STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335694	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Health Care Facility L L C	801 Gazzola Blvd East Patchogue, NY 11772

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and interviews the facility did not ensure drugs and biologicals used in the facility must be labeled and stored in accordance with currently accepted professional principles. This was identified for six (6) (medication carts on Unit A high side, Unit B low and high side, Unit C high side, and Unit D high and low side) of six (6) medication carts reviewed during the Medication Storage Task. Specifically, the medication carts were observed with unidentified loose medication tablets and a hearing screening device stored without a container. The carts were soiled with debris and dried liquid medication residue. The findings are: The Medication/Treatment Labeling and Storage Policy dated 07/2025 documented medications/treatments are stored under proper conditions of sanitation, temperature, light, moisture and ventilation. The policy documented medication/treatment carts are to be kept clean, organized, restocked, and fully equipped. Only drugs/treatments and equipment for preparing and administering drugs/treatments should be stored in a medication cart, medication cabinet, controlled substances cabinet, and medication refrigerator or treatment carts. During an observation of the Unit A high side medication cart on 03/04/2026 at 07:17 AM, in the presence of Licensed Practical Nurse #6, the second drawer was observed with three unidentified loose medication tablets. Licensed Practical Nurse #6 was immediately interviewed and stated all nurses are responsible for cleaning the medication carts. Licensed Practical Nurse #6 stated they try to clean the medication cart at the end of their shift. During an observation of the Unit B low side medication cart on 03/04/2026 at 07:30 AM, in the presence of Licensed Practical Nurse #7, the second drawer had four unidentified loose medication tablets. The cart was soiled with debris from the packaging of the blister packs. Licensed Practical Nurse #7 was immediately interviewed and stated there should not be any loose medications and debris in the medication carts. During an observation of the Unit B high side medication cart on 03/04/2026 at 07:37 AM, in the presence of Registered Nurse #1, the first drawer of the medication cart had hearing screening device stored without a container. The second drawer of the medication cart had seven unidentified loose medication tablets. Registered Nurse #1 was immediately interviewed and stated non-medication items and loose medications should not be in the medication carts. Registered Nurse #1 stated they did not realize there were loose medications in the medication cart. Registered Nurse #1 stated the hearing screening device had been in the drawer and they meant to remove it but forgot. Registered Nurse #1 stated it is important to make sure the medication carts do not have non medication items stored for infection control and safety. During an observation of the Unit C high side medication cart on 03/04/2026 at 07:43 AM, in the presence of Licensed Practical Nurse #8, the first drawer of the medication cart had an unidentified medication in a souffle medication cup. The second drawer had dried residue of liquid medications that were stored in the cart. Licensed Practical Nurse #8 was immediately interviewed and stated after they prepared the medication in the souffle cup, they got busy with another resident and temporarily stored the medication in the first drawer. Licensed Practical Nurse #8 stated they tried to immediately clean the residue in the second drawer when the medication spilled, and they never got a chance to thoroughly clean the medication cart. During an (continued on next page)

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

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observation of the Unit D high side medication cart on 03/04/2026 at 07:51 AM, in the presence of Licensed Practical Nurse #9, the first drawer of the medication cart had three unidentified medication tablets. The second drawer had 22 unidentified loose medications and a substantial amount of debris from the packaging of the blister packs. Licensed Practical Nurse #9 was immediately interviewed and stated they did not know there were loose medications in the drawers. During an observation of the Unit D low side medication cart on 03/04/2026 at 08:04 AM, in the presence of Licensed Practical Nurse #10, the first drawer of the medication cart had four rolls of surgical tapes. Licensed Practical Nurse #10 was immediately interviewed and stated due to infection control, the medication carts should not store surgical tapes used for wound care treatments. During an interview on 03/04/2026 at 12:17 PM, the Director of Nursing Services stated the medication carts must be cleaned by the nurses. The Director of Nursing Services stated nurses must clean any liquid medication spills immediately, and if they need help, they should call the housekeeper for assistance. The Director of Nursing Services stated nurses should ensure there are no loose pills in the medication carts, and if there are any loose medications, they should dispose of them appropriately. The Director of Nursing Services stated nurses are not allowed to pre-pour medications; and non-medication items should not be stored in the medication carts. NYCRR 415.18(e)(1-4)

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility did not ensure that each resident had the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. This was identified for two (2) (Resident #55 and Resident #123) of four (4) residents reviewed for Accident Hazards. Specifically, Resident #55 and Resident #123 were observed on 02/26/2026 and on 02/27/2026 with an inhaler at their bedside. There was no documented evidence that Resident #55 and Resident #123 were assessed by the interdisciplinary team to determine that it was safe for the residents to exercise their right to self-administer. Additionally, there were no physician orders for Resident #55 and Resident #123 to self-administer medications. The findings are:The facility policy titled Self Administration of Medications last revised 11/2021, documented continued approval of the self-administration of medication by the resident is dependent on the resident's compliance with physician orders and the facility procedures. The medication shall be stored in a locked drawer or locked compartment under proper temperature conditions.-Resident #55 was admitted with diagnoses that included type 2 diabetes mellitus (the body's inability to use insulin properly resulting in high blood sugar), chronic obstructive pulmonary disease (lung disease that causes obstructed airflow and breathing difficulty), and depression. The Quarterly Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. A nursing self-medication administration data collection tool dated 10/27/2025 was in progress and was not completed. A physician's order dated 02/18/2026 documented Albuterol Sulfate inhalation aerosol solution, 108 micrograms per activity, 2 puffs inhaled orally every 6 hours as needed for chronic obstructive pulmonary disease. The physician's order did not indicate the resident may self-administer the medication. A Comprehensive Care Plan for decision making dated 02/18/2026 documented Resident #55 had some difficulty making decisions in new situations only. Interventions included medications to be administered by nurse per resident preference. During an observation and interview on 02/26/2026 at 11:38 AM, Resident #55 was in bed watching television. An albuterol inhaler was noted on their overbed table. Resident #55 stated they use the inhaler themselves, as needed. Resident #55 stated they keep the inhaler at the bedside, and the nurses are aware the resident has the inhaler in the room and are self-administering the inhaler medication.During an observation on 02/27/2026 at 1:32 PM, Resident #55 was seen in bed sleeping with the albuterol inhaler on their overbed table.During an interview on 03/02/2026 at 11:21AM, Licensed Practical Nurse Unit Coordinator #1 stated there was no physician's order for Resident #55 to self-administer their medications. Licensed Practical Nurse Unit Coordinator #1 stated the resident had a physician's order to self-administer their medications in the past, but the resident went to the hospital, and the order was not regenerated upon their return. Licensed Practical Nurse Unit Coordinator #1 stated the Social Worker should have initiated the self-administration evaluation and then the Physician should have given the order. -Resident #123 was admitted with diagnoses that included chronic obstructive pulmonary disease (lung disease that causes obstructed airflow and breathing difficulty), acute and chronic respiratory failure with hypoxia (a combination of long-term low blood oxygen exacerbated by a sudden, severe drop in oxygen levels), and hypertension (high blood pressure). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, indicating Resident #123 was cognitively intact. A physician's order dated 05/25/2025 documented Albuterol Sulfate inhalation aerosol solution, 108 micrograms per activity, 2 puffs inhaled orally every 6 hours as needed for shortness of breath. The physician's order did not indicate the resident may self-administer the medication. A nursing self-medication administration data collection tool dated 09/23/2025 was in progress and was not completed. A Comprehensive Care Plan last revised 12/29/2025 documented Resident #123 had some difficulty making decisions in new (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	situations only and the resident preferred medications to be left at the bedside for the resident to self-administer and then store in the medication cart. Interventions included nurses to monitor for adherence to medication time frame.During an observation and interview on 02/26/2026 at 11:18 AM, Resident #123 was in a wheelchair sitting by their bedside. An albuterol inhaler was noted on the overbed table. Resident #123 stated they use the inhaler themselves, as needed. During an observation on 02/27/2026 at 1:30 PM, Resident #123 was not in their room, and the albuterol inhaler was noted on the overbed table.During an interview on 03/02/2026 at 11:21 AM, Licensed Practical Nurse Unit Coordinator #1 stated Resident #123 was evaluated to self-administer medications. Licensed Practical Nurse Unit Coordinator #1 stated Resident #123 did not have a physician's order for self-administration of medications and there should be a physician's order. During an interview on 03/03/2026 at 7:17 AM, the Director of Nursing Services stated when a resident wants to self-administer medications an assessment should be completed by the Social Worker and the Nurse. The Director of Nursing Services stated the nurse should contact the Physician to obtain a physician's order. The Director of Nursing Services stated the interdisciplinary team should confirm that the residents has a locked drawer to store the medication and nursing staff are expected ensure the resident used the locked drawer. 10 NYCRR 415.3(f)(1)(vi)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility did not ensure that it established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This was identified for two (2) (Resident #55 and Resident #171) of ten (10) Residents reviewed for Infection Control. Specifically, 1) Resident #55 had a physician's order for Enhanced Barrier Precautions and Certified Nursing Assistant #1 was observed providing high contact activities such as dressing the resident, transferring the resident to a chair, and then making the resident's bed, without wearing a gown as required ; 2) Licensed Practical Nurse #2 was observed performing a finger stick blood glucose check on Resident #171 and subsequently cleaned the shared glucometer with a 70% alcohol wipe instead of utilizing an antimicrobial disinfectant as per the manufacturer's instructions.The findings are:1) The facility policy titled Disease Specific Isolation/Precautions last revied 12/19/2024, documented barrier precautions are employed when performing the following high-contact resident care activities dressing, bathing or showering and transferring. Enhanced barrier precautions are used in conjunction with standard precautions and expand the use of personal protective equipment to donning (put on) of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (bacteria or germs that develop resistance to multiple antimicrobial drugs) to staff hands and clothing.Resident #55 was admitted with diagnoses that included type 2 diabetes mellitus (the body's inability to use insulin properly resulting in high blood sugar), chronic obstructive pulmonary disease (lung disease that causes obstructed airflow and breathing difficulty), and depression. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. The Quarterly Minimum Data Set assessment documented Resident #55 required partial to moderate assistance for lower body dressing and supervision or touching assistance to transfer from the bed to the chair.The Certified Nursing Instructions for March 2026 documented Enhanced Barrier Precautions for safety.The physician's order dated 02/18/2026 documented Silvadene external cream (topical wound care cream) 1%, apply to sacrum topical every day for pressure ulcer, cleanse with normal saline pat dry apply thin later followed by bordered gauze.The physician's order dated 02/19/2026 documented Enhanced Barrier Precautions.An enhanced barrier precaution signage on Resident #55's shared room door documented that providers must wear gowns and gloves for dressing, bathing, showering, transferring, changing linens and providing hygiene care.During an observation on 02/26/2026 at 11:05 AM, Certified Nursing Assistant #1 was observed at the bedside assisting Resident #55 with getting dressed, transferring the resident to a chair, and then making the resident's bed. Certified Nursing Assistant #1 had gloves and a mask on; however, they were not wearing a gown while providing care to Resident #55.During an interview on 02/26/2026 at 11:08 AM, Certified Nursing Assistant #1 stated they should have put on a gown when providing care to Resident #55, but they forgot. During an interview on 03/02/2026 at 11:17 AM, Licensed Practical Nurse Unit Coordinator #1 stated Resident #55 is on Enhanced Barrier Precautions because they have a sacral wound and all staff should follow the instructions as per the enhanced barrier precaution signage that is posted on the resident's room door. Licensed Practical Nurse Unit Coordinator #1 stated personal protective equipment supplies are readily available outside the resident's room.During an interview on 03/03/2026 at 7:14 AM, the Director of Nursing Services all staff should use gowns and gloves to provide high contact activities for a resident on enhanced barrier precautions.2) The facility policy titled Even Care Glucose Monitoring dated 01/30/2020 documented glucometers are cleaned and disinfected with an approved disinfectant after each use.The blood glucose meter manufacturer's instruction manual last revised 03/2024 instructed cleaning and disinfecting the device between each patient. The meter is validated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to withstand a cleaning and disinfection cycle of ten times per day for an average period of three years. The manual listed the products that were approved to clean the device and the 70% alcohol was not on the approved list.Resident #171 was admitted with diagnoses that included type 2 diabetes mellitus (the body's inability to use insulin properly resulting in high blood sugar), gout (inflammatory form of arthritis caused by levels of uric acid crystalizing in the joints), and hypertension (high blood pressure). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10, indicating Resident #171 had moderate cognitive impairment.A physician's order dated 07/03/2025, documented Humalog Kwik pen subcutaneous solution pen injector, 100 units per milliliter, inject as per sliding scale before meals and at bedtime for diabetes mellitus.During an observation and interview on 03/02/2026 at 5:34 AM, Unit D Licensed Practical Nurse #2 completed a finger stick for glucose monitoring for Resident #171. Licensed Practical Nurse #1 then cleaned the shared glucometer with a 70% isopropyl alcohol pad. Licensed Practical Nurse #2 stated they always clean the glucometer with an alcohol pad after each use. Licensed Practical Nurse #2 stated they were educated to clean the glucometer with an alcohol pad after each use. Licensed Practical Nurse #2 stated they have germicidal wipes available on the unit. During an interview on 03/02/2026 at 6:35 AM, Unit B Licensed Practical Nurse #3 stated they use an alcohol wipe to clean glucometer after each resident use. Licensed Practical Nurse #3 stated they were educated by the facility to clean the glucometer with the alcohol wipe after each use. During an interview on 03/02/2026 at 11:17 AM, Unit B Licensed Practical Nurse Unit Coordinator #1 stated the facility uses the purple top germicidal wipe, in between resident use to clean the glucometer. The nursing staff should not use an alcohol wipe to clean the glucometer between each use. During an interview on 03/02/2026 at 11:59 AM, Registered Nurse Educator #1 stated they expect the staff to use the germicidal wipes and not an alcohol pad to clean the glucometer between each use. Registered Nurse Educator #1 stated the manufacturer does not recommend using alcohol wipes. During an interview on 03/03/2026 at 7:11 AM, the Director of Nursing Services stated they expect the nursing staff to clean the glucometer after each use with a germicidal disinfectant wipe. The alcohol wipe would not effectively kill all the blood borne pathogens. The nurses should have followed the facility policy and education. 10 NYCRR 415.19(a)(1-3)