STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335837	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maria Regina Rehabilitation and Nursing	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)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review during survey, the facility failed to ensure an assessment accurately reflected each resident's status. This was identified for one (1) (Resident #4) of one (1) resident reviewed for catheter. Specifically, Resident #4 was admitted without an indwelling urinary catheter (a flexible tube inserted through the urethra or abdominal wall into the bladder to continuously drain the urine into an external bag). The admission 5-Day Minimum Data Set assessment dated [DATE] inaccurately documented that the resident had an indwelling catheter.The findings include:The facility policy titled Minimum Data Set Completion Assignment last reviewed 10/10/2025 documented the interdisciplinary team members are responsible for accurately completing and signing for their assigned sections on all initial, annual, quarterly, significant change, and Medicare assessments.Resident #4 was admitted with diagnoses including benign prostatic hyperplasia (a noncancerous enlargement of the prostate gland that commonly affects men as they age) with lower urinary tract symptoms, obstructive and reflux uropathy (conditions that interrupt normal urine flow, causing backflow into the kidneys), and neuromuscular dysfunction of the bladder (loss of bladder control caused by nerve damage). The admission 5-Day Minimum Data Set assessment dated [DATE] documented a Brief interview for Mental Status score of 13, indicating the resident was cognitively intact. Section H titled Bladder and Bowel of the Minimum Data Set assessment documented the resident had an indwelling catheter and was always continent of the bladder during the assessment lookback period.A hospital Patient Review Instrument (PRI-a mandatory assessment to determine if an individual requires skilled nursing facility care) dated 04/15/2026 for Resident #4 documented the Resident did not have an indwelling or external catheter.An admission Nursing assessment dated [DATE] documented the resident did not have an indwelling urinary catheter.A nursing progress note dated 04/16/2026 documented an admission comprehensive assessment was completed and Resident #4 had no indwelling urinary catheter present upon admission.A Certified Nursing Assistant Accountability Record for Resident #4 for April 2026 documented a Foley catheter care initiated 04/16/2026 and ended 04/20/2026. The Certified Nursing Assistant Accountability Record documented Foley catheter care was not provided.A review of Resident #4's medical record revealed the resident had no physician's order related to the use and care of an indwelling urinary catheter or a comprehensive care plan related to the use and care of an indwelling urinary catheter.During an interview on 04/30/2026 at 11:39 PM, Resident #4 stated they do not have a urinary indwelling catheter.During an interview on 05/05/2026 at 1:42 PM, Certified Nursing Assistant #1, the assigned certified nursing assistant for Resident #4, stated the resident did not use an indwelling urinary catheter, the resident wore briefs and received assistance for toileting.During an interview on 05/05/2026 at 1:43 PM, Licensed Practical Nurse #1, the charge nurse, stated the resident was not admitted to the unit with an indwelling urinary catheter.During an observation on 05/06/2026 at 9:28 PM, Resident #4 was observed in bed prior to receiving care in the presence of Certified Nursing Assistant #2. The resident was observed with incontinence briefs on and had no urinary indwelling catheter.During an interview on 05/06/2026 at 12:16 PM, the Minimum data Set Assessor stated they were responsible for completing multiple sections of the Minimum Data (continued on next page)

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

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	335837	A. Building B. Wing	05/06/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set including Section H, Bladder and Bowel. The [NAME] Data Set Assessor stated they reviewed the resident's chart including the Certified Nursing Assistant Accountability Record to gather information when completing the assessment. The Minimum Data Set Assessor stated the medical record system automatically answered on the Minimum Data Set assessment that the resident had an indwelling catheter because the system captured that information from the resident's Certified Nursing Assistant Accountability Record. The Minimum Data Set Assessor stated they did not correct this discrepancy at the time they completed Section H of the assessment, and it was an oversight.During an interview on 05/06/2026 at 2:05 PM, the Minimum Data Set Coordinator stated Resident #4 had a Foley catheter during previous admission in October 2025 and the medical record system saved that information. When the resident was admitted again on 04/16/2026, the resident's Certified Nursing Assistant Accountability Record saved the task for Foley catheter care from the October 2025 admission. The system then automatically documented in the Minimum Data Set assessment dated [DATE] that the resident had an indwelling catheter based on the information captured on the Certified Nursing Assistant Accountability Record. The Minimum Data Set assessment was completed within 24 hours of the resident's admission and prior to when the Certified Nursing Accountability Record was updated. This discrepancy on the Minimum Data Set assessment should have been immediately corrected by the Minimum Data Set Assessor prior to completing the section of the assessment. During an interview on 05/06/2026 at 2:30 PM, the Director of Nursing Services stated the Minimum Data Set Assessor should have clarified the information in Section H of the Minimum Data Set assessment for Resident #4 with nursing staff to confirm if the resident had an indwelling catheter and corrected the information on the assessment.10 New York Code Rules and Regulations 415.11(b)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the survey, the facility failed to ensure that a resident who needs respiratory care is provided with such care, consistent with professional standards of practice. This was identified for one (1) (Resident #146) of three (3) residents reviewed for respiratory care. Specifically, Resident #146 had physician's orders for oxygen therapy via nasal cannula two liters per minute as needed for the treatment of chronic obstructive pulmonary disease. On 4/30/2026 the oxygen tubing label was dated 4/21/2026. The findings include: The facility policy for Oxygen Administration revised on 01/2026 documented the Physician will order oxygen therapy stating specific flow rate, diagnosis related to need for therapy and type of delivery device (nasal cannula, mask, venti-mask). Oxygen tubing (connecting tubing and nasal cannula) will be changed weekly, every Sunday during the 11:00 PM to 7:00 AM shift and as needed regardless of the administration orders. Resident #146 was admitted to the facility with diagnoses including chronic obstruction pulmonary, hypertension, and shortness of breath. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of 5, indicating the resident had severely impaired cognition. The Minimum Data Set assessment documented the resident was utilizing oxygen therapy. The physician's orders last renewed on 04/22/2026 documented oxygen therapy via nasal cannula with a flow rate of two liters per minute as needed every day during all shifts. The physician's orders also indicated to change the oxygen tubing weekly. Schedule: as needed for shortness of breath. The Oxygen Care Plan initiated on 03/13/2025 and revised on 02/27/2026 documented interventions including providing oxygen therapy as per the physician's orders. The comprehensive care plan did not indicate how often to change oxygen tubing. During an observation on 04/30/2026 at 11:45 AM, Resident #146 was in the dining room sitting in their wheelchair with a portable oxygen tank and was receiving oxygen via nasal cannula. The oxygen tubing was dated 04/21/2026. During an interview on 05/06/2026 at 02:05 PM, Licensed Practical Nurse #2 stated Resident #146 utilizes oxygen therapy during all shifts. Licensed Practical Nurse #2 stated nurses are supposed to change oxygen tubing every Sunday during the 11:00 PM to 7:00 AM shift. Licensed Practical Nurse #2 stated they did not realize the oxygen tubing label was dated 04/21/2026 for Resident #146. Licensed Practical Nurse #2 stated they also did not realize the physician's order for oxygen therapy tubing change indicated as needed instead of weekly. Licensed Practical Nurse #2 stated the oxygen therapy tubing must be changed every week for infection control. During an interview on 05/06/2026 at 02:12 PM, Registered Nurse #1 stated the 11:00 PM to 7:00 AM shift nurse is supposed to change oxygen therapy tubing every Sunday, to prevent infection. Registered Nurse #1 stated they did not know Resident #146's oxygen therapy tubing was not changed weekly, and they did not know why it was dated 04/21/2026 because that date was not a Sunday. Registered Nurse #1 stated the physician's order to change the oxygen tubing should have been weekly on Sundays, instead of as needed. During an interview on 05/06/2026 at 02:18 PM, Licensed Practical Nurse #3, who worked on the 11:00PM to 07:00AM shift on Sundays, stated Resident #146 utilizes the supplemental oxygen on each shift. The oxygen tubing should be changed weekly, on Sundays during the 11:00 PM to 07:00 AM shift. The physician's order to change the oxygen tubing should every Sunday from 11:00PM to 07:00 AM instead of as needed because the oxygen tubing should be changed weekly to promote infection control. During an interview on 05/06/2026 at 02:38 PM, the Director of Nursing Services stated the nurses who work during the 11:00 PM to 7:00 AM shift on Sundays should have changed the oxygen therapy tubing weekly to promote infection control. The Director of Nursing Services stated the physician's order for oxygen tube changes should have been a standing order as per the facility policy and not an as needed order. 10 New York Code Rules and Regulations 415.12(k)(6)