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	11/19/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, during the Recertification Survey initiated on 09/14/2025 and completed on 09/18/2025, the facility did not maintain equipment for respiratory care, such as oxygen equipment, in accordance with federal, state, and local laws and regulations. This was identified for two (2) (Resident #200 and Resident#142) of five (5) residents reviewed for Respiratory Care. Specifically, during an observation on 09/14/2025, the oxygen tubing for Resident #142's and Resident #200's oxygen concentrator and nebulizer machines were not changed since 08/25/2025.The findings are:The facility's policy titled Care of Nebulizer Equipment, last reviewed on 09/05/2025, documented to administer treatment via nebulizer as ordered by the physician and to maintain the cleanliness of the equipment. Change the tubing, mouthpiece, and reservoir every seven (7) days, and label.The facility ?s policy titled Care of Oxygen Equipment, last reviewed on 09/05/2025, documented that to provide oxygen therapy in accordance with medical orders and aseptic principles. Licensed Nurses are responsible for implementing oxygen delivery orders as prescribed by the physician. Oxygen tubing, nasal cannulas, and masks will be changed weekly and labeled; more frequently if soiled by the 11:00 PM -07:00 AM staff.1) Resident #200 was admitted with diagnoses that include Heart Failure, Chronic Obstructive Pulmonary Disease, and Chronic Respiratory Failure. The Quarterly Minimum Data Set, dated [DATE] documented a Brief Interview of Mental Status score of 11, indicating the resident had moderately impaired cognition. The Minimum Data Set documented that the resident received oxygen therapy during the assessment lookback period.The physician's orders dated 08/09/2025 documented Oxygen therapy 2 liters per minute via nasal cannula or mask, continuously, every shift for shortness of breath. Change the Oxygen tubing every week during the 11:00 PM -7:00 AM shift on Sundays. Clean the Oxygen filter every week during the 11:00 PM-7:00 AM shift on Sundays. Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) 0.083%, inhale orally via nebulizer every 4 hours as needed for shortness of breath or wheezing. There were no physicians' orders for changing the nebulizer tubing per facility policy.The care plan for oxygen dated 08/19/2025 documented the resident received Oxygen Therapy related to Congestive Heart Failure. The interventions documented that the oxygen concentrator required cleaning weekly.The care plan for nebulizer dated 08/19/2025 documented that the resident had Chronic Obstructive Pulmonary Disease related to exposure to industrial pollutants and Respiratory Failure. The care plan documented administering medications as ordered, monitoring for side effects, and assessing effectiveness. During an observation on 09/14/2025 at 10:00 AM, Resident #200 was in bed receiving oxygen therapy. The oxygen tubing was dated 08/25/2025. There was a nebulizer machine on top of the resident's nightstand with the nebulizer tubing with a date of 08/25/2024.A review of the Treatment Administration Record for September 2025 indicated the last Oxygen tubing change was completed on 09/07/2025. There was no documented evidence of routine tubing changes for the nebulizer machine. During an observation on 09/16/2025 at 2:00 PM, Resident #200 was in bed receiving oxygen therapy. The oxygen tubing and nebulizer tubing were dated 09/14/2025.2) Resident #142 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Failure, and Hypertensive Heart Disease. The Quarterly Minimum Data Set assessment dated [DATE] (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented a Brief Interview for Mental Status score of nine (9), which indicated the resident had moderately impaired cognition. The Quarterly Minimum Data Set assessment documented the resident did not receive oxygen therapy during the assessment lookback period.The physician's orders, renewed on 09/05/2025, documented Oxygen Therapy 2-3 liters per minute via nasal cannula or mask every 4 hours as needed. Ipratropium Bromide Solution 0.02 %, 2.5, inhale orally via nebulizer every six (6) hours for Chronic Obstructive Pulmonary Disease.During an observation on 09/14/2025 at 10:30 AM, Resident#142 was observed in their bed watching the television. The resident was not utilizing the oxygen therapy at the time. The oxygen concentrator was behind the resident's wheelchair, and a nebulizer machine was on the nightstand. The oxygen therapy tubing and the nebulizer tubing were both dated 08/25/2025.During an observation on 09/16/2025 at 10:45 AM, Resident #142 was seated in their wheelchair in their room. The nebulizer machine was on the nightstand, and the nebulizer tubing was dated 09/14/2025.A review of the Treatment Administration Records for August and September 2025 indicated no documented evidence of routine tubing changes for the nebulizer machine or the oxygen concentrator for Resident #142.During an interview on 09/18/2925 at 10:20 AM, Licensed Practical Nurse #1 stated the nurses who work during the 11:00 PM to 7:00 AM shift were supposed to replace the oxygen and nebulizer tubing and clean the filters weekly on every Sunday. Licensed Practical Nurse#1 stated they did not realize the oxygen and nebulizer tubing were dated 08/25/2025. Licensed Practical Nurse #1 stated that changing the oxygen and nebulizer tubing prevents the spread of infections.During an interview on 09/18/2025 at 10:38 AM, Registered Nursing Supervisor #3 stated oxygen and nebulizer tubing are supposed to be replaced every Sunday during the 11:00 PM to 7:00 AM shift. Registered Nursing Supervisor #3 stated there should be a physician's order for the oxygen and nebulizer tubing to be changed weekly.During an interview on 09/18/2025 at 10:52 AM, the Director of Nursing Services stated that all physicians' orders for oxygen and nebulizer treatments need to have directions for tubing change every Sunday during the 11:00 PM to 7:00 AM shift. The floor nurses are responsible for changing the oxygen and nebulizer tubing every week to prevent the spread of infection.10 NYCRR 415.12(k)(6)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/14/2025 and completed on 09/18/2025, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was identified during the initial Kitchen tour and during the Dining Task observation of the lunch meal on 09/14/2025. Specifically, 1) several frozen food items in the walk-in freezer were stored undated and with open packaging; and 2) the facility did not monitor the temperature of cold food items. The findings are: A facility policy and procedure titled Food Storage/Dating Procedures, effective date May 2023, documented that food is stored in compliance with applicable Federal, State, and local regulations regarding sanitary storage conditions. Perishable storage: all food items are dated upon receiving. All food is re-dated once opened with the open date. All food not in the original container is stored in non-absorbent containers, covered, labeled, and dated. A facility policy and procedure titled Storeroom/Food Delivery and Dating Procedures, effective date July 2022, documented the purpose to ensure that all food items delivered are monitored by dietary with proper rotating and dating, and stored in a clean environment. All items received are dated and used first-in and first-out basis. All items needing refrigeration will be dated upon delivery, including but not limited to milk, juice, dairy, frozen, and prepared bulk food items. A facility policy and procedure titled Cold Food Temperature Monitoring of Meal, effective date May 2022, documented that food temperatures are monitored during the food service process and foods are served at acceptable temperatures. The Supervisor will monitor and record the temperature of cold tray items prior to [the food] leaving the kitchen. The Dietary Aide will bring food trucks and food on ice/or a cooler bag up to the assigned unit. Once reaching the dayroom, they will take the temperature of cold food prior to serving to ensure that the food is at the proper serving temperature, less than 41 degrees Fahrenheit. Food will immediately be served after confirmation of proper food temperature. 1) During the initial tour of the Kitchen with the Food Service Supervisor on 09/14/2025 at 08:45 AM, a three (3)-door roll-in refrigerator was observed with three (3) trays of pudding, not dated. A walk-in refrigerator (identified as #1 dairy) was observed with five (5) sandwiches, three (3) cups of cottage cheese, a tray of pudding, and an open bag of shredded mozzarella cheese, not dated. An open bag of shredded cheddar cheese was also observed without a label or a date. A walk-in refrigerator combination (identified as refrigerator #2/freezer #3) freezer section was observed with a box of cheese omelets with the inner plastic bag open, and the product was exposed to the air. During an interview on 09/14/2025 at 09:00 AM, the Food Service Supervisor stated that all food should be labeled and dated, and the food should not be exposed to open air, as it will reduce the food quality. 2) During the Dining Task observation of lunch meal service in Unit one (1) [NAME] day room on 09/14/2025 at 11:55 AM, the cold food items, including milk, juice, yogurt, and desserts, were observed in a container with ice. The individual resident trays were set up on a mobile rack, with a material outer cover. The sandwiches were observed on the individual resident trays without ice or other cooling mechanism. At 12:16 PM, Dietary Aide #1 was observed taking and recording the temperatures of the hot food items. Dietary Aide #1 was immediately interviewed and stated that they only take the temperature of the hot food items and that there was no cold food to be checked. On 09/14/2025 at 12:34 PM, the first lunch tray was being prepared to be served with hot food. A turkey sandwich was observed on the tray. Dietary Aide #1 measured the temperature of the turkey sandwich, which registered 82 degrees Fahrenheit. On 09/14/2025 at 12:35 PM, a chicken salad sandwich from another tray measured 72 degrees Fahrenheit. A review of the Temperature Log, dated 9/14/2025, for Unit one (1) [NAME] and for Unit two (2) [NAME] had no documented/recorded temperature readings for the puree dessert, regular dessert, cold beverage, juice, and sandwiches for breakfast and lunch. During an interview on (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	09/14/2025 at 12:40 PM, the Food Service Director stated that the sandwich temperatures were not appropriate, as they were outside of the safe serving zone (there is an increased risk for bacterial growth when the food is outside of the safe temperature zone). During an interview on 09/18/2025 at 02:19 PM, the Administrator stated they were aware of the requirement to monitor food temperatures and to label and date items stored in the refrigerator and/or freezer. They further stated that they were not aware that it was not being done and should have been. 10 NYCRR 415.14(h)

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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 record review and interviews during the Recertification and Abbreviated Survey (2569298), initiated on 09/14/2025 and completed on 09/18/2025, the facility did not ensure that each resident had the right to make choices about aspects of their life in the facility that are significant to them. This was identified for one (Resident #78) of four Residents reviewed for Abuse. Specifically, Resident #78 wanted a shower on their scheduled shower day; however, Certified Nursing Assistant #6 gave a bed bath against the resident's wishes.The finding is:The facility's policy titled Resident's Rights and Organizational Ethics, dated 11/2016 and last reviewed 09/05/2025, documented that the facility shall ensure that all residents are afforded the right to a dignified existence, self-determination, respect, full recognition of their individuality, consideration, and courtesy in treatment and care of personal needs. All employees shall be in-serviced on Residents' Rights upon hire and annually thereafter. Each resident shall have the right to exercise his or her rights as a Resident of the facility and as a citizen or resident of the United States.The facility's policy titled Bed Bath, dated 08/2020, and reviewed on 09/05/2025, documented that all residents shall receive a bath between scheduled showers or tub/whirlpool bath unless otherwise requested by the resident.The facility's policy tilted Activities of Daily Living dated 11/2018 and reviewed on 09/05/2025, 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's unavoidable.Resident #78 was admitted with diagnoses that included Multiple Sclerosis, Paraplegia (the partial or complete loss of motor and sensory function in the lower half of the body, including both legs), and Acute Respiratory Failure with Hypoxia (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide, leading to low levels of oxygen in the blood). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating Resident #78 was cognitively intact. The Minimum Data Set documented Resident #78 was dependent on two or more staff members for bed mobility, including rolling left and right, where the helper did all the effort for the resident to complete the activity.The Comprehensive Care Plan titled The resident has Activities for Daily Living, Self-Care Performance Deficit related to Multiple Sclerosis, dated 06/09/2025, documented interventions that included the resident required the assistance of two (2) Staff members for rolling from side to side.The Certified Nursing Assistant documentation report for July 2025, documented Resident #78 received a shower/bath on 07/22/2025 by Certified Nursing Assistant #6. It further documented that Resident #78 was dependent on two (2) Staff members for bathing, including washing, rinsing, and drying self; the assistance of two (2) or more helpers is required for the resident to complete the activity. The resident required two-person assistance for bed mobility for rolling side to side.During an observation and interview on 09/15/2025 at 09:03 AM, Resident #78 was in bed eating breakfast, and stated that Certified Nursing Assistant #6 came into their room on shower day on 07/22/2025 during the day shift and said they would give them a bed bath and not a shower. Resident #78 stated they refused the bed bath and told Certified Nursing Assistant #6 that they wanted a shower. Certified Nursing Assistant continued to give them a bed bath by themselves, even though they said no and it was not their wish. They stated Certified Nursing Assistant #6 instructed them to turn to their side, and they informed Certified Nursing Assistant #6 that they could not turn on their side. Certified Nursing Assistant #6 roughly turned the resident on their side to wash their back. Resident #7 stated they reported the incident to the Activities Aide #1 later that day, and told the Assistant Director of Nursing Services, they did not want Certified Nursing Assistant #6 to take care of them.During an interview on 09/17/2025 at 08:37 AM, Certified Nursing Assistant #6 stated they were assigned once to Resident #78's unit on 07/22/2025, and only took (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care of Resident #78 once. Certified Nursing Assistant #6 stated they were not familiar with Resident #78's care. Certified Nursing Assistant #6 stated they asked the unit staff to help them with the resident's shower, but everyone was busy. Certified Nursing Assistant #6 stated Resident #78 refused the bed bath, but they gave the resident a bed bath anyway, because they did not want to get written up. The resident was not happy and said no, as they did not want a bed bath. Certified Nursing Assistant #6 stated they gave Resident #78 a bed bath by themselves; however, they were not rough during care. During an interview on 09/18/2025 at 09:59 AM, Social Worker #1 stated they met with Resident #78 in the presence of the Assistant Director of Nursing Services on 07/22/2025. Resident #78 stated Certified Nursing Assistant #6 was rough during care, and when they requested a shower, Certified Nursing Assistant #6 gave them a bed bath instead of the shower. The resident complained that, despite their refusal, Certified Nursing Assistant #6 did not listen to them and continued to give a bed bath. Social Worker #1 stated they offered emotional support to the resident and referred the resident for a psychiatric evaluation.During an interview on 09/18/2025 at 11:33 AM, the Assistant Director of Nursing Services stated Resident #78 told them they were provided a bed bath against their wishes by Certified Nursing Assistant #6 instead of a shower. Resident #78 did not want Certified Nursing Assistant #6 to care for them anymore. The resident was very upset and complained that Certified Nursing Assistant #6 did what they wanted to do and not what the resident wanted. The Assistant Director of Nursing Services stated physical assessment was conducted for Resident #78, and there were no injuries. Local law enforcement was notified, and Certified Nursing Assistant #6 was removed from the resident's assignment. The Assistant Director of Nursing Services stated that Resident #78 required the assistance of two staff members for bed mobility, bed bath, and showers. The Assistant Director of Nursing Services stated Certified Nursing Assistant #6 should have asked for assistance from other staff to provide resident care and should have provided a shower instead of the bed bath as per the resident's preferences. During an interview on 09/18/2025 at 01:29 PM, the Director of Nursing Services stated Certified Nursing Assistant #6 did not follow the resident's plan of care and also disregarded the resident's preferences. Resident #78 required two-person assistance with showers, bed baths, and bed mobility.10 NYCRR 415.5(b)(1-3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the Recertification Survey initiated on 09/14/2025 and completed 09/18/2025, the facility did not ensure that all residents received treatment and care in accordance with professional standards of practice. This was identified for one (1) (Resident #225) of two (2) residents reviewed for Skin Conditions. Specifically, Resident #225 was identified with two skin tears to the left forearm on 09/11/2025. Registered Nurse #5 applied the treatment to the skin tears; however, there was no documented evidence of the skin assessment and physician orders for the wound care treatment until 09/16/2025.The finding is:The Facility policy titled Non-Pressure Related Skin Ulcer/Wounds, reviewed on 09/05/2025, documented [the facility will] conduct assessments of wounds and document the clinical basis or underlying conditions contributing to the ulceration. The policy for non-pressure ulcers will emphasize prevention, assessment, treatment, documentation, education, and quality improvement. The [facility will] differentiate the ulcer type, provide appropriate interventions and treatments, and provide high-quality care that promotes the best possible outcomes for residents with non-pressure ulcers.Resident #225 was admitted with diagnoses including Cerebral Infarction, Peripheral Vascular Disease, and Malignant Neoplasm (cancer) of the Colon. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of 99, indicating the resident had severely impaired cognition. The Minimum Data Set assessment documented the resident was at risk for pressure ulcers/injuries.The comprehensive care plan for potential for skin breakdown dated 03/18/2025 documented that the resident had thin and fragile skin. Interventions included fragile skin precautions: Gentle handling during care and offloading both heels with pillows when in bed. The care plan was updated on 09/15/2025, including completing skin risk assessment as per facility policy and providing protective/preventative skin care as per protocol.During an observation on 09/14/2025 at 09:53 AM, Resident #225 was in their bed and had two 4-inch by 4-inch border gauzes applied to their left forearm. The gauze was dated 09/11/2025 and was signed by Registered Nurse #5.A review of the resident's medical record indicated no evidence of a physician's order, treatment administration to the left forearm, the nature of the injury, or an assessment of the resident's change in skin condition.A physician's order initiated on 09/16/2025 documented to cleanse the resident's left forearm wound with Dermaklenz (wound cleanser), apply Xeroform (petroleum base dressing) to the wound bed, and cover with dry protective dressing, every day and as needed during the day shift.During an interview on 09/16/2025 at 11:15 AM, Registered Nurse #5 stated they worked on 09/11/2025 from 7:00 AM to 7:00 PM and they were assigned to Resident #225. Registered Nurse #5 stated they observed the resident's left forearm with two open areas. Registered Nurse #5 stated they notified Wound Care Nurse #1 as soon as they saw the resident's arm on 09/11/2025. Wound Care Nurse #1 directed them to apply Xeroform dressing and cover the open areas with the border gauze. Registered Nurse #5 stated they did not notify the Physician and did not enter the physician's order or their assessment in the electronic medical record because they thought Wound Care Nurse #1 would assess the resident.During an interview on 09/18/2025 at 07:40 AM, Wound Care Nurse #1 stated they did not remember that Registered Nurse #5 had notified them of the resident's forearm skin tears on 09/11/2025. Wound Care Nurse #1 stated the resident already had other skin tears on the bilateral legs due to the fragile skin. Wound Care Nurse #1 stated they were notified of Resident #225's left forearm skin tears on 09/14/2025 by Licensed Practical Nurse #1. Wound Care Nurse #1 stated they saw the resident on 09/14/2025. The resident did not have a dressing in place on their forearm, and the area had dried scabbing. Wound Care Nurse #1 stated they did not write a progress note or notify the attending Physician because the scabs looked dry and healed. Wound Care Nurse #1 stated that on 09/16/2025, the dried scab opened again, and that is when they notified the attending Physician. Wound Care Nurse #1 stated Registered Nurse #5 should have called the attending Physician on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/11/2025 to obtain a physician's order.During an interview on 09/18/2025 at 10:45 AM, Registered Nurse Supervisor #3 stated they worked on 09/11/2025 during the 7:00 AM to 7:00 PM shift. Registered Nurse Supervisor #3 stated they were not notified of the resident's left forearm skin tears. Registered Nurse Supervisor #3 stated that a wound treatment required a physician's order. Registered Nurse Supervisor #3 stated that if nursing staff notice any skin changes, the nurse must do a skin assessment, notify the Supervisor, and the Physician.During an interview on 09/18/2025 at 11:01 AM, the Director of Nursing Services stated that the nurses are not allowed to apply a wound treatment without a physician's order. The Director of Nursing Services stated the nurse should have notified the Nursing Supervisor, the Physician, and the Wound Care Nurse to ensure the resident received the correct treatment.10 NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification and Abbreviated Survey (# 2569298) initiated on 09/14/2025 to 09/18/2025, the facility did not ensure each resident received adequate supervision and assistance devices to prevent Accidents. This was identified for one (1) (Resident #78) of five (5) residents reviewed for Accidents. Specifically, Resident #78 was assessed to require two-person assistance for bath/shower and bed mobility as per their plan of care. Certified Nursing Assistant #6 provided a bed bath to Resident #78 by themselves, without assistance from another staff member.The finding is:The facility policy titled Activities of Daily Living, dated 11/2018 and reviewed 09/05/2025, documented that Individualized care plans are based on an accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident.The facility policy titled Care Planning Process, dated 07/2022, documented that the purpose of the Care Plan is to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well-being.Resident #78 was admitted with diagnoses that included Multiple Sclerosis, Paraplegia (the partial or complete loss of motor and sensory function in the lower half of the body, including both legs), and Acute Respiratory Failure with Hypoxia (a condition where the lungs are unable to adequately exchange oxygen and carbon dioxide, leading to low levels of oxygen in the blood). The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating Resident #78 was cognitively intact. The Minimum Data Set documented Resident #78 was dependent on two or more staff members for bed mobility, including rolling left and rolling right, where the helper did all the effort for the resident to complete the activity.The Comprehensive Care Plan titled The resident has Activities for Daily Living, Self-Care Performance Deficit related to Multiple Sclerosis, dated 06/09/2025, documented interventions that included the resident was dependent on two (2) staff members for rolling from side to side.The Certified Nursing Assistant documentation report for July 2025, documented Resident #78 received a shower/bath on 07/22/2025 by Certified Nursing Assistant #6. It further documented that Resident #78 was dependent on two (2) Staff members for bathing, including washing, rinsing, and drying self; the assistance of two (2) or more helpers is required for the resident to complete the activity. The resident required two-person assistance for bed mobility for rolling side to side.An Accident/Incident Report dated 07/22/2025 documented that Resident #78 reported to the Recreation Aid that Certified Nursing Assistant #6 was rough with them during a bed bath, causing discomfort while turning. A full body assessment was performed by the Assistant Director of Nursing Services; psychological consult was ordered. Certified Nursing Assistant was suspended pending the investigation.The Summary of the Accident/Incident Report dated 07/22/2025 documented that, based on the investigation, there was insufficient evidence to substantiate the allegation of physical abuse or neglect.A review of the written statement from Certified Nursing Assistant #6 dated 07/22/2025, documented they provided a bed bath to Resident #78 because no one assisted them.During an observation and interview on 09/15/2025 at 09:03 AM, Resident #78 was in bed eating breakfast, and stated that Certified Nursing Assistant #6 came into their room on shower day on 07/22/2025 during the day shift and said they would give them a bed bath and not a shower. Resident #78 stated they refused the bed bath and told Certified Nursing Assistant #6 that they wanted a shower. Certified Nursing Assistant continued to give them a bed bath by themselves, even though they said no and it was not their wish. They stated Certified Nursing Assistant #6 instructed them to turn to their side, and they informed Certified Nursing Assistant #6 that they could not turn on their side. Certified Nursing Assistant #6 roughly turned the resident on their side to wash their back. Resident #7 stated they reported the incident to the Activities Aide #1 later that day, and told the Assistant Director of Nursing Services, they did not want Certified Nursing (continued on next page)

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	335681	A. Building B. Wing	11/19/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant #6 to take care of them.During an interview on 09/17/2025 at 08:37 AM, Certified Nursing Assistant #6 stated they were assigned once to Resident #78's unit on 07/22/2025 and only took care of Resident #78 once. Certified Nursing Assistant #6 stated they were not familiar with Resident #78's care. Certified Nursing Assistant #6 stated they asked the unit staff to help them with the resident's shower, but everyone was busy. Certified Nursing Assistant #6 stated Resident #78 refused the bed bath, but they gave the resident a bed bath anyway, because they did not want to get written up. The resident was not happy and said no, as they did not want a bed bath. Certified Nursing Assistant #6 stated they gave Resident #78 a bed bath by themselves; however, they were not rough during care. During an interview on 09/17/2025 at 10:14 AM, Registered Nurse #4 stated Resident #78 preferred showers in the morning. The resident required the assistance of two staff members to complete showers or a bed bath. Registered Nurse #4 stated they could not recall any incident related to Resident #78 on 7/22/2025. Registered Nurse #4 stated they did not know that Certified Nursing Assistant #6 provided a bed bath against the resident's wishes, instead of a shower, and did not seek assistance from other staff members. Registered Nurse #4 stated that if they knew that the resident was refusing the bed bath, they would have spoken to the resident and would have instructed Certified Nursing Assistant #6 to shower the resident. Certified Nursing Assistant #6 should have reviewed the resident's Kardex for instructions related to the assistance needed for showers or bed baths for Resident #78.During an interview on 09/18/2025 at 09:03 AM, Recreation Aide #1 stated they went to Resident #78's room on 7/22/2025 to provide 1:1 recreation therapy, and the resident complained that Certified Nursing Assistant #6 was rough with them and gave them a bed bath when they refused. Recreation Aide #1 reported the incident to their supervisor, who then reported to the Assistant Director of Nursing Services.During an interview on 09/18/2025 with Certified Nursing Assistant #7 at 09:44 AM, Certified Nursing Assistant #8 at 09:53 AM, Certified Nursing Assistant #9 at 10:17 AM, and Certified Nursing Assistant #3 at 11:05 AM, all stated that Certified Nursing Assistant #6 did not request them to assist with Resident #78's bed bath or shower on 7/22/2025.During an interview on 09/18/2025 at 09:53 AM, Certified Nursing Assistant #8 stated that Certified Nursing Assistant #6 requested assistance with Resident #78's shower; however, they could not assist as they (Certified Nursing Assistant #8) were covering the day room at that time and were not allowed to leave the residents in the day room unattended. Certified Nursing Assistant #8 instructed Certified Nursing Assistant #6 to ask other staff for assistance. Resident #78 required a two-person assist for showers and bed mobility.During an interview on 09/18/2025 at 09:59 AM, Social Worker #1 stated they met with Resident #78 in presence of the Assistant Director of Nursing Services on 07/22/2025. Resident #78 stated Certified Nursing Assistant #6 was rough during care, and when they requested a shower, Certified Nursing Assistant #6 gave them a bed bath instead of the shower. The resident complained that, despite their refusal, Certified Nursing Assistant #6 did not listen to them and continued to give a bed bath. Social Worker #1 stated they offered emotional support to the resident and referred the resident for a psychiatric evaluation.During an interview on 09/18/2025 at 11:33 AM, the Assistant Director of Nursing Services stated Resident #78 told them they were provided a bed bath against their wishes by Certified Nursing Assistant #6 instead of a shower. Resident #78 did not want Certified Nursing Assistant #6 to care for them anymore. The resident was very upset and complained that Certified Nursing Assistant #6 did what they wanted to do and not what the resident wanted. The Assistant Director of Nursing Services stated physical assessment was conducted for Resident #78, and there were no injuries. Local law enforcement was notified, and Certified Nursing Assistant #6 was removed from the resident's assignment. The Assistant Director of Nursing Services stated that Resident #78 required the assistance of two staff members for bed mobility, bed bath, and showers. The Assistant Director of Nursing Services stated Certified Nursing Assistant #6 should have asked for assistance from other staff to provide resident care and should have provided a shower instead of the bed bath as per the resident's preferences. During an interview on 09/18/2025 at 01:29 PM, the Director of Nursing Services stated Certified (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing Assistant #6 did not follow the resident's plan of care and also disregarded the resident's preferences. Resident #78 required two-person assistance with showers, bed baths, and bed mobility.10NYCRR 415.12(h)(2)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, record review, and interviews during the Recertification Survey initiated on 09/14/2025 and completed on 09/18/2025, the facility did not ensure that nurse staff posting data was posted on a daily basis at the beginning of each shift in a prominent place readily accessible to residents and visitors. Specifically, the facility entrance lobby was observed on 09/14/2025 at 09:00 AM with the Daily Staff Posting dated 09/12/2025. There were no Daily Staff Postings for 09/13/2025. The finding is:During an observation on 09/14/2025 at 09:00 AM, a Daily Staff Posting dated 09/12/2025 was observed near the facility reception area. During an interview on 09/14/2025 at 01:29 PM, the Registered Nurse Supervisor #3 stated they were responsible for posting the Daily Staff Posting sheet at the front desk reception area. Registered Nurse # 3 stated that they did not work on 09/13/2025 and stated there was no excuse why the posting for actual staff was not posted for 09/13/2025.During an interview on 09/18/2025 at 02:37 PM, the Director of Nursing stated the Registered Nurse Supervisors were responsible for ensuring the Daily Staff Posting, which included the number of licensed and unlicensed staff, was posted daily. The Director of Nursing Service stated they were unable to explain why the Daily Staff Posting from 09/12/2025 was still posted on 09/14/2025.10 NYCRR415.13

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 09/14/2025 and completed on 09/18/2025, the facility did not ensure that the attending Physician acted upon a consultant Pharmacist's drug regimen review recommendation regarding the use of a as-needed (PRN) psychotropic medication for one (1) (Resident #12) of five (5) residents reviewed for unnecessary medications. Specifically, the consultant Pharmacist recommended to consider having a stop date for Xanax ([NAME]-anxiety) medication that was ordered as needed (PRN) basis by the resident's Physician. A decision to agree or disagree to the recommendation was not documented by the Physician. The physician orders did not document a stop date on physician orders and continued prescribing Xanax on an as needed basis.The finding is:Resident #12 was admitted with diagnoses including Insomnia (difficulty falling asleep), Chronic Obstructive Pulmonary Disease (COPD), and anxiety disorder. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The resident had no behaviors and was on anti-anxiety medications.The physician orders reviewed from July 2025 to September 2025 included Xanax Tablet 0.25 MG (Alprazolam)- Give 1 tablet by mouth every 12 hours as needed for Anxiety. The order did not have a stop date. The Pharmacist's review dated 07/07/2025 documented No stop order for Xanax. The Physician did not agree or disagree and documented on the Pharmacist's review sheet psychiatry consult.During an interview on 09/18/2025 at 10:21 AM, the Physician stated they don't want to make Xanax a standing order because the resident has Chronic Obstructive Pulmonary Disease (COPD). The resident requires Xanax on an as-needed basis, and a stop date should have been documented.During an interview on 09/18/2025 at 12:41 PM, the Director of Nursing Services stated that the pharmacy review was given to them to be reviewed by the Physician, and it was the Physician's responsibility to address the Pharmacist's recommendations. During an interview on 09/18/2025 at 01:10 pm Medical Director stated that anytime an as-needed (PRN) antipsychotic or anti-anxiety medication is ordered, a stop date should be documented. The medication should be evaluated after the stop date to assess if the resident continues to need the medication.10 NYCRR 415.18(c)(2)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey on 09/14/2025 and completed on 09/18/2025, the facility did not ensure call bells were within reach for each resident at their bedside. This was identified for one (Resident #201) of one resident reviewed for call systems. Specifically, on multiple occasions, the call bell was not within Resident #201's reach while in bed. The finding is:The facility's policy titled Call Light, last reviewed 09/05/2025, documented every call light shall be attached to the resident's bed within easy reach of the resident.Resident #201 was admitted with diagnoses including Ogilvie syndrome (acute dilatation of the colon in the absence of any mechanical obstruction in severely ill patients), Intellectual Disabilities, and a history of Falls. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set documented that the resident required substantial/maximal assistance for transferring to the chair from the bed, with the helper doing more than half the effort. The Minimum Data Set documented the resident required substantial/maximal assistance for walking 10 feet, with the helper doing more than half the effort.A Care Plan titled Risk for Falls, dated 08/22/2025, documented intervention that included ensuring the resident's call light is within reach and encouraging the resident to use the call bell for assistance as needed. The resident needs a prompt response to all requests for assistance.During an observation on 09/14/2025 at 10:07 AM, Resident #201 was seen sleeping in bed with the call bell rolled up and placed on the night table out of reach of the resident. The resident was sleeping and was not interviewed at this time.During a second observation on 09/15/2025 at 09:07 AM, the call bell was seen rolled up and placed on the night table out of reach of the resident. Resident #201 was seen sitting up in bed, just finishing their breakfast. During an interview on 09/15/2025 at 09:08 AM, Resident #201 stated that the call bell is always on the night table and was not within their reach. They stated they were not sure why the staff put the call bell on the night table. During an observation on 09/15/2025 at 09:21 AM, the call bell was rolled up on the night table. During an interview on 09/15/2025 at 09:27 AM, Certified Nursing Assistant #4 stated they have worked here for one month, and they are a float Certified Nursing Assistant. The call bell should be left in reach of the resident. They stated the call bell was on the resident's bed when they delivered the morning meal tray, and they were not sure who came in and moved the call bell. The call should be within reach of each resident; this resident could not reach the night table on their own. During an interview on 09/18/2025 at 11:45 AM, the Assistant Director of Nursing stated the call bell should be within reach of each resident. They stated they were made aware recently that the call bell was being thrown on the floor by the resident and was out of reach. This is a new behavior they have not noticed before with this resident. The call bell should have been placed within reach of the resident and not curled up on the night table out of reach; they were not sure who rolled the call bell up and placed it on the night table. During an interview on 09/18/2025 at 02:17 PM, the Director of Nursing stated the call bell should be clipped on the bed or within reach of the resident. All staff are responsible for ensuring the call bell is accessible to the resident.10 NYCRR 415.29