

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER Maria Regina Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Brentwood Road Brentwood, NY 11717	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423</p> <p>Based on observations, interviews, and record review during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure all drugs and biologicals were stored in locked compartments under proper temperature controls. This was identified for one (Resident #31) of four residents reviewed for Vision and Hearing. Specifically, a plastic cup containing two bottles of Refresh Liquigel eye drops and two bottles of Systane Lubricant eye ointment medications were observed on Resident #31's bedside table on [DATE]. The Refresh Liquigel eye drops expiration date was documented as ,d+[DATE] and the resident was observed to self-administer the expired eye drops.</p> <p>The finding is:</p> <p>The facility policy titled Storage of Medication dated ,d+[DATE] documented that drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Compartments containing drugs and biologicals shall be locked when not in use. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.</p> <p>Resident #31 was admitted with diagnoses including Dry Eye Syndrome of both eyes and Cataract. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident's cognition was intact. The Minimum Data Set assessment documented the resident had adequate vision and used corrective lenses.</p> <p>A Comprehensive Care Plan titled Sensory Deficit: Visual Deficit dated [DATE] documented interventions including Ophthalmology and Optometry consults as appropriate, encourage the resident to ask for assistance as needed, and maintain eyeglasses.</p> <p>There was no documentation in the resident's medical record of an assessment or a comprehensive care plan to self-administer medications.</p> <p>A Physician's order dated [DATE] last renewed on [DATE] documented to administer Systane Nighttime 95 percent to 3 percent eye ointment to both eyes at bedtime.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on [DATE] at 10:34 AM, Resident #31 was observed lying in bed with their bedside table placed directly in front of the resident. A plastic cup was observed on the bedside table containing four bottles of eye drops including two Refresh Liquigel bottles and two Systane eye ointments. The resident took the Refresh Liquigel eye drops from the cup and self-administered the eye drops to the right eye. The Refresh Liquigel eye drops documented an expiration date of [DATE]. The resident stated the nurses gave them the Refresh Liquigel to self-administer the eye drops.</p> <p>During an interview on [DATE] at 11:09 AM, Licensed Practical #5, the medication nurse, stated they were not aware Resident #31 had a plastic cup with four bottles of eye medications available to them in the room. Licensed Practical Nurse #5 stated the resident did not have a physician's order to self-administer any medication and these medications should not be stored in the resident's room, especially the expired medication.</p> <p>During an interview on [DATE] at 11:14 AM, Licensed Practical Nurse #4 stated Resident #31 should not have had any medications including any expired medication in their room because they do not have a Physician's order to self-administer medication.</p> <p>During an interview on [DATE] at 4:08 PM, the Pharmacist stated that Refresh eye drops should be discarded after the manufacturer's expiration date. The Pharmacist stated they do not recommend using any medication past the expiration date because the medication may become less effective.</p> <p>During an interview on [DATE] at 11:22 AM, the Director of Nursing Services stated Resident #31 should not have had any eye drops stored in the resident's room without an evaluation and a physician's order to self-administer the medication. The resident should not have had access to any expired medication.</p> <p>10 NYCRR 415.18(e),(d+[DATE])</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 1/21/2025 and completed on 1/28/2025, the facility did not ensure that injuries of unknown origin were reported by the covered individual including the Certified Nursing Assistants within 24 hours of identifying the injury. This was identified for one (Resident #273) of three residents reviewed for Skin Condition (non-pressure). Specifically, Certified Nursing Assistant #6 did not report a bruise of unknown origin on the back of Resident #273's left forearm when they identified the bruise on 1/18/2025.</p> <p>The finding is:</p> <p>The facility's Abuse Prevention policy dated 10/2022 documented that the facility staff are trained regarding the facility policies related to Abuse Prevention and Reporting at the time of orientation and at least annually thereafter. The orientation and in-service included but were not limited to identifying what constitutes abuse, neglect exploitation, and misappropriation of property, to report injuries of unknown origin, and to whom to make a report including the importance of reporting immediately.</p> <p>The facility's policy entitled Potential for Risk in Skin Integrity Prevention and Treatment last updated on 5/2011 documented the Certified Nursing Assistant was responsible for monitoring the resident's skin during activities of daily living care and reporting any changes in skin integrity immediately to the nurse in charge.</p> <p>Resident #273 was admitted with diagnoses that included Stage III Pressure Ulcer to the left elbow and Repeated Falls. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14, which indicated intact cognition. The resident had no behavioral symptoms. The resident used a walker and had no functional limitations to the upper and lower extremities. The resident required partial to moderate assistance for dressing, toilet hygiene and personal hygiene, bed mobility, and transfers including toilet transfers. The resident received nutrition or hydration intervention to manage skin problems. The resident did not receive anticoagulant medications during the lookback period.</p> <p>The Admission Skin assessment dated [DATE] had no documentation of discoloration to the resident's left forearm.</p> <p>A Comprehensive Care Plan for Skin Integrity dated 1/2/2025 documented the resident was at risk for skin breakdown related to impaired mobility. Interventions included for the Certified Nursing Assistant to evaluate the resident's skin condition daily during care and to report any skin abnormalities to the nurse.</p> <p>A Review of the Baseline Care Plan dated 1/2/2025 lacked documented evidence of a bruise to the resident's left forearm.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 1/21/2025 at 2:36 PM, Resident #273 was sitting in their room in a wheelchair at their bedside. The resident was observed with a bruise to the left forearm.</p> <p>During an interview on 1/24/2025 at 2:07 PM, Certified Nursing Assistant #6 stated they usually care for the resident during the night shift (11:00 PM to 7:00 AM) and routinely perform skin checks and inform the nurses if there are any new changes to the resident's skin. Certified Nursing Assistant #6 stated they had seen the bruise on Resident #273's forearm when they worked on the previous weekend 1/18/2025-1/19/2025 overnight night shift. Certified Nursing Assistant #6 stated they did not report the bruise and thought someone already reported it.</p> <p>During an interview on 1/24/2025 at 2:46 PM, Licensed Practical Nurse #6 who was assigned to Resident #273 on the 7:00 AM to 3:00 PM shift stated they have cared for the resident since admission. Licensed Practical Nurse #6 stated they were not aware of the discoloration on the resident's left forearm. Licensed Practical Nurse #6 stated the resident usually wears long-sleeved shirts and they did not receive any report of a bruise on the resident's left forearm. Licensed Practical Nurse #6 stated that it was the Certified Nursing Assistant's responsibility to report any changes in the resident's skin to the nurses.</p> <p>During an interview on 1/24/2025 at 3:42 PM, the Wound Care Registered Nurse stated on 1/3/2025 they evaluated the resident's left elbow stage III pressure ulcer and did not recall the resident having any discoloration to their left forearm. The Wound Care Registered nurse did not notice the discoloration until today, 1/24/2025.</p> <p>During an interview on 1/27/2025 at 2:07 PM, Registered Nurse #4 stated they completed the admission assessment for Resident #273 on 1/2/2025. Registered Nurse #4 stated they completed a head-to-toe assessment and the resident did not have any discoloration or a bruise on their left forearm. Registered Nurse #4 stated when they completed their assessment if they had observed a discoloration on the resident's forearm that they would have documented the bruise in their skin assessment.</p> <p>During an interview on 1/28/2025 at 12:01 PM, the Director of Nursing Services stated that Certified Nursing Assistant #6 should have reported the bruise to the charge nurse or the supervisor. The Director of Nursing Services stated the supervisor should have then initiated an Accident/Incident Report to determine the root cause of the incident. The Director of Nursing Service stated they had initiated an investigation as soon as they were informed on 1/24/2025 and abuse was ruled out.</p> <p>10 NYCRR 415.4(b)(2)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28173</p> <p>Based on record review and interviews during the Recertification Survey initiated on 1/21/2025 and completed on 1/28/2025, the facility did not ensure an assessment was completed to reflect the resident's status accurately. This was identified for one (Resident #128) of four residents reviewed for Dementia Care. Specifically, the Quarterly Minimum Data Set assessment for Resident #128 dated 1/6/2025 inaccurately reflected the resident as comatose.</p> <p>The finding is:</p> <p>The facility's policy titled Minimum Data Set Completion Assignment, last reviewed on 10/18/2023 documented that interdisciplinary care team members are assigned to specific Care Area Assessment which they have to document key findings regarding the resident's status based on the triggered care area. The care area assessment summary must be completed at the time of Minimum Data Set completion. The Minimum Data Set Coordinator is responsible for checking the completion of all Minimum Data Set 3.0 assessments.</p> <p>Resident #128 was admitted with diagnoses including Dementia and Depression. The Annual Minimum Data Set assessment dated [DATE] documented under item B0100 the resident's status as comatose. The remaining Section B (Hearing, Speech, and Vision) was left blank due to the resident's comatose status.</p> <p>The 5-day Minimum Data Set assessment dated [DATE] documented under item B0100 the resident as not being comatose in status, with adequate hearing, clear speech, and a Brief Interview for Mental Status score of 5, indicating severe cognitive impairment.</p> <p>A Comprehensive Care Plan titled Cognition, dated 8/20/2024 and last revised on 10/31/2024 documented that the resident was able to make themselves understood. The interventions included monitor for changes in decline in cognitive status and allowing for ample time for the resident to absorb and respond to information provided.</p> <p>A Physician's Order dated 1/16/2025 documented an order for a floor ambulation program, 100 feet with a rolling walker.</p> <p>During an observation on 1/24/2025 at 2:48 PM the resident was sitting at a table in the unit dining room. The resident smiled and waved at the surveyor when greeted.</p> <p>During an interview on 1/24/2025 at 1:16 PM, Social Worker #1, stated they were responsible for completing the Minimum Data Set Assessment Section B (Hearing, Speech, and Vision). Social Worker #1 stated the resident was not comatose when they completed the 1/6/2025 assessment. Social Worker #1 further stated they made an error and documented the resident's status incorrectly under the Hearing, Speech, and Vision section of the Minimum Data Set assessment.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/24/2025 at 1:20 PM, the Minimum Data Set Assessment Coordinator stated the Minimum Data Set assessment dated [DATE] for Resident #128 was incorrect and should not have documented the resident status as comatose. The Minimum Data Set Assessment Coordinator stated this was an error. The Minimum Data Set Assessment Coordinator stated they do not review the Minimum Data Set individual sections for accuracy and only review the booklet for completion.</p> <p>10 NYCRR 415.11(b)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48827</p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 1/21/2025 and completed on 1/28/2025, the facility did not ensure comprehensive care plans were reviewed and revised by the interdisciplinary team to reflect each resident's preferences and status after each assessment. This was identified for one (Resident #102) of six residents reviewed for Communication. Specifically, Resident #102 had a Physician's order to use bilateral hearing aides daily. The resident exhibited noncompliance and frequently removed the hearing aids; however, the comprehensive care plan for the hearing deficit was not updated to indicate the resident's behavior.</p> <p>The finding is:</p> <p>The facility's policy titled Care Plans dated 8/2022 documented the plan of care is reviewed on a quarterly and annual basis by the interdisciplinary team and or when the resident has a significant change in condition. Following the Minimum Data Set assessment schedule, the nursing department or designee will ensure that each care plan has been completed and updated within seven days of the end of the lookback period established by the Minimum Data Set schedule.</p> <p>Resident #102 was admitted with diagnoses including Dementia with severe agitation, Anxiety Disorder, and Chronic Obstructive Pulmonary Disease. The Minimum Data Set assessment documented a Brief Interview for Mental Status score of 2, indicating the resident had severely impaired cognition. The Minimum Data Set assessment documented the resident used hearing aids.</p> <p>A Comprehensive Care Plan, titled Hearing Deficit effective 1/09/2025, documented the resident used hearing aids. The interventions included checking for the placement of the hearing aids each shift.</p> <p>A physician's order dated 7/25/2024 last renewed on 1/21/2025 documented to insert bilateral hearing aids every morning, remove at bedtime, and for the 11 PM-7 AM shift to check that the hearing aids were in the treatment cart.</p> <p>The Treatment Administration Record for 1/2025 indicated documented evidence that the nurse placed the hearing aids in Resident #102's ears and removed them at bedtime.</p> <p>During an observation on 1/21/2025 at 10:14 AM, Resident #102 was not able to hear and did not respond to greetings. The resident was not wearing hearing aids in both ears.</p> <p>During a second observation on 1/22/2025 at 10:55 AM, Resident #102 was in their room in their wheelchair, with no hearing aids in their ears.</p> <p>During an interview on 1/24/2025 at 10:37 AM, Licensed Practical Nurse Charge Nurse #2 stated Resident #102 often refused to wear their hearing aids. The resident also had a behavior of removing the hearing aids and Licensed Practical Nurse Charge Nurse #2 did not notify anyone about the resident's behavior. Licensed Practical Nurse Charge Nurse #2 stated that the care plan for Hearing Deficit should have been updated to reflect the resident's behavior and noncompliance.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/27/2025 at 10:50 AM, the Director of Nursing Services stated the comprehensive care plan should have been updated to indicate the resident's refusal to wear or remove the hearing aids.</p> <p>10 NYCRR 415.11(c)(1)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732</p> <p>Based on record review and staff interviews during the Recertification Survey initiated on 1/21/2025 and completed on 1/28/2025, the facility did not ensure that each resident maintained, to the extent possible, acceptable parameters of nutritional and hydration status. This was identified for one (Resident #5) of five residents reviewed for Nutrition. Specifically, Resident #5 had an 8.48% significant weight loss in 90 days, from October 2024 to January 2025, which was not addressed by the Clinical Dietitian.</p> <p>The finding is:</p> <p>The facility's undated policy titled, Weight Monitoring documented, once weights have been recorded in the Electronic Medical Record (EMR), the unit Clinical Dietitian will review the resident's weight status over the specified period of time to identify any residents who have experienced a significant weight change. Significant weight change is defined as 5% weight loss/gain in 30 days, 7.5% weight loss/gain in 90 days, and 10% weight loss/gain in 180 days. Residents experiencing a significant weight change will be referred to their attending Physician by the Clinical Dietitian for further review and interventions.</p> <p>The facility's policy titled, Weight Loss dated 2/2019 documented interventions initiated by the Dietitian will be evaluated for effectiveness when continued declines in weights are identified and evaluation and assessment will be conducted at a minimum if in one month there is a significant (weight) loss of 5% or a severe (weight) loss greater than 5%; in three months there is a significant (weight) loss of 7.5% or a severe (weight) loss greater than 7.5%; in six months there is a significant (weight) loss of 10% or a severe (weight) loss greater than 10%. The Primary Medical Doctor will be notified of any significant weight (loss) and will follow up accordingly.</p> <p>Resident #5 has diagnoses which include Type 2 Diabetes Mellitus and Hypertension. The annual Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderately impaired cognitive skills for daily decision-making. The resident required supervision or touching assistance of one person for eating. The resident's height was 60 inches and they weighed 122 pounds.</p> <p>The resident's Weight Trend documented that on 10/6/2024 the resident weighed 130.9 pounds and on 1/1/2025 the resident weighed 119.8 pounds which indicated an 11.1 pounds or an 8.48% significant weight loss in 90 days or three months.</p> <p>The Physician's Order dated 12/13/2024 and last renewed 1/21/2025 documented the resident's diet as Therapeutic: No Added Salt (NAS), Low Concentrated Sweets (LCS), Low Fat; Consistency: Minced and Moist; Liquids: Thin.</p> <p>A review of the resident's Electronic Medical Record (EMR) on 1/24/2025 at 12:10 PM revealed no documented evidence that the resident's significant weight loss was addressed by the resident's Clinical Dietitian (Clinical Dietitian #1).</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/24/2025 at 1:00 PM, Clinical Dietitian #1 stated the Certified Nursing Assistants take the residents' weights and document the weights on a worksheet on the unit. Clinical Dietitian #1 stated it was their (the Dietician's) responsibility to enter the residents' weights into the Electronic Medical Record (EMR). Clinical Dietitian #1 stated according to the facility's policy, if a resident gained or lost 5 pounds in one month, a reweigh is requested to determine the accuracy of the weight. Clinical Dietitian #1 stated they also generate a report of all significant weight losses by using a computer program every month, after the 10 th of the month, when all monthly weights should be obtained.</p> <p>During a subsequent interview on 1/24/2025 at 1:20 PM, Clinical Dietitian #1 stated when they enter a monthly weight into a resident's Electronic Medical Record, they do not look for a 7.5% weight loss in three months, but mainly for a 5% weight loss from month to month. Clinical Dietitian #1 stated all resident weights have to be obtained by the tenth of the month; however, this month they ran the report for this month's weights on 1/22/2025. The report indicated Resident #5 had an 8.48% weight loss in 90 days. Clinical Dietitian #1 stated they did not have the time to write any significant weight loss notes yet for the month of January 2025. Clinical Dietitian #1 stated the notes would be completed before the end of the month.</p> <p>During an interview on 1/24/2025 at 1:50 PM, the Chief Clinical Dietitian stated on the first of every month, Certified Nursing Assistants start to take residents' monthly weights which are usually completed within 5 days and all reweighs have to be done by the tenth of the month. The Chief Clinical Dietitian stated that all Clinical Dietitians are responsible for putting the weights into the Electronic Medical Record. If there is a weight gain or loss of five pounds from one month to the next, a reweigh must be obtained to ensure the accuracy of the weight. The Chief Clinical Dietitian stated a significant weight loss was 5% in one month, 7.5% in three months, and 10% in six months. The Chief Clinical Dietitian stated that Clinical Dietitian #1 may not have been looking for 7.5% weight losses in three months when entering monthly weights into the residents' Electronic Medical Records, but should have.</p> <p>During an interview on 1/27/2025 at 10:10 AM, Licensed Practical Nurse #1, who was the Charge Nurse on Resident #5's unit, stated the Clinical Dietitian reviews all the weights and if they see that a resident had significant weight loss, they inform any Nurse on the unit who then contacts the resident's Primary Physician to inform them of the significant weight loss. Licensed Practical Nurse #1 stated that Clinical Dietitian #1 never told them that the resident had a significant weight loss. Licensed Practical Nurse #1 stated that if they had been informed, they would have contacted the resident's Primary Physician and written a Nursing Progress Note.</p> <p>During an interview on 1/27/2025 at 11:10 AM, the Director of Nursing Services stated the Clinical Dietitians are responsible for identifying significant weight losses and reporting them to the Interdisciplinary Team (Nursing, Social Work, Rehabilitation, and Activities) during the morning report. A Unit Nurse should also be made aware. The nurse should notify the resident's Primary Physician of the significant weight loss to obtain any new orders to address the resident's weight loss, such as ordering blood work or nutritional supplements.</p> <p>10 NYCRR 415.12(i)(1)</p>		

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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17732</p> <p>Based on record review and staff interviews during the Recertification Survey initiated on 1/21/2025 and completed on 1/28/2025, the facility did not ensure that the medical care of each resident was supervised by the Physician including monitoring changes in the resident's medical status. This was identified for one (Resident #5) of five residents reviewed for Nutrition. Specifically, Resident #5 had an 8.48% significant weight loss in 90 days, from October 2024 to January 2025, which was not addressed by their Primary Physician.</p> <p>The finding is:</p> <p>The facility's undated policy titled, Weight Monitoring documented, once weights have been recorded in the Electronic Medical Record (EMR), the unit Clinical Dietitian will review the resident's weight status over the specified period of time to identify any residents who have experienced a significant weight change. Significant weight change is defined as 5% weight loss/gain in 30 days, 7.5% weight loss/gain in 90 days, and 10% weight loss/gain in 180 days. Residents experiencing a significant weight change will be referred to their attending Physician by the Clinical Dietitian for further review and interventions.</p> <p>The facility's policy titled, Weight Loss dated 2/2019 documented interventions initiated by the Dietitian will be evaluated for effectiveness when continued declines in weights are identified and evaluation and assessment will be conducted at a minimum if in one month there is a significant (weight) loss of 5% or a severe (weight) loss greater than 5%; in three months there is a significant (weight) loss of 7.5% or a severe (weight) loss greater than 7.5%; in six months there is a significant (weight) loss of 10% or a severe (weight) loss greater than 10%. The Primary Medical Doctor will be notified of any significant weight (loss) and will follow up accordingly.</p> <p>Resident #5 has diagnoses which include Type 2 Diabetes Mellitus and Hypertension. The annual Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderately impaired cognitive skills for daily decision-making. The resident required supervision or touching assistance of one person for eating. The resident's height was 60 inches and they weighed 122 pounds.</p> <p>The resident's Weight Trend documented that on 10/6/2024 the resident weighed 130.9 pounds and on 1/1/2025 the resident weighed 119.8 pounds which indicated an 11.1 pounds or an 8.48% significant weight loss in 90 days or three months.</p> <p>The Physician's Order dated 12/13/2024 and last renewed 1/21/2025 documented the resident's diet as Therapeutic: No Added Salt (NAS), Low Concentrated Sweets (LCS), Low Fat; Consistency: Minced and Moist; Liquids: Thin.</p> <p>The Medical Progress Note dated 1/21/2025 documented that the resident was seen by their Primary Physician (Primary Physician #1) for their monthly visit on 1/18/2025; however, the current eight and change in weight portion of the visit was left blank.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Maria Regina Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 Brentwood Road Brentwood, NY 11717	
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<p>F 0710</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/24/2025 at 1:20 PM, Clinical Dietitian #1 stated when they enter a monthly weight into a resident's Electronic Medical Record, they do not look for a 7.5% weight loss in three months, but mainly for a 5% weight loss from month to month. Clinical Dietitian #1 stated all resident weights have to be obtained by the tenth of the month; however, this month they ran the report for this month's weights on 1/22/2025. The report indicated Resident #5 had an 8.48% weight loss in 90 days. Clinical Dietitian #1 stated they did not have the time to write any significant weight loss notes yet for the month of January 2025. Clinical Dietitian #1 stated the notes would be completed before the end of the month.</p> <p>During an interview on 1/27/2025 at 10:10 AM, Licensed Practical Nurse #1, who was the Charge Nurse on Resident #5's unit, stated the Clinical Dietitian reviews all the weights and if they see that a resident had significant weight loss, they inform any Nurse on the unit who then contacts the resident's Primary Physician to inform them of the significant weight loss. Licensed Practical Nurse #1 stated that Clinical Dietitian #1 never told them that the resident had a significant weight loss. Licensed Practical Nurse #1 stated that if they had been informed, they would have contacted the resident's Primary Physician and written a Nursing Progress Note.</p> <p>During an interview on 1/27/2025 at 10:25 AM, the resident's Primary Physician (Primary Physician #1) stated they should have documented the resident's weight in their monthly review. Primary Physician #1 stated they did not realize they had left the monthly weight review section blank. Primary Physician #1 stated they had only compared this month's weight with the resident's weight from the month before and did not see a significant weight loss. Primary Physician #1 stated that the facility Dietitians and Nurses are pretty good in letting them know if a resident had a significant weight loss, but they were never informed that the resident had an 8.48% significant weight loss from October 2024 to January 2025.</p> <p>During an interview on 1/27/2025 at 10:40 AM, the Medical Director stated, The dietitians are excellent in contacting the Physician about weight loss, but the Primary Physician can also look at the weights [themselves] to see if there have been any significant weight losses. The Medical Director stated that the resident's Primary Physician was supposed to document the resident's weight in their monthly review and if a significant weight loss was identified, interventions such as supplements should be added. The Physician should document the cause of the weight loss. The Medical Director stated that all questions on a monthly visit template absolutely should be answered.</p> <p>10 NYCRR 415.15(b)(1)(i)(ii)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827</p> <p>Based on record review and interviews during the Recertification Survey and abbreviated Survey (Complaint # NY 00337758) initiated on 1/21/2025 and completed on 1/28/2025, the facility did not ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for each resident. This was identified for one (Unit 2 East) of six nursing units during the Sufficient Staffing Task. Specifically, a review of the daily staffing sheets and grievance reports indicated that Unit 2 East did not have sufficient nursing staff available during the weekends to care for residents in March 2024.</p> <p>The finding is:</p> <p>The facility's policy titled Staffing dated 8/2001 documented that the facility will ensure that staff of sufficient size and appropriate qualifications is maintained in order to carry through the policies, programs, and responsibilities of the facility, as well as to provide quality care to its residents. A sufficient number of Registered Nurses and Licensed Practical Nurses will be available for administration of medications and treatments. A sufficient number of Certified Nursing Assistants will be available to meet the healthcare needs of all residents.</p> <p>The Facility Assessment last reviewed on 1/2025 documented the acuity of each unit is determined based on resident diagnoses, assistance required with activities for daily living, and specialized treatments needed. The Facility Assessment documented for census based on 100% occupancy, Unit 2 East would require four Certified Nursing Assistants and two licensed Nurses during the 7:00 AM to 3:00 PM shift.</p> <p>A review of the daily Census reports from 3/3/2024 to 3/31/2024 revealed Unit 2 East had a capacity of 35 beds with a census of:</p> <ul style="list-style-type: none"> - 34 residents on 3/3/2024, 3/10/2024, and 3/17/2024. - 35 residents on 3/24/2024 and 3/31/2024. <p>A review of the daily staffing sheets from 3/3/2024 to 3/31/2024 for Unit 2 East during the 7:00 AM to 3:00 PM shift revealed the following:</p> <ul style="list-style-type: none"> - Two Licensed Practical Nurses and three Certified Nursing Assistants were scheduled on 3/3/2024; however, the Facility Assessment documented a need for four Certified Nursing Assistants. - One Licensed Practical Nurse and three Certified Nursing Assistants were scheduled on 3/24/2024; however, the Facility Assessment documented a need for two Licensed Nurses and four Certified Nursing Assistants. - One Licensed Practical Nurse and two Certified Nursing Assistants were scheduled on 3/10/2024, 3/17/2024, and 3/31/2024; however, the Facility Assessment documented a need for two Licensed Nurses and four Certified Nursing Assistants. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A grievance report dated 3/19/2024 filed by a family member of a resident, who was discharged on [DATE], documented that on 3/10/2024 and 3/17/2024, Unit 2 East had only two Certified Nursing Assistants to assist the residents during the 7:00 AM to 3:00 PM shift. In response to the grievance, the 7:00 AM to 3:00 PM Nurse Supervisor was educated on how to staff the unit for the callouts. The response also documented that the facility actively recruited new nursing staff, and corrective disciplinary measures were implemented for employees with excessive callouts.</p> <p>A review of Resident Council minutes for October, November, and December 2024 revealed there were no staffing complaints from the residents.</p> <p>During the Resident Council meeting on 1/21/2025 at 2:00 PM, 10 of 10 residents who attended the meeting presently had no complaints related to staffing.</p> <p>During an interview on 1/23/2025 at 11:07 AM, the Administrator stated they were newly hired at the facility back in early 2024 and at that time nurse staffing was low. The Administrator stated since then they hired new staff. The Administrator stated they also educated the Weekend Nurse Supervisors to adjust work assignments and call in additional staff to cover callouts. The Administrator provided a list of newly hired staff and stated they have hired over 100 new employees since March 2024.</p> <p>During an interview on 1/24/2025 at 10:31 AM, Certified Nursing Assistant #1 stated Unit 2 East used to be short-staffed with just two Certified Nursing Assistants assigned to the unit. Certified Nursing Assistant #1 stated currently, the unit has four Certified Nursing Assistants and sometimes five. Certified Nursing Assistant #1 stated when there were just two Certified Nursing Assistants in the Unit, they asked the nurse to help get the assigned residents up and dressed.</p> <p>During an interview on 1/24/2025 at 10:35 AM, Licensed Practical Nurse Charge Nurse #2 stated there used to be just two or three Certified Nursing Assistants on Unit 2 East during the 7:00 AM to 3:00 PM shift. Licensed Practical Nurse Charge Nurse #2 stated Unit 2 now has four or five Certified Nurse Assistants during the 7:00 AM to 3:00 PM shift.</p> <p>During an interview on 1/27/2025 at 8:22 AM, Certified Nursing Assistant #2 stated when there are two Certified Nursing Assistants, they would prioritize the residents who like to be out of bed early and the remaining residents would stay in bed longer. Certified Nursing Assistant #2 stated they would have to wait until the other Certified Nursing Assistant or the Nurse was free to provide care that required two-person assistance.</p> <p>During an interview on 1/27/2025 at 8:52 AM, the Staffing Coordinator stated each unit should have at least four Certified Nursing Assistants during the 7:00 AM to 3:00 PM shift. The Staffing Coordinator stated that they are not available on the weekends and it is up to the nursing supervisors to adjust the assignments and find additional nursing staff to cover a shift as needed.</p> <p>During an interview on 1/27/2025 at 10:58 AM, the Director of Nursing Services stated they were aware the facility was understaffed in March 2024. The Director of Nursing Services stated that the Administrator hired more nursing staff since March 2024. The facility is partnered with nursing schools to hire new staff.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance at the time of this survey for this specific regulatory requirement.</p> <p>-A review of the staffing sheets from October 2024 to December 2024 and from 1/21/2025 to 1/28/2025 indicated sufficient nursing staff were available to care for the resident.</p> <p>-A review of Resident Council minutes for October, November, and December 2024 revealed there were no staffing complaints from the residents.</p> <p>-The facility presented evidence of 100 newly hired staff which included nursing staff since March 2024 and hired sufficient staff by August 2024.</p> <p>-Interview with Resident Council members on 1/21/2025 confirmed improved staffing and staff responses to resident needs.</p> <p>-Interview with facility staff indicated improved staffing levels since March 2024.</p> <p>-During the survey frequent observations and review of the facility staffing level indicated compliance with F725.</p> <p>10 NYCRR 483.35(a)(1)(2)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50423</p> <p>Based on observations, interviews, and record review during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure all drugs and biologicals were stored in locked compartments under proper temperature controls. This was identified for one (Resident #31) of four residents reviewed for Vision and Hearing. Specifically, a plastic cup containing two bottles of Refresh Liquigel eye drops and two bottles of Systane Lubricant eye ointment medications were observed on Resident #31's bedside table on [DATE]. The Refresh Liquigel eye drops expiration date was documented as ,d+[DATE] and the resident was observed to self-administer the expired eye drops.</p> <p>The finding is:</p> <p>The facility policy titled Storage of Medication dated ,d+[DATE] documented that drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Compartments containing drugs and biologicals shall be locked when not in use. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals.</p> <p>Resident #31 was admitted with diagnoses including Dry Eye Syndrome of both eyes and Cataract. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating the resident's cognition was intact. The Minimum Data Set assessment documented the resident had adequate vision and used corrective lenses.</p> <p>A Comprehensive Care Plan titled Sensory Deficit: Visual Deficit dated [DATE] documented interventions including Ophthalmology and Optometry consults as appropriate, encourage the resident to ask for assistance as needed, and maintain eyeglasses.</p> <p>There was no documentation in the resident's medical record of an assessment or a comprehensive care plan to self-administer medications.</p> <p>A Physician's order dated [DATE] last renewed on [DATE] documented to administer Systane Nighttime 95 percent to 3 percent eye ointment to both eyes at bedtime.</p> <p>During an observation and interview on [DATE] at 10:34 AM, Resident #31 was observed lying in bed with their bedside table placed directly in front of the resident. A plastic cup was observed on the bedside table containing four bottles of eye drops including two Refresh Liquigel bottles and two Systane eye ointments. The resident took the Refresh Liquigel eye drops from the cup and self-administered the eye drops to the right eye. The Refresh Liquigel eye drops documented an expiration date of [DATE]. The resident stated the nurses gave them the Refresh Liquigel to self-administer the eye drops.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 11:09 AM, Licensed Practical #5, the medication nurse, stated they were not aware Resident #31 had a plastic cup with four bottles of eye medications available to them in the room. Licensed Practical Nurse #5 stated the resident did not have a physician's order to self-administer any medication and these medications should not be stored in the resident's room, especially the expired medication.</p> <p>During an interview on [DATE] at 11:14 AM, Licensed Practical Nurse #4 stated Resident #31 should not have had any medications including any expired medication in their room because they do not have a Physician's order to self-administer medication.</p> <p>During an interview on [DATE] at 4:08 PM, the Pharmacist stated that Refresh eye drops should discarded after the manufacturer's expiration date. The Pharmacist stated they do not recommend using any medication past the expiration date because the medication may become less effective.</p> <p>During an interview on [DATE] at 11:22 AM, the Director of Nursing Services stated Resident #31 should not have had any eye drops stored in the resident's room without an evaluation and a physician's order to self-administer the medication. The resident should not have had access to any expired medication.</p> <p>10 NYCRR 415.18(e),(d+[DATE])</p>