

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335755	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/05/2025
NAME OF PROVIDER OR SUPPLIER  Bellhaven Center for Rehab and Nursing Care		STREET ADDRESS, CITY, STATE, ZIP CODE  110 Beaver Dam Road Brookhaven, NY 11719	

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)
<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>(continued on next page)</p>

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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<p>F 0700</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and staff interview during the abbreviated survey (NY00375947) the facility did not review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation of bed rails for four (4) of 27 residents (Resident #1, #2 and #3, #4) reviewed. Specifically, the facility failed to assess the residents for risk of entrapment from bed rails prior to installation and failed to ensure the bedrails did not pose a risk of entrapment, asphyxiation, suffocation or injury. The facility failed to protect all four (4) residents from the likelihood of entrapment. This resulted in no actual harm with likelihood of serious harm that is Immediate Jeopardy and Substandard Quality of Care to all residents' using bedrails health and safety. The findings are: The facility policy titled Seizure Precautions and Care dated 06/2018, and revised 01/2023, documented Residents with a seizure diagnosis will have bilateral side rails with padding for protection when in bed. Resident #1 had diagnoses including Seizure disorder, muscle wasting and atrophy, and dementia. The Minimum Data Set (an assessment tool) dated 07/02/2025, documented a brief interview for mental status of 99, indicating severe cognitive impairment. There was no documented evidence of the use of side railsA physicians' order dated 09/03/2024 for Resident #1 documented two quarter side rails. A Comprehensive Care Plan dated 12/02/2023 documented that Resident #1 was at risk for seizures. It documented the following interventions, two quarter added siderails, monitor and report to Medical Doctor the intensity and duration of any seizure activity, protect head during seizure. There was no documented evidence in the medical record that Resident #1 was assessed for the risk of entrapment prior to the side rail installation, or that the resident and representative were educated regarding the risks and benefits and consented to the use of bilateral quarter side rails. Resident# 2 had diagnoses including seizure disorder, cerebral palsy, and muscle wasting and atrophy. The Minimum Data Set, dated [DATE] documented a brief interview for mental status score of 9 indicating moderate cognitive impairment. There was no documented evidence of the use of side railsA physicians' orders dated 12/10/2024 documented seizure precautions two quarter added side rails. A Comprehensive Care Plan dated 12/14/2016 documented Resident #2 had a diagnosis of a seizure disorder. Interventions include pad both upper side rails used as enablers for safety. During seizure, avoid restraining, keep suction equipment available, place pillow under neck, position on side, provide privacy, after monitor level of consciousness. There was no documented evidence in the medical record that Resident #2, was assessed for the risk of entrapment prior to the side rail installation or the resident and representative were educated regarding the risks and benefits and consented to the bilateral quarter side rails. Resident# 3 had diagnoses including seizures, cerebral palsy, and asthma. The Minimum Data Set, dated [DATE] documented Resident #3's brief interview for mental status score of 99 indicating severe cognitive impairment. There was no documented evidence of the use of side railsA physicians' orders dated 08/15/2025 for Resident #3 documented seizure precautions quarter padded side rails. A Comprehensive Care Plan dated 08/15/2025 documented Resident #3 was at risk for seizures. Seizure precautions documented interventions as follows: pad both upper side rails used as enablers for safety, protect head during seizure, monitor and report to Medical Doctor the intensity and duration of any seizure activityThere was no documented evidence in the medical record Resident #3 was assessed for the risk of entrapment prior to the side rail installation or the resident and representative were educated regarding the risks and benefits and consented to the bilateral quarter side rails.During an observation on 08/26/2025 at 11:36 AM, staff were unable to locate padding for Resident #1's side rails. During an observation on 08/27/2025 at 9:36 AM, Resident #1 was in bed with bilateral side rails up, and blankets taped to side rails. During an observation on 08/28/2025 at 8:10 AM Resident #1 was in bed with blankets taped to side rails.During an observation of the unit on 08/27/2025 at 11:48 AM Resident #2's side rails were up with one pad and one blanket noted over side rails. During an observation on 08/28/2025 at 8:10 AM Resident #2 was in bed with one pad and one blanket over side rails.During an observation on 08/27/2025 at 11:42 AM, Resident #3 was in bed with one blanket and one pillow in place over side railsDuring an observation on 08/28/2025 at 8:20 AM Resident #3 was in bed with one blanket and one pillow covering the side rails.During an observation on 08/29/2025 at 9:00 AM Resident #3 was in bed, with quarter bilateral side rails up. One rail had a pad covering, and the other rail was covered with a pillow. During an interview on 08/27/2025 at 10:05 AM, Director of Nursing Services stated they were aware that blankets and pillows were being used instead of pads on the quarter side rails. The Director of Nursing</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review and interviews during the abbreviated Survey (complaint # NY00375947) the facility did not ensure it was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for four (4) (Resident #1, #2, #3 and #4) of twenty-seven (27) residents with the potential to affect all 27 residents. Specifically, the facility failed to assess the residents for risk of entrapment from bed rails prior to installation and failed to ensure that the bedrails did not pose a risk of entrapment, asphyxiation, suffocation or injury. Additionally, the facility had blankets and pillows attached with tape to the siderails of four (4) of four (4) residents siderails in place of side rail pads further adding to the likelihood of entrapment. The facility failed to protect all four (4) residents from the likelihood of injury caused by entrapment. Refer to F700 siderails: Scope and Severity of K. The findings are: The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents. The facility policy titled Seizure Precautions and Care dated 06/2018, and revised 01/2023 documented Residents with a seizure diagnosis will have bilateral side rails with padding for protection when in bed. Resident's #1 had diagnoses including Seizure disorder, Muscle Wasting and Atrophy, and Dementia. The minimum data set assessment dated [DATE] documented a brief interview for mental status score of 99 indicating severe cognitive impairment. A physicians' order dated 09/03/2024 documented bilateral (both sides), quarter padded side rails. During an observation on 08/27/25 at 9:36 AM Resident #1 was in bed with bilateral quarter side rails up, with blankets taped to each quarter side rail. During an observation on 08/28/25 at 8:10 AM Resident #1 was observed in their bed with blankets taped to each quarter side rail. There was no documented evidence in the medical record that Resident #1, was assessed for the risk of entrapment prior to the bilateral (both sides) quarter side rail installation, or the resident and representative were educated regarding the risks and benefits and consented to the bilateral quarter side rails. During an interview on 8/28/2025 at 11:46 AM, with the Administrator, they stated they were aware that resident #2 had blankets and pillows taped to their side rails to be used in lieu of pads. They stated they have always utilized this practice and found it acceptable. The Administrator stated they did not think it caused a suffocation or entrapment risk. Resident's # 2 had diagnoses including seizure disorder, Cerebral Palsy, and Muscle Wasting and Atrophy. The minimum data set assessment dated [DATE] documented Resident#2's brief interview for mental status score of 9 (nine) indicating moderate cognitive impairment. A physicians' orders dated 12/10/2024 documented seizure precautions utilize 2 bilateral quarter padded side rails. During an observation of the unit on 08/27/2025 at 11:48 AM Resident #2's side rails were up with one pad and one blanket noted over both quarter side rails. During an observation on 08/28/2025 at 8:10 AM Resident #2 was in bed with one pad one of the siderails and a blanket over the other side rail. There was no documented evidence in the medical record that Resident #2, was assessed for the risk of entrapment prior to the side rail installation, the resident and representative were educated regarding the risks and benefits and consented to the bilateral quarter side rails. During an interview on 8/28/2025 at 11:46 AM, with the Administrator, they stated they were aware that resident #2 had blankets and pillows taped to their side rails to be used in lieu of pads. They stated they have always utilized this practice and found it acceptable. The Administrator stated they did not think it caused a suffocation or entrapment risk. Resident's # 3 had diagnoses including Seizures, Cerebral Palsy, and Asthma. The minimum data set assessment dated [DATE] documented Resident#3's brief interview for mental status score of 99 indicating severe cognitive impairment. It did not document the use of side rails. A physicians' orders dated 08/15/2025 documented seizure precautions, utilize bilateral padded quarter side rails. During an observation on 08/27/2025 at 11:42 AM, Resident #3 was observed in bed with one blanket and one pillow in place over the residents one (1) quarter side rail. During an observation on 08/28/2025 at 8:20 AM, Resident #3 observed in bed with one blanket and one pillow covering one (1) quarter side rail. During an observation on 08/29/2025 at 9:00 AM, Resident #3 was observed in their bed, with bilateral quarter side rails up. One quarter side rail had a pad covering, and the other quarter side rail was covered with a pillow. There was no documented evidence in the medical record that Resident #3, was assessed for the risk of entrapment prior to the side rail installation or the resident and representative were educated regarding the</p>		

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<p>F 0865</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on observations, record review, and interviews during the abbreviated survey complaint # (NY00375947) the facility did not ensure the Quality Assurance Performance Improvement committee developed and implemented appropriate plans of action to correct identified issues with the facility's side rail padding concern identified for four (4) of twenty-seven (27) residents (Resident #1, #2, #3 and #4) reviewed. Specifically, the facility failed to assess the residents for risk of entrapment from bed rails prior to installation and failed to ensure that the bedrails did not pose a risk of entrapment, asphyxiation, suffocation or injury. Additionally, the facility had blankets and pillows attached with tape to the siderails of four (4) of four (4) residents siderails in place of side rail pads further adding to the likelihood of entrapment. The Quality Assurance Performance Improvement Committee did not address, review, analyze, and act on available data on the identified issue to make improvements and to ensure improvements are sustained. Cross Reference: F 700 F 609 The finding is: During an observation on 08/26/2025 at 11:36 AM, Certified Nursing Assistant #4 could not locate siderail padding for Resident #1's bilateral quarter side rails. During an observation on 08/27/2025 at 11:42 AM, Resident #3 was observed in bed with one blanket and one pillow in place over both quarter side rails. During an observation of the unit on 08/27/2025 at 11:48 AM Resident #2's side rails were up with one pad and one blanket over both quarter side rails. During an observation on 08/28/2025 at 8:10AM Resident #2 was in bed with one pad and one blanket over both quarter side rails. During an observation on 08/28/2025 at 8:20 AM Resident #3 observed in bed with one blanket and one pillow covering both quarter side rails. During an observation on 08/29/2025 at 9:00 AM Resident #3 observed in bed, with both quarter side rails up. One rail had a pad covering, and the other rail was covered with a pillow. During an interview on 8/27/25 at 10:05AM with Director of Nursing Services, they stated they were aware that blankets and pillows were being used in lieu of siderail pads on the bilateral quarter side rails. The Director of Nursing Services stated the nurses are responsible to make sure the siderail pads are in place. Director of Nursing Services stated that blankets and pillows provided padding, and they (the facility) found it acceptable. During an interview on 8/28/2025 at 11:46 AM, with the Administrator, they stated they were aware the staff were utilizing blankets and pillows taped to the resident's quarter side rails to be used in lieu of pads. They stated they have always utilized this practice and found it acceptable. The Administrator stated they did not think it caused a suffocation or entrapment risk, and the topic has not been discussed at any of our Quality Assurance Performance Improvement (QAPI) committee meetings. 10 NYCRR 483.75 (a)(2)(h)(i)</p>		