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	04/07/2026

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

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure the Minimum Data Set assessment was completed to accurately reflect each resident's status. This was identified for one (1) (Resident #7) of one (1) resident reviewed for restraints. Specifically, the quarterly Minimum Data Set assessment dated [DATE] inaccurately indicated Resident #7 utilized a physical restraint in a chair or out of bed, when they did not.The findings include: The facility policy titled, MDS (Minimum Data Set) Completion dated 10/18/2024 documented the Interdisciplinary Team was responsible for completing the assigned sections in the Minimum Data Set. The policy did not document the information provided should also be accurate.Resident #7 has diagnoses that include frontotemporal dementia (an umbrella term for a group of brain diseases that mainly affect the frontal and temporal lobes of the brain. These areas of the brain are associated with personality, behavior, and language) and depression. The quarterly Minimum Data Set assessment dated [DATE] documented the resident had severely impaired cognitive skills for daily decision making. The Minimum Data Set assessment documented the resident used physical restraints in a chair or out of bed. During an observation on 04/01/2026 at 10:20 AM, the resident was observed seated in a Geri chair (geriatric recliner) in the facility's main dining room with no physical restraint.A review of the resident's Physician Orders from January 2025 to March 2026 revealed no documented evidence that the resident used physical restraints. A review of Resident #7's entire Comprehensive Care Plan revealed no documented evidence that the resident used physical restraints.The annual Rehabilitation Screen dated 11/06/2025 documented the resident's type of wheelchair was a Geri chair. There was no documented evidence that the resident used physical restraints. During an interview on 04/02/2026 at 1:55 PM, Rehabilitation Coordinator #1 stated Resident #7 did not utilize any restraints. Rehabilitation Coordinator #1 stated the resident had poor trunk control and used a Geri chair for proper positioning, decreasing their fall risk, and maintaining their skin integrity. During an interview on 04/03/2026 at 9:55 AM, Registered Nurse Minimum Data Set Coordinator #1 stated the facility was restraint free. Registered Nurse Minimum Data Set Coordinator #1 stated they made a mistake on the quarterly Minimum Data Set assessment dated [DATE] by indicating Resident #7 had physical restraints in a chair or out of bed. Registered Nurse Minimum Data Set Coordinator #1 stated Resident #7 was totally dependent on staff for all Activities of Daily Living, had poor trunk control, could not sit upright, and could not move unless someone moved them, therefore use of the Geri chair was not considered a restraint. During an interview on 04/03/2026 at 12:15 PM, the Director of Nursing Services stated the documentation in the quarterly Minimum Data Set assessment dated [DATE] regarding the physical restraint was a mistake. Director of Nursing Services stated the information documented in a Minimum Data Ser assessment was expected to be accurate. During an interview on 04/03/2026 at 1:35 PM, the Administrator stated they would expect the information documented in a Minimum Data Set assessment to be accurate. 10 New York Code Rules and Regulations 415.11(b)

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility did not ensure that each resident had a person-centered Comprehensive Care Plan (CCP) developed and implemented that includes measurable objectives and time frames to meet a resident's medical, nursing, mental and psychosocial needs. This was identified for one (Resident #7) of one resident reviewed for Restraints. Specifically, the Resident #7's out of bed status was not accurately reflected in the Comprehensive Care Plan The findings include:The facility policy titled, Comprehensive Person-Centered Care Planning dated 09/01/2025 documented the facility must develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and time frames to meet each individual resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment.Resident #7 has diagnoses that include frontotemporal dementia (an umbrella term for a group of brain diseases that mainly affect the frontal and temporal lobes of the brain. These areas of the brain are associated with personality, behavior, and language) and depression. The quarterly Minimum Data Set assessment dated [DATE] documented the resident had severely impaired cognitive skills for daily decision making. During an observation on 04/01/2026 at 10:20 AM, the resident was observed seated in a Geri chair (geriatric recliner) in the facility's main dining room with no physical restraint.The Certified Nursing Assistant Plan of Care, initiated on 01/03/2025 and last reviewed on 12/04/2025, documented no evidence of the resident being out of bed to a Geri chair.The Rehabilitation To Nursing Correspondence form dated 01/04/2025 documented the resident transferred dependently with a mechanical Hoyer lift with two people.On 04/02/2026 at 1:30 PM, the resident's current Physician Orders last renewed on 03/16/2026 were reviewed and there was no documented evidence of what the resident's out of bed status was.On 04/02/2026 at 1:35 PM, the resident's entire Comprehensive Care Plan was reviewed and there was no documented evidence of the resident being out of bed to a Geri chair. During an interview on 04/02/2026 1:55, Rehabilitation Coordinator #1 stated there was no documentation in the resident's Comprehensive Care Plan regarding the out of bed status to indicate use of a Geri chair and there should have been. Rehabilitation Coordinator #1 stated the resident was utilizing the Geri chair since admission and the Comprehensive Care Plan should have included the resident's out of bed status. During an interview on 04/03/2026 at 12:15 PM, the Director of Nursing Services stated the resident's Geri chair should have been documented on the resident's Activities of Daily Living Comprehensive Care Plan to show the resident transferred dependently to a reclining Geri chair so it would be also documented on the Certified Nursing Assistant Plan of Care. The Director of Nursing Services stated Rehabilitation Coordinator #1 was responsible for adding the Geri chair to the resident's Comprehensive Care Plan. 10 New York Code Rules and Regulations 415.11(c)(1)

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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** Based on observation, interviews, and record review during survey, the facility failed to ensure each resident's environment remained free of accident hazards. This was identified for one (1) (Resident #6) of four (4) reviewed for Accidents. Specifically, on 04/01/2026, a bottle of Dicyclomine tablets and a bottle a Nitroglycerin sublingual tablets were observed on Resident #6's nightstand. Resident #6 had no physician's order to self-administer any medication or a physician's order for Nitroglycerin. Furthermore, the bottle of Dicyclomine documented instructions to discard the medication after 09/11/2025.The findings include:A facility policy titled Medication Storage Requirements dated 11/24/2025 documented medications are stored under proper conditions as defined by manufacturers to ensure medication stability. All medications will be stored in the medication refrigerators on the nursing unit or in a locked medication cart.Resident #6 was admitted with diagnoses including angina pectoris (chest pain or discomfort when blood flow to the heart is reduced), hypertension, and irritable bowel syndrome (a condition that causes recurrent attacks of abdominal discomfort in association with bowel habits). The five (5) day scheduled Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating the resident's cognitive function was intact.A Comprehensive Care Plan titled Cardiovascular initiated 02/19/2025 documented interventions including administer medications as per the physician's orders and monitor for effectiveness and adverse effects; monitor for signs and symptoms of cardiovascular dysfunction; and monitor vital signs as per physician orders.A Comprehensive Care Plan titled Gastrointestinal initiated 02/19/2026 documented interventions including administer medications as per the physician's order and monitor for signs and symptoms such as abdominal pain, bleeding, nausea/vomiting, and tarry stools.A Comprehensive Care Plan titled Education and knowledge initiated 02/19/2026 documented the resident was unable to comprehend educational material related to forgetfulness. The interventions included to provide education at the appropriate educational level and to accommodate disabilities; provide education in the resident's primary language, using simple and direct wording.An admission Self Medication Assessment for Resident #6 dated 02/19/2026 documented Resident #6 was not a candidate to self-administer medications.A physician's order dated 03/14/2026 documented to administer Dicyclomine 20 milligrams tablet, one (1) tablet orally every eight (8) hours as needed for irritable bowel syndrome.A physician's order dated 03/14/2026 documented to administer Ranolazine 1,000 milligram tablet extended release, one tablet orally every 12 hours for angina pectoris.A review of the electronic medical record revealed there was no physician's order for Nitroglycerin or for the resident to self-administer any medications.During an observation and interview on 04/01/2026 at 10:00 AM, a bottle of Dicyclomine 20 milligram tablets and a bottle of Nitroglycerin 0.4 milligram sublingual tablets were observed on Resident #6's nightstand. The bottle of Dicyclomine documented instructions to discard the medication after 09/11/0225. Resident #6 stated they preferred to keep the medications on their nightstand for easy access even though the nightstand had a locked drawer. Resident #6 stated they were evaluated for self-administering medication at the facility and stated they had no issues self-administering these medications. Resident #6 stated they could not recall the last time they took either of the medications.During an interview on 04/01/2026 at 11:56 AM, Licensed Practical Nurse #3, the assigned medication nurse for Resident #6, stated they noticed the bottle of Dicyclomine and Nitroglycerin on Resident #6's nightstand when they entered the room at approximately 10:30 AM on 04/01/2026. Licensed Practical Nurse #3 stated Resident #6 could not self-administer their medications and the nurses were responsible for administering the medications to Resident #6. The resident's medications should be stored in the locked medication cart and there should not have been (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any medications, including expired medications on the resident's nightstand.During an interview on 04/01/2026 at 12:55 PM, Registered Nurse #1 stated Resident #6 could not safely self-administer their medication and the medications should not have been stored in the resident's room including any expired medication. Registered Nurse #1 stated the resident could inappropriately administer the medications or potentially take a duplicate dose as the resident can get confused or forgetful, or staff would not be monitoring for potential side effects or adverse reactions because they were not aware of the medication the resident kept at the bedside. Registered Nurse #1 stated there was potential for other residents to wander into Resident #6's room and potentially access the medication placed on the nightstand.During an interview on 04/03/2026 at 12:23 PM, the Director of Nursing Services stated the Resident #6 had an evaluation completed on admission that determined the resident was not able to self-administer medications. The Director of Nursing Services stated that no medications of any sort should have been stored in the resident's room, including any expired medications or medications that should be discarded.10 New York Code Rules and Regulations 415.18(e)(1-4)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that it established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was identified for one (1) (Resident #65) of six (6) residents reviewed for the Infection Control task. Specifically, Resident #65 had a physician's order for Enhanced Barrier Precautions and Certified Nursing Assistant #3 was observed providing hands-on care without wearing a gown as required.The findings include:The facility policy titled Enhanced Barrier Precautions, last reviewed 04/07/2025, documented enhanced barrier precautions are an infection control intervention designed to reduce transmission of resistant organisms through employee transmission on hands and or on clothing. Gowns and gloves are required during high contact resident care activities. Residents who meet enhanced barrier precautions will have the enhanced barrier precautions sign above their bed to alert all staff. A physician's order for enhanced barrier precautions will be obtained and documented in the medical record. Gowns and gloves must be worn for high-contact resident care activities such as dressing, personal hygiene, changing of briefs or providing toileting assistance. All staff will be educated regarding enhanced barrier precautions upon initiation and annually thereafter.Resident #65 was admitted with diagnoses that included dementia (decline in mental ability), chronic respiratory failure (lungs cannot adequately exchange oxygen and carbon dioxide, leading to low blood oxygen), and anxiety (feelings of nervousness, or unease about imminent events or outcomes). The admission Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score was not completed indicating Resident #65 was rarely/never understood and had severely impaired cognition. The Minimum Data Set assessment documented Resident #65 was dependent upon staff for all activities of daily living, and was incontinent of bladder and bowel, and was admitted with one (1) stage 1 pressure ulcer and one (1) stage 3 pressure ulcer.A physician's order dated 03/03/2026, documented enhanced barrier precautions due to left breast and sacral wounds, personal protective equipment when performing high-contact care, resident is not restricted to their room.A care plan titled enhanced barrier precautions, for left breast and sacral wounds documented interventions that included proper personal protective equipment to be used during high contact resident care activities that included dressing, bathing, and changing briefs.The Certified Nursing Assistant instructions dated 03/03/2026, documented enhanced barrier precautions, use proper personal protective equipment during high contact resident care activities that included dressing, bathing, and changing briefs.During an observation on 04/01/2026 at 10:30 AM, Resident #65 was in bed sleeping, in a private room with an enhanced barrier sign observed over the bed. The enhanced barrier precaution signage documented staff must wear gowns and gloves for dressing, bathing, showering, transferring, changing linens, and providing hygiene care.During an observation on 04/02/2026 at 10:17 AM, Certified Nursing Assistant #3 was in Resident #65's room providing hands on care such as changing and checking the brief and dressing the resident and was not wearing a gown. The enhanced barrier precaution signage was observed posted above Resident #65's bed with guidance to wear gowns and gloves for dressing, bathing, showering, transferring, changing linens, and providing hygiene care. During an interview on 04/02/2026 at 10:18 AM, Registered Nurse Supervisor #2 stated Resident #65 was on enhanced barrier precaution because they had wounds. Certified Nursing Assistant #3 should have put on appropriate personal protective equipment to provide care to Resident #65. The enhanced barrier precautions are also documented on Resident #65's Certified Nursing Assistants instructions. Registered Nurse Supervisor #2 stated all staff must follow the instructions that are documented on the enhanced barrier precaution signs.During an interview on 04/02/2026 at 10:21 AM, Certified Nursing Assistant #3 stated they knew that the resident was on enhanced barrier precautions due to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wounds on the backside and on the breast; however, they forgot to put on a gown while providing care to Resident #65.[NAME] an interview on 04/03/2026 at 8:18 AM, the Director of Nursing Services stated to prevent the spread of infection, staff should be donning (put on) a gown and gloves when providing direct care to residents who are on enhanced barrier precautions.10 New York Code Rules and Regulations 415.19(a)(1-3)