

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335676	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Haven Manor Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Gateway Boulevard Far Rockaway, NY 11691	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to maintain the residents' right to a safe, clean, and comfortable environment. This was evident on the 6th Floor. Specifically, observation on the 6th Floor include but is not limited to stained ceiling tiles in some of residents' rooms, radiators were rusted and the base had cracks, window blinds had stains, bedside tables were dirty. The findings are: The facility's policy and procedure titled Maintenance Services with a reviewed date 01/2026 documented the Environmental Services Department is responsible for managing the maintenance function in the most cost-effective manner possible while maximizing the useful life of equipment, rooms, and properties while striving to provide the best service to our residents. Observations were conducted from 01/15/2025 at 10:00 AM to 01/23/2026 at 12:30 PM and the following were observed on the 6th Floor: 1. The hallway ceiling was observed with brown colored stains. 2. room [ROOM NUMBER] had cracked tile below the sink close to the floor. 3. The air/heating unit in room [ROOM NUMBER] had a crack around the bases exposing the wall with brown and grey substance. 4. The ceiling tiles in room [ROOM NUMBER] had brown colored stains and had a crack around the air/heating unit. 5. The window blinds in room [ROOM NUMBER]-A had brown stains. 6. The male shower room had black colored substance around the perimeter. The window perimeter was covered with brown colored substance. 7. There was a dirty bedside table in the hallway. 8. room [ROOM NUMBER] ceiling tiles were in disrepair, hanging off the ceiling. The window blinds had brown stains on the border. 9. The top of the air-conditioning unit in room [ROOM NUMBER] was coming off. 10. The radiator and bedside table in room [ROOM NUMBER] were dirty. 11. The bathroom in room [ROOM NUMBER] had a hole. 12. The ceiling in room [ROOM NUMBER] B had brown stains, and the floor tiles under the sink had cracks. 13. The radiator in room [ROOM NUMBER] had rust and the surrounding wall was in disrepair with black colored substance. The window blinds were discolored, and the metal surrounding the light above the sink was rusted. 14. The radiator in the residents' dining room had brownish color and had exposed sharp metals. 15. The ceiling ventilation in the residents' dining room had brown stains and was dusty. On 01/23/2026 at 12:01 PM Registered Nurse #3, who was also the Nursing Supervisor for 6th Floor, was interviewed and stated they write things in need of repair in the maintenance logbook if they see that it is unsafe or may cause immediate jeopardy to the resident. On 01/23/2026 at 11:49 AM, Housekeeper #1 was interviewed and stated that their responsibility is to make sure the residents' unit is clean. They stated they notify the Maintenance Director for any repairs that need to be done. On 1/23/2026 at 12:10 PM, the Maintenance Director was interviewed and stated that the tiles are old and need to be replaced. They stated there is nothing they can do with the radiators because the stains were caused by the weather and the water that was coming from outside caused the disrepair. They stated that the window blinds look rusty because of the bleach that housekeeping use to sanitize it and it gets oxidized. On 01/23/2026 at 12:30 PM, the Administrator was interviewed and stated they are not sure what repairs are needed. They stated the Maintenance Department makes daily rounds to see if there are any needed repairs and they also have a consultant who comes in and makes rounds in the unit. They stated there is a maintenance logbook in each unit where needed repairs are logged. 10 NYCRR 415.5(h)(2)		

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the Recertification Survey from 01/15/2026 to 01/23/2026, the facility did not ensure residents had a right to make choices regarding aspects of their life for two (2) of two (2) residents out of 38 residents reviewed for smoking. Specifically, the facility did not allow the residents to go out and smoke and did not offer a smoking cessation program for Resident # 103 and Resident #102, who were known smokers at the time of admission. The findings are: The policy and procedure titled 'Safe Smoking Program' reviewed 01/26 documented the facility will permit smoking in a designated area, at a designated time for those residents who choose to smoke while ensuring the safety of all other residents, staff and visitors. Residents who desire or request assistance with smoking cessation will be assisted through the Activities, Nursing and Social Service Departments. The policy also documented that smoking will be permitted only in the designated patio area at the designated time as weather permits. On 01/20/2026 at 1:37 PM, observation of safe smoking did not occur. During an interview the Recreation Director stated it is cold outside, and smoking is only done when the weather permits residents to go outside. 1. Resident #103 was admitted to the facility with diagnosis that included Anxiety Disorder, Depression, and Schizophrenia. The Annual Minimum Data Set assessment dated [DATE] documented Resident #103 was cognitively intact. The Comprehensive Care Plan titled 'Smoking/Use of Electronic Cigarettes' documented Smoking: Psychosocial history reveals Resident #103 is a known smoker. Potential for safety hazard due to resident choosing to smoke. Allow resident to smoke in designated smoking area with supervision as needed, provide assistance when smoking in the designated area. During an interview on 01/21/2026 at 10:39 AM, Resident #103 stated it has been more than a month since they were permitted to smoke, and they did not know why they had not been allowed to out and smoke. Review of Progress Notes dated 12/03/2025 through 12/09/2025 revealed no documented evidence Resident #103 engaged in unsafe smoking behaviors. There was no documented evidence Resident #103 was given a choice to smoke cigarettes during cold weather or was offered a smoking cessation program such as a nicotine replacement option when the facility implemented a policy to prohibit smoking to cold weather. 2. Resident #21 was admitted to the facility with diagnoses which included Non-Alzheimer's Dementia and Schizophrenia. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #21 was cognitively intact. The Comprehensive Care Plan titled 'Smoking/Use of Electronic Cigarettes' documented Resident will smoke safely within the designated smoking area. Allow resident to smoke in designated smoking area with supervision as needed and provide assistance when smoking in the designated area. Review of Progress Notes dated 12/01/2025 through 12/31/2025 revealed no documented evidence Resident #21 engaged in unsafe smoking behaviors. There was no documented evidence Resident #21 was given a choice to smoke cigarettes during cold weather or was offered a smoking cessation program such as a nicotine replacement option when the facility implemented a policy to prohibit smoking due to cold weather. On 01/21/2026 at 09:34 AM, Resident #21 was interviewed and stated they have not been allowed to smoke for more than three (3) weeks and has no issue with going out to smoke in the cold weather if they wear a hat and coat. Resident #21 also stated they were told they cannot go out to smoke due to the cold weather. Review of a Resident Who Smoke List and Smoking Schedule documented there are 38 residents who smoke, and the designated smoking times are 08:30 - 09:30 AM, every day, weather permitting and designated smoking location is on the patio. On 01/20/2026 at 01:37 PM, the Recreation Director was interviewed and stated it is cold outside, and residents can only go out to smoke when weather permits. The Recreation Director also stated smoking occurs once a day and the schedule was changed from 8:30 AM in the morning to 2:00 PM. The Recreation Director further stated during the COVID-19 pandemic residents did not go out to smoke and since (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then the facility changed from a non-smoking facility and made smoking weather-permitting instead. The Recreation Director stated if residents come down to smoke and it is cold outside, they are not allowed to go outside and smoke. The Recreation Director also stated residents are not allowed to have any smoking cessation aids such as nicotine gum or a patch while they are identified as known smokers. On 01/20/2026 at 01:50 PM, the Director of Nursing was interviewed and stated the Director of Recreation does the assessment for the smokers, and residents can go out to smoke if the weather permits. The Director of Nursing also stated the weather has been fluctuating in the past couple of months, and smoking privileges were revised to meet to meet resident's needs and safety, which we go by first. The Director of Nursing stated residents are informed on admission that smoking is once per day and weather permitting, and when the residents come down to the Recreation room, they are informed then whether smoking will be permitted that day. The Director of Nursing also stated the last time residents were allowed to smoke was on 01/09/2026, and the residents cannot have any gum or nicotine offered as a smoking cessation. The Director of Nursing further stated if a resident asked to go and smoke today, they cannot because they are bonded by the contract that documents residents can only smoke when the weather permits. On 01/22/2026 at 03:14 PM, Medical Doctor #1 was interviewed and stated they did not know residents were not being allowed to go out and smoke and had not smoked in three (3) weeks. Medical Doctor #1 stated if residents have not smoked for a while, the facility has a smoking cessation protocol, such as the nicotine patch, which can be offered to residents. Medical Doctor #1 stated they observed residents going down to smoke today. On 01/22/2026 at 05:07 PM, the Medical Director was interviewed and stated smoking is a privilege for the residents and the facility has the right to change the time and the amount of cigarettes the resident smoke. The Medical Director also stated there is a schedule for smoking, and no residents have spoken to them about not being permitted to smoke. The Medical Director also stated smoking cessation aids are not necessary as residents are only permitted to smoke one cigarette once a day. On 01/23/2026 at 09:50 AM, the Assistant Administrator was interviewed and stated residents were not allowed to go out and smoke because Department of Health regulations stated that if it is below 40 degrees the resident should not be outside, and if they go outside, they should wear a hat and gloves. The Assistant Administrator also stated they were not sure when the notice was distributed but knows that the information came from the Department of Health. 10 NYCRR 415.5(f)(2)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Number of residents sampled: 3Number of residents cited: 1 Based on record review and interviews, the facility did not ensure that a resident or their designated representative was provided appropriate notification at the termination of Medicare Part A benefits. This was evident for one (1) resident (Resident #216) of three (3) residents reviewed for Beneficiary Notification. Specifically, there is no documented evidence that the Notice of Medicare Non-Coverage form was mailed to Resident #216's designated representative on the same day the telephone notification was made. The findings are: The facility provided no policy and procedure on the delivery of the Notice of Medicare Non-Coverage and Skilled Nursing Facility Advanced Beneficiary Notice. Resident #216 was discharged from skilled services on 01/14/2026 with 93 benefit days of Medicare Part A remaining and remained in the facility. The Notice of Medicare Non-Coverage and Skilled Nursing Facility Advanced Beneficiary Notice were completed. The Notice of Medicare Non-Coverage documented Resident # 216's representative was contacted on 1/12/2026 at 12:20 PM. A Certified Mail Receipt documented postage was not postmarked until 01/15/2026. There was no documented evidence that the form was mailed to Resident #216's Representative on the date that telephone notification was made. On 01/23/2026 at 1:58 PM, Registered Nurse #1, who is also the Minimum Data Set Coordinator, stated when skilled services are going to be discontinued, they prepare the letter and give it to the Social Worker to issue to the family. Registered Nurse #1 also stated once the letters have been signed, they prepare the envelope and give it to the secretary to mail. Registered Nurse #1 further stated mail is usually sent the next day because we are only going to the post office once a day. Registered Nurse #1 stated they usually follow-up with the secretary but did not do so in this case. 10 NYCRR 415.3(g)(2)(i)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility failed to ensure residents' rights to privacy and confidentiality were maintained. This was evident for one (1) (2nd Floor) of two (2) units observed for medication administration. Specifically, Licensed Practical Nurse #3 walked away from the medication cart without locking the laptop computer exposing Resident #136's medical record. The findings include: The facility's policy titled Resident Privacy, Confidentiality, and Resident Records with a last reviewed date of 01/2026 documented that the facility will protect each resident's right to privacy and will maintain confidentiality and security of all residents' records. On 01/16/2026 at 9:30 AM, during medication pass observation on the 2nd Floor unit, Licensed Practical Nurse #3 left the medication cart with the computer laptop open and walked towards room [ROOM NUMBER]. The computer screen displayed Resident #136's medical record. There were two (2) housekeeping staff in the hallway directly across the medication cart. On 01/16/2026 at 9:33 AM, Licensed Practical Nurse #3 was interviewed and stated they were supposed to close the computer laptop screen before leaving the medication cart. On 01/23/2026 at 9:13 AM, the Director of Nursing was interviewed and stated that computer laptop monitor must be closed or locked when leaving the medication cart so that others do not gain access to the resident's medical record. 10 NYCRR 415.3(e)(1)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents were free from any physical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. This was evident for two (2) residents (Resident #143 and Resident #141) of three (3) residents investigated for Physical Restraint. Specifically, 1). Resident #143 was observed wearing a seat belt in wheelchair and Resident #143 stated they did not know how to remove the seat belt, and staff had to remove it. 2). Resident #141 was observed with a lap seat belt affixed while seated in a wheelchair on multiple occasions. Resident #141 was not able to remove the seat belt on their own. The findings are: The facility policy titled 'Restraints' dated last reviewed 1/2026 stated it is the facility's policy to promote and encourage a restraint- free environment. All residents have the right to be free from physical and chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident medical symptoms. The policy also stated that before a resident is restrained, the facility must determine the presence of a specific medical symptom that will require the use of restraint. The policy further stated a Physician will order the restraints based on the Interdisciplinary Team indicating the need for the restraints, and risks and potential hazard of restraints use need to be considered prior to use. The policy listed seatbelts as an example of trunk restraints. 1. Resident #143 had diagnoses which included Paranoid Schizophrenia and muscle spasms, and constipation. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #143 was cognitively intact, required partial to moderate assistance with most activities of daily living and mobility, used a wheelchair, had no falls since the prior assessment, and did not use physical restraints or alarms. The comprehensive care plan titled 'Falls' created 12/02/2017 and revised 11/22/2025 documented interventions which included constant reinforcement of safety measures, use of the call bell, and holding bed rails. The comprehensive care plan did not document the use of a seat belt. On 01/16/2026 at 1:07 PM, Resident #143 was observed seated in a wheelchair wearing a blue colored seat belt. On 01/20/2026 at 2:46 PM, Resident #143 was observed in the day room playing dominoes with other residents, showing no signs of distress, with the seat belt on. Review of Physician orders last reviewed 1/1/2026 contained no order for a seat belt, or directions on how the seat belt was to be used or monitored. There was no documented evidence of an evaluation of the need for restraints, and the medical necessity for use of the seat belt. Review of the comprehensive care plan revealed no documented evidence a care plan was created for use of restraints. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/22/2026 at 9:56 AM, Certified Nursing Assistant #4 was interviewed and stated Resident #143 has been wearing a seat belt as long as they can recall. Certified Nursing Assistant #4 also stated when Resident #143 is having lunch they will release the seat belt so they can be comfortable when they eat, but they were not instructed to do so, and the seat belt is not listed in their tasks. Certified Nursing Assistant #4 stated Resident #143 thinks they are going to fall and sometimes they can remove the seat belt and at other times they are not able to do so. On 01/23/2026 at 9:57 AM, Registered Nurse #3 was interviewed and stated Resident #143 was transferred to the third floor at the end of October 2025 and has always worn a seat belt on this unit. Registered Nurse #3 also stated there are some residents who learn forward in their wheelchairs and the seat belt helps them to maintain their safety. Registered Nurse #3 further stated Resident #143 should have an order for seat belt use and they were not able to locate orders or an evaluation for the use of seat belts. State Surveyor observed Resident #143 with Registered Nurse #3 and when Registered Nurse #3 asked Resident #143 to remove the seat belt they stated they were not able to remove the seat belt because they were not good with their hands. Registered Nurse #3 stated if Resident #143 was not able to remove the seat belt this would be considered a restraint. On 01/23/2026 at 2:05 PM, Registered Nurse #1 who is also the Minimum Data Set Coordinator, was interviewed and stated they were unaware of Resident #143's daily seat belt use as there was no order or care plan. Registered Nurse #1 also stated they did not observe Resident #143 was wearing and a seat belt when they conducted their assessment. Restraints are reviewed in the Minimum Data Set process. Registered Nurse #1 further stated that if a resident cannot remove the seat belt independently, it is considered a restraint. 2. Resident #141 was admitted with diagnosis which included Non-Alzheimer's Dementia, Depression, and Schizophrenia. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #141 had severely impaired cognition, no indicators of Psychosis, and no behavioral symptoms. The Quarterly Minimum Data Set assessment also documented Resident #141 required partial/moderate assistance of one person for oral hygiene, toileting hygiene, shower/bath, upper/lower body dressing, and personal hygiene. The Quarterly Minimum Data Set assessment documented Resident #141 did not ambulate, and no restraint was used. On 01/15/2026 at 10:10 AM, Resident #141 was observed sitting in the dining area with a seat belt over their upper thigh area. Resident #141 was mumbling to themselves and responded when greeted. Resident #141 appeared confused and had no response when asked if they could remove the seat belt. On 01/15/2026 at 1:56 PM, Resident #141 was observed sitting in a wheelchair with seat belt locked across upper limbs in the dining area. Resident #141 was holding hands to their head and appeared more confused than earlier. On 01/20/2026 at 9:23 AM, Resident #141 was observed sitting in the dining area in a wheelchair with a turquoise blue seat belt with button in middle to press to release seat belt. Resident #141 was unable to follow instructions to remove the seat belt. On 01/20/2026 at 2:24 PM, Resident #141 was observed with Licensed Practical Nurse #2 in the dining room. Resident #141 had seat belt fastened and did not respond when greeted. Licensed Practical Nurse #2 stated Resident #141 always has the seat belt in place. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/20/2026 at 2:29 PM, Resident #141 was observed with Registered Nurse Supervisor #1 sitting in the dining room. Resident #141 had a seat belt across their upper thighs and Registered Nurse Supervisor #1 stated the seat belt is to keep Resident #141 from sliding from the wheelchair. Registered Nurse Supervisor #1 also stated Resident #141 can remove the seat belt, however Resident #141 was not able to remove the seat belt when directed to do so by Registered Nurse Supervisor #1. Review of Physician orders last reviewed 1/15/2026 contained no order for a seat belt, or directions on how the seat belt was to be used or monitored. There was no documented evidence of an evaluation of the need for restraints, and the medical necessity for use of the seat belt. Review of the comprehensive care plan revealed no documented evidence a care plan was created for use of restraints. On 01/23/2026 at 9:23 AM, the Director of Nursing was interviewed and stated restraints is applied as the last measure and is only implemented when there is an assessment and documentation by staff. The Director of Nursing also stated the facility have monthly restraints meetings before and after a restraint is initiated, and it is discussed in Quality Assurance and Performance Improvement meeting. The Director of Nursing further stated staff must monitor the resident, observed for triggers/tolerance when the restraint is implemented. The Director of Nursing stated they do not know how the facility missed Resident #141's seat belt as Resident #141 may have inherited a wheelchair with a seat belt and staff used it on the resident. The Director of Nursing stated the lack of a physician's order for Resident #141 should have been a red flag, and it was also not included on the Certified Nursing Assistant plan of care. On 01/20/2026 at 2:25 PM, Registered Nurse Supervisor #1 was interviewed and stated restraints include such items as side rails, mittens, seatbelts, and abdominal binders. Registered Nurse Supervisor #1 also stated if a restraint is in place it must be released, and the seat belt monitored, it is discussed in the restraint committee meetings if the resident needs it or it can be discontinued. Registered Nurse Supervisor #1 further stated the seat belt needs a physician order for the seat belt and could not locate an order in the electronic medical record. Registered Nurse Supervisor #1 stated the seat belt had been in place for a long time, and they could not locate a consent, assessment or any documentation related to the restraint in the electronic medical record. On 01/22/2026 at 3:20 PM, Certified Nursing Assistant #2 stated Resident #141 has had the seat belt in place for almost two years, and they are not sure why it was in place. On 01/20/2026 at 2:17 PM, Licensed Practical Nurse #2 was interviewed and stated Resident #141 is confused, needs one-person physical assist with dressing and lately needs encouragement to eat, as they yell at times and will throw their tray. Licensed Practical Nurse #2 also stated the seat belt was always in place as Resident #141 attempts to get up from the wheelchair and needs the seat belt to prevent them from getting up. On 01/20/2026 at 11:06 AM, Certified Nursing Assistant #1 was interviewed and stated when Resident #141 is placed in the wheelchair and taken to the dining area for activities put the seat belt on and once the seat belt is on Resident #141 is unable to remove and makes no attempts to remove the seat belt. Certified Nursing Assistant #1 also stated the seat belt stay in place throughout the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a copy of the discharge notice was sent to a representative of the Office of the State Long-Term Care Ombudsman. This was evident for one (1) of one (1) resident (Resident #214) reviewed for Discharge. Specifically, there was no documented evidence that a copy of Resident #214's discharge notice was sent to the Office of the State Long-Term Care Ombudsman.The findings are:The facility's policy and procedure titled Discharge Planning with a revision date of 09/2025 documented that when a resident's discharge plan has been determined, a Notice of Discharge is prepared, and a copy of the notice will be sent to the Long-Term Care Ombudsman, and a copy is retained by the facility in the resident record.Resident #214 was admitted to the facility on [DATE] with diagnosis including Kidney Failure, DM, Metabolic Encephalopathy, and borderline personality disorder.The discharge Minimum Data Set assessment dated [DATE] documented Resident #215 was cognitively intact.Resident #214's discharge and instruction summary form documented they were being discharged to the community with family.A discharge care plan dated 10/30/2025 documented Resident #214 will be discharged to the community with family members.There was no documentation in Resident #214's medical record that the Long-Term Care Ombudsman office was notified of the discharge in writing. On 01/22/2026 at 12:35 PM, Social Worker #1 was interviewed and stated that they were not present at the time of the resident's discharge. They stated that a copy of the notice should have been sent to the Ombudsman.01/22/2026 at 12:40 PM, the Director of Nursing was interviewed and stated that a copy of Resident #214's discharge notice should have been emailed to the Ombudsman. However, the Director of Nursing was not able to provide evidence that a copy has been sent. They stated during a subsequent interview at 4:00 PM that they cannot find proof that the discharge notice has been sent. 10 NYCRR 415.3		

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NAME OF PROVIDER OR SUPPLIER Haven Manor Health Care Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Gateway Boulevard Far Rockaway, NY 11691	
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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 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 failed to ensure that a comprehensive person-centered care plan for each resident was developed and implemented, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. This was evident for two (2) of 4 (four) (Residents #141 and #143) residents observed for restraints. Specifically, Residents #141 and #143 was observed on multiple occasions wearing seatbelts. There was no care plan developed for both residents to address ongoing use of restraints. Cross Reference F-tag 604: Right to be Free from Physical Restraints The findings include: The facility's policy titled Comprehensive Care Plan with a last reviewed date of 01/2026 documented that it is the facility purpose to ensure that each resident is provided with individualized, goal-directed care, which is reasonable, measurable, and based on resident needs. The policy further documented the Comprehensive Care Plan should include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs as identified in the comprehensive assessment. The objectives will be used to monitor the residents' progress and alternative interventions will be documented as needed. 1. Resident #141 was admitted to the facility with diagnoses that included Cancer, Anemia, and Schizophrenia. On 01/15/2026 at 10:10 AM, Resident #141 was observed sitting in the dining area with seat belt over the upper thigh area. On 01/15/2026 at 1:56 PM, Resident #141 was observed sitting in a wheelchair with seat belt locked across upper limbs in the dining area. On 01/20/2026 at 9:23 AM, Resident #141 was observed sitting in the dining area in a wheelchair with a seatbelt that has a button in middle for release. 01/20/2026 at 2:24 PM, Resident #141 was observed in the dining room sitting on a wheelchair with a seatbelt. Licensed Practical Nurse #2, who was present during the observation, stated that Resident #141 was always wearing a seatbelt. On 01/20/2026 at 2:29 PM, Resident #141 was observed in the dining room sitting on a wheelchair with a seatbelt across their upper thighs. Registered Nurse Supervisor #1 stated that Resident #141 wears a seatbelt to keep them from sliding from the wheelchair. A review of Resident #141's medical record revealed that a care plan was not developed to address ongoing use of restraint. On 01/22/2026 at 2:30 PM, Registered Nurse Supervisor #1 was interviewed and stated they are responsible for assessing residents and initiating care plans. They stated that the Certified Nursing Assistants placed the seatbelt for Resident #141's safety without physician's order. On 01/23/2026 at 9:23 AM, the Director of Nursing was interviewed and stated that the licensed nurse is responsible for initiating care Plans. The Director of Nursing stated that a care plan for restraint (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not developed because the staff did not report using a seatbelt for Resident #141. 2. Resident #143 had diagnoses which included Paranoid Schizophrenia and muscle spasms, and constipation. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #143 was cognitively intact, required partial to moderate assistance with most activities of daily living and mobility, used a wheelchair, had no falls since the prior assessment, and did not use physical restraints or alarms. On 01/16/2026 at 1:07 PM, Resident #143 was observed seated in a wheelchair wearing a blue colored seat belt. On 01/20/2026 at 2:46 PM, Resident #143 was observed in the day room playing dominoes with other residents, showing no signs of distress, with the seat belt on. There was no documented evidence that a comprehensive care plan had been created to address use of a seat belt for Resident #143. On 01/23/2026 at 9:57 AM, Registered Nurse #3 was interviewed and stated Resident #143 was transferred to the third floor at the end of October 2025 and has always worn a seat belt on this unit. Registered Nurse #3 also stated there are some residents who learn forward in their wheelchairs and the seat belt helps them to maintain their safety. State Surveyor observed Resident #143 with Registered Nurse #3 and when Registered Nurse #3 asked Resident #143 to remove the seat belt they stated they were not able to remove the seat belt because they were not good with their hands. Registered Nurse #3 stated if Resident #143 was not able to remove the seat belt this would be considered a restraint. Registered Nurse #3 stated they are responsible for creating care plans and a care plan should have been created for the seat belt which may have been missed. 10 NYCRR 415.11(c)(1)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a resident who was administered enteral tube feedings received the appropriate treatment and services to prevent complications. This was evident in two (2) of two (2) (Residents #10 and #12) residents reviewed for tube feeding out of 38 total sampled residents. Specifically, Residents #10 and #12's enteral tube feeding formula and water bag were not labeled with the resident's name, the date and start time of the administration. The findings include: The facility's policy and procedure titled Enteral Feedings with a last revised date of 01/2026 documented that the formula containers will be labeled with resident's name, date, rate and time container was started. 1. Resident #10 was admitted with diagnoses that included Anemia, Parkinson's Disease, Malnutrition, Gastrostomy status. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #10 had severe impairment in cognition and required total dependence of staff for all activities of daily living. The Minimum Data Set also documented that Resident #10 is on feeding tube, proportion of total calories the resident received through parenteral, or tube feeding is 51% or more; and the average fluid intake per day was 501 cubic centimeter per day or more. The Comprehensive Care Plan for feeding tubes dated 07/08/2025 documented Resident #10 was on enteral feeding related to Dysphagia; Failure to thrive, percutaneous endoscopic gastrostomy tube placement on 06/28/2025, and was at high risk for aspiration pneumonia. The facility interventions include aspiration precautions; to check feeding pump (if in use) before each feeding; and to check gastric residuals before each feeding & document amount. A physician's order dated 01/15/2026 documented: Tube Feeding - Continuous using pump kit, Formula: Peptamen 1.5, 1000 cubic centimeter/day at 50 cubic centimeter /hour, start at: 4:00 PM over 20 hours if not interrupted; Total Formula Volume: 1000 cubic centimeter. On 01/15/2026 at 10:16 AM, Resident #10 was observed with tube feeding running at 50 milliliters/hour. The enteral feeding bag was not labeled with resident's name, date, rate and the time the feeding started. On 01/16/2026 at 8:50 AM, Resident #10 was observed with tube feeding running at 50 milliliters/hour. The enteral feeding bag was not labeled with resident's name, date, rate, and the time the feeding started. 2. Resident #12 was admitted with diagnoses that included Hypertension, Malnutrition, and Adult failure to thrive. The Significant Change in Status Minimum Data Set assessment dated [DATE] documented that Resident #12 had severe impairment in cognition and required total dependence of staff for most activities of daily living. The Minimum Data Set also documented that Resident #12 was on feeding tube, proportion of total calories the resident received through parenteral, or tube feeding is 51% or more; and the average fluid intake per day was 501 cubic centimeter/day or more. The Comprehensive Care Plan for feeding tubes dated 12/08/2025 and was last updated on 01/06/2026 documented that Resident was placed on gastrostomy tube on 12/05/2025 due to refusal to eat/decreased oral intake. A Physician's order dated 01/06/2026 documented: Tube Feeding - Continuous using pump kit, Formula: TwoCal-HN 1000 milliliter at 50 milliliter /hour, start at 4:00 PM until volume infused. On 01/15/2026 at 10:30 AM, Resident #12 was observed in bed, on ongoing tube feeding. The feeding bottle was not labeled with resident's name, date, rate and time feeding was started. On 01/16/2026 at 8:53 AM, Resident #12 was observed in bed with tube feeding infusing at 50 milliliters per hour, amount left in bottle was approximately 200 milliliters. The enteral feeding bottle was not labeled with resident's name, date, rate and time container was started. On 01/22/2026 at 9:16 AM, Licensed Practical Nurse #1 was interviewed and stated that the 3:00 PM to 11:00 PM nurse hangs the feeding, and they are expected to document the start date and time when the feeding started. On 01/22/2026 at 9:23 AM, Registered Nurse Supervisor #1 was interviewed and stated that the nurses who starts the tube feeding at 4:00 PM are supposed to label and date the enteral feeding bottle and water bag. Registered Nurse Supervisor #1 stated that they usually label them when they are making rounds and (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted that the feeding bottle and irrigation were not labeled. Registered Nurse Supervisor #1 further stated that they were asked to work on the evening shift on those days because there was shortage of nurses, and they did not realize that the feeding bottles were not properly labeled. On 01/22/2026 at 2:40 PM, the Director of Nursing was interviewed and stated that resident's enteral feeding bottle must be labeled with the resident's name, date, and time as per facility protocol by the nurse who hangs and initiates the feeding. 10 NYCRR 415.12(g)(2)		

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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. Based on observation, record review, and interview, the facility did not ensure that medication and biologicals drugs were labeled in accordance with currently accepted professional principles on the Medication Cart on the 4th floor. Specifically, Residents #119 and #186's eye drops did not have the resident's name on the vial. This was evident for one (1) (4th Floor) of five (5) units reviewed for Medication Storage. The findings are: The facility's Policy titled Label/Store Drugs and biologicals dated last review January 2026 documented all medications and the biologicals must remain in original Pharmacy labeled packaging, unless administered per authorized dispensing practice. The policy further documented the required elements as applicable include the resident name if resident -specific, medication name, strength, dosage form, directions for use, prescriber name, date dispensed, expiration date, Pharmacy name and Prescription number. On 01/20/2026 at 9:08 AM, during the medication storage facility task the fourth (4th) floor medication cart was examined with Licensed Practical Nurse Number one (1). Latanoprost 0.0005% eye drop for resident number 119 and resident number 186 was observed in a dark plastic bag with label on the outside bags and both dated open 1/8/2026. There were no labels observed on the vials. Licensed Practical Nurse number one (1) stated the eye drops will expire 42 days after opening. On 01/23/2026 at 09:47 AM, a Telephone interview completed with Pharmacist from Spectrum Pharmacy refused to give full name and identify self as Pharmacist for the facility. The Pharmacist stated is responsible for labeling medications for Pharmacy. The Pharmacist stated the eye drops are labeled with the patient's name, room number, date of birth and a label is placed on the bag, the box and the bottle. Pharmacist stated if the label is not on the bottle the facility will call the Pharmacy, and the Pharmacy will resend the item new. The Pharmacist stated the facility must send pictures and describe that the label was missing. The pharmacist stated that the Pharmacist is legally required to label all medications and saw that the eye drops for the residents were last process on 1/6/2026 and stated did not get any phone call from the facility regarding the eyedrops. Pharmacists stated that they were not sure what would happen in these cases. On 01/23/2026 at 9:11 AM, The Director of Nursing stated medications must be labeled with the resident's name, the dosage, instructions and the bottle is affixed to the bottle. The Director of Nursing stated if the label is missing the nurse should report to the supervisor who in turn can call the pharmacies and or Director of Nursing and a new medication is sent or if the Pharmacist Consultant is in the building cand assist. The Director of Nursing stated Nurse do not affix labels to any medications and the nurse needs to report to the Supervisor. The Director of Nursing stated monitors by doing rounds, medication audits, and staff reporting any issues or concerns. 01/22/2026 2:53 PM Infection Control Preventionist stated it all came from the pharmacy, and the pharmacy put the labels and stated cannot label things because the facility cannot label things and do stock eye drops, and usually there is bag and bottle, and the eye drops have a bag and not sure what happened there. Infection Control Preventionist stated the nurse should make sure there is a label and if there is not, they need to reach out to the pharmacy and or let the Infection Control Preventionist Director of Nursing aware. On 01/20/2026 at 9:12 AM Licensed Practical Nurse number one (1) stated there was no label on the bottle, but the bottles are dated when opened on 1/8/2026. Licensed Practical Nurse number one (1) stated will know who the medications belong to by checking all the other eye drops to ensure each resident has their drops to make sure it is the right resident if do not see any label on the bottle. Licensed Practical Nurse number one (1) LPN gave no reason why the bottles were not labeled with the resident name and stated will make the Supervisor aware. 10 NYCRR 415.18 (d)		

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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. Based on observation, record review, and interviews, the facility failed to ensure infection control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident for one (1) of three (3)(Licensed Practical Nurse #3) nurses observed during medication administration. Specifically, Licensed Practical Nurse #3 failed to sanitize the sphygmomanometer (an equipment used to take blood pressure) and the blood pressure cuff before and after use and in between residents. The findings include: The facility's policy titled Reprocessing of Reusable Resident Medical Equipment with a last reviewed date of 01/2026 documented equipment or items in the resident environment likely to have been contaminated with infections fluids or other potentially infectious matter must be handled in a manner so as to prevent transmission of infectious agent example wearing gloves for handling soiled equipment, and properly clean and disinfect or sterilize reusable equipment. The policy further documented that blood pressure machine/cuff used by nursing, medical and rehabilitation department must be cleaned before and after using with a sanitizing cloth wipe. On 01/16/2026 at 9:14 AM, during medication administration observation on the 2nd Floor. Licensed Practical #3 was observed taking Resident #102's blood pressure without sanitizing the blood pressure cuff before and after using. On 01/16/2026 at 9:30 AM, Licensed Practical Nurse #3 used the same blood pressure cuff onto Resident #136. The Licensed Practical Nurse failed to sanitize the blood pressure cuff before and after use between each resident. On 01/16/2026 at 9:33 AM, Licensed Practical Nurse #3 was interviewed and stated they were supposed to clean and sanitize the blood pressure cuff with sanitizing wipes before and after use and between each resident to prevent infection but stated that they forgot. On 01/20/2026 at 2:48 PM, Registered Nurse Supervisor #1 was interviewed and stated they are responsible for supervising Licensed Practical Nurse #3 to ensure that they properly sanitize the reusable equipment. Registered Nurse Supervisor #1 stated the blood pressure cuff must be cleaned in-between residents and the staff should use the purple top sanitizing wipes. On 01/22/2026 at 2:47 PM, the Infection Preventionist was interviewed and stated that the blood pressure machine and its cuff must be sanitized and must wait for it to dry before using it for the next resident. On 01/23/2026 at 9:11 AM, the Director of Nursing was interviewed and stated that the blood pressure cuff must be cleaned with a purple top sanitizing wipes between residents use for infection control measures. 10 NYCRR 415.19		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interviews, the facility failed to provide a safe and comfortable environment for the staff. This was evident during physical environment observation in the laundry room on the basement and the 6th Floor nurses' station. The findings include: The facility's policy and procedure titled Maintenance Services with a reviewed date 01/2026 documented the Environmental Services Department is responsible for managing the maintenance function in the most cost-effective manner possible while maximizing the useful life of equipment, rooms, and properties while striving to provide the best service to our residents. 1. On 01/16/2026 at 9:41 AM, during observation in the laundry room at the basement, the back of washing machines #3 and #4 was rusted and the gray colored panels were loose and disconnected from the machine. 2. On 01/16/2026 at 12:19 PM, the nurses' station on the 6th Floor was observed with mismatched floor tiles, there was a brown colored substance on the wall under the desk, and the desk was chipped. On 1/23/2026 at 12:10 PM, the Maintenance Director was interviewed and stated that the tiles are old and need to be replaced. On 01/23/2026 at 12:30 PM, the Administrator was interviewed and stated they are not sure what repairs are needed. They stated the Maintenance Department makes daily rounds to see if there are any needed repairs and they also have a consultant who comes in and makes rounds in the unit. They stated there is a maintenance logbook in each unit where needed repairs are logged. 10 NYCRR 415.29		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that Minimum Data Set assessments accurately reflected the resident's status. This was evident for three (3) of 3 (three) (Residents #141, 100, and 143) reviewed for resident assessment. Specifically, 1.) Resident #141's use of restraint was not accurately documented in the Minimum Data Set assessment. 2.) Resident #100 who had a physician's order for clopidogrel (an antiplatelet drug used to prevent blood clot by preventing platelets from clumping together in the blood), was coded in the Minimum Data Set assessment as receiving anticoagulant. 3.) Resident #143's use of restraint was not accurately documented in the Minimum Data Set assessment. Cross Reference to F-tag 604: Right to be Free from Physical RestraintsThe findings include: The facility's policy titled Resident Assessment Minimum Data Set 3.0 with a last reviewed date of 01/2026 documented it is the policy of the facility to ensure a comprehensive and accurate assessment of residents. The policy stated the assessment will include direct observations, and communication with the residents, as well as communication with licensed and non-licensed direct care staff members on all shifts. 1. Resident number 141 was admitted to the facility with diagnoses that included Cancer, Anemia, and Schizophrenia. On 01/15/2026 at 10:10 AM, Resident #141 was observed sitting in the dining area with seat belt over the upper thigh area. On 01/15/2026 at 1:56 PM, Resident #141 was observed sitting in a wheelchair with seat belt locked across upper limbs in the dining area. On 01/20/2026 at 9:23 AM, Resident #141 was observed sitting in the dining area in a wheelchair with a seatbelt that has a button in middle for release. 01/20/2026 at 2:24 PM, Resident #141 was observed in the dining room sitting on a wheelchair with a seatbelt. Licensed Practical Nurse #2, who was present during the observation, stated that Resident #141 was always wearing a seatbelt. On 01/20/2026 at 2:29 PM, Resident #141 was observed in the dining room sitting on a wheelchair with a seatbelt across their upper thighs. Registered Nurse Supervisor #1 stated that Resident #141 wears a seatbelt to keep them from sliding from the wheelchair. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #141 was severely cognitively impaired. The assessment did not document the use of restraints. On 01/23/2026 at 10:24 AM, the Minimum Data Set Coordinator was interviewed and stated they do not recall seeing Resident #141 wearing a seatbelt when on a wheelchair. They stated they always see Resident #141 in bed. They stated that there was no order for Resident #141's seatbelt therefore, it cannot be coded as a restraint. 2. Resident #100 was admitted to the facility with diagnoses of Cerebrovascular Disease, Hypertension, and Hyperlipidemia. (continued on next page)		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	A physician's order with a last reviewed date of 01/15/2026 documented an order for clopidogrel 75 milligram give one tablet by oral route once daily which is an antiplatelet for Cerebrovascular disease. There was no physician's order for any anticoagulant. The Minimum Data Set, dated [DATE] documented that Resident #100 was receiving an anticoagulant. On 01/23/2026 at 10:11 AM, the Minimum Data Set Coordinator was interviewed and stated that clopidogrel is not an anticoagulant and that coding it as antiplatelet in the Minimum Data Set assessment was an error. 3. Resident #143 had diagnoses which included Paranoid Schizophrenia and muscle spasms, and constipation. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #143 was cognitively intact, required partial to moderate assistance with most activities of daily living and mobility, used a wheelchair, had no falls since the prior assessment, and did not use physical restraints or alarms. On 01/16/2026 at 1:07 PM, Resident #143 was observed seated in a wheelchair wearing a blue colored seat belt. On 01/20/2026 at 2:46 PM, Resident #143 was observed in the day room playing dominoes with other residents, showing no signs of distress, with the seat belt on. The Minimum Data Set assessment for Resident #143 did not accurately reflect the use of a seat belt. On 01/23/2026 at 9:57 AM, Registered Nurse #3 was interviewed and stated Resident #143 was transferred to the third floor at the end of October 2025 and has always worn a seat belt on this unit. Registered Nurse #3 also stated there are some residents who learn forward in their wheelchairs and the seat belt helps them to maintain their safety. Registered Nurse #3 further stated Resident #143 should have an order for seat belt use and they were not able to locate orders or an evaluation for the use of seat belts. State Surveyor observed Resident #143 with Registered Nurse #3 and when Registered Nurse #3 asked Resident #143 to remove the seat belt they stated they were not able to remove the seat belt because they were not good with their hands. Registered Nurse #3 stated if Resident #143 was not able to remove the seat belt this would be considered a restraint. On 01/23/2026 at 2:05 PM, Registered Nurse #1 who is also the Minimum Data Set Coordinator, was interviewed and stated they were unaware of Resident #143's daily seat belt use as there was no order or care plan. Registered Nurse #1 also stated they did not observe Resident #143 was wearing and a seat belt when they conducted their assessment. Registered Nurse #1 further stated that if a resident cannot remove the seat belt independently, it is considered a restraint and should be coded on the Minimum Data Set Assessments. 10 NYCRR 415.11 (b)		