #3 stated on 3/15/2025, they were notified by a Certified Nursing Assistant (name not recalled) that Resident #73 had a skin tear on the left forearm. Licensed Practical Nurse #3 stated they applied gauze dressing to stop the bleeding. Licensed Practical Nurse #3 stated they forgot to notify the Registered Nurse Supervisor to assess the skin tear and the Physician about the resident's skin tear. Licensed Practical Nurse #3 stated they should have obtained a physician's order for the skin tear treatment. During a wound care observation with Licensed Practical Nurse #1 on 3/17/2025 at 2:01 PM, Resident #73's left forearm was noted with an open skin purpura that measured 3 centimeters in length by 0.3 centimeters wide with no drainage. During a re-interview on 3/18/2025 at 1:10 PM, Nurse Practitioner #1 stated Licensed Practical Nurse #3 was supposed to call them or the attending Physician to obtain a treatment order for Resident #73's left forearm skin tear on 3/15/2025. Nurse Practitioner #1 stated it was important to treat skin tears promptly to prevent infection or deterioration. Nurse Practitioner #1 further stated if the wrong treatment was applied to the skin tear, the injury may not properly heal. During an interview on 3/18/2025 at 1:21 PM, the Director of Nursing Services stated Licensed Practical Nurse #3 should have informed the Registered Nurse Supervisor to assess the skin tear and should have called the Physician to obtain a treatment order. 10 NYCRR 415.12

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and staff interviews during the Recertification Survey initiated on 3/16/2025 and completed on 3/19/2025, the facility did not ensure all drugs and biologicals were stored in a locked compartment. This was identified for two (Resident #51 and Resident #7) of five residents reviewed for Accident Hazards. Specifically, 1) Resident #51 was observed with a bottle of Hydrocortisone lotion on their nightstand; the resident did not have a Physician's Order for the use of Hydrocortisone lotion. 2) Resident #7 was observed with a medication cup containing four tablets on their overbed table. There were nursing staff in the vicinity. The findings are: The facility's policy titled Medication Administration last revised on 10/2024 documented that only authorized licensed practitioners can administer medication. Nurses may not administer medications to residents during meals unless indicated by a Physician's Order. Nurses must observe the consumption of the medication before leaving the resident and document the administration/consumption of medications immediately. 1) Resident #51 was admitted with diagnoses including Cardiomegaly (enlarged heart), Congestive Heart Failure, and Candidiasis (fungal infection) of skin and nails. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated that Resident #51 had intact cognition. The Quarterly Minimum Data Set assessment documented Resident #51 did not have any wounds, ulcers, or skin problems. A Comprehensive Care Plan renewed on 12/10/2024 titled Skin: Potential for skin tears, open purpura and abrasions related to fragile skin documented interventions including keeping nails trimmed, checking and filing any rough edges, avoiding friction and sheer during care, repositioning and transfer; observe skin daily during care; and report any concerns or changes. During an observation on 3/16/2025 at 7:39 AM, Resident #51 was sitting in a wheelchair in their room. An unlabeled bottle of Hydrocortisone lotion 1% with an expiration date of 4/2025 was observed on top of the nightstand. Resident #51 stated they use the Hydrocortisone lotion when they have redness on their hands and cheeks. Resident #51 stated they could not recall where the medication bottle came from. A review of Resident #51's electronic medical record revealed there was no Physician's Order for Hydrocortisone lotion 1% as of 3/16/2025. During an interview on 3/16/2025 at 7:57 AM, Licensed Practical Nurse #1 stated Resident #51 did not have a Physician's order for Hydrocortisone use and they had never seen the bottle of Hydrocortisone lotion with Resident #51. Licensed Practical Nurse #1 stated if they had seen the Hydrocortisone lotion, they would have taken the bottle of Hydrocortisone lotion and made the Charge Nurse aware. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/17/2025 at 1:15 PM, Licensed Practical Nurse #2 stated they had never seen Resident #51 use the Hydrocortisone lotion. Licensed Practical Nurse #2 stated if they had seen the lotion, they would have taken it and given the lotion to the supervisor. During an interview on 3/17/2025 at 1:54 PM, Certified Nursing Assistant #1 stated they took care of Resident #51 during the 7:00 AM to 3:00 PM shift. Certified Nursing Assistant #1 stated they had never seen the Hydrocortisone lotion on Resident #51's nightstand. Certified Nursing Assistant #1 stated they would have reported to the Nurse if they had seen the Hydrocortisone lotion in Resident #51's room. During an interview on 3/18/2025 at 8:06 AM, Registered Nurse #1, the Unit Supervisor, stated that residents should not have medications stored in their rooms. Registered Nurse #1 stated they did not know Resident #51 had a bottle of Hydrocortisone lotion. Registered Nurse #1 stated they would have assessed the resident and notified the Physician. During an interview on 3/18/2025 at 11:29 AM, the Director of Nursing Services stated nursing staff should be aware of the environment when taking care of residents. The Director of Nursing Services stated Resident #51 should not have any medications stored in their room. All medications should be locked and stored in the medication carts and only the Nurses can administer medications. 2) Resident #7 was admitted with diagnoses including Malnutrition, Hypertension, and Bradycardia (slow heart rate). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated Resident #7 had intact cognition. An Admission Self-Medication assessment dated [DATE] revealed that Resident #7 did not want to self-medicate. The current Physician's Order documented Multivitamin one tablet orally once a day for Nutritional Deficiency; Preservision AREDS-2 (Vitamin C, E-Zinc-Copper-Lutein-Zeaxan) capsule; 250-90-40-1 milligrams one capsule orally twice a day for Vitamin Deficiency; Loratadine 10 milligrams one tablet orally once a day for Allergic Rhinitis (allergic response causing itchy, watery eyes and sneezing); Calcium 500 milligrams plus D (calcium carbonate-vitamin d3) tablet; 500 milligrams-5 micrograms (200 units) one tablet orally once a day for Nutritional Deficiency; and Sotalol 80 milligrams give 40 milligrams orally once a day. Hold for systolic blood pressure of less than 90 and/or Heart rate of less than 55 for Hypertension. A Comprehensive Care Plan dated 11/7/2022 last revised on 1/24/2025 titled PolyPharmacy documented interventions including administering medications as per Physician's Order; monitoring for side effects of medications, being alert for drug-to-drug interactions; and notifying the Physician for any untoward effects of medications observed. During an observation on 3/16/2025 at 7:57 AM, Resident #7 was sitting in a wheelchair in front of their overbed table. The resident stated they finished their breakfast meal a few minutes ago. A cup of medications containing four tablets (Calcium, Loratadine, Preservision AREDs, and Multivitamins) was observed on the overbed table next to the completed breakfast meal tray. There was no Nurse in the vicinity. Resident #7 stated they requested for the Nurse to leave the medications in their room at 7:35 AM and told the Nurse that they would take the medications after breakfast. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/16/2025 at 8:00 AM, Licensed Practical Nurse #1 stated Resident #7 requested to leave the cup of their medications on their overbed table because Resident #7 was still eating their breakfast. Licensed Practical Nurse #1 stated Resident #7 was alert and oriented and knew their medications. Licensed Practical Nurse #1 stated they went to another resident's room to finish their medication administration after leaving Resident #7's room at 7:35 AM. Licensed Practical Nurse #1 stated they should have waited for Resident #7 to finish breakfast before giving the medications. Licensed Practical Nurse #1 stated they should have never left the medications with Resident #7 unattended. During an interview on 3/17/2025 at 1:40 PM, Resident #7 stated they did not want to be responsible for self-administration of their medications while living at the facility. During an interview on 3/18/2025 at 8:06 AM, Registered Nurse #1, the Unit Supervisor, stated Licensed Practical Nurse #1 should not have left the medications in the resident's room unattended. Registered Nurse #1 stated Nurses should not give medications during mealtimes or when residents are eating. Registered Nurse #1 stated Resident #7 was alert and oriented but did not have an order to self-medicate. Registered Nurse #1 stated the Nurses are still responsible for administering medications to the resident. During an interview on 3/18/2025 at 11:41 AM, the Director of Nursing Services stated that all residents are screened for medication self-administration during admission. The Director of Nursing Services stated Resident #7 was capable but did not want to be responsible for their medications while in the facility. The Director of Nursing Services stated that residents should not have any medications stored in their rooms without the supervision of a licensed nurse. 10NYCRR 415.18(e)(1-4)