STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335808	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hempstead Park Nursing Home	800 Front Street Hempstead, NY 11550

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure that residents' drug regimens were free from unnecessary psychotropic medications. This was identified for one (Resident #14) of five residents reviewed for Unnecessary Medications. Specifically, Resident #14 had a Physician's Order to receive Olanzapine (an antipsychotic medication) 5 milligrams once a day from 04/16/2025 to 05/15/2025. On 05/16/2025, the Physician lowered the resident's Olanzapine dose to 2.5 milligrams once a day. On 06/04/2025, the facility changed its Electronic Medical Record (EMR) to another vendor company. Resident #14's Olanzapine order was inadvertently reverted to 5 milligrams of Olanzapine daily without the consent or knowledge of the resident or the resident's Physician.The finding is:The facility's policy titled Psychoactive Medications, last reviewed on 03/06/2025, documented the Psychiatrist will attempt to reduce psychotropic medications in accordance with regulatory requirements for Gradual Dose Reduction as stipulated by the Centers for Medicare & Medicaid Services. The Primary Physician will review the recommendations made by the Psychiatrist and incorporate them into the medical record.Resident #14 had diagnoses that include Schizophrenia and Anxiety Disorder. The significant change Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three (3), which indicated the resident had severely impaired cognitive skills for daily decision making. The resident received an antipsychotic medication in the last seven (7) days.The readmission Physician's Order in the old Electronic Medical Record system dated 04/16/2025 documented for the resident to receive Olanzapine 5 milligram tablet, give one tablet by oral route once daily for Schizophrenia, and Sertraline (an antidepressant medication) 25 milligram tablet, give 1 tablet by oral route once daily for Anxiety Disorder. The old Electronic Medical Record (EMR) system Medication Administration Record (MAR) for April 2025 documented the resident received Olanzapine 5 milligram tablet by oral route once daily for Schizophrenia from 04/17/2025 to 04/30/2025. The old Electronic Medical Record (EMR) system Medication Administration Record (MAR) for May 2025 documented the resident received Olanzapine 5 milligram tablet by oral route once daily for Schizophrenia from 05/01/2025 to 05/15/2025. The Psychiatric Consultation dated 05/15/2025 documented the plan/recommendation was to lower the resident's Olanzapine to 2.5 milligrams once daily in the evening. The Physician's Monthly Progress Note dated 05/16/2025 documented the resident was seen by the Psychiatrist on 05/15/2025 for Mood Disorder and Neurocognitive Disorder with Agitation. The plan/recommendation was to lower the resident's Olanzapine to 2.5 milligrams once daily in the evening. The Physician's Order in the old Electronic Medical Record system dated 05/16/2025 documented to discontinue Olanzapine 5 milligrams. The Physician's Order in the old Electronic Medical Record system dated 05/16/2025 documented for the resident to receive Olanzapine 2.5 milligram tablet, give one tablet by oral route once daily every day at 5:00 PM for Schizophrenia. The old Electronic Medical Record (EMR) system Medication Administration Record (MAR) for May 2025 documented the resident received Olanzapine 2.5 milligram tablet by oral route once daily for Schizophrenia from 05/16/2025 (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 05/31/2025. The old Electronic Medical Record (EMR) system Medication Administration Record (MAR) for June 2025 documented the resident received Olanzapine 2.5 milligram tablet by oral route once daily for Schizophrenia from 06/01/2025 to 06/03/2025.The Physician's Order in the new Electronic Medical Record system dated 06/04/2025, documented for the resident to receive Olanzapine 5 milligram tablet, give one tablet by oral route in the evening.The Physician's Monthly Progress Note dated 06/16/2025 documented the resident was seen by the Psychiatrist on 05/15/2025 for Mood Disorder and Neurocognitive Disorder with Agitation. The plan/recommendation was to lower the resident's Olanzapine to 2.5 milligrams once daily in the evening. The new Electronic Medical Record system Medication Administration Record (MAR) for June 2025, documented the resident received Olanzapine 5 milligram tablet by oral route in the evening from 06/04/2025 to 06/30/2025. The Physician's Monthly Progress Note dated 07/15/2025 documented the resident was seen by the Psychiatrist on 05/15/2025 for Mood and Neurocognitive Disorder with Agitation. The plan/recommendation was to lower the resident's Olanzapine to 2.5 milligrams once daily in the evening. The new Electronic Medical Record (EMR) system, Medication Administration Record for July 2025, documented the resident received Olanzapine 5 milligram tablet by oral route in the evening from 07/01/2025 to 07/29/2025. During an interview on 08/01/2025 at 10:30 AM, the Pharmacy Electronic Medical Record Specialist #1 stated all the facility's Pharmacy Orders were electronically moved from the previously used Electronic Medical Record system to a new Electronic Medical Record system on 05/14/2025; however, the new system went live on 06/04/2025. Resident #14's Olanzapine 5 milligram Physician's Order that was in place on 05/14/2025 was also moved to the new system. The Pharmacy Electronic Medical Record Specialist #1 stated that someone from the facility should have manually entered the order for the 2.5 milligrams of Olanzapine to the new Electronic Medical Record system on 05/16/2025 since the order was changed after the data was transferred to the new system on 05/14/2025. During an interview on 08/01/2025 at 11:10 AM, Primary Physician #1 stated they were not aware the resident was receiving the higher dose of Olanzapine 5 milligrams instead of Olanzapine 2.5 milligrams. Primary Physician #1 stated the resident should have received 2.5 milligrams of Olanzapine, and it was never their (Primary Physician #1's) intention for the resident to go back to the higher dosage. During an interview on 08/01/2025 at 11:20 AM, the Administrator stated they were not monitoring how the Pharmacy Orders were carried over when the facility changed from one Electronic Medical Record system to another. The Administrator stated they were only monitoring that staff attended educational meetings to learn how to use the new Electronic Medical Record system. During an interview on 08/04/2025 at 3:00 PM, Licensed Practical Nurse #5 stated they did not double-check if the Physician Orders for Resident #14's Olanzapine were transferred accurately from the old Electronic Medical Record system to the new Electronic Medical Record. Licensed Practical Nurse #5 stated they dispensed whatever Olanzapine dosage was indicated in the new Electronic Medical Record System Medication Administration Record.During an interview on 08/05/2025 at 11:50 AM, the Director of Nursing stated Licensed Practical Nurse #5 should have clarified the order for the Olanzapine before administering the medication.10NYCRR 415.4(a)(1) and 415.3(d)(1)(vii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified on one (1) (Unit 4 South) of six (6) units reviewed for the Sufficient Nursing Staffing Task. Specifically, the Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Two 2025 (January 1st-March 31st) indicated that the facility had a one (1)-star staffing rating. Additionally, there were multiple occasions when the facility had insufficient Licensed Practical Nurses assigned to Unit 4 South, as specified on the Facility Assessment. The finding is:The Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Two 2025 (January 1st-March 31st) documented the facility triggered for the Metric of One Star Staffing Rating.The Facility assessment dated [DATE], last reviewed and/or updated on 06/2025, documented that the facility had a 251-bed capacity with an average daily census of 225.The Administrator provided an updated Facility Assessment on 08/01/2025, which indicated Unit 4 South had a 41-bed capacity and required two Licensed Practical Nurses during the 7:00 AM-3:00 PM shift.A review of the Facility Unit Census logs from 01/05/2025 to 01/11/2025; 02/09/2025 to 02/15/2025; 03/16/2025 to 03/22/2025, and 07/28/2025 to 08/04/2025 revealed resident census on Unit 4 South was between 37 and 41 residents.A review of the 7:00 AM-3:00 PM shift schedule for Unit 4 South from 01/05/2025 to 01/11/2025 indicated the following:- On 01/06/2025, 01/07/2025, 01/08/2025, 01/09/2025, and 01/10/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 38 residents.A review of the 7:00 AM-3:00 PM shift schedule for Unit 4 South from 02/09/2025 to 02/15/2025 indicated the following:- On 02/10/2025 and 02/11/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 40 residents.- On 02/12/2025, 02/13/2025, and 02/14/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 41 residents. A review of the 7:00 AM-3:00 PM shift schedule on Unit 4 South from 03/16/2025 to 03/22/2025 indicated the following:- On 03/17/2025 and 03/19/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 37 residents.- On 03/16/2025, 03/20/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 38 residents.- On 03/21/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 38 residents.A review of the 7:00 AM-3:00 PM shift schedule on Unit 4 South from 07/28/2025 to 08/4/2025 indicated the following:- On 07/28/2025 and 07/30/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 39 residents.- On 08/01/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 40 residents.Resident #133 was admitted with diagnoses of Type 2 Diabetes Mellitus, Hypertension, and Major Depressive Disorder. The Annual Minimum Data Set assessment dated [DATE] documented that Resident #133 had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. During an interview on 07/28/2025 at 10:35 AM, Resident #133 stated that they had not received their morning medications today.During the Medication Administration task observation with Licensed Practical Nurse #8 on 07/28/2025 from 11:07 AM to 11:30 AM, Licensed Practical Nurse # 8 administered Resident #133's 10:00 AM medications at 11:30 AM, which was 30 minutes beyond the facility's required time frame. During an interview immediately after the observation on 07/28/2025, Licensed Practical Nurse #8 stated they were the regularly assigned charge nurse on Unit 4 South. Licensed Practical Nurse #8 stated there were usually two Licensed Practical Nurses assigned to each of the 4th-floor units (4 South and 4 North). Licensed Practical Nurse #8 stated that both the assigned Licensed Practical Nurses were (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for administering medications. Licensed Practical Nurse #8 stated today (07/28/2025) they were alone on the unit, and the second Licensed Practical Nurse (# 2), who usually worked on Unit 4 South, was assigned to work alone on Unit 4 North. Licensed Practical Nurse #8 stated they were passing medications and providing treatments by themselves and therefore were not able to administer Resident #133's morning medications on time. During an interview on 07/28/2025 at 11:40 AM, Licensed Practical Nurse #2 stated that they regularly worked with Licensed Practical Nurse #8 on Unit 4 South and were reassigned to Unit 4 North today (07/28/2025) due to a call-out. Licensed Practical Nurse #2 stated there should be two Licensed Practical Nurses assigned to each unit (4 South and 4 North).During an interview on 07/29/2025 at 12:22 PM, the Staffing Coordinator stated they have worked as a Staffing Coordinator for six months at the facility. The Staffing Coordinator stated that based on the par levels, there should be two Licensed Practical Nurses assigned to each resident unit during the day shift (7:00 AM-3:00 PM) on weekdays (Monday to Friday).During an interview on 07/30/2025 at 10:37 AM, Registered Nurse #1stated there should be two Licensed Practical Nurses on each unit on the 4th floor. Registered Nurse #1 stated there was one Licensed Practical Nurse on each unit (4 South and 4 North) today (07/30/2025). Registered Nurse #1 stated that they had to assist with dining room monitoring today, which would normally be the Licensed Practical Nurse's responsibility.During a re-interview on 07/30/2025 at 11:47 AM, Licensed Practical Nurse #8 stated that they were working alone on unit 4 South today. Licensed Practical Nurse #8 stated that Registered Nurse #1 had to assist them with Dining room monitoring so they could give medications to residents on time. Licensed Practical Nurse #8 stated it is overwhelming when they have to give medication and treatment all by themselves. During a re-interview on 08/05/2025 at 9:56 AM, the Staffing Coordinator stated they were not able to schedule Licensed Practical Nurses during the day shift (7:00 AM-3:00 PM) on weekdays, according to the par levels (provided to them by the Corporate staff), due to a shortage of available Licensed Practical Nurses. The Staffing Coordinator stated that the Director of Nursing Services, the Administrator, and the Human Resources personnel were aware of the issue, and they (the Staffing Coordinator) were told, We are working on it. The Staffing Coordinator stated that the 4th floor units (4 South and 4 North) only had one Licensed Practical Nurse assigned to each unit on 07/28/2025 and 07/30/2025 due to staff vacation and call-out. During an interview on 08/05/2025 at 11:22 AM, the Director of Nursing Services stated they were not familiar with the facility's overall nursing staffing needs; however, each nursing unit should have two Licensed Practical Nurses assigned on the day shift during the weekdays as per the Facility Assessment.During an interview on 08/05/2025 at 11:50 AM, the Administrator stated each resident unit should have two Licensed Practical Nurses assigned on the day shift during the weekdays as per the Facility Assessment. The Administrator stated they submitted the Payroll-Based Journal Staffing Data Report, but did not know that the facility triggered the Metric of One Star Staffing Rating. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey and Abbreviated Survey (Complaint #697429) initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure resident rights to be free from abuse. This was identified for two (Resident #83 and Resident #98) of three residents reviewed for Abuse. Specifically, on 04/25/2025, Resident #83, with intact cognition, was using a common bathroom. Resident #98, with severely impaired cognition, attempted to enter the same bathroom, and Resident #83 told Resident #98 to get out. Resident #98 made a fist and swung at Resident #83. Resident #83, in turn, punched Resident #98 in the right eye; Resident #98 was sent to the emergency room for evaluation for complained of pain and redness in the right eye.The finding is:The facility's Abuse Prevention Policy, dated 9/19/2022 and revised on 2/3/2025, documented to provide a safe resident environment that protects residents from abuse, including verbal, mental, sexual, or physical abuse. This includes staff-to-resident abuse of any type, resident-to-resident abuse of any type, and visitor-to-resident abuse of any type. Physical abuse is inappropriate physical contact resulting in injury or likely to harm a resident. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. The policy defined willful as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.Resident #83 was admitted to the facility with diagnoses of Diabetes, Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and Metabolic Encephalopathy (a brain disorder caused by a chemical imbalance). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #83 had intact cognition. The Minimum Data Set documented that Resident #83 did not exhibit any behaviors.A Comprehensive Care Plan titled Risk for Abuse, dated 04/24/2023 and updated on 04/24/2025, with interventions including observing changes in customary routines, keeping the resident away from other peers whenever possible, and staff to observe during rounds and care.Resident #98 was admitted to the facility with diagnoses of Diabetes, Alzheimer's, and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated Resident #98 had severe cognitive impairment. The Quarterly Minimum Data Set assessment documented that Resident #98 did not exhibit any behaviors.A review of the Abuse Risk assessment dated [DATE] revealed that Resident #98 had behavior factors of being verbally disruptive, repetitive calling out, and had a history of being aggressive to peers.A Comprehensive Care Plan titled Behaviors, as evidenced by an altercation dated 04/25/2025, documented interventions including administering medications as ordered, observing for changes in behaviors, and redirecting the resident to an alternative environment. The Resident-to-Resident Altercation Report dated 04/25/2025 documented that Resident # 83 was in the common bathroom, by the Activity Room, when Resident #98 went in [the same bathroom] to wash their hands. Resident #83 told Resident #98 to get out, but Resident #98 insisted on coming in. Resident #98 then swung their fist, tapping Resident #83's right side of the chin. Resident #83 then punched Resident #98's right eye. The Recreation Aide (#1) immediately intervened and separated both residents. The investigation summary concluded there was no evidence of abuse, neglect, or mistreatment. The incident was unpredictable. Resident #98's insights and judgment were poor. The facility will continue to offer resident #98 diversional activities and redirection.The Accident and Incident report dated 04/25/2025 for Resident #83 documented a statement from Resident #83 indicating stated the resident was using the bathroom, and Resident #98 opened the bathroom door. Resident #83 stated they told Resident #98 to leave, but Resident #98 refused. Resident #83 stated they hit Resident #98.The Accident and Incident report dated 04/25/2025 for Resident #98 documented a statement from Resident #98 indicating the resident went (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the bathroom, but Resident #83 was inside, and they (Resident #98) told Resident #83 to leave. Resident #98 stated that Resident #83 punched them (Resident #98) in the face.During an interview on 07/29/2025 at 10:30 AM, Resident #83 stated they remembered the altercation with Resident #98. Resident #83 stated they were using the bathroom first and needed privacy, and Resident #98 did not acknowledge their request to wait until they were finished using the bathroom. Resident #83 stated they punched Resident #98 to stop them (Resident #98) from coming into the bathroom.During an interview on 07/31/2025 at 8:47 AM, the Recreation Aide #1 stated that they went into the bathroom when a resident reported to them that something was going on in the bathroom. Resident #83 and Resident #98 were already separated. The Recreation Aide stated that they immediately reported the incident to Registered Nurse #2. Recreation Aide #1 stated Resident #83 participates in most activities. Resident #98 would join activities at times, and a staff member would accompany Resident #98 from the Unit to the Activity Room because Resident #98 needed redirection. The Recreation Aide #1stated that Resident #98 often sat next to them (Recreation Aide #1) during activity because the resident needed assistance with participation.During an interview on 08/01/2025 at 12:27 PM, Registered Nurse #2, Unit Manager, stated they were called to assess Resident #83 and Resident #98 after the Recreation Aide had reported the incident on 04/25/2025. Registered Nurse #2 stated that Resident #98 had redness around the right eye and complained of pain. Resident #98's Physician ordered to send Resident #98 to the emergency room for evaluation. Resident #83 told Registered Nurse #2 that Resident #98 would not leave the bathroom, so they punched Resident #98 to get them out.During an interview on 08/05/2025 at 11:17 AM, the Director of Nursing Services stated that they were not the Director of Nursing at the time of the incident. The Director of Nursing Services stated that they had two staff members in the Activity Room to supervise the Activity, but there was no staff in the lobby leading to the bathroom where the incident occurred between Resident #83 and Resident #98. The Director of Nursing Services stated that Residents with cognitive impairment should have been supervised more because they are at risk for abuse.10 NYCRR 415.4(b)(1)(i)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure that the resident representative and Ombudsman were notified for each resident discharged from the facility. This was identified for one (Resident #241) of two residents reviewed for Discharge. Specifically, Resident #241 had a planned discharge from the facility on 04/20/2025 to another facility. There was no documented evidence that the resident's representatives and the Ombudsman were notified of the discharge.The finding is:The facility's policy titled Transfer and Discharge Planning and Documentation, effective 4/28/2025, documented notifying the resident/family/ombudsman in writing before a transfer or discharge. The unit Social Worker will be responsible for ensuring that the resident (and representative when applicable) receives written notice of any discharge. The Director of Social Work will be responsible for ensuring that the Ombudsman receives notice of all discharges. When the discharge is planned, the facility's Social Worker will send a copy of the notice to the representative of the Office of the State Long-Term Care Ombudsman as soon as practicable.Resident #241 was admitted with diagnoses including Bipolar Disorder, Depression, and Chronic Obstructive Pulmonary Disease. The 03/12/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact.A Comprehensive Care Plan, effective 03/05/2025, titled Discharge Planning, documented the resident's discharge status was uncertain. The resident was transferred from another facility and indicated they would like to be discharged back to the community. Resident has a PASRR (a person-centered evaluation that is completed for anyone having a serious mental illness to ensure they are properly placed in the nursing home) screen in place, and discharge was unknown at this point.A progress note written by Social Worker #1, dated 04/21/2025, documented that the resident inquired about returning to the former facility. A discharge note written by Social Worker #1 dated 04/30/2025 documented the resident requested to return to the former facility and was accepted by them. The resident left (to go to the requested facility) around 11:45 AM today via ambulette. Review of the medical record revealed no documented evidence that the resident's representative or the Ombudsman was notified of the discharge.During an interview on 07/31/2025 at 11:45 AM, Social Worker #1 stated that an email was sent to the Ombudsman regarding the discharge, and they would have to find the email. During an interview on 07/31/2025 at 1:10 PM, Social Work Director #1 stated there was an oversight; Resident #241's name was inadvertently removed from the list of discharges that was prepared for notification to the Ombudsman, therefore, the notification to the Ombudsman regarding Resident #241's discharge did not take place. The notification was sent out today.During a re-interview on 08/1/2025 at 9:52 AM, Social Worker #1 stated they did not notify the resident's representative of the resident's discharge to the other facility. The resident was their own representative because they were alert and oriented. The resident did not request to notify their representative. The resident had their own cellphone and was in communication with their family. Social Worker #1 stated they did not believe the resident had anyone listed in the medical record as their contact on their contact list.A review of the resident's contact list in the electronic medical record revealed that there were three family members on the list.During a re-interview on 08/01/2025 at 10:30 AM, Social Work Director #1 stated that if a resident did not want the facility to call their family regarding a discharge, that should be documented. In general, the facility would call the resident representative unless the alert resident specifically requested not to notify their representative.10NYCRR 415.3

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure it developed and implemented a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This was identified for one (1) (Resident #65) of two (2) residents reviewed for Rehabilitation and one (1) (Resident #11) of two (2) residents reviewed for Positioning/Mobility. Specifically, 1) Resident #65 had a right above-the-knee amputation and was in the process of getting a prosthetic limb device. There was no comprehensive care plan regarding the amputation, including the status of the prosthetic device; and 2) Resident #11 had a Physician's order to apply a hand roll at all times or as tolerated. On 07/28/2025 and 08/01/2025, the resident was observed without any hand roll to the right hand. The findings are: The facility's policy titled Comprehensive Care Planning, last reviewed 08/01/2025, documented that each resident will have a comprehensive person-centered care plan developed that is in compliance with Federal and State regulations. The facility will establish an interdisciplinary team care planning process to ensure that resident care and treatment are planned appropriately for the resident's needs and condition, impairment, disability, or disease process in a timely, systematic, and comprehensive manner. The interdisciplinary team will address individualized resident needs to include medical, physical, psychosocial, cognitive, functional, activities, spiritual, cultural, and communication needs. 1) Resident #65 was admitted with diagnoses including Diabetes Mellitus, Bipolar Disorder, and Acquired Absence of Limb (amputation). The 03/12/2025 admission Minimum Data Set Assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact and had a limited range of motion on one side of the lower extremities. The Physician's admission Evaluation Note dated 03/07/2025 documented that the resident had a right above-knee amputation. Comprehensive Care Plans titled Resident has Limited Physical Mobility Related to Weakness, initiated on 06/05/2025, and Fall Prevention, initiated 06/19/2025, did not document that the resident had a right above-knee amputation. During an interview on 07/29/2025 at 10:12 AM, Resident #65 stated they had the right above-knee amputation approximately one year ago and were told that upon admission to this facility, they would be fitted for a prosthetic leg. The resident stated they were unsure about the status of the plan and would like to get the prosthetic so that they could walk again. During an interview on 07/312025 at 11:07 AM, the Rehabilitation Department Director #1 stated that the Rehabilitation Department would not create a care plan until the device is obtained from the orthotic provider. They stated that the communications with the orthotic provider are not documented in the medical record but are documented in a book in the Rehabilitation Department, and a care plan is not developed until the prosthetic device is delivered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hempstead Park Nursing Home	800 Front Street Hempstead, NY 11550

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A letter provided from the Prosthetic Lab to the facility dated 07/31/2025 documented: Unfortunately, very few prosthetic components exist that will accommodate the patient's weight of 380 pounds. Both the knee and the foot (of the prosthetic) are affected by these criteria. An additional hurdle was to ensure that this componentry would be covered by the insurance carrier. We were also apprised that the patient had an existing prosthesis, and we were trying to determine the date on which it was manufactured, as there are restrictions on frequency for a new device. One of the problems we have also encountered is that the insurance policy that the patient possesses does not cover the cost of the specialized components necessary to make the prosthesis according to the current weight. We have casted, fabricated, and fit check sockets since we have encountered the patient to attempt to expedite the process. Once we receive authorization from the insurance company, fabrication and delivery will happen in a timely manner. During a re-interview on 08/04/2025 at 2:59 PM, Rehabilitation Department Director #1 stated the efforts to obtain the prosthesis are in process, but it is difficult to make the prosthesis for Resident #65, due to the resident's weight. The resident was last seen by a prosthetist in May 2025. The Rehabilitation Department does not make a care plan until the prosthesis is in place. The Rehabilitation Department develops the care plan for the prosthesis, and the Nursing staff is responsible for developing the care plan for the amputation. During a re-interview on 08/05/2025 at 9:45 AM, Resident #65 was in bed, and their old orthotic device was on the floor. The resident stated the device did not fit well, and when they put on the device, it was uncomfortable. The resident stated they want a new prosthesis so they can start walking again. During an interview on 08/05/2025 at 9:47 AM, Registered Nurse Wound Care Nurse #1 (and acting supervisor on the unit) stated that care plans should be initiated on admission by the admission nurse. All licensed nurses can generate care plans based on the resident's needs. The care plan for the amputation should have been in place because the amputation has a significant effect on the resident's life. During an interview on 08/05/2025 at 10:21 AM, the Director of Nursing Services stated there should be a care plan in place for the amputation, especially when the resident is waiting for a prosthesis to be developed. The care plan should address the progress of the prosthesis development. 2) Resident #11 was admitted with the diagnoses including Central Pain Syndrome (a chronic pain condition caused by damage to the central nervous system), Diabetes Mellitus, and Pyridoxine (Vitamin B6) Deficiency. The Quarterly Minimum Data Set assessment dated [DATE] indicated a Brief Interview for Mental Status was not conducted because the resident's cognitive skills for daily decision making were severely impaired. The minimum data set assessment documented the resident had impairment to the range of motion of both upper extremities. A Physician's Order dated 07/03/2025 documented to apply a hand roll to the right hand at all times or as tolerated by the resident. Remove as scheduled and for Activities of Daily Living Care, restorative nursing program, or functional maintenance program, and check skin integrity. A comprehensive care plan titled Activities of Daily Living, last revised on 07/22/2025, documented interventions including applying a hand roll to the right hand at all times or as tolerated by the resident. Remove as scheduled and for Activities of Daily Living Care, restorative nursing program, or functional maintenance program, and check skin integrity. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Kardex (a summary of a resident's needs and care instructions) for Resident #11 documented to apply a hand roll to the right hand at all times or as tolerated by the resident. Remove as scheduled and for Activities of Daily Living Care, Restorative nursing program, or functional maintenance program, and check skin integrity. During an observation on 07/28/2025 at 11:12, Resident #11 was observed lying in bed with no hand roll to the right hand. During a subsequent observation on 08/01/2025 at 10:44 AM, the resident was observed lying in bed in their room with no hand roll applied to the right hand. During an interview on 08/01/2025 at 10:51 AM, Certified Nursing Assistant #8, the regularly assigned Certified Nursing Assistant for Resident #11, stated that the resident does not use a hand roll and is very resistant when staff tries to touch or provide care to the resident's hands. Certified Nursing Assistant #8 stated they could not recall ever seeing a hand roll in the resident's room. Certified Nursing Assistant #8 stated there were no instructions for the use of a hand roll documented in the Certified Nursing Assistant Accountability Record. During an interview on 8/1/2025 at 12:43 PM, Licensed Practical Nurse #7, the charge nurse, stated Resident #11 had an order to apply a hand roll to the right hand. Licensed Practical Nurse #7 stated at times they would apply a rolled gauze to the resident's right hand; however, they did not instruct the Certified Nursing Assistants to do the same, as they (Licensed Practical Nurse #7) were responsible for applying the hand roll. Licensed Practical Nurse #7 stated that if a hand roll was missing, they were supposed to notify the Rehabilitation department, but they usually get so busy on the unit that they lost track of it. Licensed Practical Nurse #7 further stated the hand roll should have been applied to Resident #11's right hand as ordered. During an interview on 8/1/2025 at 1:28 PM, the Occupational Therapist stated they had treated Resident #11 several months ago, and Resident #11 started with a rigid joint to the right hand and had low potential for any significant improvements. The Occupational therapist stated they trialed several devices for the resident, including hand splints and palm guards, but ultimately the resident was only able to tolerate a hand roll. The Occupational Therapist stated they were not aware of the missing hand roll for Resident #11. During an interview on 08/05/2025 at 9:45 AM, the Director of Nursing Services stated that the nursing staff should have ensured that a device was in place as per the Physician's orders. The Director of Nursing Services stated that nursing staff should have followed the order and instructions for Resident #11's hand roll. 10 NYCRR 415.11(c)(1)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (1) (Resident #232) of three (3) residents reviewed for Choices. Specifically, Resident #232 returned to the facility from the hospital on [DATE] after a Pacemaker (a small implanted medical device that helps regulate a slow heart rate by sending electrical impulses to the heart) Implantation. Resident #232 had a recommendation from the hospital for a follow-up consultation with an Electrophysiologist (a Cardiologist who specializes in diagnosing and treating heart rhythm disorders) after three weeks. There was no documented evidence that a follow-up consultation with the Electrophysiologist was scheduled; the direct care nurses were not aware that the resident needed to be connected to the Pacemaker transmitter; no interventions were put in place to monitor the pacemaker site; and there was no physician's order for Pacemaker monitoring until 07/29/2025. The finding is:The facility's policy titled Pacemaker and Internal Defibrillator Monitoring, last revised on 06/2025, documented that upon admission, the Nurse will review the resident's medical history and ascertain the presence of a Permanent Pacemaker (PPM) for inclusion in the resident's medical record. Nursing will care plan for the appropriate Pacemaker as indicated. The Primary Physician will order a Pacemaker battery check regularly. Pacemaker checks will be ordered by the Physician as recommended by the Electrophysiologist/Cardiologist, and these will be done outside the facility at an Arrhythmia Center (specializing in heart rhythm disorders). The facility's policy titled Consultants, last revised on 02/2025, documented that the Charge Nurse in the Unit is responsible for informing the Physician of the Consultant's recommendations. It is expected that all consults will be completed in 30 days, and the Physician will be notified in situations when the consult is not possible. Any difficulties in obtaining consults and /or following up with recommendations must be brought to the attention of the Director of Nursing and the Medical Director. The facility's policy titled Comprehensive Care Planning, last revised on 05/10/2025, documented that the care plan for each resident is revised when appropriate to reflect the resident's current needs based on evaluation and episodic changes to include but not limited to; significant changes in the resident's status, response to care and treatment and changes in activities of daily living function. Resident # 232 was admitted with diagnoses including Left Bundle Branch Block (a delay or blockage of electrical impulses to the left side of the heart), Congestive Heart Failure, and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of three (3), which indicated Resident #232 had severe cognitive impairment. The Minimum Data Set (MDS) assessment documented that Resident # 232 had an Active Diagnosis of Presence of a Cardiac Pacemaker. A review of Resident #232's Pacemaker transmitter device manual documented that the Pacemaker transmitter device must be placed on a sturdy, flat, hard surface, including a nightstand. The Pacemaker transmitter manual documented that scheduled sessions and device checks occur automatically if requested by an Arrhythmia Clinic. An unscheduled session sends data manually as per the Clinician's instructions.The Progress Note dated 04/13/2025 documented that Resident #232 was readmitted from the Hospital at 06:52 PM. Resident #232's skin assessment documented that Resident #232 had a dressing on the left chest wall after a Pacemaker Implantation.The hospital Discharge summary dated [DATE] documented that Resident #232 required a follow-up consultation with the Electrophysiologist in three (3) weeks. A review of Resident#232's electronic medical record revealed no evidence of the Pacemaker site monitoring or that the Pacemaker transmitter was set up, until 07/29/2025.A Comprehensive Care Plan titled Cardiovascular Alteration, dated 01/29/2025 and revised on 04/13/2025, documented that Resident #232 had Congestive Heart Failure, Hypertension, and Hyperlipidemia (high cholesterol) with interventions including monitoring vital signs and oxygen (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	saturation as necessary, Cardiology consult, and monitoring laboratory values.A review of Resident #232's Comprehensive Care Plan did not indicate that Resident #232 had a Pacemaker until 07/30/2025.During an observation on 07/28/2025 at 9:54 AM, Resident #232 was lying in bed. A sealed box of a Pacemaker transmitter device was noted on the floor next to Resident #232's bed. Resident #232 was unable to identify the contents of the box.During a second observation on 07/29/2025 at 9:00 AM, Resident #232 was lying in bed. A sealed box of a Pacemaker transmitter device was on the floor next to Resident #232's bed. Registered Nurse #1, the Unit Supervisor, came into the room and identified that the box next to Resident #232's bed was a Pacemaker transmitter device.During an interview on 07/29/2025 at 10:59 AM, Registered Nurse #1 stated they were the covering Unit Manager as the regularly assigned Unit Manager was on vacation. Registered Nurse #1 stated they knew that Resident #232 had a Pacemaker but did not know that a Pacemaker transmitter was to be set up to monitor the resident's cardiac rhythm. Registered Nurse #1 stated that the Unit Manager was responsible for setting up the Pacemaker transmitter.During a subsequent interview on 07/31/2025 at 10:00 AM, Registered Nurse #1 stated Resident #232's Discharge Summary from the Hospital indicated that the resident should have had a follow-up consultation with the Electrophysiologist within three weeks of when the Pacemaker was first implanted. Registered Nurse #1 stated they did not know why the consultation visit was not scheduled. Registered Nurse #1 stated they called the Arrhythmia Clinic on 07/28/2025, and the Pacemaker transmitter was set up in Resident #232's room on 07/29/2025. Registered Nurse #1 stated they did not know why there was no order for monitoring the Pacemaker. Registered Nurse #1 stated that the Nurse should have revised the care plan to reflect the Pacemaker for Resident #232.During an interview on 07/31/2025 at 11:00 AM, Licensed Practical Nurse #2 stated they only administer medications; Resident #232 often refuses their medications, and they seldom go to Resident #232's room. Licensed Practical Nurse #2 stated they did not know Resident #232 had a Pacemaker transmitter box in their room and that the Pacemaker transmitter should have been set up for the Arrhythmia clinic to remotely monitor the resident's cardiac activities.During an interview on 07/31/2025 at 11:44 AM, Physician Assistant #1 at the Arrhythmia Clinic stated they started receiving transmission from Resident #232's Pacemaker on 07/29/2025. Physician Assistant #1 stated that ideally, the Pacemaker transmitter should have been set up in April 2025, when the resident returned from the Hospital, to ensure that the Pacemaker was functioning. Physician Assistant #1 stated that Resident #232 needed an Electrophysiologist consult at the Arrhythmia Clinic as soon as possible. Physician Assistant #1 stated that Resident #232 should have had a consult two to three weeks after their discharge from the Hospital.During a subsequent interview on 08/01/2025 at 11:03 AM, Physician #3 stated the facility should have followed up on Resident #232's consultation with the Electrophysiologist to evaluate the Pacemaker treatment and monitoring.During an interview on 08/04/2025 at 8:30 AM, the Director of Nursing Services stated that when Resident #232 returned from the Hospital with a Pacemaker, the care plan should have been revised, and the Pacemaker should have been added to the care plan. The Director of Nursing Services stated there should have been a Physician's Order to monitor the Pacemaker, and the follow-up consultation with the Electrophysiologist should have been arranged by the facility.10 NYCRR 415.12

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interviews during the Recertification Survey initiated on 7/28/2025 and completed on 8/5/2025, the facility did not ensure that each resident who needs respiratory care, including tracheostomy care and tracheal suctioning, was provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences. This was identified for one (Resident #6) of two residents reviewed for Respiratory Care. Specifically, Resident #6 had a Tracheostomy (a surgical procedure where a hole is made in the windpipe (trachea) to create an opening in the neck, allowing a tube to be inserted for breathing assistance). The facility converted to a different electronic medical record company in June 2025. When this occurred, the orders for daily tracheostomy care did not carry over to the new electronic medical record, and therefore, the nurses did not document that daily tracheostomy care and suctioning were being done. In addition, the physician's order was for the resident to receive oxygen at 3 liters per minute; however, the resident was receiving 8 liters per minute during multiple observations, and there was no documented evidence that the resident's oxygen saturation status was being checked and monitored.The finding is:The facility's policy titled Care of the Resident with Tracheostomy, effective 7/30/2021, documented that Tracheostomy care and stoma (opening) care will be done each shift and as needed. Residents will be assessed for the need for suctioning. Residents with a disposable inner cannula (a removable tube within the tracheostomy that can be easily cleaned and replaced without having to remove the main tracheostomy tube) will have a new inner cannula inserted daily on the 7:00 AM-3:00 PM shift and as needed. Tracheostomy care, stoma care, and suctioning will be documented on the treatment administration record.The facility's policy titled Oxygen Therapy, effective 7/30/2021, documented that residents will be provided with oxygen therapy as ordered by the Physician. The Physician will specify the flow rate and whether the oxygen is continuous or as needed. The nurse will check the liter flow rate on the tank or concentrator and sign the treatment record each shift.Resident #6 was admitted with diagnoses including Chronic Respiratory Failure, Diabetes Mellitus, and Morbid Obesity. The 05/17/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 8, indicating the resident had moderate cognitive impairment and received tracheostomy care and oxygen therapy.Review of the Physician's orders from the previous electronic medical record revealed the following:-Tracheostomy inner cannula Shiley size 6 IC75 renewed 05/30/2025,-Oxygen as needed at 3 liters per minute; the order was renewed on 05/30/2025.-Suction tracheal secretions every shift and as needed; the order was renewed on 05/30/2025.-Tracheostomy care every shift; the order was renewed on 05/30/2025.- Change the tracheostomy inner cannula daily; the order was renewed on 05/30/2025.Review of the Treatment Administration Record from the former electronic medical record revealed that the last day the nurses signed for these orders was 06/03/2025.Review of the Treatment and Medication Administration records from the new electronic medical record revealed that nurses began signing for the physician's orders on 06/04/2025 (when the new electronic medical record was rolled out); however, the orders identified above (Tracheostomy inner cannula Shiley size 6, Oxygen at 3 liters per minute, Suction tracheal secretions, Tracheostomy care, and Changing the tracheostomy inner cannula) were not signed for until 07/31/2025, indicating no documentation between 6/3/2025 and 07/31/2025.The Physician's order dated 06/06/2025 for Oxygen 3 liters per minute via tracheostomy mask as needed for Acute Respiratory Failure with Hypoxia (low oxygen level in blood) was not carried over from the previous electronic medical record to the current electronic medical record. Additionally, there was no order to monitor the resident's oxygen saturation (oxygen concentration in the blood).During an interview on 07/29/2025 at 10:26 AM, Resident #6 was observed in bed. The resident had a tracheostomy. The resident stated they have difficulty breathing at times and frequently feel the need to call the nurse for attention. The oxygen concentrator was set at 8 liters per minute.A Respiratory Therapy note dated 07/31/2025 at 12:34 AM documented the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was resting comfortably, alert, and responsive with no respiratory distress. The resident received tracheostomy care and suctioning. All respiratory equipment was checked and was working properly. The resident remained stable. Continue to monitor the resident as needed.During an interview on 07/31/2025 at 10:53 AM, Resident #6 was observed in bed. The oxygen concentrator was set at 8 liters per minute. The resident stated that the nurse (Licensed Practical Nurse #1) changes the tracheostomy dressing every day. They stated, I have a little trouble breathing right now.During an interview on 07/31/2025 at 11:00 AM, Licensed Practical Nurse #1 stated they provide tracheostomy care for Resident #6 every day; however, they did not Licensed Practical Nurse #1 observed the oxygen setting of 8 liters on the concentrator, checked the resident's orders in the current electronic medical record, and stated there were no current orders for the tracheostomy care, the inner cannula size, or for suctioning, and that the oxygen order was for 3 liters of oxygen per Licensed Practical Nurse # stated the orders for tracheostomy care, the inner cannula, and suctioning were not transferred over to the new electronic medical record that went into effect in June 2025. Licensed Practical Nurse #1 could not state where they were documenting the tracheostomy care when there were no orders in the current electronic medical record.During a re-interview on 07/31/2025 at 1:22 PM, Licensed Practical Nurse #1 stated, there was no explanation related to how the care was documented between 06/04/2025 and 07/31/2025. Licensed Practical Nurse #1 stated they were not able to document the care because the orders were not there. They said they monitor oxygen saturation for Resident #6 when they provide tracheostomy care and suction the resident but have not been documenting the result.During an interview on 8/1/2025 at 8:27 AM, Registered Nurse Wound Care Nurse #1 (and acting supervisor for the unit) stated that if a treatment order was not carried over after the electronic medication record changed, the treatment or medication nurse should have notified the supervisor rather than continuing the care without orders. During an interview on 08/01/2025 at 10:20 AM, the Director of Nursing Services stated if the treatment nurse noticed that the orders for tracheostomy care and the inner cannula were not in the new electronic medical record and therefore could not document the care, the nurse should have reached out to the supervisor to get this rectified.During an interview on 08/01/2025 at 11:17 AM, the Administrator stated there was some catch-up still taking place to make sure all the orders from the previous electronic medical record had been transferred over to the new electronic medical record. The corporate staff was in charge of the electronic medical record transfer. The Administrator stated their (Administrator's) role was to make sure that the facility staff attended meetings to learn how to use the new electronic medical record. They were not following the process of how the transition was taking place.During an interview on 08/04/2025 at 8:19 AM, Physician #2 stated the oxygen saturation should be checked every shift for a resident with a tracheostomy, and the result should be documented in the electronic medical record.10NYCRR 415.12(k)(6)

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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** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure that drugs and biologicals were stored in a locked compartment. This was identified for one (1) (Resident #208) of eight (8) residents reviewed for Accidents. Specifically, a tube of unlabeled Hydrocortisone (a steroid cream to treat inflammation and allergies) cream 0.5 percent, and a labeled Triamcinolone (a prescription steroid cream to treat allergies and inflammation), 0.1 percent, cream were observed on Resident #208's overbed table. Additionally, there was a labeled Chlorhexidine Gluconate (anti-microbial mouthwash to treat inflammation of the gums) 0.12 percent bottle, a labeled Fluticasone (nasal spray for allergy) nasal spray, a labeled Patadine (eye drop for allergy) 0.1 percent eye drop bottle, and an unlabeled Refresh (eye lubricant) eye drop bottle on Resident #208's nightstand. There was no Nursing staff in the vicinity of Resident #208's room. Resident #208 was not assessed to self-administer their medications. The finding is:The facility's undated policy titled Storage of Drugs documented that all medications and other drugs, including treatment items, shall be stored in a locked cabinet inaccessible to residents and visitors. Only Registered Nurses, Licensed Practical Nurses, the Consultant Pharmacist, Attending Physicians, and the Medical Director are authorized to have access to the keys of locked medication storage cabinets and carts. Resident #208 was admitted with diagnoses including Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, and Hypertension. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated that Resident #208 had intact cognition. The Quarterly Minimum Data Set assessment documented that Resident #208's vision was adequate. A Physician's Order dated 01/08/2025 and renewed on 06/04/2025 documented Flonase Allergy Relief 50 micrograms nasal spray for each nostril as needed. A Physician's Order dated 2/14/2025 documented Peridex (Chlorhexidine Gluconate-antiseptic mouthwash) 0.12 percent mouthwash, place 15 milliliters in the mouth by mucous membrane route twice a day, swish for 30 seconds, then spit out. A Physician's Order dated 03/24/2025 Olopatadine (Patadine) Hydrochloride ophthalmic solution (anti-allergy) 0.1 percent, one drop in both eyes twice a day. A Physician's Order dated 05/09/2025 documented Triamcinolone acetonide (cortisone cream) 0.1 percent topical ointment. Apply one applicator by the topical route twice a day for four weeks to the back of both elbows. A review of Resident #208's electronic medical record revealed that Resident #208 did not have a Physician Order for the Hydrocortisone 0.5 percent cream or the Refresh eye drops. A review of Resident #208's Electronic Medical Record revealed that Resident #208 did not have an assessment to self-administer any of their medications. A Comprehensive Care Plan (CCP) titled Respiratory Disorder/Chronic Obstructive Pulmonary Disease, dated 01/2/2022, documented interventions including administering medications as per the Physician's Orders and monitoring respiratory status, lung sounds, and shortness of breath. During an observation on 07/28/2025 at 10:40 AM, Resident #208 was observed with a tube of unlabeled Hydrocortisone (a steroid cream to treat inflammation and allergies) cream 0.5 percent, a labeled Triamcinolone (a prescription steroid cream to treat allergies and inflammation) 0.1 percent cream on Resident #208's overbed table. Additionally, there was a labeled Chlorhexidine Gluconate (anti-microbial mouthwash to treat inflammation of the gums) 0.12 percent bottle, a labeled Fluticasone (nasal spray for allergy) nasal spray, a labeled Patadine (eye drop for allergy) 0.1 percent eye drop bottle, and an unlabeled Refresh (eye lubricant) eye drop bottle on Resident #208's nightstand. There was no Nursing staff in the vicinity of Resident #208's room.During an interview on 07/28/2025 at 10:45 AM, Licensed Practical Nurse #2, Medication Nurse, stated they had already administered the medications to Resident #208 outside Resident #208's room. Licensed Practical (continued on next page)

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	335808	A. Building B. Wing	08/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hempstead Park Nursing Home	800 Front Street Hempstead, NY 11550

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #2 stated they did not know that Resident #208 had some of their medications in the room; otherwise, they would have removed the medications from the resident's room. During an interview on 07/28/2025 at 11:30 AM, Registered Nurse #1, the Unit Manager, stated that Resident #208 should not have any medications stored in their room. Registered Nurse #1 stated that Resident #208's medications should be stored in the medication cart. Registered Nurse #1 stated that the facility did not initiate a self-administration assessment because Resident #208 had never requested to administer their medications. During an interview on 07/29/2025 at 8:44 AM, Resident #208 stated that they did not remember if the Nurses had left the medications on their overbed table and the nightstand. Resident #208 stated they had some medications from home, but they never used those medications. Resident #208 stated that the Nurses bring the medications and supervise Resident #208 in administering the medications, particularly the mouthwash. Resident #208 stated they are capable of administering their medications but wanted the nurses to supervise. During an interview on 08/04/2025 at 8:25 AM, the Director of Nursing Services stated that the Nursing staff should not have left any medications on Resident #208's table and the nightstand. The Director of Nursing Services stated they expect all their Nursing staff to check the rooms for unattended medications and report to the Nursing Supervisors. 10NYCRR 415.18(e) (1-4)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during the recertification survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure If the facility did not employ a qualified professional person to furnish a specific service to be provided by the facility, services were furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act for each resident. This was identified for one (1) (Resident #179) of one (1) resident reviewed for Vision/Hearing. Specifically, Resident #179 was seen by the Optometrist on 04/28/2025 and recommended a referral for an Ophthalmology consult for Cataract (a clouding of the lens of the eye) surgery. The facility did not arrange an appointment with the Ophthalmologist until 08/04/2025, approximately three (3) months after the recommendation was made. The finding is:The facility policy titled Consultants, last reviewed on 02/2025, documented the nurses on the unit will pick up an order for a consultant and complete a consult form. If the consultant is an outside consultant, the nurse will fill out a consultant form and forward the form to the Medical Records Coordinator. The Medical Records Coordinator will make arrangements for the transportation. The Charge nurse is responsible for informing the primary Physician of the consultant's recommendations. It is expected that consults will be completed in a thirty-day period. Resident #179 was admitted with the diagnoses including Glaucoma (an eye condition that damages the optic nerve), Parkinson's Disease, and Hypertensive Heart Disease. The Quarterly Minimum Assessment Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating the resident had intact cognition. The Minimum Data Set assessment documented the resident had adequate vision and wore corrective lenses.A comprehensive Care Plan titled Visual Function initiated 06/23/2025 and last revised 08/04/2025 documented potential for visual impairment due to Cataracts of the right and left eye. Interventions included identifying/recording factors affecting visual function and providing reading glasses as requested. An Optometry Consult form dated 04/28/2025 documented Resident #179 had Cataracts to the left and right eye with no impact to activities of daily living or quality of life, and to monitor for progression. Prescription glasses were not ordered for Resident #179. The recommendations included a referral to an Ophthalmologist for Cataract surgery. A review of the electronic medical record indicated no physician order for an Ophthalmology consult until 08/04/2025. A Physician's order dated 08/04/2025 documented a scheduled appointment for an Ophthalmology consult for 08/08/2025 at 11:00 AM. During an interview on 07/28/2025 at 10:24 AM, Resident #179 stated they needed new glasses as the previous glasses broke, and they still had not received. During an interview on 08/01/2025 at 11:15 AM, Licensed Practical Nurse #7 stated Resident #179 complained about their eyeglasses, and an order for an Optometry consultation was placed. Licensed Practical Nurse #7 stated they put the consult form for the Optometrist in their mailbox and did not know what happened after that During an interview on 08/04/2025 at 11:52 AM, Optometrist #1 stated they had been following the resident for years. Optometrist #1 stated they did not order any glasses for Resident #179 during the last visit on 4/28/25 because glasses would not benefit the resident due to the Resident's Cataracts. Optometrist #1 stated they recommended a referral for an Ophthalmology consult for cataract surgery.During an interview on 08/04/2025 at 1:25 PM, Registered Nurse #4 stated the nursing supervisor was responsible for printing out consultation forms from the Optometrist and informing the Medical Records/Transportation Coordinator to arrange an appointment and transportation according to the recommended referral. During an interview on 08/04/2025 at 02:10 PM, the Medical Records/Transportation Coordinator stated they were only made aware on 08/04/2025 that Resident #179 needed an appointment for an Ophthalmologist, and they then scheduled an appointment for 08/08/2025.During an interview on 08/04/2025 at 03:04 PM, Registered Nurse #5, the nursing supervisor for the unit where Resident #179 resides, stated that the previous (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing Services provided the nursing supervisors a list of residents that were seen by an in-house consultant, including the Optometrist. The supervisor would then review the consult note and the recommendations. If the recommendations included a referral to another consultant or specialist, then the supervisor would place an order for the referral and provide a copy of the order to the Medical Records/Transport Coordinator to set up an appointment. Registered Nurse #5 could not recall if Resident #179 was seen by the Optometrist on 04/28/2025, and did not know why the recommendations for the Ophthalmology consult made by the Optometrist were not addressed in April 2025.During an interview on 08/05/2025 at 09:29 AM, the Director of Nursing Services stated that the Ophthalmologist consult for Resident #179 should have been ordered and scheduled as soon as possible after the recommendations were received from the Optometrist. 10 NYCRR 15.26(e)(1)(i-iv)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure each resident's bedside was adequately equipped to allow residents to call for staff assistance through a communication system that relayed the call directly to a staff member or to a centralized staff work area. This was identified for one (Resident #40) of three (3) residents reviewed during the Environmental Task. Specifically, on 07/28/2025 and 07/29/2025, Resident #40's call bell was not functioning, and the annunciator system at the nursing station did not register the calls from Resident #40's room. The finding is:The facility's policy, titled Resident's Use of Call Bells, last reviewed on 07/29/2025, documented call bell functioning will be checked monthly and as needed by the Maintenance Department. A supply of tap bells/hand bells will be available in the event of a call bell system malfunction. Any staff member who hears or sees a call bell activated is responsible for answering immediately. A review of the call bell check log on Unit 4 South, dated 07/18/2025, documented that the call bells were checked in Resident #40's room and required repairing. Resident #40 was admitted with diagnoses of Spinal Stenosis (narrowing of the spinal canal), Pain, and Atrial Fibrillation. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #40 had a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. Resident #40 had clear speech, was able to understand, and was understood. Resident #40 was dependent for activities of daily living, including toileting, hygiene, and upper/lower body dressing. Resident #40 was dependent for bed mobility, including rolling left to right, sitting to lying. Resident #40 did not have the ability to walk ten feet. During the Resident Screening and Environmental observation on 07/28/2025 at 10:11 AM, Resident #40 was heard shouting from inside their room, calling for staff assistance. When the surveyor approached Resident #40's room at 10:17 AM, Resident #40 was still shouting for assistance. The call light above Resident #40's room was not turned on. There was no call bell sound emitting from the room. There was no staff in the vicinity. Upon entry to the resident's room, Resident #40 was observed in bed, holding and pressing the call bell. Resident #40 stated they had been pressing the call bell and calling for help for the last 30 minutes because they were feeling cold and could not turn the air conditioner off themselves. Resident #40 stated that no staff had responded to their call. During an observation on 07/28/2025 at 10:20 AM, in the presence of the Lead Engineer, Resident #40's bedside call bell did not trigger the sound or the call light above the resident's room door. The Lead Engineer stated they most likely needed to replace a new call bell cord, and they would follow up. During an interview on 07/28/2025 at 10:45 AM, the Lead Engineer stated there was no call bell issue identified during the last inspection; however, they did not know when the call bell system was last checked on Resident #40's unit. The Lead Engineer stated that they had replaced a new call bell cord for Resident #40 today (07/28/2025), and the call bell is now functioning properly. During an observation on 07/29/2025 at 9:28 AM, Resident #40 was again heard from the hallway calling out for help from their room. The call light above Resident #40's room was not turned on. There was no call bell sound emitting from the room. There was no staff in the vicinity. Registered Nurse # 1, who was the unit supervisor, was called to Resident #40's room by the surveyor and confirmed that Resident #40's call light did not turn on. Registered Nurse #1 was immediately interviewed and stated that the call bell should trigger a light and sound above the door to alert staff. Registered Nurse # 1 stated that the call bell system was also connected to the nursing station monitor, which would indicate which room had the call bell activated. Registered Nurse # 1 stated they did not know Resident #40's call bell was not working. During an observation of the nursing station call bell annunciator with Licensed Practical Nurse # 8 on 07/29/2025 at 9:33 AM, there was no sound or light activated when the call bell was pressed by Registered Nurse #1 from Resident #40's room. During an interview on 07/30/2025 at 10:07 AM, the Director of Maintenance stated that the call bell system in (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident's room was inspected monthly. The Director of Maintenance stated that residents must have working call bells at all times so they can ask for assistance as needed. The Director of Maintenance stated that nursing staff should provide a handbell to the resident if the resident's call bell issue could not be resolved immediately. During an interview on 07/31/2025 at 9:39 AM, the Administrator stated that residents should have working call bells at all times so they can ask for help when needed. 10 NYCRR 415.29

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the Recertification Survey initiated on 07/28/2025 and completed on 08/5/2025, the facility did not ensure the Facility Assessment considered specific staffing needs for each resident unit for each shift, such as day, evening, and night. This was identified during the Sufficient Nursing Staffing Task. Specifically, the Facility Assessment, last reviewed in June 2025, did not indicate staffing needs for Certified Nursing Aides, Monday to Friday, for each unit and each shift. Additionally, the Facility Assessment did not specify the staffing needs for Licensed Practical Nurses for each unit for the 3:00 PM-11:00 PM shift and the 11:00 PM-7:00 AM shift during the weekdays. The finding is:The facility's policy, titled Facility Assessment, last reviewed/revised on 8/1/2024, documented the facility will conduct and document a facility-wide assessment to determine the resources necessary to care for residents competently during day-to-day operations and emergency services. The Facility Assessment will identify the facility's resident population, including the number of residents, residents' capacity, and the care required by the residents. The Facility Assessment will provide a staffing template for both weekday and weekend/holiday staffing [need] for each shift.A review of the Facility assessment dated [DATE], revealed the Facility Assessment did not indicate weekdays (Monday to Friday) staffing needs for Certified Nursing Aides for each unit and each shift (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM). Additionally, the Facility Assessment did not specify the staffing needs for Licensed Practical Nurses for each unit for the 3:00 PM-11:00 PM shift and the 11:00 PM-7:00 AM shift during the weekdays. During an interview on 08/1/2025 at 08:45 AM, the Administrator stated they and the Director of Nursing Services were involved in developing and reviewing the Facility Assessment. The Administrator stated the Director of Nursing Services was responsible for completing the nursing staffing portion of the Facility Assessment. The Administrator stated they were responsible for reviewing and ensuring the Facility Assessment was completed accurately. The Administrator stated they were not aware that the Facility Assessment did not include the number of nursing staff required for each unit, each shift, for the weekdays (Monday to Friday). The Administrator stated that the Facility Assessment should have clearly indicated specific nursing staffing needs by resident units for each shift, and it was an oversight. The Administrator stated that the Director of Nursing Services, who was responsible for the nursing staffing portion of the Facility Assessment, was no longer employed at the facility.10 NYCRR 415.26