STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335798	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Townhouse Center for Rehabilitation & Nursing	755 Hempstead Turnpike Uniondale, NY 11553

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 45349 Based on record review and interviews during the Recertification Survey initiated on 1/15/2025 and completed on 1/23/2025, the facility did not ensure that all completed Minimum Data Set assessments were electronically transmitted to the Centers for Medicare and Medicaid Services within 14 days of the resident assessment completion date. This was identified for two (Resident #223 and Resident #171) of two residents reviewed for the Resident Assessment Task. Specifically, Resident #223's Discharge Minimum Data Set assessment was not submitted within 14 days from the completion of the Minimum Data Set assessment. Resident #171's quarterly Minimum Data Set assessment was not submitted within 14 days from the completion of the Minimum Data Set assessment. The finding is: The facility's policy and procedure titled Completion of the RAI [Resident Assessment Instrument] Process documented that for all residents in certified beds, regardless of payer [source], assessments will be completed within the guidelines outlined in the Resident Assessment Instrument Manual. All assessments will be scheduled within Centers for Medicare Services guidelines. The Minimum Data Set Coordinator will be responsible for the transmission of Minimum Data Set assessments within the time frames outlined in the Resident Assessment Instrument manual and for checking validation reports to ensure acceptance of records sent. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report dated 10/25/2024 documented Resident #223's Discharge Minimum Data Set assessment, with an assessment reference date of 9/23/2024, was completed on 10/7/2024. The assessment was transmitted on 10/25/2024. Resident#223's Minimum Data Set assessment was transmitted four days late. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report dated 1/13/2025 documented Resident #171's quarterly Minimum Data Set assessment, with an assessment reference date of 12/15/2024 was completed on 12/29/2024. The assessment was transmitted on 1/13/2025. Resident #171's Minimum Data Set assessment was transmitted one day late. During an interview on 1/21/2025 at 1:22 PM, the Minimum Data Set Director stated the Minimum Data Set assessments are submitted weekly. For the two identified records, there was a discrepancy in the activity of daily living documentation, so the records were sent back to the interdisciplinary team for review to ensure accuracy, and that is what caused the delay in submission. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/2025 at 1:35 PM, the Administrator stated the Minimum Data Set assessments were late because some corrections related to activities of daily living were needed, which caused the delay in submission of the assessment. 10 NYCRR 415.11

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and staff interviews during the Recertification and Abbreviated Survey (NY 00347071) initiated on 1/15/2025 and completed on 1/23/2025, the facility did not ensure that each resident's comprehensive person-centered care plan was reviewed and revised by the interdisciplinary team after each assessment. This was identified for one (Resident #146) of one resident reviewed for Skin Condition. Specifically, Resident #146 had a diagnosis of Hyperkeratosis (a condition that causes thick, rough, patches of skin) of the bilateral feet; however, there was no care plan developed for the Hyperkeratosis until 1/21/2025. The finding is: The facility's policy titled Care Planning Policy, last revised on 1/2025 documented the facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident's rights, measurable objectives, and time frames to meet the resident's medical, nursing, mental and psychosocial needs that are identified in their assessment. Resident #146 was admitted with diagnoses including Pressure Ulcers, Type 2 Diabetes, and Schizophrenia. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #146 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #146 had unhealed pressure ulcers and utilized a pressure-reducing device for the chair. A review of Resident #146's Comprehensive Care Plan (CCP) revealed that the facility had archived (stored, no longer in effect a care plan for Hyperkeratosis of bilateral feet on 3/5/2024 and was not renewed until 1/21/2025. A Progress Note dated 5/13/2024, from Dermatology Nurse Practioner#1, documented that Resident #146 was seen for a consultation due to Hyperkeratosis and Resident #146 had dry cracked skin on both feet. Dermatology Nurse Practitioner#1 recommended continuing Ammonium Lactate lotion to bilateral feet twice daily. A Physician's Order dated 5/31/2024 last renewed on 1/13/2025 documented Ammonium Lactate 12 percent lotion applied to arms, legs, and feet twice daily for Hyperkeratosis. A Progress note dated 1/20/2025, from Dermatology Nurse Practioner #1, documented that Resident #146 was seen for a consultation due to Hyperkeratosis. The resident had dry cracked skin on bilateral feet. Dermatology Nurse Practitioner #1 recommended continuing Ammonium Lactate lotion to bilateral feet twice daily. During an interview on 1/21/2025 at 8:16 AM, the Wound Care Nurse stated care plans are initiated by the Unit Registered Nurses. The Wound Care Nurse stated Resident #146 had a care plan for Hyperkeratosis in the past. The Wound Care Nurse stated they were not aware that the care plan was archived and was never renewed. The Wound Care Nurse stated that a care plan for Hyperkeratosis should continue due to Resident #146 chronic (long-lasting) diagnosis of Hyperkeratosis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/2025 at 1:27 PM, Registered Nurse #6, the Unit Manager, stated they and the other Registered Nurses were responsible for initiating care plans. Registered Nurse #6 stated that Resident#146's care plan for Hyperkeratosis was not renewed when Resident #146 was readmitted from the Hospital. Registered Nurse #6 stated they should have renewed the care plan because the resident has chronic Hyperkeratosis. During an interview on 1/22/2025 at 8:52 AM, the Director of Nursing Services stated that the care plan for Hyperkeratosis should have been initiated and they expected the Registered Nurses to evaluate, update, and initiate the required care plans. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observation, record review, and interviews during the Recertification Survey initiated on 1/15/2025 and completed on 1/23/2025 the facility did not ensure that each resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. This was identified for one (Resident #115) of three residents reviewed for Skin Conditions. Specifically, Resident #115 was recommended to use an orthotic carrot device (a device shaped like a carrot that supports the hand, prevents injury, and improves function) for their left hand by the Occupational Therapy Department on 4/7/2023. A Physician's order for the use of an orthotic carrot device was never obtained, therefore, Resident #115 was never offered and did not use the orthotic carrot device. The finding is: The facility's policy titled Rehabilitation Services, dated 1/1/2025 documented the facility offers specialized rehabilitative services by qualified personnel in Physical, Occupational, and Speech Therapy to improve and maintain optimal functioning. Residents will also be screened quarterly, annually, and for significant changes or as needed. If further assessment and modifications to the plan of care are needed by the Therapy Department, a Physician's order will be obtained to complete a full evaluation. Resident #115 was admitted with diagnoses including Diabetes Mellitus, Hemiplegia (weakness on one side of the body) affecting the left non-dominant side, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating the resident had moderately impaired cognition. The resident had Functional Limitation in Range of Motion on one side of the upper extremities and both sides of the lower extremities. On 1/21/2025 at 8:21 AM, Resident #115 was observed in bed. The resident's left hand appeared contracted. The resident stated they have not been offered any type of device to wear for the left hand. The resident used their right hand to open the fingers of their left hand. There was no orthotic device in the resident's left hand. A Quarterly Rehabilitation Department Screen dated 4/7/2023 completed by Occupational Therapist (Registered-Licensed) #1 documented the resident had a functional limitation to range of motion to the upper extremity. The screen Recommendations to Nursing documented Left Hand Carrot Orthosis to be worn at all times. Remove for skin check, hygiene, and range of motion exercises. A Quarterly Rehabilitation Department Screen dated 1/15/2025 completed by Occupational Therapist (Registered-Licensed) #1 documented the resident had a functional limitation to range of motion to the upper extremity. The Recommendations to Nursing included the left-hand carrot orthosis to be worn at all times. Remove the carrot orthosis for skin check, hygiene, and range of motion exercises. A review of the medical record revealed no Physician's orders for the left-hand carrot orthosis or range of motion exercises for the left upper extremity. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/21/2025 at 8:36 AM, Certified Nursing Assistant #1 stated this was the first time they were assigned to care for Resident #115. Certified Nursing Assistant #1 stated they did not know anything about the left-hand orthotic device. During an interview on 1/21/2025 at 8:37 AM, Registered Nurse Unit Manager #2, at the surveyor's request, checked the resident's room and stated they could not find the orthotic device and were not aware of the resident using the device. Registered Nurse Unit Manager #2 stated they would have to check with the Rehabilitation Department for clarification. During an interview on 1/21/2025 at 2:23 PM, Rehabilitation Department Director #1 stated the orthotic device was never ordered for Resident #115. Rehabilitation Department Director #1 stated they asked Occupational Therapist #1 to perform another screen today, 1/21/2025, to determine if the orthotic device was still appropriate for Resident #115. The Occupational Therapy screen was completed on 1/21/2025 which indicated that the orthotic carrot device was no longer appropriate. New recommendations for the range of motion to the left upper extremities were provided and a new Physician's order for the range of motion was obtained on 1/21/2025. A Rehabilitation Department Screen dated 1/21/2025, completed by Occupational Therapist #1, recommended Active (completed by the resident) Range of Motion to the Right Upper Extremity and Passive Range (assisted by the staff) of Motion to the Left Upper Extremity, 5-10 repetitions twice a day as tolerated during Activities of Daily Living care. A Physician's order dated 1/21/2025 documented Active Assist Range of Motion to the Right Upper Extremity and Passive Range of Motion to the Left Upper Extremity, 5-10 repetitions twice a day as tolerated during Activities of Daily Living care. During an interview on 1/22/2025 at 9:39 AM, Occupational Therapist #1 stated the resident never received the orthotic carrot device after the resident was screened by them on 4/7/2023 because they (Occupational Therapist (Registered-Licensed) #1) did not obtain an order from the Physician for the device. Occupational Therapist #1 stated they again completed the Rehabilitation Screen for Resident #115 on 1/21/2025 and determined the orthotic carrot device was no longer indicated at this time because the resident needed range of motion exercises. During a re-interview on 1/23/2025 at 10:35 AM, Rehabilitation Director #1 stated when Therapists make recommendations, they need to follow up and obtain the physician's order related to the recommendations. Resident #115 did not receive the recommended orthotic carrot device because Occupational Therapist #1 did not obtain the Physician's order for the orthotic carrot device and should have. 10 NYCRR 415.12(e)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observations, record review, and interviews during the Recertification Survey initiated on 1/15/2025 and completed on 1/23/2025, the facility did not ensure that drug records were in order and accounted for all controlled drugs. This was identified for one (Unit 3 North) of five units reviewed during the Medication Storage Task. Specifically, Licensed Practical Nurse #1 administered 3 tablets of Methadone 5 milligram tablets to Resident #124 and 1 tablet of Lorazepam 0.5 milligram to Resident #15 on 1/16/2025 during the 9:00 AM medication administration pass. Licensed Practical Nurse #1 did not reconcile the Individual Controlled Medication Records to reflect the actual number of remaining tablets in the blister packs. The findings are: The facility policy titled Medications -Management of Controlled Substances, last reviewed on 11/2024, documented that when a controlled substance is to be administered, the nurse will remove the dose from the inventory, the dose is then given to the resident, and the medication [administration administration] documented on the resident's MAR [Medication Administration Record] and on the Individual Controlled Medication Record. If the medication is not administered (refusal, medication dropped, held, etc.), two nurses must dispose of the medication properly by flushing the medication in the sink and both nurses will document the wasting of the medication. 1) Resident #124 was admitted with diagnoses that included Chronic Pain Syndrome, Type 2 Diabetes Mellitus, and Hypertension. The Minimum Data Set, dated dated dated [DATE], documented that Resident #124 had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. The Minimum Data Set documented Resident #15 had Chronic Pain and received a scheduled pain medication regimen which included an Opioid medication during the assessment period. A Physician's order dated 8/22/2023 last renewed on 1/9/2025 documented Methadone 5-milligram tablets; give 3 tablets (15 milligrams) by oral route once daily. During the Medication Storage task on Unit 3 North on 1/16/2025 at 10:50 AM, the narcotics cabinet was observed with Resident #124's Methadone 5 milligram tablet blister pack containing 18 tablets. The Controlled Substance Administration Record documented Resident #124's Methadone 5 milligram tablets were last administered on 1/15/2025 at 8:10 AM and the remaining amount was 21 tablets. The Medication Administration Record for January 2025 documented three tablets of Methadone 5 milligrams, for a total of 15 milligrams, were administered to Resident #124 on 1/16/2025 at 9:00 AM. 2) Resident #15 was admitted with diagnoses that included Chronic Pain, Anxiety Disorder, and Major Depressive Disorder. The Minimum Data Set, dated dated dated [DATE] documented that Resident #15 had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. Resident #15 received a scheduled pain medication regimen during the assessment period. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Physician's order dated 7/14/2021 last renewed on 1/14/2025 documented Lorazepam 0.5 Milligram tablet to be given 1 tablet twice a day by oral route. During the Medication Storage task on Unit 3 North on 1/16/2025 at 10:50 AM, the narcotics cabinet was observed with Resident #15's Lorazepam 0.5 Milligram tablet blister pack containing one tablet. The Controlled Substance Administration Record documented Resident #15's Lorazepam 0.5 milligram tablet was last administered on 1/15/2025 at 9:00 PM and the remaining amount was 2 tablets. The Medication Administration Record for January 2025 documented one Lorazepam 0.5 milligram tablet was last administered to Resident #15 on 1/16/2024 at 9:00 AM. During an interview on 1/16/2025 at 11:25 AM, Registered Nurse Unit Manager #1 stated Licensed Practical Nurse #1 should have updated the Individual Controlled Medication Record immediately after they administered the medications to the residents. The number of medications in the blister pack should match the Individual Controlled Medication Record count. During an interview on 1/16/2025 at 11:28 AM, Licensed Practical Nurse #1 stated they should have updated the Individual Controlled Medication Record when they administered the medications to Resident #15 and Resident #124. Licensed Practical Nurse #1 did not know why they did not update the Individual Controlled Medication Record when they completed the medication administration. During an interview on 1/17/2025 at 11:39 AM, the Director of Nursing Services stated the medication nurse should immediately document the number of tablets remaining in the blister pack onto the Individual Controlled Medication Record after they administer the medication to the resident. 10 NYCRR 415.18(b)(1)(2)(3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827 Based on observation, record review, and interviews during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure that all drugs and biologicals were labeled in accordance with professional standards of practice. This was identified for one (Unit 3 North medication cart A) of eight Medication Carts reviewed during the Medication Storage task and for one (Resident #498) of five residents reviewed for Accidents. Specifically, 1) the Unit 3 North medication cart was observed with two unlabeled medication cups, with medication tablets, in the top drawer. Licensed Practical Nurse #2 stated they stored the pre-poured medications in the medication cart because Resident #41 and Resident #105 had refused their medications during the medication administration pass. 2) Resident #498 was observed with multiple medications in their room that were not ordered by the resident's Physician. The findings are: 1) The facility's policy titled Mediation Storage, last reviewed on ,d+[DATE], documented that medications must be stored in accordance with the manufacturer's specifications and secured in locked storage areas in compliance with State and Federal requirements and accepted professional standards of practice. The facility's policy titled Medication Administration and Documentation, last reviewed on ,d+[DATE], documented that all medications that are expired, contaminated, or refused [by the residents] will be disposed of promptly and properly by licensed medical/nursing personnel in accordance with applicable laws and guidelines. This process is designed to prevent medication misuse, diversion, and environmental harm. Resident #41 was admitted with diagnoses that included Adult Failure to Thrive, Hypertension, and Peripheral Vascular Disease. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #41 was rarely or never understood and had severe cognitive impairment. Resident #41 received anticoagulant medication during the seven-day lookback period. A physician's order renewed on [DATE] documented to administer one tablet of Amlodipine 10 milligrams once a day by oral route. A physician's order renewed on [DATE] documented to administer one chewable tablet of Aspirin 81 milligrams once a day by oral route. The Medication Administration Record documented Resident #41 refused Amlodipine (heart medication) 10-milligram and Aspirin (blood thinner) 81-milligram chewable tablets on [DATE] during the 9:00 AM medication administration. (continued on next page)

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	335798	A. Building B. Wing	01/23/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #105 was admitted with diagnoses that included Cerebral Infarction, Diabetes Mellitus Type 2, and Hypertension. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #105 was rarely or never understood and had severe cognitive impairment. Resident #105 received anticoagulant medication during the seven-day lookback period. A physician's order renewed on [DATE] documented to administer one tablet of Metoprolol (medication to treat high blood pressure) Succinate extended-release 50-milligrams once a day by oral route; one tablet of Hydralazine 50 milligrams (medication to treat high blood pressure) once daily by the oral route; one tablet of Allopurinol 100 milligrams (medication (used to prevent or lower high uric acid levels in the blood) once daily by the oral route; and one tablet of Eliquis 5 milligrams (blood thinner) every 12 hours by oral route. The Medication Administration Record documented Resident #105 refused Metoprolol Succinate extended-release 50-milligram tablet, Hydralazine 50 milligram tablet, Allopurinol 100 milligram tablet, and Eliquis 5 milligram tablet on [DATE] during the 9:00 AM medication administration. During an observation on [DATE] at 10:23 AM, with Licensed Practical Nurse #2, Unit 3 North for the Medication Storage and Labeling task, Licensed Practical Nurse #2 opened the top drawer of the medication cart which contained two unlabeled medication cups with some tablets. Licensed Practical Nurse #2 stated initially they had mistakenly documented that the medications were administered to Resident #41 and Resident #105 and that they should not have signed for the medications before administering the medications to the resident. Licensed Practical Nurse #2 then proceeded to throw away the medications in the garbage pail. During an interview on [DATE] at 10:36 AM, Registered Nurse Unit Manager #1 stated the dispensed medications should not be stored in a medication cup in the medication cart. Medications refused by the resident should be discarded immediately and not saved in a medicine cup inside the medication cart. During a re-interview on [DATE] at 8:57 AM, Licensed Practical Nurse #2 stated they saved the unlabeled medication cups with Resident #41 and Resident #105's medications in the cart because they intended to reapproach the residents; however, they got too busy. Licensed Practical Nurse #2 stated they first documented that they had given the medications and that was in error, they then went back and corrected the record to document the refusal and notified the Physician. During an interview on [DATE] at 11:39 AM, the Director of Nursing Services stated nurses are expected to discard the medication if the resident refuses their medications and document the refusal in the Medication Administration Record. The Director of Nursing Services stated the nurse should not leave the medications in an unlabeled medication cup inside the medication cart. 45349 3) Resident #498 was admitted with diagnoses of Pulmonary Fibrosis and Pneumonia. The Minimum Data Set assessment was not yet completed as the resident was recently admitted to the facility. (continued on next page)

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	335798	A. Building B. Wing	01/23/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on [DATE] at 9:22 AM, multiple medications including Flonase (allergy relief medication) nasal spray, Deep Sea Premium Saline spray, and Icy Hot (topical pain reliever) Jar, with labels from the hospital, were observed on Resident #498's nightstand. There were additional medications including eye lubricant drops and Systane eye drops (used for eye lubrication) without a label were also noted on the resident's nightstand. There were no Physician's orders for Flonase (allergy relief medication) nasal spray, Deep Sea Premium Saline spray, Icy Hot, eye lubricant drops, and Systane eye drops. During an interview on [DATE] at 9:52 AM, Registered Nurse Manager #3 stated that medications should not be stored in a resident's room. All medications should be stored in the medication cart. A Physician's progress note dated [DATE] at 10:46 AM documented that Resident #498 was seen and examined. A clear plastic bag containing over-the-counter medications was found in the resident's personal belongings. The resident's family was contacted and confirmed that the observed medications belonged to Resident #498 and were inadvertently left at the facility. During an interview on [DATE] at 10:45 AM, the Director of Nursing Services stated only nurses handle medications. Nurses should remove the medications that are left in the resident's room. 10 NYCRR 415.18 (e) (,d+[DATE])

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	335798	A. Building B. Wing	01/23/2025

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 34798 Based on record review and interviews during the Recertification Survey initiated on 1/15/2025 and completed on 1/23/2025, the facility did not ensure it provided timely laboratory services to each resident. This was identified for one (Resident #398) of two residents reviewed for Mood and Behavior. Specifically, Resident #398's Physician ordered a Urinalysis (a test that checks urine for signs of health issues like infections and kidney problems) STAT (without delay/prioritized with urgency) on 1/18/2025 to rule out Urinary Tract Infection. The results of the test were not reported by the laboratory to the facility timely. The finding is: The facility's policy titled Laboratory Services, Results, and Physician Notification, dated 5/2024 documented the facility will provide and/or obtain laboratory services in a timely manner to meet the needs of its residents. The facility will provide and/or obtain laboratory services when ordered by a practitioner (physician, physician assistant, nurse practitioner, and or clinical nurse specialist) in accordance with State and Federal regulatory requirements. The physician and/or practitioner will be notified in a timely manner of the laboratory results that fall outside of clinical reference ranges. STAT labs [specimen samples] will be drawn/ collected by the laboratory service provider within 4-6 hours. Laboratory results will be reported to the ordering medical practitioner or designee by unit nursing staff assigned during the shift the laboratory results are received. The nurse will document the Physician's notification of the laboratory results on the laboratory result sheet and/or the progress note. Resident #398 was admitted with diagnoses including Diabetes Mellitus, Chronic Obstructive Pyelonephritis (kidney infection), and Cerebrovascular Accident. The 12/24/2024 Admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 12, indicating the resident had moderately impaired cognition. The resident had no behavioral issues and no signs and symptoms of Delirium. The resident had an indwelling urinary catheter. A progress note dated 1/18/2025 (Saturday) at 11:39 AM, written by Physician #1, documented the Physician was asked by the resident's family member to see the resident because the resident was hallucinating (hearing, seeing, smelling, tasting, or feeling things that appear to be real but only exist in your mind). The resident's blood pressure was 74/44 millimeters of Mercury (normal range 120/80 millimeters of Mercury). Physician #1 documented the resident may have Sepsis (a serious response to an infection) or over-diuresis (excessive urination). Physician #1 recommended bolus (quick delivery) intravenous fluids and checking STAT laboratory workup to look for Sepsis or Azotemia (kidneys not filtering enough nitrogen out of blood). A Physician's order dated 1/18/2025 at 11:35 AM documented to obtain a Urinalysis and a Urine Polymerase Chain Reaction (PCR) test (a laboratory test that detects bacterial organisms and some antibiotic resistance genes in a urine sample) STAT. A Physician's order dated 1/18/2025 at 11:35 AM documented Comprehensive Metabolic Panel STAT. (continued on next page)

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	335798	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Townhouse Center for Rehabilitation & Nursing	755 Hempstead Turnpike Uniondale, NY 11553

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the laboratory requisition form documented that the urine sample was picked up from the facility by the laboratory on 1/18/2025 at 4:15 PM. A review of the medical record revealed there was no documented follow-up regarding the Urinalysis results until 1/21/2025. During an interview on 1/21/2025 at 11:20 AM, Registered Nurse Unit Manager #3 stated Resident #398 had a change in mental status over the weekend and the resident was hallucinating. Registered Nurse Unit Manager #3 stated that this morning, they noticed that Resident #398's Urinalysis results were not received over the weekend. A nursing progress note, written by Registered Nurse #5 (weekend supervisor), dated 1/21/2025 at 1:23 PM documented that on 1/18/2025 laboratory results, including Complete Blood Count and Comprehensive Metabolic Panel, were obtained and reviewed with the Physician. The Urinalysis sample was also collected during the 7:00 AM-3:00 PM shift on 1/18/2025 and the results were pending. During an interview on 1/21/2025 at 1:44 PM, Laboratory Representative #1 stated the blood sample was collected on 1/18/2025 at noon and STAT bloodwork results were reported back to the facility within 6 hours of collection. Laboratory Representative #1 stated there was no record of the Urinalysis order or sample collection that was ordered on 1/18/2025; the courier who collected the samples on 1/18/2025 did not return to the laboratory with the urine sample. Laboratory Representative #1 stated they did not know what happened with the Urinalysis testing. A Medical progress note dated 1/21/2025 at 2:39 PM, written by Physician #2, documented to start empiric (based on observation or experience) treatment with Ceftriaxone (an antibiotic) 1 gram intravenous once daily for 7 days while awaiting results of Urinalysis and Urine Culture. A review of the laboratory results revealed that the Urinalysis results were received by the facility on 1/21/2025 at 8:11 PM. The report indicated that the urine sample had a cloudy appearance; was positive for Nitrites (indicative of Urinary Tract Infection); had a small amount of blood; many bacteria; and a large amount of Leukocyte Esterase (an enzyme found in white blood cells). A comment was added from the laboratory in the Urinalysis report on 1/22/2025 documenting that the laboratory will follow up with the culture/sensitivity (a lab procedure that identifies the cause of an infection and determines the best treatment). A comment from Physician #2 (primary physician) in the Urinalysis report dated 1/22/2025 documented that Urinalysis looks positive (for infection); Empiric Ceftriaxone (an antibiotic) was in progress while awaiting urine culture results. During an interview on 1/22/2025 at 8:49 AM, Registered Nurse #5 (the weekend supervisor) stated they reported the STAT bloodwork results to Physician #1 on 1/18/2025. There was no Urinalysis result available on 1/18/2025. Registered Nurse #5 stated they called the laboratory on 1/18/2025 but the laboratory staff did not pick up the phone. Registered Nurse #5 stated they did not know what happened to the Urinalysis or why the urine test was not completed as ordered. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/22/2025 at 9:01 AM, Primary Physician #1 stated they discussed the blood test results with Registered Nurse #5 on 1/18/2025; however, the Urinalysis results were not available on 1/18/2025. Primary Physician #1 stated STAT orders for blood work and Urinalysis should be collected the same day and results should be returned the same day. During an interview on 1/22/2025 at 10:06 AM, the Director of Nursing Services stated they would expect STAT laboratory orders to be carried out and completed the same day including receiving the laboratory results. During an interview on 1/23/2025 at 10:28 AM, Primary Physician #2 stated results for a STAT order should be returned within the day to begin timely treatment. 10 NYCRR 415.20

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review, and interviews during the Recertification Survey initiated on 1/15/2025 and completed on 1/23/2025, the facility did not ensure the Binding Arbitration Agreement explicitly granted the resident and their representative the right to rescind the agreement within 30 calendar days of signing the agreement. This was identified for two (Resident #139 and Resident #238) of two residents reviewed during the Arbitration Task. Specifically, the Binding Arbitration Agreement signed by Resident #139 and Resident #238's representatives did not specify that the resident/representatives had 30 calendar days to rescind the agreement. The finding is: The facility's policy titled Optional Arbitration Agreement dated 6/2023 documented that residents and responsible parties must be advised prior to admission that the facility will honor any written request by a resident and/or their representative to terminate the Optional Arbitration Agreement if such notice of termination is delivered either personally or by certified mail. The policy did not indicate a specific timeframe by which the written agreement could be rescinded. The facility's Optional Arbitration Agreement did not include that the resident and/or their representatives had the right to rescind the Optional Arbitration Agreement within 30 calendar days of signing the agreement. Resident # 139 was admitted with diagnoses including Hypertension, Hyperlipidemia (high cholesterol), and Gout. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. A Binding Arbitration Agreement, signed by Resident #139 on 10/9/2024 did not include that the resident and/or their representatives had the right to rescind the Optional Arbitration Agreement within 30 calendar days of signing the agreement. Resident # 238 was admitted with Diagnoses including Osteoarthritis, Joint Replacement Surgery, and Hypertension. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A Binding Arbitration Agreement, signed by Resident 139's representative on 12/19/2024, did not include that the resident and/or their representatives had the right to rescind the Optional Arbitration Agreement within 30 calendar days of signing the agreement. During an interview on 1/17/2025 at 2:22 PM, Resident #139 stated they were educated about entering the Optional Arbitration Agreement. Resident #139 stated they were verbally informed that they could cancel any services or agreement including the Optional Arbitration Agreement at any time. Resident #139 stated they reviewed the Optional Arbitration Agreement before signing but did not recall if the agreement included information on how to rescind it. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/17/2025 at 1:34 PM, Resident #238 stated they permitted their family member to participate, review, and sign all documents on their behalf. Resident #238 stated the facility would have discussed the admission agreement including the Optional Arbitration Agreement with the family member. During an interview on 1/21/2025 at 9:23 AM, Resident #238's family member stated they handled Resident #238's paperwork upon admission. Resident #238's family member stated they were educated about entering the Optional Arbitration Agreement prior to signing the document. Resident #238's family member stated they were verbally informed of their right to opt out of the agreement anytime. Resident #238's family member was not aware that the Optional Arbitration Agreement did not include a written statement on how to rescind it. During an interview on 1/17/2025 at 3:28 PM, the Director of Admissions stated resident and/or their representative were verbally educated that they could rescind the Optional Arbitration Agreement at any time during their stay. The timeframe to rescind the agreement is not limited to 30 calendar days from signing the Optional Arbitration Agreement. The Director of Admissions stated the Optional Arbitration Agreement did not include documented evidence that the agreement could be rescinded within 30 calendar days of signing the agreement. During an interview on 1/21/2025 at 1:51 PM, the Administrator stated they were aware that the resident and/or representative must be granted the right to rescind the Optional Arbitration Agreement within 30 calendar days of signing the agreement as per the regulation. The Administrator stated the facility's legal team was responsible for drafting the agreement. The Administrator stated they believed the agreement was written in compliance with all regulations. The Administrator acknowledged that the Optional Arbitration Agreement did not include written information about the resident's right to rescind the agreement within 30 calendar days of signing the agreement. The Administrator stated the resident and/or representative can request to opt out of the agreement at any time, even if the decision to rescind exceeds 30 calendar days. 10 NYCRR 415.30

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. 21478 Based on record review and interviews during the Recertification Survey initiated on 1/15/2025 and completed on 1/23/2025, the facility did not ensure it established and maintained an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development, and transmission of communicable diseases and infections. This was identified during the Infection Control Task. Specifically, the facility did not provide documented evidence of testing of the potable water system for Legionnaires' and other Waterborne pathogens. The facility did not provide documented evidence of a Flow Diagram to indicate a description of the building's water systems as per the facility's policy. The finding is: The facility's Legionella Water Mgmt. Plan (WMP) policy dated 2/06/2017 last reviewed on 10/17/2024 documented the Water Management Plan including but not limited to Flow Diagram and tables for each Water System The Laboratory Certificate of Analysis documented a water sample was collected from the Cooling Tower on 6/7/2024 and results were reported on 6/21/2024 with no Legionella isolates. There was no documented evidence that the facility performed testing of the potable water system in other areas of the building where there was a high probability of opportunistic pathogens in the building water system. The facility did not provide a Flow Diagram and tables for each Water System as indicated in the facility's policy. During an interview on 1/17/2025 at 2:30 PM the Director of Environmental Services stated they recently took over the Maintenance Department responsibilities and were still learning about the building systems. The Director of Environmental Services was notified to provide records of the Legionella testing and results of the potable water system, the design description of the potable water system identifying potential points of Legionnaires and other waterborne pathogens. The requested records were not provided at the conclusion of the survey. During an interview on 1/17/2025 at 2:30 PM, the Administrator stated it is the Director of Environmental Services' responsibility to maintain an updated Water Management Plan. The Administrator stated the Director of Environmental Services was recently assigned to the Maintenance Department and was still learning about the building systems. 10 NYCRR 415.19(a)(1-3)