

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335718	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER The Five Towns Premier Rehabilitation & Nursing Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that the resident's Designated Representative was notified when the need to start a new form of treatment was identified. This was identified for one (Resident #5) of three residents reviewed for Notification of Change. Specifically, Resident #5 was started on amoxicillin 875 milligrams-potassium clavulanate 125 milligrams (an antibiotic to treat infections) on 08/07/2025 for cough. There was no documented evidence that Resident #5's designated representative was notified of the resident's change in condition and the need to start a new treatment of antibiotic until 08/12/2025. Complaint #2663274 The findings include: The facility policy titled, Change in Condition last revised on 05/2026 documented that it is the facility's policy to identify and communicate changes in condition to the Physician and other team members to implement interventions to prevent further deterioration and possible event of hospitalization. The resident's family/health care agent will be notified about the change in conditions. Resident #5 was admitted with diagnoses including chronic kidney disease, hypertension (high blood pressure), and atelectasis (lung collapse). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 6, which indicated that Resident #5 had severe cognitive impairment. The Quarterly Minimum Data Set (MDS) assessment documented an active diagnosis of respiratory failure and chronic lung disease. A Nursing Progress Note dated 08/07/2025 documented Resident #5 had occasional productive cough with no shortness of breath. Physician #2 was notified and had ordered antibiotics. A Physician's Order dated 08/07/2025 documented Amoxicillin 875 milligrams-potassium clavulanate 125 milligrams, one tablet twice a day for seven days for cough. A Comprehensive Care Plan (CCP) titled, Infection: Cough dated 08/11/2025 documented interventions including administering medications as ordered by the Physician, monitoring for signs and symptoms of side effects of antibiotics, and monitoring vital signs as ordered. An Electronic Medication Administration Record (EMAR) dated 08/07/2025 documented Amoxicillin 875 milligrams-potassium clavulanate 125 milligrams one tablet twice a day for seven days for cough. The Electronic Medication Administration Record indicated that from 08/07/2025 until 08/14/2025 Resident #5 received the antibiotics as prescribed by the Physician. During an interview on 06/11/2026 at 12:15 PM, Licensed Practical Nurse #14, the medication nurse, stated that the charge nurse was responsible for notifying the resident representatives related to any changes in the resident's condition. Licensed Practical Nurse #14 stated they wrote a progress note in the resident's medical record indicating the antibiotic was administered; however, they did not call the resident's designated representative. During an interview on 06/11/2026 at 12:25 PM, Registered Nurse #13, the charge nurse, stated that they were responsible for notifying the resident representative of any changes in resident's condition and treatment. Registered Nurse #13 stated when they first received the antibiotics order for Resident #5, they forgot to notify Resident #5's designated representative regarding the change in resident's condition and the new antibiotic orders. During an interview on 06/11/2026 at 3:15 PM, Physician #2 stated that the physicians do not call the designated representatives unless there is a request from the family or designated representative for a phone call (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or if they (Physician #2) needed clarification regarding the resident's history or allergies. Physician #2 stated they did not know the facility's policy on notification for any changes in residents' condition. During an interview on 06/11/2026 at 3:47 PM, the Director of Nursing Services stated that nurses should notify residents designated representatives for changes in the resident's condition in a timely manner and there should be proper documentation regarding the notification.10 New York Code Rules and Regulations 415.3(f)(2)(ii)(c)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a resident requiring dialysis services received such services consistent with professional standard of practice. This was identified for one (Resident #3) of three residents reviewed for dialysis. Specifically, Resident #3, who receives dialysis treatment at the facility three times per week, was not provided dialysis treatment on their scheduled day on 06/20/2026 due to lack of communication between the facility staff and the dialysis center staff. The findings include: The facility's policy titled, Dialysis last revised on 01/2020 documented that the facility will ensure that all residents who need hemodialysis treatment will receive the services as ordered by the Attending Physician. A dialysis communication tool will be initiated by the unit Nurse, and all pertinent information will be communicated between dialysis and the Nursing unit through the communication tool. Notify the dialysis center of any changes in the resident's condition, new medications, abnormal laboratory results from test done at the facility. If a resident refuses to attend dialysis, the unit Nurse will inform the dialysis center for possible rescheduling, the attending physician and the social worker and will document the refusal in the medical record. Resident #3 was admitted with diagnoses including sepsis (the body's response to a life-threatening infection), type two diabetes (high blood sugar) and pneumonia (infection in one or both lungs). An Annual Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated that Resident #3 had intact cognition. The Annual Minimum Data Set (MDS) documented Resident #3 received dialysis treatment. A physician's order dated 06/19/2025 documented hemodialysis (most common type of dialysis where blood is pumped out of the body through vascular (blood vessel) access, filtered by a machine and then returned to the body) every Monday, Wednesday and Friday at the facility's in-house dialysis center. A Comprehensive Care Plan (CCP) dated 07/01/2025 titled Dialysis documented interventions including monitoring dialysis access site for signs and symptoms of infections, communication will occur between skilled Nursing staff and hemodialysis center related to the care needs of residents and providing renal (special diet for residents with chronic kidney disease and kidney failure) diet as per physician's order. Nursing Progress Note dated 06/19/2025 at 10:47 PM documented that the facility received an order from the discharging hospital that Resident #3 needed a blood transfusion on 06/20/2025 due to a hemoglobin (iron rich protein that carries oxygen from the lungs to the rest of the body) level of 7.5 grams per deciliter (normal range 12.0-15.5 grams per deciliter) and hematocrit (blood test that measures the percentage of red blood cells in your total blood volume) level of 24.7 percent (normal range 41-50 percent). Physician #2 was notified and gave instructions that Resident #3 needed to be evaluated in the morning. A review of the Physician's order for June 2025 indicated no orders for blood transfusion. A Medical Progress Note dated 06/20/2025 at 11:44 AM documented that Physician #1 had seen Resident #3 and gave instructions to Registered Nurse #1 to repeat the complete blood count level on 06/23/2025. The dialysis communication tool dated 06/20/2025 documented that Resident #3 had scheduled blood transfusion on 06/20/2025 and Resident #3 was rescheduled for dialysis on 06/21/2025 at 10:00 AM. A review of the electronic medical record indicated no documentation related to the resident not receiving the dialysis treatment on 06/20/2026. During an interview on 06/10/2026 at 11:47 AM, Physician #1 stated that they saw Resident #3 on 06/20/2025 and determine that blood transfusion was not necessary and gave orders to Registered #1 to repeat the complete blood count on 06/23/2025 for Resident #3. Physician #1 stated they reviewed the hospital discharge summary and determined that the resident's hemoglobin level was stable. Physician #1 stated they were not aware Resident #3 did not receive their scheduled for dialysis treatment on 06/20/2025. During an interview on 06/10/2026 at 1:07 PM, the Director of Nursing Services stated that they were not the facility's Director of Nursing Services in June 2025. The Director of Nursing Services stated that the facility staff should have coordinated with the dialysis staff to reschedule the resident's dialysis (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treatment that was originally scheduled for 06/20/2025. The Director of Nursing Services stated that they expect communication between Nursing and dialysis staff for any changes in the resident's condition. During an interview on 06/10/2026 at 1:20 PM, the Dialysis Director stated that Resident #3 did not receive their dialysis treatment on 06/20/2025 because Resident #3 was scheduled to receive blood transfusion that day. The Dialysis Director stated that the dialysis center is open until 8:00PM-9:00 PM and the dialysis center is flexible with scheduling the in-house residents for the dialysis treatments. The Dialysis Director stated that the facility staff did not coordinate with the dialysis staff that Resident #3's blood transfusion was cancelled, otherwise they (dialysis staff) would have scheduled the dialysis treatment for Resident #3 on 06/20/2025. During an interview on 06/16/2026 at 12:51 PM, Registered Nurse #1 stated they did not know why dialysis staff were not contacted to reschedule Resident #3's dialysis treatment, after the physician had recommended canceling the blood transfusion. 10 New York Code Rules and Regulations 415.12		