

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335798	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/07/2026
NAME OF PROVIDER OR SUPPLIER Townhouse Center for Rehabilitation & Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 755 Hempstead Turnpike Uniondale, NY 11553	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on observation, record review, and interviews during an abbreviated survey (2631774), the facility did not ensure that all alleged incidents of a staff-to-resident abuse was reported immediately, but not later than 2 hours if there were serious bodily injuries or not later than 24 hours if there were no serious bodily injuries. This was identified for one (Resident #1) of three residents reviewed for abuse. Specifically, on 08/27/2025 Family Member #1 reported to the facility that Resident #1 alleged Certified Nursing Assistant #2 was rough with them and pulled their arms. The facility did not report the alleged abuse to the New York State Department of Health (NYSDOH). Findings include: Facility Policy titled Abuse Prohibition Policy dated 10/2025 documented All Residents will be protected from Abuse, Neglect, Mistreatment, Exploitation, or Misappropriation of property in accordance with State and Federal Regulations. All alleged or suspected incidents of Abuse, Neglect, Mistreatment, Exploitation or Misappropriation of Residents property will be reported to New York State Department of Health, thoroughly investigated, and findings documented. Resident #1 was admitted with diagnosis that include Type II diabetes, bipolar disorder, and chronic obstructive pulmonary disease. On 03/14/2026 a Minimum Data Set Brief Interview of Mental Status was completed for Resident #1 and documented a score of 09 indicating moderate cognitive impairment. The Progress Notes for Resident #1 were reviewed from 08/01/2025 through 10/01/2025, and there was no documentation of the reported allegations in the progress notes. Comprehensive Care Plan for Resident #1 dated 01/04/2021 documented Resident #1 had a care plan for behaviors related to their diagnosis of bipolar disorder. Behaviors of accusatory behavior, screaming at others; puts the resident at significant risk for physical illness or injury; significantly interferes with resident's care (essential nursing, medical, rehabilitation, personal care); significantly interferes with the resident's participation in activities or social interaction. Interventions include assess for unrecognized needs; preferences or illness; analyze key times; place, circumstances; triggers and what de-escalates behaviors; intervene before resident's agitation escalates. Grievance Reporting Form dated 08/27/2025 documented Family Member #1 & Resident #1's account of August 27th incident. Resident #1 expressed that the aide was physical with them and described the aide grabbing on to Resident #1's arms and pushing and pulling their arms while they argued about using (or not using) the bathroom. Resident #1 stated that they felt like they needed to call 911. The investigation concluded that no abuse had occurred and was signed by Administrator, Director of Nursing, and Registered Nurse Risk Manager on 08/28/2025. There was no documentation the facility reported the allegation to the New York State Department of Health within required twenty-four (24) hour timeframe. During an interview with Administrator on 04/01/2026 at 12:27 PM, the Administrator stated they are responsible for reporting allegations of abuse to the New York State Department of Health. They acknowledged the incident was an allegation of abuse but was not reported to the New York State Department of Health due to Resident #1's history of making false allegations. They stated they were aware that all allegations of abuse must be reported to the New York State Department of Health. The facility investigated the incident and found no evidence of abuse. NYCRR 415.4(b)(1)(i)</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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