STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335696	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gurwin Jewish Nursing and Rehabilitation Center	68 Hauppauge Road Commack, NY 11725

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility did not ensure the Minimum Data Set assessment was completed to accurately reflect each resident's status. This was identified for one (1) (Resident #11) of three (3) residents reviewed for Physical Restraints. Specifically, Resident #11's Minimum Data Set assessments dated 10/31/2025 and 11/11/2025 inaccurately documented that Resident #11 used physical restraint in a chair or out of bed daily.The finding is: The facility's policy titled Minimum Data Set Accuracy last revised on 09/2025, documented the Minimum Data Set Assessor will ensure the Minimum Data Set is coded accurately to reflect the resident's status. All Minimum Data Set assessments must be completed accurately and within the required timeframes. Minimum Data Set coding must be supported by clinical documentation in the medical record. Minimum Data Set entries must reflect the resident's status and services provided during the applicable look-back period. The Minimum Data Set discrepancies between documentation and Minimum Data Set coding are to be resolved prior to submission. Resident #11 was admitted with diagnoses that included [NAME] Syndrome (a rare severe skin reaction often triggered by mediations or infections causing flu like symptoms and rash), vascular dementia (a decline in thinking skills due to damaged blood vessels in the brain), and type 2 diabetes mellitus (the body does not make enough insulin). The Five (5) Day Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set assessments dated 10/31/2025 and 11/11/2025 documented in Section P0100H that Resident #11 used other physical restraint in a chair or out of bed daily. The Centers for Medicare and Medicaid Services (CMS) form 802 (matrix used to identify pertinent resident care categories) dated 12/31/2025 documented Resident #11 had physical restraints. A review of Resident #11's medical record revealed there was no documented evidence that the resident utilized a physical restraint. During an observation on 01/07/2026 at 08:30 AM, Resident #11 was observed resting in bed with no physical restraints noted. Resident #11 declined to be interviewed. During an interview on 01/07/2026 at 08:46 AM, Registered Nurse Unit Manager #1 stated they were not sure why the use of restraints was checked on the matrix for Resident #11. Registered Nurse Unit Manager #1 stated they were responsible for completing the matrix for the unit and the use of restraints for Resident #11 must have been entered in error because the resident did not use any type of restraints. Registered Nurse Unit Manager #1 stated they were not sure why other restraints were indicated on the Minimum Data Set assessment tools. Registered Nurse Unit Manager #1 stated the Minimum Data Set coordinator was responsible for completing the Minimum Data Set assessment. During an interview on 01/07/2026 at 2:05 PM, Minimum Data Set Assessor #3 stated work per diem at this facility and were not too familiar with Resident #11. Minimum Data Set Assessor #3 stated they completed both the 10/31/2025 and the 11/11/2025 Minimum Data Set assessments for Resident #1 and erroneously entered that the resident utilized restraints, and it was an oversight on their part. During an interview on 01/07/2026 at 2:52 PM, the Chief Minimum Data Set Officer stated the facility uses a scrub program (specialized software for skilled nursing facilities that automatically audits resident assessments for errors, inconsistencies, and compliance issues before they are sent to the Centers (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for Medicare & Medicaid Services) to make sure the Minimum Data Set assessments are accurate. The Chief Minimum Data Set Officer stated they called the scrub program vendor and were told that Section P0100H is excluded from the audit for unknown reasons. The Chief Minimum Data Set Officer stated the Minimum Data Set assessor should have verified the accuracy of the data. During an interview on 01/08/2026 at 08:42 AM, the Chief Nursing Officer (Director of Nursing Services) stated the Minimum Data Set assessor should review the accuracy of the Minimum Data Set assessments before signing for completion. 10 NYCRR 415.11(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** Based on observations, interviews, and record review, the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. This was identified for one (1) (Resident #30) of three (3) residents reviewed for Activity of Daily Living. Specifically, Resident #30 had limited range of motion for both hands and required assistance with hand hygiene. The resident was observed with accumulation of moisture and brown sticky substance with a strong odor in the resident's hands. The assigned Certified Nursing Assistant #8 acknowledged not providing hand hygiene to the resident due to not being able to open the resident's hands.The finding is: The facility Activity of Daily Living policy revised on 09/2025 documented care and services will be provided for activities of daily living such as bathing. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, personal, and oral hygiene. Resident #30 was admitted with diagnoses including cerebral infarction (brain tissue death caused by a blocked artery, cutting off oxygen and nutrients), dysphagia (difficulty swallowing), and dementia (decline in mental ability severe enough to interfere with daily life, affecting memory, thinking, and behavior). The Annual Minimum Data Set assessment dated [DATE] documented the resident had severely impaired cognition and was rarely/never understood. The resident was dependent on staff with all activities of daily living and had impairment to both upper and lower extremities. The care plan for self-care/mobility performance deficit initiated on 10/12/2023 and revised on 10/02/2025 documented interventions including shower/bathe (as per Certified Nurse's Assistant task); monitor and report any signs and symptoms of immobility such as contractures forming or worsening, or skin-breakdown. During an observation on 01/07/2026 at 10:30 AM, Resident #30 was lying in their bed. The resident's hands were observed to be contracted with closed fists. During an observation on 01/07/2026 at 10:35 AM, Certified Nursing Assistant #8 opened Resident #30's hands. There was a strong foul-smelling odor, and the resident's palms were observed with an accumulation of moisture and brown sticky substance. Certified Nursing Assistant #8 scraped out the accumulated sticky substance and discarded the residue in the garbage. During an interview on 01/07/2026 at 10:55 AM, Certified Nursing Assistant #8 stated they were the full time Certified Nursing Assistant for Resident #30. The resident receives a shower twice a week and a bed bath five times a week. Certified Nursing Assistant #8 stated Resident #30 was unable to perform any self-care tasks. Certified Nursing Assistant #8 stated they did not wash Resident #30's palms because it is difficult to open the resident's hand and clean. Certified Nursing Assistant #8 stated they had notified the unit nurses (could not recall the name) about the difficulty in opening the resident's hands. The resident used to use the gauze roll for their palms; however, the gauze roll was discontinued because the resident did not like using the gauze roll. The resident was supposed to get passive range of motion exercises daily. Certified Nursing Assistant #8 stated they provided the passive range of motion to the resident's hands daily; however, they did not pay attention to the resident's palms and did not clean the resident's hands. During an observation and interview with Licensed Practical Nurse #4 on 01/07/2026 at 11:04 AM, Resident #30 was lying in their bed with both their palms half opened. Some of the moist brown sticky substance was still present in the resident's palms. Licensed Practical Nurse #4 stated Resident #30's palms were dirty and appeared they have not been washed properly. Licensed Practical Nurse #4 stated Certified Nursing Assistants were responsible to provide grooming and hygiene to each resident on their assignment. During an interview on 01/07/2026 at 1:00 PM, Wound Care Nurse #1 stated the brown sticky substance was a buildup of sweat and debris and were a result of the hands not being washed properly for a while. Wound Care Nurse #1 stated after they observed the condition of the resident's hands, they called the Physician and obtained an order to cleanse the resident's palms with hydrogen peroxide and normal saline one time only. Wound Care (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 stated the residue came off from the resident's palms. Wound Care Nurse #1 stated the resident's hand hygiene should have been maintained to keep the skin intact and prevent infections. The physician orders dated 01/07/2026 documented to cleanse bilateral palms and in between fingers with 1/2 Hydrogen Peroxide 3% and normal saline one time only for Dry flaky skin for one (1) day. Apply Zeasorb-AF Powder 2 % (an antifungal) to bilateral hands topically, every day and evening shift for moisture after cleaning with soap and water. During an interview on 01/08/2026 at 2:22 PM, Chief Nursing Officer stated Certified Nursing Assistants should provide grooming and hygiene care the residents including washing the residents' hands. 10 NYCRR 415.12(a)(3)

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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, interviews, and record review (Complaint #2698214), the facility did not ensure each resident environment remained as free of accident hazards as possible. This was identified for one (1) (Resident #473) of five (5) residents reviewed for Accidents. Specifically, Resident #473 required two (2) person assistance for transfers as per their plan of care. On 12/19/2025, the assigned Certified Nursing Assistant #5 transferred Resident #473 alone from the wheelchair to a shower chair, resulting in the resident sustaining multiple skin tears to the right hand, left hand, and left shin.The finding is:A facility policy titled Activities of Daily Living last revised 09/2022 documented Certified Nursing Assistants must review the Certified Nursing Assistant Taks List and Kardex to ensure adherence to the resident's plan of care. Care and services will be provided including transfer and ambulation; locomotion on/off unit; and walk in the corridor with the use of the safety and assistive devices.An undated facility policy titled Safe Transfers and Movement of Residents? documented residents shall be transferred, repositioned, and assisted with mobility only in accordance with their current assessment and care plan, using appropriate assistive devise, proper body mechanics, and the required level of staff assistance. Transfers shall be performed in a manner that promotes resident safety, dignity, and comfort and minimizes the risk of injury to residents and staff.Resident #473 was admitted with muscle weakness, spinal stenosis (narrowing of spaces within the spine), and difficulty in walking. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment. The Minimum Data Set assessment documented the resident had functional limitation in range of motion to the lower extremity on one side and was dependent (helper does all the of the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) on staff with sit-to-stand mobility, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. The resident used a wheelchair as a mobility device. The resident did not have any falls since the prior Minimum Data Set assessment.An Occupational Therapy Communication Form dated 06/19/2025 documented the resident was dependent on two (2) person assistance for tub/shower transfer and toilet transfer.A Kardex -Certified Nursing Assistant Task (a summary of resident care instructions for Certified Nursing Assistants) for 12/2025 documented Resident #473 required two (2)-person assistance for transfers including chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer.A Comprehensive Care Plan titled Self-Care/Mobility Performance Deficit initiated on 12/03/2024 and last revised on 01/08/2026 documented interventions including perform tub/shower transfer as instructed on the Certified Nursing Assistant Task; perform toilet transfer as instructed on the Certified Nursing Assistant Task; and provide Occupational Therapy evaluation as per the physician's orders.A Nursing Progress Note dated 12/19/2025 documented Certified Nursing Assistant #5 reported Resident #473 sustained skin tears during a transfer from the wheelchair to the shower chair. Certified Nursing Assistant #5 instructed the resident to hold the grab bar. The resident stood up; however, was unable to turn. Certified Nursing Assistant #5 seated the resident back in the wheelchair and then attempted the transfer again. At that time, the Certified Nursing Assistant #5 observed Resident #473 was bleeding and immediately notified the nurse. The resident was observed with a skin tear on top of the right hand measuring 1 centimeter in length and 1 centimeter in depth; a skin tear to the left lateral (side) hand measuring 4 centimeters in length and 0.5 centimeters in width; and a skin tear to the left shin measuring 2 centimeters in length and 2 centimeters in width.An Accident and Incident Report dated 12/19/2025 documented at approximately 04:30 PM, Certified Nursing Assistant #5 reported Resident #473 having new skin tears after transferring Resident #473 from a wheelchair to a shower chair, to the nurse. The investigation determined the transfer was not performed in accordance with the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care plan, which required two-person assistance for all transfers.A Physician's Order Dated 12/19/2025 documented to cleanse the skin tears to the left lateral hand, right hand, and left shin with normal saline, apply Bacitracin external ointment topically, and cover with a dry protective dressing every day shift.An Investigative Summary dated 12/24/2025 concluded Resident #473 sustained multiple skin tears as a result of failure to follow the established plan of care during transfers by Certified Nursing Assistant #5.A Physical Therapy Communication Form dated 12/24/2025 documented the resident required two (2) person assistance for sit-to-stand and chair/bed-to-chair transfer. The resident did not use a mechanical lift and was not able to ambulate.During an observation and interview on 12/31/2025 at 11:08 AM, Resident #473 was observed with a dressing to their right hand and left forearm. Resident #473 stated recently (date not recalled) when they were getting out of the shower one staff member was helping them and they sustained skin tears.During an interview on 01/07/2026 at 11:24 AM, Licensed Practical Nurse #2 stated they do not recall Resident #473's transfer status as they are not regularly assigned to the resident. On 12/19/2025, they worked during the evening shift and at approximately 04:30 PM Certified Nursing Assistant #5 brought Resident #473 to the nursing station. The resident was observed with impaired skin on the left hand and left leg. Licensed Practical Nurse #2 stated they immediately called the nursing supervisor. Certified Nursing Assistant #5 said the resident sustained the skin tears during the shower. Licensed Practical Nurse #2 stated Certified Nursing Assistant #5 did not ask them for assistance with Resident #473 in the shower room.During an interview on 01/07/2026 at 12:31 PM, Registered Nurse #5 stated they were called to the unit by Licensed Practical Nurse #2 regarding Resident #473. The resident was assessed with superficial skin tears to both arms and left shin. Registered Nurse #5 stated Certified Nursing Assistant #5 acknowledged that they transferred the resident from the wheelchair to the shower chair by themselves and the resident sustained skin tears during the transfer. Registered Nurse #5 stated the resident required two (2) person assistance for transfers and that Certified Nursing Assistant #5 could not provide a reason for transferring the resident by themself. Registered Nurse #5 stated they informed the Chief Nursing Officer and Certified Nursing #5 was sent home.During an interview on 01/07/2025 at 01:06 PM, the Chief Rehabilitation Officer stated that Resident #473 was discharged from rehabilitation services in July 2025. The Chief Rehabilitation Officer stated as of 12/19/2025, Resident #473 required two (2) person assistance for tub/shower transfers as instructed on the Occupational Therapy Communication dated 6/19/2025. The Chief Rehabilitation Officer stated the resident should have been transferred with the assistance of two (2) staff members into the shower chair, and that a one (1) person transfer from the wheelchair to the shower chair was an unsafe transfer. During an interview on 01/07/2025 at 02:25 PM, Certified Nursing Assistant #5 stated they were regularly assigned to care for Resident #473. Certified Nursing Assistant #5 stated they typically did not check a resident's Kardex. Certified Nursing Assistant #5 stated on 12/19/2025 at approximately 04:00 PM to 04:15 PM they took Resident #473 to the shower room for a scheduled shower. Certified Nursing Assistant #5 stated they were alone in the shower room with the resident. They instructed Resident #473 to hold the grab bars in the shower room; however, they were not able to transfer the resident into the shower chair in the first attempt as the resident said, they needed a second. Certified Nursing Assistant #5 stated they again attempted to transfer the resident and were able to complete the transfer by grabbing the back of the resident's pants and pivoting the resident from the wheelchair into the shower chair. Certified Nursing Assistant #5 stated once they completed the transfer, they noticed the resident had skin tears and took the resident to the nursing station. Certified Nursing Assistant #5 stated they were aware Resident #473 needed two (2) person assistance with transfers and had no explanation or excuse as to why they transferred the resident alone. Certified Nursing Assistant #5 stated they did not ask for assistance from other staff prior to transferring the resident into the shower chair and did not perform a safe transfer for Resident #473 on 12/19/2025 as per the resident's plan of care.During an interview on 01/08/2026 at 09:12 AM, the Assistant Director of (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing stated Resident #473's plan of care required two (2) person assistance for transfers. Certified Nursing Assistant #5 did not follow the resident's plan of care and unsafely performed the transfer alone, resulting in multiple skin tears to the resident's hands and left leg. The Assistant Director of Nursing Stated the resident was re-evaluated by rehabilitation services and it was determined that the resident continued to require two (2) person assistance with the transfers During an interview on 01/08/2026 at 11:15 AM, the Chief Nursing Officer stated Certified Nursing Assistant #5 should not have transferred Resident #473 alone because Resident #473 required two (2) person assistance for transfers. The Chief Nursing Officer stated Certified Nursing Assistant #5 should have sought assistance to transfer Resident #473 into the shower chair. The resident sustained superficial skin tears with no other injuries as a result. The Chief Nursing Officer stated Certified Nursing Assistant #5 was immediately removed from the schedule and on 12//22/2025 Certified Nursing Assistant #5 resigned from the facility. 10 NYCRR 415.12(h)(1)

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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 interviews and record review, the facility did not ensure the irregularities identified by the Pharmacist during the drug regimen review was documented on a separate, written report and the attending Physician documented in the resident's medical record that the irregularity identified by the Pharmacist had been reviewed and what action had been taken to address the recommendations. This was identified for one (1) (Resident #358) of five (5) residents reviewed for Unnecessary Medications. Specifically, Pharmacist #1 documented a medication regimen review recommendation in Resident #358's medical record on 12/2/2025 to review duplicate use of sleeping agents Melatonin (a sleep medication) and Ramelteon (a prescription sleep medication for adults with sleeping difficulty-a melatonin receptor). There was no documented evidence that a separate, written report of the recommendations was sent to the attending Physician, the Medical Director and the Director of Nursing Services. Additionally, Nurse Practitioner #1 discontinued the Melatonin on 12/9/2025 without documenting the rationale to discontinue the medication. The finding is: The facility's policy titled Medication Regimen Review dated 06/16/2023 documented all [pharmacy] recommendations which have the potential for immediate morbidity or mortality to a resident if left unaddressed will be communicated verbally to the appropriate medical staff. The communication will be documented in the electronic medical record document or pharmacy progress notes. All other recommendations may be transmitted verbally to the medical staff or by printing a medication regimen review form. The form will be placed in the appropriate medical staff's mailbox. The medical staff will respond to the written medication regimen review form within seven (7) days. The medical staff will acknowledge the recommendations and may either agree or disagree with the recommendation but must complete a written response on the form. All completed medication regimen review with the physician responses will be maintained and fully accessible in the pharmacy department, in addition to being scanned into each resident's permanent medical record. Resident #358 was admitted with diagnoses including dementia (a condition characterized by progressive or persistent loss of intellectual functioning), Parkinson's disease (a progressive neurodegenerative disorder of the central nervous system), and hypertension (the pressure in the blood vessel is too high). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 11, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented the resident reported trouble falling or staying asleep or sleeping too much for several days (2-6 days) in the past two (2) weeks. The current physician's order initially ordered on 02/05/2025 documented to administer Ramelteon oral tablet 8 milligrams one (1) tablet by mouth at bedtime for Insomnia (difficulty falling asleep). A physician's order first ordered on 02/14/2025 documented to administer Melatonin oral tablet 3 milligrams one (1) tablet by mouth at bedtime for sleep wake cycle. The order was discontinued on 12/09/2025. The Comprehensive Care Plan for Insomnia last revised on 07/17/2025 documented the resident was being treated for insomnia. Interventions included to provide medications as per physician's order and monitor for effectiveness; encourage/facilitate a regular bedtime routine, and to monitor for possible negative sign and symptoms of use of insomnia medications. The monthly Medication Regimen Review progress note, written in the electronic medical record, dated 12/02/2025, signed by Pharmacist #1 documented that Resident #358 was on Melatonin and Ramelteon, a duplicate treatment for sleep. There was no physician response, signature, or date in the medication regimen review progress note to acknowledge, agree or disagree with the recommendations. There was no documented evidence that the identified irregularity was reported to the attending Physician, the Medical Director or the Director of Nursing Services. A review of Resident #358's medical record from 12/02/2025 to 01/06/2026 revealed there was no medication regimen review form for Resident #358 related to the pharmacy recommendation made on 12/2/2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/06/2026 at 12:43 PM, Pharmacist #1 stated they reviewed Resident #358's medication regimen at least monthly and notified the medical provider of any recommendation through a Health Insurance Portability and Accountability Act compliant electronic communicating channel; the physician would respond to their recommendations through the electronic communication channel. Pharmacist #1 stated they documented their monthly medication regimen review in the resident's progress note. Pharmacist #1 stated that they were not informed that the monthly medication regimen review had to be documented on a separate written report, in addition to the progress note. Pharmacist #1 stated they did not write a separate report of their recommendations to provide to the attending Physician, Medical Director or the Director of Nursing Services on 12/02/2025. During an interview on 01/06/2026 at 1:23 PM, the Chief Pharmacy Officer stated they were responsible for developing the Medication Regimen Review policies and in-serviced the pharmacy staff of the task requirements. The Chief Pharmacy Officer stated since August 2025, they have directed the pharmacy staff to communicate the medication regimen review recommendations to all medical providers via the Health Insurance Portability and Accountability Act- compliant electronic communicating channel. The Chief Pharmacy Officer stated they did not require the pharmacists to document any identified irregularities on a separate written report because the facility is not required to do so. The Physician respond promptly by using the electronic communication channel. The Chief Pharmacy Officer stated they expected the medical providers to document their rationale of agreeing or disagreeing with pharmacist's recommendation in the medical progress notes. The Chief Pharmacy Officer stated that not all the medication regimen review recommendations are sent to the Medical Director and the Chief Nursing Officer. The recommendations are only brought to the Medical Director or the Chief Nursing officer's attention when the physician do not appropriately address the recommendations. During an interview on 01/06/2026 at 2:29 PM, Nurse Practitioner #1 stated they discontinued the Melatonin medication after reviewing the pharmacist's medication regimen review recommendation via the electronic communicating channel. Nurse Practitioner #1 stated they did not receive a separate written report addressing the medication regimen review on 12/02/2025. Nurse Practitioner #1 stated they agreed with the recommendation to discontinue Melatonin; however, they did not document the agreement in the resident's medical record. Nurse Practitioner #1 stated they should have documented a response when they reviewed the pharmacist's recommendation to include what actions were taken to address the identified irregularity. During an interview on 01/07/2026 at 09:58 AM, Physician #1, who was Resident #358's attending Physician, stated Nurse Practitioner #1 was assigned to Resident #358 and was responsible for providing medical care, under their (Physician #1) supervision. Physician #1 stated that Nurse Practitioner #1 could review the Pharmacist's recommendations and decide to follow up on the recommendations on their (Physician #1) behalf. Physician #1 stated Nurse Practitioner #1 should have documented their review of the Pharmacist's recommendation and the rationale to discontinue melatonin for Resident #358. During an interview on 1/7/2026 at 11:57 AM, the Medical Director stated they were involved in developing the Medication Regimen Review policy. The Medical Director stated they were notified of some pharmacy recommendations through the Health Insurance Portability and Accountability Act- compliant electronic communicating channel. The Medical Director stated they were aware that most pharmacy irregularities were communicated through this forum and not in a separate written report. The Medical Director stated that the medical providers can provide more efficient responses using the communication system instead of responding to written reports. The Medical Director stated they expected medical providers to document their review of the Pharmacist's recommendations in the progress notes and what action had been taken to address the identified irregularities. The Medical Director stated they do not receive all pharmacy recommendations in a separate written report and that the facility should comply with the regulatory requirement and ensure all Medication Regimen Reviews are documented in a separate, written report. During an interview on 01/08/2026 at 8:43 AM, the Chief Nursing Officer stated they were notified of some pharmacist recommendations through the (continued on next page)

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Gurwin Jewish Nursing and Rehabilitation Center	68 Hauppauge Road Commack, NY 11725

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Health Insurance Portability and Accountability Act- compliant electronic communicating channel. The Chief Nursing Officer did not receive any written reports and was not aware that pharmacist recommendations must be sent to them in a separate, written report. The Chief Nursing Officer stated that the facility should comply with the regulatory requirement and ensure all pharmacy recommendation are documented in a separate, written report. The Chief Nursing Officer stated that medical providers should document when a pharmacy irregularity was reviewed and addressed. 10 NYCRR 415.18(c)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335696	A. Building B. Wing	01/08/2026

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility did not ensure that it maintained an infection prevention and control program designed to help prevent the development and transmission of infectious diseases. This was identified for one (1) (Resident #432) of nine (9) residents reviewed for Infection Control. Specifically, Resident #432 had a physician's order for contact isolation precautions for a diagnosis of shingles (blistering skin rash caused by the reactivation of the varicella-zoster virus). Certified Nursing Assistant #1 was observed in Resident #432's room making the resident's bed without wearing appropriate personal protective equipment.The finding is: The facility policy titled Transmission Based Precautions dated 04/28/2024, documented transmission-based precautions are a group of infection prevention and control practices that are used in addition to standard precautions for residents who may be infected or colonized with infectious agents that require additional control measures to prevent transmission effectively. Healthcare personnel caring for residents on contact precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. Resident #432 was admitted with diagnoses including chronic obstructive pulmonary disease (a progressive lung condition causing airflow obstruction, making breathing difficult), and gastrostomy Status (a surgically created opening into the stomach for long term feeding, medications, or drainage). The admission Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. A physician's order dated 12/28/2025 documented Contact Precautions, left flank rash/presumed shingles. A comprehensive care plan titled Resident has an infection Herpes Zoster (Shingles) dated 12/29/2025 and resolved on 01/02/2026 documented interventions that included to maintain contact isolation precautions. During an observation on 12/31/2025 at 11:41 AM, a contact precaution signage was on the doorway of Resident #432's room. The signage indicated staff must put on gloves and a gown before entering the room. Certified Nursing Assistant #1 was inside Resident #432's room and had gloves on. Certified Nursing Assistant #1 was not wearing a gown and was observed touching and shaking the blankets and bedsheets to lay smoothly on Resident #432's bed. During an interview on 12/31/2025 at 11:18 AM, Certified Nursing Assistant #1 stated the signage on Resident #432's door indicated the resident was on contact precautions. Certified Nursing Assistant #1 stated they took off their gown after providing care to Resident #432, changed their gloves and then proceeded to make the resident's bed. Certified Nursing Assistant #1 stated they thought they did not need a gown when making the resident's bed. They were only required to have the gown on before entering the resident's room and when providing care for the residents who were on contact precautions. During an interview on 12/31/2025 at 12:23 PM, the Infection Preventionist stated staff should wear gloves and a gown when they enter a resident room with contact precautions. Certified Nursing Assistant #1 should not have shaken the blankets and linen when making Resident #432's bed and should have put on the appropriate personal protective equipment, including a gown, when in contact with the resident's environment. During an interview on 01/07/2026 at 8:02 AM, the Chief Nursing Officer (Director of Nursing Services) stated staff should follow the contact precautions directions and wear appropriate personal protective equipment. The Chief Nursing Officer stated if a staff member goes into a contact isolation room without the proper personal protective equipment, they could spread the infection to other residents and staff. 10 NYCRR 415.19(a)(1-3)