STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335681	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Neck Nursing & Rehabilitation Center	134 Great East Neck Road West Babylon, NY 11704

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024 the facility did not provide each resident access to personal and medical records pertaining to themselves, upon an oral or written request, in the form and format requested by the individual. This was identified for one (Resident #222) of one resident reviewed for Dignity. Specifically, Resident #222 was readmitted to the facility from the hospital on 7/13/2024 and requested a copy of their hospital Discharge Summary, which was received by the facility upon the resident's return from the hospital. The facility did not make the requested discharge summary available to Resident #222 within the required timeframe. The finding is: The facility policy titled, Medical Record Request Policy last revised on 3/2023 documented that if an individual should request a release of medical records from the facility, the individual shall be referred to the Social Worker who shall provide the Health Insurance Portability and Accountability Act (HIPAA) authorization form. The Social Worker will review the request to determine the individual's capacity and the validity of the request. The Social Worker will forward the request with any supporting documentation to the Medical Record Clerk. The Medical Record Clerk will send the medical record request and all supporting documents to the Legal Department for final review and approval. A resident or qualified person/personal representative has the right to request access to patient information. The facility shall allow access to inspect medical records to individuals and their legal representatives within 24 hours or provide copies of medical records within 48 hours after receipt of a valid request for medical records. Resident #222 was admitted with diagnoses including Traumatic Subarachnoid Hemorrhage (brain bleed), Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #222 had intact cognition. Resident #222 was interviewed on 8/5/2024 at 3:00 PM and stated they had requested a copy of the hospital discharge summary and hospital recommendations after they were readmitted from the hospital to the facility in July 2024. Resident #222 stated they needed the discharge summary recommendation information to schedule their follow-up appointments with the specialists from the hospital. Resident #222 stated they requested the discharge summary from Social Worker #3 and were told that they (Resident #222) could request the documents directly from the hospital. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the hospital Discharge Instructions dated 7/13/2024 documented that Resident #222 needed a follow-up consultation with a Neurosurgeon in one week due to a diagnosis of Traumatic Subarachnoid Hematoma (brain bleed). Social Worker #3 was interviewed on 8/6/2024 at 11:04 AM and stated that Resident #222 had requested a copy of their hospital discharge summary for the July 2024 hospital stay. Social Worker #3 stated they gave Resident #222 a copy of the Health Insurance Portability and Accountability Act (HIPAA) authorization form and told Resident #222 that they could also obtain the requested records directly from the hospital. Social Worker #3 stated they did not follow up with Resident #222 to ascertain if the resident received the requested records. A review of Resident #222's electronic medical record revealed there was no documented evidence of the Health Insurance Portability and Accountability Act (HIPAA) authorization form present in the resident's medical record. The Medical Record Clerk was interviewed on 8/6/2024 at 12:03 PM and stated they did not receive the Health Insurance Portability and Accountability Act (HIPAA) authorization form from Resident #222. The Medical Record Clerk stated Social Worker #3 did not follow up with their department regarding Resident #222's medical record request. Resident #222 was re-interviewed on 8/7/2024 at 10:54 AM and stated they did not receive the Health Insurance Portability and Accountability Act (HIPAA) authorization form from the facility. Resident #222 stated they asked the facility staff for the hospital discharge summary for the July 2024 hospital stay numerous times and were told to request the record from the hospital. The Director of Nursing Services was interviewed on 8/7/2024 at 11:30 AM and stated that Resident #222 should not have difficulties obtaining their medical record. The Director of Nursing Services stated that Social Worker #3 should have assisted Resident #222 in obtaining the medical records. The Administrator was interviewed on 8/7/2024 at 2:39 PM and stated that Resident #222 should have been assisted by Social Worker #3 in obtaining the requested medical records. The Administrator stated that Resident #222 did not have to request their (Resident #222) medical record from the hospital. 10 NYCRR 415.3(c)(1)(iv)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00339563) initiated on [DATE] and completed on [DATE], the facility did not ensure each resident transferred to the hospital and discharged from the facility had documentation in the medical record of the attempts made by the facility to meet the needs of the resident before the resident was discharged to the hospital. This was identified for one (Resident #413) of three residents reviewed for death and the facility did not ensure each resident had documentation from a Physician of the necessity to transfer or discharge the resident. This was identified for two (Resident #413 and #414) of three residents reviewed for death. Specifically, Resident #413 suffered a cardiac arrest (occurs when the heart suddenly and unexpectedly stops pumping) in the facility and attempts of cardiopulmonary resuscitation and the use of an automated external defibrillator were not documented in the resident's medical record. Additionally, Resident #413 and Resident #414 suffered a cardiac arrest and were transferred to the hospital. There was no discharge note written by the Physician for both residents. The finding is: The facility's policy titled Cardiopulmonary Resuscitation-Emergency Response Code Blue, dated ,d+[DATE] documented that the staff responding (to Code Blue) is responsible for documenting the interventions and outcome of the emergency response in the resident's medical record. The facility's policy titled Hospital Transfers, effective ,d+[DATE], documented that when nursing staff notices a change in the resident's condition indicating medical intervention, the charge nurse/nursing supervisor shall evaluate the resident and report their findings to the attending/covering physician. The Registered Nurse will document findings and actions in the medical record using the Situation, Background, Assessment, and Recommendation (SBAR) note or progress note. In addition, the Physician/Nurse Practitioner shall document the present medical condition in the space provided on the institutional transfer form. Registered Nurse/Nursing Supervisor shall document a transfer note in the Situation, Background, Assessment, and Recommendation (SBAR) form. Resident #413 was admitted to the facility with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Depression. The [DATE] Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A Comprehensive Care Plan titled Resident Does Not Have Advanced Directives (legal documents to make provisions for future health care decisions in the event the individual is unable to make such decisions for themselves) in place, initiated on [DATE] documented to educate the resident on advanced directives and give the resident an opportunity to enact an advanced directive. A Situation, Background, Assessment, and Recommendation (SBAR) note dated [DATE] at 2:15 PM, created by Registered Nurse #3, documented Resident #413 had a cardiac arrest and respiratory arrest (no breathing). The resident was unresponsive. The resident was a full code (cardiopulmonary resuscitation can be used). Nurse Practitioner #1 was notified with an order to call Emergency Medical Services (911) and transfer the resident to the hospital. The section titled Nursing Notes in the Situation, Background, Assessment, and Recommendation (SBAR) form was blank. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation in the medical record that cardiopulmonary resuscitation was initiated for Resident #413. Additionally, there was no documentation from the Physician regarding the resident's transfer/discharge or disposition after the resident was transferred to the hospital. Registered Nurse #3 was interviewed on [DATE] at 11:57 AM and stated they were no longer employed at the facility and did not recall Resident #413. Registered Nurse #3 stated if the resident was a full code, the facility staff would have initiated cardiopulmonary resuscitation and documented it in the resident's medical record. Assistant Director of Nursing #1, the Nurse Educator, was interviewed on [DATE] at 12:34 PM and stated there should absolutely be notes written detailing what actions were taken by facility staff during a full code. If staff initiated cardiopulmonary resuscitation and used an automatic external defibrillator, this should be documented. Licensed Practical Nurse #2, the medication nurse, was interviewed on [DATE] at 1:37 PM and stated on [DATE], they found Resident #413 unresponsive and called Code Blue; a lot of staff responded, and they (Licensed Practical Nurse #2) initiated the cardiopulmonary resuscitation. Staff also attempted to use the automatic external defibrillator but there was no shock advised. Cardiopulmonary resuscitation was continued until the emergency medical services arrived and then they took over. The emergency medical services transported the resident to the hospital. Licensed Practical Nurse #2 stated they did not write a progress note because the nursing supervisor usually writes the notes. The Registered Nurse is responsible for completing the Situation, Background, Assessment, and Recommendation (SBAR) form which should include all interventions that were applied before the resident's transfer to the hospital. If a resident is pronounced dead at the hospital, the nursing supervisor gets a call from the hospital and should then write a progress note to document the resident's disposition. Nurse Practitioner #1 was interviewed on [DATE] at 8:15 AM and stated they did not write a transfer/discharge note for Resident #413 because they (Nurse Practioner #1) were not there at the time the Emergency Response Code was called. Nurse Practitioner #1 stated they would not write a note if they were not present. Physician #3, the attending Physician, was interviewed on [DATE] at 10:30 AM and stated they did not write a discharge summary or note in Resident #413's medical record because they did not see the resident and were not involved with the Emergency Response Code. Physician #3 stated the emergency room called them and told them that the resident expired in the emergency room . If they were present during the Emergency Response Code, they would have written a note. Physician #3 stated that a discharge note is more important when a resident is being discharged to the community. The facility has a protocol for when a resident is being discharged home, I am not sure about a discharge to the hospital. The Director of Nursing Services was interviewed on [DATE] at 12:10 PM and stated they did not know if the facility protocol requires the doctor to write a note when a resident is transferred to the hospital. The Medical Director was interviewed on [DATE] at 8:30 AM and stated that doctors should write a note when a resident is transferred or discharged to the hospital. Any resident who gets discharged from the facility must have a discharge summary. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #414 was admitted with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Hypertension. The [DATE] Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A Comprehensive Care Plan titled Resident Does Not Have Advanced Directives (legal documents to make provisions for future health care decisions in the event the individual is unable to make such decisions for themselves) in Place, initiated [DATE] documented to educate the resident on advanced directives and give the resident an opportunity to enact an advanced directive. A nursing progress note for Resident #414 dated [DATE] at 9:55 AM documented the resident was found unresponsive to verbal and tactile stimuli, no pulse, and no respiratory movement. The resident was a full code. Code Blue was initiated at 8:40 AM and 911 was called. An automated external defibrillator was applied, and shock was advised one time. Emergency medical technicians arrived at the facility at approximately 8:51 AM. The resident left the facility via ambulance at 9:30 AM. A nursing progress note dated [DATE] at 10:56 AM documented writer called the hospital and spoke with a Physician who stated the resident arrived at the hospital in cardiac arrest and was pronounced dead at 9:52 AM. There was no documentation in Resident #414's medical record from the resident's physician regarding the resident's transfer/discharge. Physician #1, Resident #414's attending physician, was interviewed on [DATE] at 12:02 PM and stated they were away in February 2024 when Resident #414 expired. Physician #2 was covering their residents. Physician #1 stated there should be a Physician discharge note in place that includes the reason the resident went to the hospital and the outcome. The Director of Nursing Services was interviewed on [DATE] at 12:10 PM and stated they did not know if the facility protocol requires the doctor to write a note when a resident is transferred to the hospital. Physician #2 was interviewed on [DATE] at 12:36 PM and stated they usually write discharge summaries for residents who are under their care. Resident #414 was not their resident and perhaps Physician #1 missed documenting the discharge summary since they (Physician #1) were away. The Medical Director was interviewed on [DATE] at 8:30 AM and stated that doctors should write a note when a resident is transferred or discharged to the hospital. Any resident who gets discharged from the facility must have a discharge summary. 10 NYCRR 415.3(i)(1)(ii)(a)(b)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00333364) initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain grooming, personal, and oral hygiene. This was identified for one (Resident #5) of five residents reviewed for pressure ulcers and one (Resident #132) of two residents reviewed for activities of daily living. Specifically, 1) on 8/7/2024, Resident #5's fingernails on both hands were observed to be long and dirty, with a brown substance under the nails and 2) on 8/2/2024, Resident #132's right palm was observed with dark crusty flakes and a musty odor was detected coming from their right hand. The findings are: The facility's policy titled Activities of Daily Living, effective 11/2018, documented the facility will provide the necessary care and services based on the comprehensive assessment of a resident and consistent with the resident's needs, choices, and preferences, to maintain or improve, the resident's ability to perform activities of daily living and to prevent decline unless it is unavoidable. Activities of daily living include hygiene, such as bathing, dressing, grooming, and oral care; individualized care plans are based on an accurate assessment of the resident's self-performance and the amount and type of support being provided. When a resident refuses to comply with activities of daily living, nursing staff shall solicit assistance from other disciplines to determine the cause for refusal, offer options and alternatives, and document refusal in the medical record. 1) Resident #5 was admitted with diagnoses including Schizophrenia, Parkinson's Disease, and Diabetes Mellitus. The 7/10/2024 significant change Minimum Data Set assessment documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident had mood concerns, including feeling down, depressed, and feeling bad about themselves nearly every day. The resident was dependent on staff for personal hygiene tasks. A comprehensive care plan titled Activities of Daily Living Self-Care Performance Deficit Related to Aggressive Behaviors, Limited Range of Motion, initiated 5/24/2024, documented the resident was dependent on staff for Personal Hygiene needs and will remain clean, neat, dressed appropriately, and free of body odor and that. The Kardex (nursing care instructions for Certified Nursing Assistants), as of 8/7/2024, documented that the resident was dependent on staff for personal hygiene needs and to observe the resident for proper hand hygiene. Under the Personal Hygiene heading, oral care was the only care area listed. Resident #5 was observed in bed on 8/7/2024 at 9:47 AM. The resident's fingernails on both hands were excessively long and dirty, with a brown substance under the nails. The resident stated they would like their nails trimmed. During an observation on 8/7/2024 at 9:53 AM with Certified Nursing Assistant #2 and Registered Nurse #7 (acting unit charge nurse) Resident #5's fingernails were observed to be long and dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nursing Assistant #2, who was the resident's regularly assigned Certified Nursing Assistant, was interviewed on 8/7/2024 at 9:54 AM. Certified Nursing Assistant #2 stated the nurses were supposed to cut Resident #5's fingernails because the resident was Diabetic. Certified Nursing Assistant #2 stated the nurses see the resident every day, which is why they (Certified Nursing Assistant #2) did not report the resident's long fingernails to the nurse. Registered Nurse #7 was interviewed on 8/7/2024 at 9:55 AM and stated the nurses were responsible for cutting Resident #5 nails because the resident was Diabetic and any nurse could have cut the resident's fingernails. Registered Nurse #8, the medication nurse, was interviewed on 8/7/2024 at 10:03 AM and stated they administered the morning medications to Resident #5 and did not notice the resident's fingernails. Registered Nurse #8 then proceeded to check the resident's fingernails and stated the fingernails needed to be trimmed and cleaned. Registered Nurse #8 asked the resident if they wanted their fingernails trimmed and the resident responded yes. Assistant Director of Nursing Services #1, the nurse educator, was interviewed on 8/7/2024 at 11:06 AM and stated the staff members have to ask the resident if they want the fingernails cut; sometimes the resident refuses and gets aggressive. Assistant Director of Nursing Services #1 stated the refusals should be documented in the medical record. Assistant Director of Nursing Services #1 stated the resident's fingernails should be clean and neatly trimmed. A review of nursing progress notes from 8/1/2024 to 8/7/2024 revealed no documentation that Resident #5 refused to have their fingernails trimmed. The Director of Nursing Services was interviewed on 8/7/2024 at 12:54 PM and stated they had never heard that Resident #5 refused care. The Director of Nursing Services stated if the resident was refusing care, there should have been a care plan in place, and the staff should have determined how to maintain the resident's hygiene including nail care. 28670 2) Resident #132 was admitted with diagnoses that included Coronary Artery Disease, Peripheral Vascular Disease, and Non-Alzheimer's Dementia. A Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 00, which indicated severely impaired cognition. The resident had no behavioral symptoms, had impairment on both sides of upper and lower extremities, and was totally dependent on staff for all aspects of Activities of Daily Living. A Comprehensive Care Plan dated 9/13/2023 and last revised on 6/7/2024 documented the resident had a deficit in Activities of Daily Living, cognitive Impairment, Dementia, limited mobility, and limited range of motion. Interventions included for staff to maintain personal hygiene including combing the resident's hair, shaving, washing, and drying the resident's face and hands. The Kardex (nursing care instructions for the Certified Nursing Assistants), from 8/1/2024 to 8/10/2024 documented to observe the resident for proper hand hygiene. Under the Personal Hygiene heading, oral care was the only care listed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 8/1/2024 at 3:09 PM the resident was observed out of bed in their room resting in a Geri chair. The Therapy Carrot was observed on the resident's chest and not appropriately positioned in the resident's right hand. During an observation on 8/2/2024 at 3:15 PM, with the Wound Care Registered Nurse (acting Nurse Manager) and the Director of Rehabilitation Services, the resident's right hand Therapy Carrot was observed resting on the resident chest. The palm of the resident's right hand was observed with dark crusty flakes and a musty odor was detected from the resident's right hands. The Director of Rehabilitation Services stated that the Therapy Carrot should be appropriately placed in the resident's palm at all times to prevent contractures. The Director of Rehabilitation Services stated if the Certified Nursing Assistants were having difficulty placing the Therapy Carrot in the resident's hand, they should have reported the concern to the charge nurse or them (Director of Rehabilitation Services). The 7:00 AM - 3:00 PM assigned Certified Nursing Assistant #11 was interviewed on 8/5/2024 at 1:51 PM and stated they were having difficulty opening the resident's right hand but did not report it to the charge nurse. Certified Nursing Assistant #11 stated they asked another Certified Nursing Assistant (could not recall the name) to assist them with opening the resident's hand and the other Certified Nursing Assistant also could not open the resident's hand. Certified Nursing Assistant #11 stated they washed the outside of the resident's hand but were unable to wash the palm of the resident's right hand. The Director of Nursing Services was interviewed on 8/8/2024 at 12:59 PM and stated that after caring for the resident the Certified Nursing Assistant was responsible for ensuring that the Therapy Carrot was appropriately in the resident's right hand and that the nurses should monitor to ensure that the device was in place. The Director of Nursing Services stated if Certified Nursing Assistant #11 was having difficulty opening the resident's right hand, they (Certified Nursing Assistant #11) should have asked the nurse for assistance. The Director of Nursing Services stated that the resident's right hand should not have been left dirty. 10 NYCRR 415.12(a)(3)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00333364) initiated on 8/1/2024 and completed on 8/8/2024, the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to prevent further decrease of range of motion. This was identified for one (Resident #132) of three residents reviewed for positioning and mobility. Specifically, Resident #132 had a physician's order for right hand Therapy Carrot (a nonsurgical device that helps position contracted hands) to be worn at all times. On 8/1/2024 and 8/2/2024 the resident was observed not wearing the right-hand Therapy Carrot as ordered by the Physician. The finding is: The facility's policy for Application and Management of Splint/Brace/Immobilizer dated 11/2017 documented the nursing staff is responsible for following the wearing schedule for the device and must complete a skin inspection every shift at a minimum unless ordered otherwise. Resident #132 was admitted with diagnoses that included Coronary Artery Disease, Peripheral Vascular Disease, and Non-Alzheimer's Dementia. A Quarterly Minimum Data Set assessment dated [DATE] documented the Brief Interview for Mental Status score was 00, which indicated the resident had severely impaired cognition. The resident had no behavioral symptoms, had impairment on both sides of upper and lower extremities, and was totally dependent on staff for all aspects of Activities of Daily Living. A physician's note dated 3/14/2024 documented Splint/Brace: Therapy Carrot to be applied to the right hand at all times by the Certified Nursing Assistant. The nurse is to spot-check for the placement of the Therapy Carrot every shift. A Comprehensive Care Plan for Activities of Daily Living dated 9/13/2023 and revised on 6/7/2024 documented interventions that included right-hand Therapy Carrot at all times to be applied by the Certified Nursing Assistant. Remove every shift for skin checks and hygiene. The Kardex (nursing care instructions for the Certified Nursing Assistants) from 7/1/2024 to 8/10/2024 documented Therapy Carrot to be applied to the right hand at all times by the Certified Nursing Assistant. The nurse is to spot-check for the placement of a Therapy Carrot every shift. Resident #132 was observed out of bed to a Geri-Lounge chair on 8/1/2024 at 3:09 PM. The resident's right hand was observed in a closed-fisted position and the resident was not able to open their right hand on command. The Therapy Carrot was observed not in the resident hand but was resting on top of the resident's torso. A subsequent observation was made on 8/2/2024 at 2:54 PM. The Therapy Carrot was observed on the resident's chest and not appropriately positioned in the resident's right hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #5, who was assigned to Resident #132, was interviewed on 8/2/2024 at 3:04 PM. Licensed Practical Nurse #5 stated that the Therapy Carrot is used for the resident to keep the fingernails from pressing into the resident's palm. Licensed Practical Nurse #5 stated that Certified Nursing Assistant #11 was responsible for ensuring the Therapy Carrot was appropriately placed in the resident's right hand. During an observation on 8/2/2024 at 3:15 PM, with the Wound Care Registered Nurse (acting Nurse Manager) and the Director of Rehabilitation Services, the resident's right hand Therapy Carrot was observed resting on the resident chest. The palm of the resident's right hand was observed with dark crusty flakes and a musty odor was detected from the resident's right hands. The Director of Rehabilitation Services stated that the Therapy Carrot should be appropriately placed in the resident's palm at all times to prevent contractures. The Director of Rehabilitation Services stated if the Certified Nursing Assistants were having difficulty placing the Therapy Carrot in the resident's hand, they should have reported the concern to the charge nurse or them (Director of Rehabilitation Services). The Wound Care Registered Nurse was interviewed on 8/2/2024 at 3:20 PM and stated that they supervised the unit on 8/1/2024 and 8/2/2024. The Wound Care Registered Nurse stated they were not sure how to properly position the Therapy Carrot and would have to follow up with the Director of Rehabilitation Services to learn to properly position the Therapy Carrot in the resident's right hand. The 7:00 AM - 3:00 PM assigned Certified Nursing Assistant #11 was interviewed on 8/5/2024 at 1:51 PM. Certified Nursing Assistant #11 stated they were assigned to Resident #132 on 8/1/2024 and 8/2/2024. Certified Nursing Assistant #11 stated that the resident should use the Therapy Carrot device in the right hand at all times. Certified Nursing Assistant #11 stated that they were having difficulty opening the resident's right hand to insert the Therapy Carrot but did not report it to the charge nurse. The Director of Nursing Services was interviewed on 8/8/2024 at 12:59 PM and stated that after caring for the resident the Certified Nursing Assistant was responsible for ensuring that the Therapy Carrot was appropriately positioned in the resident's right hand at all times and that the nurses should monitor to ensure that the device was in place. 10 NYCRR 415.12(e)(2)

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	335681	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Neck Nursing & Rehabilitation Center	134 Great East Neck Road West Babylon, NY 11704

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and staff interviews during the Recertification Survey initiated on 8/1/2024 and completed on 8/8/2024 the facility did not ensure that outside professional services were furnished timely. This was identified for one (Resident #222) of one resident reviewed for Dignity and for one (Resident #150) of five residents reviewed for Unnecessary Medications. Specifically, 1) Resident #222 was readmitted from the hospital on 7/13/2024 with a diagnosis of Traumatic Subarachnoid Hematoma (brain bleed). The hospital discharging physician recommended a follow-up with a Neurosurgeon within a week. The recommended consult was not completed as of 8/7/2024 when it was brought to the facility's attention by the Surveyor. 2) Resident #150 was admitted to the facility in November 2023. A physician's order dated 11/14/2023 documented that the resident was to be seen by the Psychiatrist for the Initial Evaluation. The Psychiatry consult/evaluation was not completed until 8/6/2024 when it was brought to the facility's attention by the State Surveyor. The findings are: The facility's policy titled Medical and Dental Consults last revised on 5/2023, documented that the facility will arrange services of qualified professional personnel to render specific medical services. An order for a consultation shall be placed in the electronic medical record (EMR) with the reason for consultation. For new admissions or readmissions, the Registered Nurse Supervisor will reconcile all hospital-scheduled outpatient appointments with the resident's attending physician and log in to the Hospital Consult Reconciliation Form. The attending physician will determine the need for further follow-up (agree, disagree, or use an in-house consultant). The Consult Coordinator will schedule the outpatient consults and arrange for transportation and escort if indicated. 1) Resident #222 was admitted with diagnoses including Traumatic Subarachnoid Hemorrhage (brain bleed), Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #222 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #222 received anticoagulant (blood thinner) medications. A Comprehensive Care Plan (CCP) titled, Anticoagulant Therapy dated 7/18/2024, documented the resident was at risk for bleeding, The interventions included reinforcing safety measures to prevent injury/bleeding and to administer medications ordered by the Physician. A review of the hospital Discharge Instructions dated 7/13/2024 documented that Resident #222 needed a follow-up consultation with a Neurosurgeon in one week due to a diagnosis of Traumatic Subarachnoid Hematoma (brain bleed). A review of the electronic medical record indicated no physician's order for a Neurosurgery consultation. A review of the electronic medical record revealed Resident #222 did not have a follow-up appointment or consult with the Neurosurgeon as recommended by the hospital. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #4 was interviewed on 8/5/2024 at 12:02 PM and stated they were one of the nurses who assisted in readmitting Resident #222 on 7/13/2024. Licensed Practical Nurse #4 stated they (Licensed Practical Nurse #4) only reviewed the medication list on the discharge summary from the hospital. Licensed Practical Nurse #4 stated it was Registered Nurse Supervisor #10 who reviewed the consult instructions for Resident #222. The Unit Clerk was interviewed on 8/5/2024 at 2:06 PM and stated they made appointments for any consultations needed for the residents after they received the consultation form from the nurses. The Unit Clerk stated they did not receive a consultation form to schedule a follow-up appointment with the Neurosurgeon for Resident #222. Registered Nurse #10, the nursing supervisor, was interviewed on 8/5/2024 at 2:21 PM and stated they admitted Resident #222 from the hospital on 7/13/2024; however, they did not see any recommendations from the hospital for a follow-up consult with a Neurosurgeon. Registered Nurse #10 stated they must have missed the recommendations documented on the discharge instructions from the hospital. Physician #2 was interviewed on 8/6/2024 at 10:30 AM and stated a Neurosurgery consult should have been completed for Resident #22 as per the hospital's recommendations. Physician #2 stated the facility was responsible for arranging for the consultation. The Director of Nursing Services was interviewed on 8/7/2024 at 11:30 AM and stated the nurses should have thoroughly checked the hospital discharge instructions for Resident #222 and ensured that the consultation form was completed and provided to the Unit Clerk to set up an appointment with the Neurologist as per the hospital discharge summary recommendations. 17732 2) Resident #150 was admitted to the facility on [DATE] with diagnoses including Atherosclerotic Heart Disease, Hypertension, and Major Depressive Disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognitive skills for daily decision-making. The Minimum Data Set assessment documented that the resident had been receiving an antidepressant medication for the last 7 days. The Physician's Order dated 11/11/2023, obtained by Licensed Practical Nurse #1, documented for the resident to receive Remeron (an antidepressant medication) 7.5 milligrams tablet- give 1 tablet by mouth at bedtime for Major Depressive Disorder. (This order was discontinued on 12/4/2023.) A review of the Psychiatry Consultation Form dated 11/11/2023, initiated by Licensed Practical Nurse #1, revealed that the Consultation Form was never completed by the Psychiatrist. The Physician's Order dated 11/14/2023, obtained by Registered Nurse #1, documented to obtain a Psychiatry Consult Initial Evaluation and follow-up. The Physician's Order dated 12/15/2023 last revised on 3/22/2024 documented to administer Mirtazapine (Remeron) 7.5 milligram - give one tablet by mouth at bedtime for Depression. (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Psychiatry Consultation Form dated 7/25/2024, initiated by the Registered Nurse Consultant (Registered Nurse #2), revealed that the Consultation Form was never completed by the Psychiatrist. Registered Nurse #1 was interviewed on 8/6/2024 at 3:05 PM and stated after they (Registered Nurse #1) receive a Physician's Order for a Psychiatric Consultation, they are supposed to initiate a Psychiatry Consultation Form in the resident's Electronic Medical Record, print the resident's face sheet, and place the resident's face sheet in the Psychiatrist's folder which is kept at the reception desk in the lobby of the facility. Registered Nurse #1 stated when the Psychiatrist comes to the facility, they (Psychiatrist) take the face sheets of the residents needing Psychiatric Consultations out of the folder and go see them. Registered Nurse #1 stated that the Psychiatrist comes weekly to the facility, and they (Registered Nurse #1) did not know why Resident #150 was never seen by the Psychiatrist. Registered Nurse #1 stated they may not have opened another Psychiatry Consultation Form after obtaining the Physician's Order on 11/14/2023 because Licensed Practical Nurse #1 had already initiated one on 11/11/2023. Licensed Practical Nurse #1 was interviewed on 8/7/2024 at 9:35 AM and stated that when a resident is admitted to the facility on psychiatric medications, the Physician automatically orders a Psychiatric consultation request. Licensed Practical Nurse #1 stated that Resident #150's Physician must have given a verbal order for the resident to have a Psychiatric Consult, but they (Licensed Practical Nurse #1) must have forgotten to enter the Physician's Order into the computer on 11/11/2023 when the resident was admitted to the facility. The Psychiatrist was interviewed on 8/7/2024 at 10:45 AM and stated they usually do not see a newly admitted resident unless ordered to by the Physician. The Psychiatrist stated that either a Nurse calls them (Psychiatrist) or the resident's face sheet is left at the reception desk for them (Psychiatrist) when a resident needs a Psychiatric Consultation. The Psychiatrist stated that once they see a resident, they (Psychiatrist) will keep track of when the resident needs to be seen for a follow-up. The Psychiatrist stated they would not know when a Psychiatric Consultation Form was initiated unless the resident's face sheet was placed in their folder at the reception desk. The Psychiatrist stated they were never notified to see the resident for their initial Psychiatric Consultation. The Director of Nursing Services was interviewed on 8/7/2024 at 10:50 AM and acknowledged that Resident #15's initial Psychiatric Consultation was never done. The Director of Nursing Services stated that a Psychiatry Consultation should be completed as per the physician's orders. 10 NYCRR 415.26(e)(1)(i-iv)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, interviews, and record review during the recertification Survey and Abbreviated Survey (NY 00332930) initiated on 8/01/2024 and completed on 8/08/2024, the facility did not provide a safe, functional, sanitary, and comfortable environment. This was identified for two (Resident #131, Resident #5) of three residents reviewed for Environment. Specifically, the toilets that were mounted to the walls in Resident #131 and Resident #5's bathroom did not have appropriate support and reinforcement. The toilets were observed with wooden blocks underneath the toilet to provide support and reinforcement. The findings are: The facility policy titled Room and Unit Maintenance dated 9/2021 documented to maintain rooms and units within the facility in a manner that provides a safe, homelike environment. -Resident #131 was admitted with diagnoses of Morbid Obesity, Type Two Diabetes Mellitus, and Chronic Obstructive Pulmonary Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status score was 15, indicating the resident had intact cognition. Resident #131 had no impairment in functional ability for toileting needs and utilized a wheelchair or walker for mobility. The Comprehensive Care Plan for Activities of Daily Living dated 7/25/2024 documented the resident required partial/moderate assistance with toileting. On 8/06/2024 at 11:15 AM Resident #131 was observed in a wheelchair coming out of their room. The resident's room had a bathroom with a toilet mounted to the wall. The toilet was supported by wooden blocks. Resident #131 was interviewed on 8/01/2024 at 10:50 AM and stated the wooden blocks holding up the toilet bowl had been there for months. -Resident #5 was admitted with diagnoses of Chronic Obstructive Pulmonary Disease, Type Two Diabetes Mellitus, and Schizophrenia. The Quarterly Minimum Data Set assessment, dated 7/10/2024, documented the resident had a Brief Interview for Mental Status score of 14, indicating the resident had intact cognition. Resident #5 was dependent and required 2 persons' assistance for toileting needs. During an observation on 8/01/2024 at 11:04 AM, Resident #5 was observed in their bed resting with the television on. The resident's room had a bathroom with a toilet mounted to the wall. The toilet was supported by wooden blocks. Resident #5 was interviewed on 8/01/2024 at 11:04 AM and was unaware of the wooden blocks underneath the toilet. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Housekeeper #1 was interviewed on 8/06/2024 at 11:29 AM and stated they did not know why Resident #131, and Resident #5's bathrooms have wooden blocks supporting the toilet. Housekeeper #1 stated they cleaned around the wooden blocks but did not move the blocks. The Director of Facility Management was interviewed on 8/07/2024 at 12:01 PM and stated the wooden blocks were placed under the toilet to provide support, due to the resident's weight. The Director of Facility Management stated they had ordered a bracket (wall-mounted toilet support) for properly supporting the toilet, but they were unsure why the brackets were not yet installed. The Director of Facility Management further stated that using the wooden blocks to support a toilet was unsafe for the residents, posed infection control issues, and was not a home-like environment. The Administrator was interviewed on 8/07/2024 at 2:38 PM and stated the wooden blocks were used to support the toilets. The Administrator stated as far as they knew, all wooden blocks were removed after the toilets were repaired. The Administrator stated using the wooden blocks in the resident's bathroom could pose an infection control issue, was unsafe for the residents, and was not a home-like environment. 10 NYCRR 415.29