STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335840	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during the survey, the facility failed to ensure that each resident received adequate supervision and assistance to prevent accidents. This was identified for one (Resident #111) of three residents reviewed for falls. Specifically, Resident #111 was totally dependent on two staff members for bed mobility and for personal hygiene as per the comprehensive care plan. On 12/09/2025, Certified Nursing Assistant #1 did not follow the resident's plan of care and provided toileting care by themselves while the resident was in bed. The resident fell out of bed and sustained a fracture to the right lower leg bones. This resulted in actual harm to Resident #111 that was not Immediate Jeopardy.The findings include: The facility's policy titled Activities of Daily Living effective 01/2026 documented the resident will be expected to maintain reasonable standards of hygiene and grooming during their stay at the facility and will be offered all necessary supplies and assistance to do so. When autonomy and independence are no longer possible or feasible, the resident care staff will provide the necessary support in all activities of daily living functioning.Resident #111 was admitted with diagnoses that included anoxic brain damage (brain injury due to lack of oxygen), quadriplegia (paralysis affecting all limbs), and seizure disorder. A quarterly Minimum Data Set (a resident assessment tool) dated 10/19/2025 documented the resident had short term and long-term memory problems, had no behavioral symptoms, and was dependent on staff for all aspects of daily living including the bed mobility (helper does all of the effort. The Resident does none of the effort to complete the activity; or the assistance of two or more helpers is required for the resident to complete the activity.) The resident had functional limitations in range of motion to both the upper and lower extremities. The resident had an external catheter and was always incontinent of the bowel. The nursing Falls Risk evaluation dated 11/05/2025, documented the resident's fall risk score was 13, which indicated the resident was at a moderate risk for falls. The Activity of Daily Living care plan initiated on 07/05/2024 and last revised 02/13/2025, documented the resident was totally dependent on two staff members for repositioning, turning in bed, personal hygiene, and bathing. The Risk for Falls Care Plan dated 07/05/2024 last revised 02/12/2025, documented the resident was at high risk for falls related to seizure disorder and diagnosis of osteopenia (a condition where your bone density is lower than normal). The interventions included to anticipate and meet the resident's needs, educate the resident/family/caregivers about safety reminders, and what to do if a fall occurs. A nursing progress note written by Registered Nurse #7 dated 12/09/2025, documented that at 05:30 PM they were notified that the resident fell out of bed while being changed by Certified Nursing Assistant #6. The resident was assessed by Registered Nurse #7 and had edema (swelling), redness, and excessive warmth to the right knee. An Accident and Occurrence report dated 12/09/2025 at 5:30 PM, documented Resident #111 fell out of bed to the floor. The resident required two-person assistance with care but assigned Certified Nursing Assistant #6 provided care [brief change] to Resident #111 by themselves. A written statement by Certified Nursing Assistant #6 dated 12/09/2025, documented that the resident was soiled and their wound dressing needed to be changed. Certified Nursing Assistant #6 notified Licensed Practical Nurse #6 of the need for the (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	treatment change. While the resident was turned on their side, Certified Nursing Assistant #6 was washing the resident's backside; the resident slipped which caused the floor mat to move and the resident's lower body hit the floor. A written statement by Licensed Practical Nurse #6 dated 12/09/2025, documented that they were called by Certified Nursing Assistant #6 to administer wound care to Resident #111's sacral wound. While they were gathering supplies, Certified Nursing Assistant #6 again asked them to come to the resident's room. Upon entering the room, Resident #111 was lying on the floor with feces on them. The undated Final Investigation Summary and Determination documented on 12/09/2025, the resident was rolled to their side for wound care and attempted to assist with bed mobility and fell out of bed. The facility documented there was no reasonable cause to believe any alleged abuse, mistreatment, or neglect had occurred. A nursing progress note dated 12/10/2025 at 12:05 AM, documented the resident left the facility at 8:30 PM (12/09/2025) with emergency services. The hospital Discharge summary dated [DATE] documented the resident was admitted [to the hospital] on 12/09/2025 due to being logrolled while being changed and fell out of the bed. The resident was admitted to the hospital with right tibial and fibula (lower leg bones) fracture. During an interview on 05/29/2026 at 1:49 PM, Certified Nursing Assistant #6 stated they were assigned to Resident #111 on 12/09/2025 during the 3:00 PM -11:00 PM shift. Certified Nursing Assistant #6 stated that the resident was soiled with feces, and they had to change the resident's brief. The resident also had a sacral wound, and the wound dressing was also soiled and needed to be changed. Certified Nursing Assistant #6 stated they knew that two staff members were required to turn and position the resident during care while in bed. Licensed Practical Nurse #6 had instructed them to start cleaning the resident. Certified Nursing Assistant #6 stated they started to clean the resident without a second staff member's help because they wanted the resident ready for the wound treatment. Certified Nursing Assistant #6 stated they were able to turn the resident to their left side so that the nurse would be able to provide the wound care and the resident fell out of the bed. Certified Nursing Assistant #6 stated they should have asked for assistance from a second staff member before providing care to Resident #111.During an interview on 06/01/2026 at 3:21 PM, Licensed Practical Nurse #6 stated Certified Nursing Assistant #6 reported to them that the resident's brief was soiled and that the sacral wound dressing needed to be changed. Licensed Practical Nurse #6 stated that they instructed Certified Nursing Assistant #6 to wait until they checked the treatment orders and got the supplies. The resident required two person assistance with care and Certified Nursing Assistant #6 should not have moved the resident alone. Licensed Practical Nurse #6 stated that they gathered the wound care supplies and were on their way to the resident's room when Certified Nursing Assistant #6 told them to hurry to the resident's room. Licensed Practical Nurse #6 stated that when they entered the resident's room, they observed the resident on the floor. Licensed Practical Nurse #6 stated that they did not instruct Certified Nursing Assistant #6 to start care without them being in the room. During an interview on 06/01/2026 at 3:37 PM, Registered Nurse #7 stated they were the nursing supervisor on duty on 12/09/2025 and were notified that while Certified Nursing Assistant #6 was changing Resident #111's brief, the resident fell out of bed. Registered Nurse #7 stated Certified Nursing Assistant #6 was providing care to Resident #111 by themself. Registered Nurse #7 stated that Certified Nursing Assistant #6 should not have administered any care to the resident by themselves and should have waited for Licensed Practical Nurse #6 or asked another certified nursing assistant for assistance. Registered Nurse #7 stated upon assessment, the resident was noted with edema, redness and warmth to their right knee. Registered Nurse #7 stated that the fall could have been prevented if Certified Nursing Assistant #6 provided care to the resident with a second staff member present in the room. During an interview on 06/01/2026 at 4:09 PM, the Director of Nursing Services stated that Certified Nursing Assistant #6 should not have initiated any care for Resident #111 without a second staff member present in the room to assist them. The Director of Nursing Services stated Certified Nursing Assistant #6 did not follow Resident #111's plan of care. Based on the investigation, the resident sustained a fracture as a direct result of the fall. The (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Director of Nursing Services stated that this fall could have been avoided if Certified Nursing Assistant #6 had waited for assistance. During an interview on 06/02/2026 at 8:46 AM, the Medical Director stated that the staff should have followed the resident's plan of care to ensure the safety of the resident. The Medical Director further stated that Resident #111's leg fracture was a result of the fall and that the fall could have been prevented if Certified Nursing Assistant #6 had followed the plan of care.10 New York Code Rules Regulations 414.12(h)(2)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to maintain an infection prevention and control program designed to help prevent the development and transmission of infectious diseases. This was identified for one (Resident #260) of five residents reviewed for infection control; two (Unit 1C medication cart and Unit 3C medication cart low side) of nine medications carts reviewed during the Medication Storage Task; and for two residents (Resident #75 and Resident #234) during the lunch meal dining observation. Specifically, 1) Resident #260 had a physician's order for contact precautions related to an infection with a carbapenem-resistant organism. Certified Nursing Assistant #3 was observed in Resident #260's room assisting the resident in the bathroom and to the wheelchair without wearing the required personal protective equipment; 2) Registered Nurse #4 and Licensed Practical Nurse #2 cleaned the glucometer machine with alcohol wipes instead of the manufacturer recommended Protection Agency (EPA) approved disinfectant to disinfect the shared glucometer; and 3) Licensed Practical Nurse #9 did not perform hand hygiene after they assisted Resident #75 with their meals and before assisting Resident #234 with their meals. The findings include: The facility policy titled Transmission Based Precautions last revised on 02/2026 documented isolation procedures are instituted whenever there is a risk of spreading infections. Transmission based isolation procedures are designed to protect other residents, personnel, and visitors from the spread of a confirmed or suspected infection or contagious disease. The Infection Prevention Nurse or designee will inform all applicable department heads of isolated residents to ensure all precautions, applicable to their department, are in place and staff in contact with the residents are aware and educated on the appropriate personal protective equipment to be used. The facility policy titled Cleaning of Glucometers in Long Term Care Facility dated 02/2026 documented cleaning the glucometer with a wipe from the purple top (EPA-registered disinfecting wipe) after each individual use. Allow the glucometer to air-dry to ensure the appropriate wet time for adequate sanitation. The facility's Hand Washing policy and procedure revised 03/2026 documented hands should be washed in between handling individual residents. 1) Resident #260 was admitted with diagnoses that included acute respiratory failure (lungs cannot properly oxygenate), epilepsy (recurrent unprovoked seizures), and tracheostomy (an opening surgically created through the neck into the windpipe to establish an airway). The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, indicating the resident had moderate cognitive impairment. A physician's order dated 05/16/20026, documented contact precautions [in sputum]. A Comprehensive Care Plan dated 05/26/2026 documented Resident #260 had carbapenem-resistant organism (CRO) Enterobacter in sputum. Interventions included placing the resident on contact precautions and for staff to utilize proper personal protective equipment when caring for the resident. During an observation on 05/26/2026 at 12:28 PM, a contact precaution signage on Resident #260's room door documented that everyone must clean their hands before entering and when leaving the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. The signage indicated that providers and staff must also put on a gown and gloves before entering the room and discard the gown and gloves before exiting the room. Resident #260 was observed in the bathroom within their bedroom with Certified Nursing Assistant #3. Certified Nursing Assistant #3 was wearing gloves but did not wear a gown. Certified Nursing Assistant #3 then exited the bathroom with Resident #260. During an interview on 05/26/2026 at 12:34 PM, Certified Nursing Assistant #3 stated they took the resident to the bathroom to use the toilet and helped them into the wheelchair afterwards. Certified Nursing Assistant #3 stated they were not sure why they did not put on the gown prior to entering Resident #260's room. Certified Nursing Assistant #3 stated they heard the call bell and went into the room without thinking. Certified Nursing Assistant #3 stated they should have read the signage and put on the appropriate personal protective equipment before going into the room. During an interview on 06/01/2026 at 12:49 PM, Registered Nurse Educator/Infection Preventionist #1 stated Certified Nursing Assistant #3 should have put on a gown prior to entering Resident #260's room because the resident was on contact precautions for a drug-resistant organism. During an interview on 06/02/2026 at 8:05 AM, the Director of Nursing Services stated the staff should follow the transmission-based precaution instructions that are posted on the door signage. Contact precautions require a gown and gloves to be worn when entering the room and staff should remove the gown and gloves when exiting the room. 2) The blood glucose meter manufacturer's instruction manual last revised on 2018 documented the glucose meter must be disinfected between patient uses by wiping it with an Environmental Protection Agency-registered disinfecting wipe in between tests. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. During an observation of the Unit 1 C cart and an interview with Registered Nurse #2 on 05/27/2026 at 6:05 AM, Registered Nurse #2 stated they clean and disinfect the glucometer with alcohol wipes between each resident use. Registered Nurse #2 then used a 70% alcohol pad to clean the glucometer. Registered Nurse #2 stated they use microbial wipes for cleaning the blood pressure cuffs, the stethoscope, and the medication cart. Registered Nurse #2 stated they were educated by the facility to use the alcohol wipes to clean the glucometer. During an interview on 05/28/2026 at 11:30 AM, Registered Nurse Clinical Care Coordinator #3 stated nurses should clean the glucometer with a microbial wipe and let the device air-dry before using the device on another resident. During an observation of the Unit 3C medication cart and an interview with Licensed Practical Nurse #2 on 05/29/2026 at 8:05 AM, Licensed Practical Nurse #2 stated they use alcohol wipes to clean and disinfect the glucometer between each resident use. Licensed Practical Nurse #2 then used a 70% alcohol prep pad to clean the glucometer. During an interview on 06/01/2026 at 12:49 PM, Registered Nurse Educator/Infection Preventionist #1 stated nurses should wipe down the glucometer with the Environmental Protection Agency-registered disinfecting wipe and wait two minutes for the glucometer to dry. Infection Preventionist #1 stated that alcohol wipes are not effective against the blood born pathogen and other microbes and are also not effective in preventing the spread of microorganisms from one resident to another resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/02/2026 at 8:02 AM, the Director of Nursing Services stated nurses should clean and disinfect the glucometer with the Environmental Protection Agency-registered disinfecting wipe and wait two minutes for the glucometer to air-dry. The Director of Nursing Services stated alcohol wipes would not kill all microbes on the glucometer. 3) During a dining room observation on 05/26/2026 at 1:10 PM, in the unit dining room, Licensed Practical Nurse #9 was observed assisting Resident #75 with their meal. After assisting Resident #75, Licensed Practical Nurse #9 was observed opening the food items on Resident #234's meal tray and feeding the resident without washing or sanitizing their hands. -Resident #75 had diagnoses that included Alzheimer's disease and hypertension. A significant change Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental score of 00, which indicated the resident had severely impaired cognition. The resident had no impairment to their upper and lower extremities, required set up help or clean up assistance for eating, and had no swallowing problems. The Certified Nursing Assistant Documentation report dated 05/2026 documented the resident required set up or clean up assistance for breakfast; however, required maximal assistance for the supper and on occasion for lunch meal. A Nutrition Comprehensive Care Plan, last reviewed 03/12/2026, documented to encourage the resident to eat slowly, chew food thoroughly before swallowing, monitor for meal and fluid completion and weight changes; monitor, document and report choking, coughing, and holding food in their mouth. -Resident #234 has diagnoses that included non-Alzheimer's dementia and diabetes mellitus. A significant change Minimum Data Set assessment dated [DATE] documented the resident had short and long term memory problems. The resident required supervision or touch assistance for eating. The Certified Nursing Assistant Documentation report dated 05/2026 documented the resident on occasion can feed themselves with set up help and required maximal assistance for completion of their meals. A Nutrition Comprehensive Care Plan dated 11/05/2025 documented the resident had potential nutritional problems. Interventions included to monitor/document/report any signs and symptoms of dysphagia (difficulty or discomfort in swallowing) such as pocketing (the act of storing food, pills, or liquid in the cheeks, lips, or under the tongue without swallowing), choking, coughing, drooling, holding food in mouth. Monitor nutritional status, serve diet as ordered, monitor intake and record. During an interview on 05/26/2026 at 1:30 PM, Licensed Practical Nurse #9 stated that Resident #75 and Resident #234 can usually feed themselves; however, at times they need assistance from staff to complete their meals. Licensed Practical Nurse #9 stated after feeding Resident #75, they should have performed hand hygiene before assisting Resident #234. During an interview on 06/01/2026 at 12:50 PM, the Infection Preventionist stated that Licensed Practical Nurse #9 should have performed hand hygiene in between providing care to each resident. During an interview on 06/02/2026 at 7:25 AM, the Director of Nursing Services stated that prior to feeding Resident #234, Licensed Practical Nurse #9 should have performed hand hygiene before assisting Resident #234. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 New York Code Rules and Regulations 415.19(a)(1-3) (b)(4)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during the survey, the facility failed to ensure that injuries of unknown origin were thoroughly investigated to rule out abuse, neglect, and mistreatment. This was identified for one (Resident #141) of five residents reviewed for accidents. Specifically, Resident #141 was observed on the floor secondary to an unwitnessed fall. The facility investigation did not include statements from all involved staff to determine the root cause and rule out abuse, neglect, and mistreatment. The findings include: The facility's Accident and Incident policy revised 04/21/2026 documented within 24 hours of the reported incident or accident, the risk manager or nurse supervisor must complete the Resident Accident & Incident Summary Report to determine if there is reason to believe that abuse, neglect, mistreatment or misappropriation has occurred and to determine the underlying cause of the reported accident or incident. The policy documented to properly document all events surrounding an accident and /or incident immediately at the time of the occurrence in order to complete a comprehensive investigation.Resident #141 was admitted with diagnosis that included severe dementia, anxiety, and cerebral vascular accident. An admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status Score of 2, which indicated the resident had severely impaired cognition. The resident had no impairment to the upper and lower extremities. The resident required supervision or touch assistance for all areas of mobility including transfers.A Fall Risk assessment dated [DATE] documented a score of 14, which indicated the resident was at a moderate risk for falls.A Comprehensive Care Plan for Falls dated 05/08/2026 documented the resident is at a high risk for falls related to confusion and generalized weakness. Interventions included ensuring the resident's call light is within reach and encouraging the resident to use the call bell for assistance as needed. The care plan was updated on 05/14/2026 and documented the resident had an unwitnessed fall and was transferred to the hospital. A Comprehensive Care Plan dated 05/08/2026 for Activities of Daily Living documented the resident had self-care performance deficit related to aggressive behaviors, confusion, and dementia. Interventions included supervision or touch assistance for transfers. A nursing progress note dated 05/14/2026, written by Registered Nurse Supervisor #8, documented that Resident #141 was observed on the floor secondary to an unwitnessed fall. Upon assessment, Resident #141 was observed laying on their back on the floor with no visible injuries noted. Resident #141 complained of a lot of pain to their right hip. Physician's orders were received to send the resident to the hospital for further evaluation. An Accident and Occurrence Report dated 05/14/2026 documented the resident was observed on the floor lying on their back secondary to an unwitnessed fall and was complaining of pain to the right hip. The Final Summary and Determination dated 05/14/2026 documented the resident's behavior and observed history showed the resident attempted to ambulate independently on an impulsive basis. The resident was sent to the hospital for evaluation. The facility documented there was no reasonable cause to believe any alleged abuse, neglect, or mistreatment regarding this resident had occurred.A nursing readmission note dated 05/20/2026 documented the resident was readmitted to the facility with a diagnosis of right hip fracture and had a right hip intramedullary (IM) nailing (a specialized metal rod inserted into the hollow medullary cavity of a long bone). During an interview on 06/02/2026 at 06:41 AM, Certified Nursing Assistant #10 stated that they were assigned to Resident #141 on 05/13/2026 -05/14/2026 on the 11:00 PM-7:00 AM shift. Certified Nursing Assistant #10 stated that the resident was not on any monitoring and was at risk for falls. Certified Nursing Assistant #10 stated that they made routine rounds to check on the resident. Certified Nursing Assistant #10 stated that they made rounds on 05/14/2026 at 02:45 AM before they went on their break. The resident was sleeping in bed at the time, and their brief was dry. Certified Nursing Assistant #10 stated they went for their break for an hour at 3:00 AM and when they returned they were told by a nurse (name not recalled) that the resident fell. During an interview on 06/02/2026 at (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06:56 AM, Licensed Practical Nurse #7 stated they were on duty from 05/13/2026-05/14/2026 on the 11:00 PM to 7:00 AM shift. Licensed Practical Nurse #7 stated they were not assigned to Resident #141, and the assigned Licensed Practical Nurse #8 and Certified Nursing Assistant #10 were on break at the time of the resident's fall. Licensed Practical Nurse #7 stated they were sitting at the nurse's station and heard someone calling for help and the sound was coming from Resident #141's room. when they heard someone calling for help. Licensed Practical Nurse #7 stated they went to Resident #141's room and observed the resident lying on the floor in their room. Licensed Practical Nurse #7 stated they immediately notified the nursing supervisor.During an interview on 06/02/2026 at 10:50 AM, the assigned Licensed Practical Nurse #8 stated that were they on duty on 05/13/2026 into 05/14/2026 on the 11:00 PM -7:00 AM shift. Licensed Practical Nurse #8 stated that the resident was not on a specific monitoring schedule according to their care plan. Licensed Practical Nurse #8 stated they were on break when the incident occurred. When they returned from their break, the resident was sitting in a wheelchair at the nurse's station and was complaining of right hip pain. The facility investigation did not include statements from all staff who were working on the unit while Resident #141's assigned Certified Nursing Assistant and Licensed Practical Nurse were on break. During an interview on 06/02/2026 at 11:12 AM, Registered Nurse #8 stated they were informed by Licensed Practical Nurse #7 that the resident fell. Registered Nurse #8 stated that they assessed the resident and there were no visible injuries; however, the resident was complaining of right hip pain. Registered Nurse #8 stated they notified the Physician and were instructed to transfer the resident to the hospital for evaluation. Registered Nurse #8 stated they initiated the investigation and obtained statements from Certified Nursing Assistant #10 and Licensed Practical Nurse #7. Registered Nurse #8 stated they did not think they needed to obtain statements from other staff members who were on the unit at the time of the incident. During an interview on 06/02/2026 at 11:57 AM, the Assistant Director of Nursing Services, who was also the Risk Manager, stated the Incident report was initiated by Registered Nurse #8 who was covering the unit. Registered Nurse #8 should have obtained statements from all staff that were on duty to rule out abuse, neglect, and mistreatment. During an interview on 06/02/2026 at 12:00 PM, the Director of Nursing Services stated statements should have been obtained from all staff and going forward a statement will be obtained not just from the assigned staff but from other staff who worked on the unit at the time of the incident. 10 New York Code Rules and Regulations 415.4(b)(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 survey, the facility failed to ensure that a comprehensive person-centered care plan was implemented for each resident to meet each resident's medical and nursing needs. This was identified for one (Resident #310) of five residents reviewed for Accidents. Specifically, Resident #310 had a physician's order for padded half side rails with for seizure precautions. On two separate occasions, Resident #310 was observed without the padded side rails.The findings include: The facility policy for Person Centered Care Planning: Care Plan Process last reviewed on October 2025 documented the care for each resident will be delivered according to the identified goals and interventions on the comprehensive care plan. The facility policy titled Seizure Precautions last revised in 2025 documented that staff members will maintain seizure precautions to minimize the risk of injury or complications associated with seizure activity. Siderails may be needed on an ongoing basis for the resident with an unstable seizure disorder or may be needed for short-term use if the resident has experienced a seizure. Padded siderails may be used to protect a resident with marked chronic activity. Resident #310 was admitted with diagnoses including seizure disorder, heart failure, and traumatic cerebral edema (brain swelling). The Quarterly Minimum Data Set, dated [DATE] documented the resident has a Brief Interview of Mental status of 10. No rejection of care. Impairment of range of motion both upper and lower extremities. The resident required assistants with all Activity of Daily Living care. The current physician's orders documented padded half siderails for seizure precautions. The comprehensive care plan revised on 03/12/2026 documented Resident #310 had padded half side rails for safety related to seizure diagnosis. Interventions included to ensure the half side rail padding is in place. During an observation on 05/26/2026 at 11:50 AM, Resident #310 was in bed with two half side rails. The half side rail on the right side of the bed was padded, and the left half side rail was not padded. During an observation on 05/28/2026 at 04:07 PM, Resident #310 was in their bed and both side rails were not padded. During an interview on 05/28/2026 at 04:08 PM, Certified Nurse Assistant #7 stated they assigned to the resident today during the 03:00 PM-11:00 PM shift and were also assigned to the resident during the 07:00 AM-03:00 PM shift on 05/26/2026. Certified Nurse Assistant #7 stated they did not know why the resident needed padded side rails. Certified Nurse Assistant #7 stated they keep forgetting to reapply the siderail pads after they provide care to Resident #310. During an interview on 06/02/2026 at 10:17 AM, Licensed Practical Nurse #3 stated that the resident has seizure disorder, and the half side rails must always be padded for seizure precautions. Licensed Practical Nurse #3 stated Nurses and Certified Nurses' Assistants should follow the plan of care for seizure precautions and make sure the siderails are padded. During an interview on 06/02/2026 at 10:27 AM, Registered Nurse #6 stated the resident has padded side rails as a safety precaution to prevent injury due to seizure disorder. Registered Nurse #6 stated the Nurses and Certified Nurses Assistants were responsible for implementing the care plan for seizure precautions. During an interview on 06/02/2026 at 11:09 AM, the Director of Nursing Services stated nursing staff must follow the resident's plan of care. The Director of Nursing Services stated to prevent injury, the nursing staff must ensure the siderails were padded for Resident #310. 10 New York Code Rules and Regulations 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335840	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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 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 survey, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with currently accepted professional principles. This was identified for one (Unit 3 C, low side Medication Cart) of nine medication carts reviewed for the Medication Storage Task and for one (Resident #194) of five residents reviewed for Accident Hazards. Specifically, 1) a Novolog FlexPen (insulin medication to control high blood sugar) was observed unopened and stored in the medication cart. The manufacturer's guidelines indicated that the Novolog FlexPen should be stored in the refrigerator before opening. 2) Resident #194 was observed on multiple occasions with Biotin supplement (helps the body convert food into energy) bottles at their bedside. The findings include: The facility policy titled Medication Storage and Handling last revised June 2025 documented medications and biologicals are stored in locked compartments under proper temperature controls. Licensed nursing staff will ensure that medications requiring refrigeration are to be labeled and kept in a refrigerator in the locked medication room to ensure an optimal level of effectiveness. 1) During the medication storage task observation on 05/29/2026 at 08:05 AM, an unopened Novolog (100 unit per milliliter) FlexPen was observed in the Unit 3C, low side, medication cart. During an interview on 05/29/2026 at 08:05 AM, Licensed Practical Nurse #2 stated the unopened Novolog FlexPen should not be stored in the medication cart and should be stored in the refrigerator until it is ready for use. Licensed Practical Nurse #2 they were not sure why the pen was stored in the medication cart instead of the refrigerator. During an interview on 06/02/2026 at 07:58 AM, the Director of Nursing Services stated the Novolog FlexPen should be stored in the refrigerator upon receipt from pharmacy and kept there until ready to use. During an interview on 06/02/2026 at 08:24 AM, the Licensed Pharmacist #1 stated the Novolog (100 unit per milliliter) FlexPen needs to be stored in the refrigerator prior to opening as per the manufacturer's recommendations to maintain the effectiveness of the medication. 2) Resident #194 was admitted with diagnoses that included obesity, bipolar disorder, and major depressive disorder. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. During an observation on 05/26/2026 at 12:32 PM, Resident #194 was observed in bed. There were two bottles of Biotin supplement on the resident's bedside table. A review of current physician's orders revealed there were no orders for the use of Biotin supplement. During an observation and interview on 05/28/2026 at 12:15 PM, Resident #194 was observed in bed. There were two bottles of Biotin supplement on the bedside table. Resident #194 stated they were (continued on next page)

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	335840	A. Building B. Wing	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medford Multicare Center for Living	3115 Horseblock Road Medford, NY 11763

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alert enough to have their own supplements and did not need a physician's order for the Biotin supplement. A review of the resident's medical record lacked documented evidence that a self – medication administration was completed. During an interview on 5/28/2026 at 12:45 PM, Unit Registered Nurse Manager #6 stated they were not aware the resident was self-administering the Biotin supplement. Unit Registered Nurse Manager #6 stated a physician's order is required for the resident to self-administer the medications including the vitamin supplement. During an interview on 05/28/2026 at 11:21AM, Licensed Practical Nurse # 5 stated they were not aware of the Biotin supplement at the resident's bedside. Licensed Practical Nurse #5 stated the resident had a physician's order to self-administer a different supplement in the past, but the resident went to the hospital and may not be able to self-administer medications because the resident had a decline in condition. During an interview on 05/29/2026 at 10:17 AM, the Director of Nursing Services stated that when a resident wants to self-administer medications, an assessment should be completed by the Social Worker and the Nurse. The Director of Nursing Services stated the nurse should contact the Physician to obtain an order for self-administration of the medications. The Director of Nursing Services stated the interdisciplinary team should confirm that the residents have a locked drawer to store the medications and nursing staff are expected to ensure the resident used the locked drawer. 10 New York Code Rules and Regulations 415.18(e) (1-4)

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	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 observation, interview, and record review during the survey, the facility failed to accurately document the resident population, the overall acuity, the care required by the resident population, and the resources needed, in the facility assessment. This was identified for one (Unit 1C) of eight nursing units reviewed for sufficient and competent nurse staffing task. Specifically, the facility has a dedicated ventilator unit with certified ventilator beds, occupied by ventilator dependent residents who receive ventilator-related respiratory care. The facility assessment did not include the ventilator dependent residents to determine what resources were necessary to care for those residents including the use of competent and qualified Respiratory therapists. The findings include:The facility policy titled Facility assessment dated [DATE] documented the facility will conduct and document a facility wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The purpose of this assessment is to allow the facility to strategically plan for emergent and non-emergent events, assess all needs of residents, and provide resident services based on this analysis. Assessment will include current census; resident demographics; resident care matrix; facility floor plan; facility staffing and requirements for all departments; competencies; facility utilized equipment; documentation of required facility policies; infection control; services provided; contracts; risk assessment; and the electronic medical record system.A review of the Facility assessment dated [DATE] did not indicate that the facility cared for the ventilator dependent residents on unit 1C and that the facility utilized services of respiratory therapists. The facility assessment also did not include the education, training, and competencies related to resident care for the respiratory therapists. During an observation of Unit 1C on 5/26/2026 between 10:30 AM and 11:30 AM there were 21 out of 33 residents who were ventilator dependent. The residents on ventilator were receiving care from nursing staff and respiratory therapists.During an interview on 06/02/2026 at 2:29 PM, the Administrator stated the facility provided care to the ventilator dependent residents; however, the facility assessment did not include use of the respiratory therapists. The Administrator stated that the facility assessment should have identified unit 1C as a ventilator unit and that respiratory therapists were assigned on the unit to provide respiratory care. 10 New York Code Rules and Regulations 415.26