STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Island Nursing and Rehab Center	5537 Expressway Drive North Holtsville, NY 11742

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/31/2025 and completed on 08/06/2025, the facility did not ensure the resident's right to self-administer medications. This was identified for one (Resident #8) of six (6) residents reviewed for Accidents. Specifically, Resident #8 was observed with a souffle medication cup containing four pills on their bedside table. There was no documented evidence Resident #8 was assessed to self-administer medications, and the resident did not have a physician's order to self-administer their medications. The finding is: The facility policy titled Medication, Self-Administration, dated 2/2017, documented that each resident shall have the right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate. Self-administering medications is [permitted] by physician order only. Medications kept at bedside are in a locked box. Resident #8 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, and Osteoarthritis (joint pain, swelling). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The current physician's order documented Aspirin enteric-coated delayed-release 81 milligrams; take 1 tablet by mouth once daily for coronary artery disease. The current physician's order documented Metoprolol Succinate Extended Release 100 milligrams, give 1 tablet by mouth once a day for Hypertension. The current physician's order documented Glyco-lax Powder, give 17 grams by mouth mixed in 8 ounces of beverage once a day for constipation, hold for loose stool. A physician's order dated 7/26/2025, documented Hydrochlorothiazide tablet 25 milligrams, give 2 tablets by mouth, 50 milligrams one time a day for Congestive Heart Failure, Hypertension.During an observation on 07/31/2025 at 11:05 AM, Resident #8 was observed in their room sitting in a wheelchair next to their overbed table. The overbed table had a souffle medication cup containing four pills and a small disposable cup with a white powder. Resident #8 stated they told the nurse to just leave the medications on the overbed table and they would take them when they eat their breakfast. Resident #8 stated that they usually tell the nurses to leave their medication on the overbed table, and they take the medications when they are ready. Resident #8 stated the nurses frequently allow them (Resident #8) to self-administer their medications. A review of Resident #8's medical record revealed there was no physician's order, no Comprehensive Care Plan to self-administer medications, and no indication that the resident was assessed to self-administer medications. During an interview on 07/31/2025 at 11:16 AM, Licensed Practical Nurse #1 stated they were unsure if Resident #8 was assessed by the interdisciplinary team to self-administer medications and that a care plan to self-administer medications was developed. Licensed Practical Nurse #1 stated they always left the medications for Resident #8 at their bedside, and Resident #8 self-administered their medications. Licensed Practical Nurse #1 stated they were trained to leave Resident #8's medications at the bedside. Licensed Practical Nurse #1 stated the medications in the souffle medication cup were the resident's 8:00 AM medications, which included one tablet of Aspirin 81 milligrams, two tablets of Hydrochlorothiazide 25 milligrams, one tablet of Metoprolol Succinate 100 milligrams one tablet, and a plastic cup with Glyco-Lax Powder 17 grams to be mixed with 8 ounces of liquid. Licensed Practical (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse #1 stated they should have verified if Resident #8 was assessed for self-administering medications and had a physician's order and a care plan for self-administering medications. During an interview on 08/04/2025 at 10:43 AM, Registered Nurse Manager #1 stated Resident #8 was not assessed to self-administer their medications and did not have a care plan to self-administer medications. Registered Nurse Manager #1 stated Licensed Practical Nurse #1 should not have left the medications at the bedside for a resident who did not have a physician's order to self-administer medications. Registered Nurse Manager #1 stated they should have been notified that Resident #8 wanted to self-administer medications, and an assessment should have been completed for the resident. During an interview on 08/06/2025 at 9:36 AM, the Director of Nursing Services stated Resident #8 did not have an order to self-administer medications. The Director of Nursing Services stated the resident should have been assessed by the physician to self-administer medications. The Director of Nursing Services stated the resident should demonstrate understanding of the time to take the medications, the reasons why they are taking the medications, and the nurse should ensure that the resident was not leaving the medications at the bedside. 10 NYCRR 415.3(f)(1)(vi)

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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 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 record review and interview during the recertification survey initiated on 07/31/2025 and completed on 08/06/2025, the facility did not ensure person-centered comprehensive care plans that included measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs were developed and implemented. This was identified for one (Resident #8) of two residents reviewed for Behavioral and Emotional Status. Specifically, Resident #8 had a Physician's order for a two-person approach in care and a Comprehensive Care Plan for Accusatory Behaviors with interventions that included a two-person approach. During an observation on 07/31/2025 at 11:05 AM, Certified Nursing Assistant #1 provided care to Resident #8 without a second caregiver in the resident's room.The finding is:Resident #8 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, and Osteoarthritis. The Quarterly Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 15, indicating the resident is cognitively intact. The Quarterly Minimum Data Set indicated that the resident did not display any behavioral issues.A Comprehensive Care Plan titled Non-Compliance, last revised on 01/09/2025, documented interventions that included the use of a two-person approach in care. A Comprehensive Care Plan titled Accusatory and Verbally Abusive dated 06/03/2022, documented interventions that included the resident required a two-person approach for care. A revision on 01/9/2025 documented interventions that included to continue the two-person approach. A physician's order dated 10/03/2024 and discontinued on 08/1/2025 documented the resident required a two-person approach in care. A physician's order dated 08/02/2025 documented a two-person approach for care secondary to accusatory behavior. A review of the Certified Nursing Assistant Accountability record for June 2025 and July 2025 revealed no documented evidence for a two-person approach during care. The Certified Nursing Assistant Accountability record for August 2025 documented a two-person approach in care for each shift. During an observation on 07/31/2025 at 11:05 AM, the door frame to Resident #8's private room had a magnet signage displaying an icon of two people. Resident #8's room door was closed, the surveyor knocked and was told to come in. Resident #8 was seated in a wheelchair next to their over-bed table, and Certified Nursing Assistant #1 was changing the Resident #8's bed linens and collecting the laundry and soiled linens in the room. During an interview on 07/31/2025 at 11:06 AM, Resident #8 stated they like to keep the door closed. Resident #8 stated Certified Nursing Assistant #1 was their regularly assigned Certified Nursing Assistant. During an interview on 07/31/2025 at 11:22 AM, Certified Nursing Assistant #1 stated that the magnet outside the resident's room indicated that the resident within the room required a two-person approach during care. Certified Nursing Assistant #1 stated Resident #8 has accusatory behavior, but usually, the resident accepted care from them alone and allowed them to come into the room alone. Certified Nursing Assistant #1 stated the facility educated them when they were hired to provide care with a second caregiver if the resident had a two-person signage on the door frame, and the Certified Nursing Assistant Accountability instruction included a two-person approach during care. During an interview on 08/04/2025 at 9:23 AM, Registered Nurse Manager #1 stated that the two-person magnet signage on the door frame was to alert staff that the resident required a two-person approach during care. The Certified Nursing Assistants and Nurses were educated on the two-person approach. During an interview on 08/06/2025 at 9:36 AM, the Director of Nursing Services stated residents should receive care from two staff members when a two-person approach is required. 10 NYCRR 415.11(c)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, and interviews during the Recertification Survey initiated on 07/31/2025 and completed on 08/06/2025, the facility did not ensure that drug records were in order and accounted for all controlled drugs. This was identified for one (Unit 3) of two units reviewed for medication storage and medication administration tasks. Specifically, during the medication storage task/medication administration task on Unit 3 on 08/01/2025 at 5:46 AM, the Controlled Substance Administration Record was not reconciled to reflect Resident #60's refusal of Tramadol hydrochloric acid medications on 07/31/2025 at 9:00 PM. The finding is: The Facility's Controlled Substances and Narcotics Policy dated January 2025 documented that when a resident refuses a controlled substance after it has been poured, the medication must be destroyed with a witness, and the back of the Controlled Drug 24-Hour Administration Record must be completed. The Nursing Supervisor must be notified. Resident #60 was admitted with diagnoses including Alzheimer's Disease, Adult Failure to Thrive, and Anxiety Disorder. The Significant Change Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of four (4), which indicated the resident had severely impaired cognition. The resident required assistance with all activities of daily living. The Minimum Data Set indicated the resident received antianxiety medication during the assessment look-back period. The Current Physician's Order documented Tramadol hydrochloric acid (pain medication) oral tablet 25 milligrams, Controlled Drug, administer 1 tablet by mouth two times a day (9:00 AM and 9:00 PM) for pain; Lorazepam (antianxiety medication that is a controlled drug) oral tablet 0.5 milligram, administer by mouth at bedtime for Anxiety. During a medication administration observation on 08/01/2025 at 5:41 AM, a Unit 3 medication cart was left unattended in the middle of the hallway. There were two medication cups on the medication cart. One cup contained two white tablets, and the other cup contained one white tablet. There was no staff in the vicinity. During an interview on 08/01/2025 at 5:55 AM, Licensed Practical Nurse #2 stated they worked a double shift, and Resident #60 refused the 9:00 PM scheduled Tramadol 25 milligram tablet and the Lorazepam 0.5 milligram. Licensed Practical Nurse #2 stated the second medication cup contained one tablet of Melatonin 3 milligrams, and they did not remember which resident refused that medication. Licensed Practical Nurse # 2 stated they kept the medications on the medication cart because they did not want to waste them. Licensed Practical Nurse# 2 stated they did not lock the medication cart and the narcotic box because they were called into a resident's room to help a Certified Nursing Assistant with a resident. Licensed Practical Nurse #2 stated they should have documented in the Controlled Drug 24 -Hour Administration Record that the resident refused the medication, notified the supervisor and wasted the controlled medications with another nurse and document in the narcotic book that the medications were wasted. During an interview on 08/01/2025 at 6:22 AM, Registered Nurse Supervisor #3 stated they were not aware that Licensed Practical Nurse #2 did not destroy the Tramadol 25 milligram 1 tablet and Lorazepam 05 milligram 1 tablet with two nurses and did not reconcile the medications in the Controlled Drug 24 -Hour Administration Record since the previous shift. Registered Nurse Supervisor #3 stated they should have been notified of the resident's refusal, the controlled medications should have been destroyed with two nurses, and the Controlled Drug 24-Hour Administration Record should have been reconciled. During an interview on 08/06/2025 at 3:00 PM, the Director of Nursing Services stated the Controlled Substance Administration Record form should be reconciled immediately after a medication is administered or destroyed. The Director of Nursing Services stated Resident #60's medication refusals should have been reported to the Nurse Supervisor, and the medication should have been destroyed. 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** Based on observations, record review, and interviews during the Recertification Survey initiated on 7/31/2025 and completed on 8/6/2025, the facility did not ensure all drugs and biologicals were stored in locked compartments and only authorized personnel were permitted to have access. This was identified for one (Unit 3) of two (2) Units reviewed during the medication storage task and for one (Resident #8) of six (6) residents reviewed for accidents. Specifically, 1) during the medication administration observation on 08/01/2025 at 5:46 AM, an unattended medication cart on Unit 3 was observed to be unlocked in the hallway with an unlocked narcotic box. Additionally, there were two cups containing Resident #60's controlled medications on the medication cart. 2) Resident #8 was observed with a souffle medication cup containing four (4) medication tablets on their overbed table and did not have a Physician's order to self-administer medications. The findings are: 1) The facility's Controlled Substances and Narcotics Policy dated January 2025 documented controlled substances and narcotics are kept in a double-locked cabinet in the medication room or double-locked in the medication cart. The facility's Medication Policy dated 01/04/2025 documented that all medications shall be contained in a locked cart and/or cabinet in a locked room. Resident #60 was admitted with diagnoses including Alzheimer's Disease, Adult Failure to Thrive, and Anxiety Disorder. The Significant Change Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of four (4), which indicated the resident had severely impaired cognition. The resident required assistance with all activities of daily living. The Minimum Data Set indicated the resident received antianxiety medication during the assessment look-back period. The Current Physician's Order documented Tramadol hydrochloric acid (pain medication) oral tablet 25 milligrams, Controlled Drug, administer 1 tablet by mouth two times a day (9:00 AM and 9:00 PM) for pain; Lorazepam (antianxiety medication that is a controlled drug) oral tablet 0.5 milligram, administer by mouth at bedtime for Anxiety. During a medication administration observation on 08/01/2025 at 5:41 AM, a Unit 3 medication cart was left unattended in the middle of the hallway. There were two medication cups on the medication cart. One cup contained two white tablets, and the other cup contained one white tablet. There was no staff in the vicinity. During an interview on 08/01/2025 at 5:55 AM, Licensed Practical Nurse #2 stated they worked a double shift, and Resident #60 refused the 9:00 PM scheduled Tramadol 25 milligram tablet and the Lorazepam 0.5 milligram. Licensed Practical Nurse #2 stated the second medication cup contained one tablet of Melatonin 3 milligrams, and they did not remember which resident refused that medication. Licensed Practical Nurse # 2 stated they kept the medications on the medication cart because they did not want to waste them. Licensed Practical Nurse# 2 stated they did not lock the medication cart and the narcotic box because they were called into a resident's room to help a Certified Nursing Assistant with a resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/01/2025 at 6:22 AM, Registered Nurse Supervisor #3 stated that Licensed Practical Nurse #2 should not leave any medications on the medication cart for safety reasons. Registered Nurse Supervisor #3 stated the medication carts must be locked when unattended, and the narcotic boxes must be double locked per the facility policy. During an interview on 08/06/2025 at 1:30 PM, the Director of Nursing Services stated it was not safe to leave medications on an unattended medication cart. The Director of Nursing stated the medication cart, and the narcotic box should not be left unlocked when unattended. 2) Resident #8 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease, Major Depressive Disorder, and Osteoarthritis (joint pain, swelling). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The current physician's order documented Aspirin enteric-coated delayed-release 81 milligrams; take 1 tablet by mouth once daily for coronary artery disease. The current physician's order documented Metoprolol Succinate Extended Release 100 milligrams, give 1 tablet by mouth once a day for Hypertension. The current physician's order documented Glyco-lax Powder, give 17 grams by mouth mixed in 8 ounces of beverage once a day for constipation, hold for loose stool. A physician's order dated 7/26/2025, documented Hydrochlorothiazide tablet 25 milligrams, give 2 tablets by mouth, 50 milligrams one time a day for Congestive Heart Failure, Hypertension. During an observation on 07/31/2025 at 11:05 AM, Resident #8 was observed in their room sitting in a wheelchair next to their overbed table. The overbed table had a soufflé medication cup containing four pills and a small disposable cup with a white powder. Resident #8 stated they told the nurse to just leave the medications on the overbed table and they would take them when they eat their breakfast. Resident #8 stated that they usually tell the nurses to leave their medication on the overbed table, and they take the medications when they are ready. Resident #8 stated the nurses frequently allow them (Resident #8) to self-administer their medications. A review of Resident #8's medical record revealed there was no physician's order, no Comprehensive Care Plan to self-administer medications, and no indication that the resident was assessed to self-administer medications. During an interview on 07/31/2025 at 11:16 AM, Licensed Practical Nurse #1 stated they always left the medications for Resident #8 at their bedside, and Resident #8 self-administered their medications. Licensed Practical Nurse #1 stated they were trained to leave Resident #8's medications at the bedside. Licensed Practical Nurse #1 stated the medications in the soufflé medication cup were the resident's 8:00 AM medications, which included one tablet of Aspirin 81 milligrams, two tablets of Hydrochlorothiazide 25 milligrams, one tablet of Metoprolol Succinate 100 milligrams one tablet, and a plastic cup with Glyco-Lax Powder 17 grams to be mixed with 8 ounces of liquid. During an interview on 08/04/2025 at 10:43 AM, Registered Nurse Manager #1 stated Licensed Practical Nurse #1 should not have left the medications at the bedside for a resident who did not have a physician's order to self-administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/06/2025 at 9:36 AM, the Director of Nursing Services stated Resident #8 did not have an order to self-administer medications, and the nursing staff should not have left the medications at the bedside. The Director of Nursing Services stated the resident should have been assessed by the physician to self-administer medications. The Director of Nursing Services stated that residents who can self-administer medications and wish to store them in their room must have the medications locked in their dresser drawer. 10 NYCRR 415.18(e)(1-4)