

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 06/25/2026
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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interviews during the survey, the facility failed to ensure that all alleged allegations of abuse, neglect, exploitation, or mistreatment were thoroughly investigated. This was identified for one (Resident #6) of two residents reviewed for accidents. Specifically, Resident #6 had an unwitnessed fall on 11/15/2025 that resulted in injuries. The facility's accident and incident investigation report did not include statements from all staff involved. Additionally, the staff statements that were obtained were inconsistent and did not accurately indicate staff's response to the incident. Incident #2706534The findings include: The facility policy titled Accident and Incident, dated 02/2026, documented it is the policy of the facility to maintain a resident environment that is as free of accident hazards as possible and to provide adequate supervision and assistive devices to prevent avoidable accidents, and to promptly respond to, report, investigate, and document all accidents and incidents in accordance with state and federal regulations. An incident report is completed promptly, documenting the date, time, location, description, witnesses, resident condition, interventions, and notifications and ensuring that all documentation is factual and objective. Resident #6 was admitted with diagnoses including muscle weakness, gait and mobility abnormality, and depression. The 11/03/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 14, indicating the resident was cognitively intact. There were no recent falls documented. A nursing progress note dated 11/15/2025 at 08:18 AM, written by Registered Nurse #7 (the charge nurse on the 7:00 AM-3:00 PM shift) documented that at approximately 7:19AM, the writer was informed by the unit nurse (Licensed Practical Nurse #1) that Resident #6 was on the floor. Resident #6 was observed on the floor, on the left side of the bed, in a supine (on back) position. A pillow was under the resident's head. Resident #6 was observed with swelling on their forehead (measuring 4.0 centimeters x 4.0 centimeters) and nose with minimal bleeding from both nostrils. Bilateral knees were also noted with redness. The resident stated that they used the restroom and when going back to bed, they tripped, fell, and hit their head. Registered Nurse Supervisor #6 (the nursing supervisor) and the Physician were notified with order to send resident to the hospital for Computerized Tomography (CT) scan of the head. Review of the 11/15/2025 Occurrence Report indicated that Licensed Practical Nurse #1 reported the resident's fall to Registered Nurse #7; however, there was no statement obtained from Licensed Practical Nurse #1. Additionally, the Certified Nursing Assistant question sheet did not indicate name of the certified nursing assistant and had illegible signature at the bottom of the sheet making it difficult to discern which staff had filled out the sheet. The Certified Nursing Assistant question sheet. indicated that prior to the unwitnessed fall the resident was last seen in their room in bed watching television at 07:10 AM. During an interview on 06/10/2026 at 11:20 AM, Licensed Practical Nurse #1 stated they did not recall the 11/15/2025 incident; Licensed Practical Nurse #1 stated if they had reported the incident, there is a documented investigative statement that they would have to provide regarding what they saw and know about the incident as per the facility protocol. During a telephone interview on 6/10/2026 at 11:50 AM, Certified Nursing Assistant #6 (who was assigned to Resident #6 on 11/15/2026 during the 7:00 AM-3:00 PM shift) stated they did not remember the incident on11/15/2025 or the affected resident. During an interview on 06/10/26 at 12:30 PM, Registered Nurse #7 (charge nurse) stated on (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/15/2025 Licensed Practical Nurse #1 informed them of Resident #6's unwitnessed fall. Registered Nurse #7 could not recall the time the incident was reported to them. Registered Nurse #7 stated they went to the resident's room and assessed the resident. Registered Nurse #7 stated they do not do the investigations; they just write a progress note and write their statement. During an interview on 6/10/2026 at 12:50 PM, Registered Nurse #8 (consultant) stated they did not recall the incident; however, whenever the facility needed assistance with occurrence reports, they would help in ensuring that all the necessary interviews and statements were obtained. They then would write the investigative summaries. The facility staff were responsible for gathering all the interview statements. Registered Nurse #8 stated that the investigative summary cannot be completed without all the details in place and Licensed Practical Nurse #1 should have provided a statement to thoroughly investigate the unwitnessed fall. Registered Nurse #8 stated the Certified Nursing Assistant's name should have been included on the Certified Nursing Assistant question sheet. Registered Nurse #8 had no explanation as to why the summary was completed without Licensed Practical Nurse #1's statement and with the Certified Nursing Assistant's name being left out of the questionnaire and the signature scribbled out. During an interview on 06/10/2026 at 1:15 PM, the Director of Nursing Services stated they are the risk manager; they stated they did not work at the facility in November 2025 and never met the consultant (Registered Nurse #8). The Director of Nursing Services stated they would have expected a statement from the staff member who found the resident on the floor, for instance what the staff member did, what time did they observe the resident etc. During a re-interview on 06/10/2026 at 2:40 PM, the Director of Nursing Services stated they just spoke to Licensed Practical Nurse #1. Licensed Practical Nurse #1 said that on 11/15/2025 they were at the nursing station when Certified Nursing Assistant #6 reported to them that Resident #6 was on the floor. Licensed Practical Nurse #1 did not go to see the resident and informed Registered Nurse #7 about the incident. The Director of Nursing Services stated the Occurrence Report was incomplete and did not accurately reflect the sequence of events regarding Resident #6's unwitnessed fall on 11/15/2025. During a re-interview on 06/25/2026 at 11:40 AM, Licensed Practical Nurse #1 stated that on 11/15/2025 they were at the nursing station and were getting ready to leave because their shift was over. Certified Nursing Assistant #6 told them that they saw Resident #6 on the floor and Licensed Practical Nurse #1 notified Registered Nurse #7 of the incident. 10 New York State Code Rules and Regulations 415.4(b)(3)		