STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335718	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Five Towns Premier Rehab & Nursing Center	1050 Central Avenue Woodmere, NY 11598

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review during an abbreviated survey conducted (complaint# 2633955) the facility failed to ensure one (1) (Resident #1) of three (3) residents received treatment and care in accordance with professional standards of practice and the comprehensive care plan. Specifically, on 09/30/2025, Resident #1 fell out of bed. Registered Nurse Supervisor #1 assessed Resident #1 and assisted lifting them into bed using a Hoyer lift. Registered Nurse Supervisor #1 failed to document the fall in Resident #1's Electronic Medical Record, failed to complete a facility Occurrence Report, failed to notify Physician of the fall, and failed to notify Resident #1's family. As a result, Resident #1 was not monitored for pain or injury by the facility following the fall and the physician did not see Resident #1 for follow-up. On 10/02/2025 Resident #1 developed bruising on their right lateral thigh and decreased range of motion due to pain. Resident #1 was sent to the hospital and diagnosed with a fractured right femur. This resulted in actual harm that is not Immediate Jeopardy.The findings are: The Facility Accident/Incident Report Policy dated 03/2025 documented Registered Nurse Supervisor will report occurrence to the physician and notify family, document treatment orders on the Occurrence Report, and review/revise the Comprehensive Care Plan.Resident #1 was admitted on [DATE] with diagnoses that include chronic kidney disease, (a long-term condition where the kidneys become damaged and gradually lose their ability to filter waste and fluid from the blood), Diabetes Type II (a condition where the body either doesn't make enough insulin or doesn't use it properly), and Major Depressive Disorder. On 09/19/2025, a Minimum Data Set (a resident assessment tool) Brief Interview of Mental Status was completed for Resident #1 and documented a score of 7, indicating severe cognitive impairment.The facility Occurrence Report for Resident #1 dated 10/02/2025 documented Resident #1 fell out of bed on 09/30/2025 and presented with visible bruising on the right lower extremity on 10/02/2025. The Medical Doctor #1 was contacted, and Resident #1 was sent to hospital. Resident #1 was diagnosed with a right fracture of the femur (leg bone).The facility 5-day Report dated 10/09/2025 documented the Director of Nursing and the Assistant Director of Nursing stated that Registered Nurse Supervisor #1 did not report any falls involving Resident #1 to them until 10/02/2025. Registered Nurse Supervisor #1 informed both that they forgot to document and report the incident. Registered Nurse Supervisor #1 has no prior history of not documenting or reporting accidents or incidents. Registered Nurse Supervisor #1 has no prior disciplinary action related to this nature in their file. Nursing Progress Note for Resident #1 written by Registered Nurse Supervisor #1 dated 10/02/2025 at 7:27 PM documented Late entry: 09/30/25, at approximately 11:00 AM, Licensed Practical Nurse #1 notified the writer to assess a resident who had a fall in the room. Upon entering the room, resident was observed lying on their back on top of the floor mat by the left side of the bed, head resting on pillow, feet towards the foot of bed direction. The floor is dry, with adequate lighting and clutter free. Resident #1 is wearing a night gown but with no socks on. Resident alert but a poor historian stated, I don't know what happened, I rolled over the bed and fell. As per Certified Nursing Assistant #2, the resident was placed to their left side, turned around to get the brief but suddenly the resident rolled over and landed on the floor mat. Initial assessment was conducted, all range of motion is at baseline but did not complain of any new pain and did not show any signs of visible pain or discomfort. Resident denied hitting their head, loss of consciousness and respiratory distress. Resident was transferred back to the bed using the Hoyer lift with the help of three (3) staff. Skin assessment was done with no swelling, redness, bruising and skin opening noted.Nurse Practitioner Note dated 10/02/2025 at 2:06 PM documented staff reports Resident #1 with discoloration of skin along the right side of resident's leg. Resident #1 seen lying in bed in no acute distress. Upon assessment, resident noted with blue and purple discoloration to side of right leg with swelling above the knee. Resident shows signs of pain with palpation to area. No recent falls reported. Resident currently on Eliquis 2.5mg (blood thinner) twice a day. Resident was sent to emergency department for further evaluation with scans. Primary care provider and family member made aware.During an interview with Certified Nursing Assistant #2 on 11/06/2025 at 10:33 AM, they stated they discovered bruising on Resident #1 on 10/02/2025. They went to provide care with another aide as Resident #1 was a two-person assist. They observed discoloration on right leg and showed Licensed Practical Nurse #2. During a telephone interview on 11/06/2025 at 10:23 AM with Certified Nursing Assistant #1, they stated they were assigned to Resident #1 on 09/30/2025 at 11:00AM. Resident #1 was screaming. Certified Nursing Assistant #1 went to the room and Resident #1 had feces on their hands