

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335850	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/26/2025
NAME OF PROVIDER OR SUPPLIER  The Hamptons Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 64 County Road 39 South Hampton, NY 11968	

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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</b></p> <p>Based on observation, record review, and interviews during an abbreviated survey (NY00368741) on 2/26/2025 the facility did not ensure that all residents were free from physical restraints imposed for the purpose of discipline or convenience and are not required to treat the resident's medical symptoms. This was identified for three residents (Resident #1, Resident #2, and Resident #3) of three residents reviewed for restraints. Specifically, Resident #1, Resident #2 and Resident #3 were observed in their beds with the bed in the lowest position with thick fall prevention mats observed on their side (length wise), pushed up against both sides of the bed restricting the resident's freedom of movement.</p> <p>The findings are:</p> <p>The facility's policy titled, Physical Restraints effective September 2018 and reviewed June 2024 documented it was the policy of the facility to promote and maintain the residents' highest practicable well-being in a restraint free environment and only utilize a physical restraint in a circumstance in which the resident had a medical symptom that may warrant the use of a restraint. The policy defined a physical restraint as any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria: is attached or adjacent to the resident's body; cannot be removed easily by the resident and restricts the resident's freedom of movement or normal access to their body.</p> <p>1) Resident #1 had diagnoses that included Parkinson's Disease, Dementia, and Dysphagia. Resident #1's Annual Minimum Data Set assessment dated [DATE] documented Resident #1's Brief Interview for Mental Status was not conducted because Resident #1 was rarely understood and rarely understands.</p> <p>Resident #1's Comprehensive Care Plan titled, Falls/Potential for Falls, effective 3/26/2017 and reviewed on 1/4/2025 documented interventions that included but were not limited to keep the bed low with the wheels in a locked position and bilateral floor mats.</p> <p>Resident #1's Certified Nursing Accountability Record dated February 2025 documented the following protective measures were in place, floor mats and low bed. The Certificated Nursing Accountably record was signed by the assigned Certified Nursing Assistant.</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 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During four observations on 2/26/2025 at 8:45 AM, 9:03 AM, 9:36 AM and 9:45 AM, Resident #1 was observed in bed with their bed in the lowest position and thick fall prevention mats were observed on their side, pushed up against both sides of the bed, and nightstands were observed pushed up against the fall prevention mats thereby restricting Resident #1's freedom of movement.</p> <p>During an interview on 2/26/2025 at 9:45 AM, Certified Nursing Assistant #1 who was assigned to Resident #1 stated they did not see Resident #1 today. Certified Nursing Assistant #1 stated they did not place the fall prevention mats on their side, against both sides of the bed with the nightstands pressed up against the mats. Certified Nursing Assistant #1 stated the instruction for the fall prevention mats are they should be placed flat to the floor and next to the bed and are used for fall prevention. Certified Nursing Assistant #1 stated a resident would not to be able to get out of bed if the mats were placed on their side, against the bed with the nightstands against the mats.</p> <p>During an interview on 2/26/2025 at 10:09 AM, Licensed Practical Nurse Manager #1 they stated the fall prevention mats are put in place when a resident is a high fall risk because they widen the surface area of the mattress should the resident fall/roll off the bed. Licensed Practical Nurse Manager #1 stated the fall prevention mats should be laid flat to floor and next to the bed so that if the resident rolled off the bed, they would not fall directly to the floor which can help decrease injuries related to falls.</p> <p>During an interview on 2/26/2025 at 2:41 PM, the Director of Nursing Services stated the correct position for the floor mats is to be laid flat on the floor next to the resident's bed and if they were higher than the bed it could restrict the resident's freedom of movement. The Director of Nursing Services stated the fall prevention mats should not be placed on their side and against the bed and to be an effective fall prevention intervention the mats had to be laid flat and next to the bed.</p> <p>2) Resident #2 had diagnoses that included Cerebral Infarction (ischemic stroke), Hemiplegia (paralysis that affects only one side of your body), and Dementia. Resident #2's Minimum Data Set assessment dated [DATE] documented Resident #2's Brief Interview for Mental Status was not conducted because Resident #2 was rarely/never understood.</p> <p>Resident #2's Comprehensive Care Plan titled, Falls/Potential for Falls, effective 2/16/2024 and reviewed on 11/24/2024 documented an intervention to keep the bed in the lowest position.</p> <p>Resident #2's Certified Nursing Accountability Record dated February 2025 documented the following protective measures were in place, floor mats and low bed. The Certificated Nursing Accountably record was signed by the assigned Certified Nursing Assistant.</p> <p>During three observations on 2/26/2025 at 8:47 AM, 9:05 AM, and 9:37 AM, Resident #2 was observed in bed with their bed in the lowest position and thick fall prevention mats were observed on their side pushed up against both sides of the bed. Additionally, one nightstand was observed pushed up against the fall prevention mat on the right side of the bed thereby restricting Resident #2's freedom of movement.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 9:37 AM, Certified Nursing Assistant #2, who was Resident #2's assigned Certified Nursing Assistant stated they checked in on Resident #2 this morning but had not provided care yet. Certified Nursing Assistant #2 stated they could not recall what position the fall prevention mats were in when they looked in on Resident #2. Certified Nursing Assistant #2 stated the fall prevention mat should be placed flat on the floor and next to Resident #2's bed as they are used to prevent the resident from hurting themselves if they fell out of bed. Certified Nursing Assistant #2 stated if the mats are on their side the resident would not be able to get out of bed.</p> <p>During an interview on 2/26/2025 at 1:24 PM, Certified Nursing Assistant #3 stated they were the assigned Certified Nursing Assistant for Resident #2 on the 11:00 PM to 7:00 AM shift. They stated when their shift ended at 7:00 AM the fall prevention mats were laid flat to the floor and next to Resident #2's bed.</p> <p>During an interview on 2/26/2025 at 2:27 PM, Licensed Practical Nurse #2 stated they gave Resident #2 medication at about 5:00 AM and observed Resident #2 in bed but did not observe the floor mats on their side and up against Resident #2's bed. Licensed Practical Nurse #2 stated a restraint would be anything that prevents a resident from moving freely. Additionally, the floor mats on their side and up against Resident #2's bed would be considered a restraint and should not be placed that way.</p> <p>During an interview on 2/26/2025 at 2:41 PM, the Director of Nursing Services stated the correct position for the floors mats is to be laid flat on the floor next to the resident's bed. The Director of Nursing Services stated if the mats are placed on their sides, and they were higher than the bed and items were placed up against mats then it could restrict the resident's freedom of movement. The Director of Nursing Services stated the fall prevention mats should not be placed on their side and against the bed and to be an effective fall prevention intervention the mats had to be laid flat and next to the bed.</p> <p>3) Resident #3 had diagnoses including Dementia, Alzheimer's Disease, and Aphasia (a language disorder that affects a person's ability to communicate effectively.) Resident #3's Annual Minimum Data Set assessment dated [DATE] documented Resident #3's Brief Interview for Mental Status was not conducted because Resident #3 was rarely understood and rarely understands.</p> <p>Resident #3's Comprehensive Care Plan titled, Falls/Potential for Falls, effective 11/7/2017 and reviewed on 2/1/2025 documented interventions including but were not limited to placing bed in lowest position and high floor mats.</p> <p>Resident #3's Certified Nursing Accountability Record dated February 2025 documented the following protective measures were in place, floor mats and low bed. The Certificated Nursing Accountably record was endorsed by the assigned Certified Nursing Assistant.</p> <p>During an observation on 2/26/2025 at 8:49 AM Resident #3 was observed in bed with their bed in the lowest position and thick fall prevention mats were observed on their side, pushed up against both sides of the bed, with both nightstands pushed up against the fall prevention mats. Additionally, a Broda chair (a supportive positioning device) was pushed up against the fall prevention mat on the left side of the bed thereby restricting Resident #3's freedom of movement.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/26/2025 at 9:08 AM Resident #3 was observed in an elevated bed receiving assistance with breakfast by Certified Nursing Assistant #1 who was on the left side of the bed. The fall prevention mat on the left side of the bed was removed and the nightstand on the left side was pushed off to the side. The Broda chair was positioned at the end of the bed. The fall prevention mat on the right side of the bed was on its side and pushed up against the bed with a nightstand pressed up against the fall prevention mat.</p> <p>During an observation and interview on 2/26/2025 at 9:21 AM with Certified Nursing Assistant #1, Resident #3 was observed in bed with their bed in the lowest position and thick fall prevention mats were observed on their side, pushed up against both sides of the bed, nightstands were observed pushed up against the fall prevention mats. Certified Nursing Assistant #1 stated they assisted Resident #3 with breakfast this morning and the fall prevention mats were on their sides against both sides of the bed with nightstands up against them. A Broda chair was also against the left fall prevention mat. Certified Nursing Assistant #1 stated they moved the items away from the left side of the bed so they could assist Resident #3 but did not place the left fall prevention mat on its side against the bed with the nightstand against it. They stated they do not know who placed the fall prevent mats in that way but should be flat on the floor.</p> <p>During an interview on 2/26/2025 at 10:09 AM, Licensed Practical Nurse Manager #1</p> <p>stated the fall prevention mats are put in place when a resident is a high fall risk because they widen the surface area of the mattress should the resident fall/roll off the bed. Licensed Practical Nurse Manager #1 stated the fall prevention mats should be laid flat to floor and next to the bed so that if the resident rolled off the bed, they would not fall directly to the floor which can help decrease injuries related to falls.</p> <p>During an interview on 2/26/2025 at 1:24 PM, Certified Nursing Assistant #3 stated when their shift ended at 7:00 AM the fall prevention mats were laid flat to the floor and next to Resident #3's bed. Certified Nursing Assistant #3 stated the fall prevention mats are used for safety because if a resident fell out of bed the fall prevention mats would stop the resident from falling to the floor.</p> <p>During an interview on 2/26/2025 at 2:41 PM, the Director of Nursing Services stated the correct position for the floors mats is to be laid flat on the floor next to the resident's bed. The Director of Nursing Services stated if the mats are placed on their sides, and they were higher than the bed and items were placed up against mats then it could restrict the resident's freedom of movement. The Director of Nursing Services stated the fall prevention mats should not be placed on their side and against the bed and to be an effective fall prevention intervention the mats had to be laid flat and next to the bed.</p> <p>483.10(e)(1)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</b></p> <p>Based on observations, record reviews, and interviews conducted during an abbreviated survey (NY00368741) on 2/26/2025 the facility did not ensure call systems were accessible to each resident while the resident were in their rooms. This was identified for three residents (Resident #1, Resident #2, and Resident #3) of three residents reviewed for call systems. Specifically, Resident #1, Resident #2 and Resident #3 were observed, multiple times in their beds, with no access to use their call bells preventing them to be able to call for assistance.</p> <p>The findings are:</p> <p>The facility's policy titled, Call Bell and Alarm Response effective October 2019 and reviewed September 2024 documented call bells and alarms will be answered promptly by all staff and to ensure the call bell has a clip for placement. The policy did not include where the resident's call bell should be placed.</p> <p>1) Resident #1 had diagnoses that included Parkinson's Disease, Dementia, and Dysphagia. Resident #1's Annual Minimum Data Set assessment dated [DATE] documented Resident #1's Brief Interview for Mental Status was not conducted because Resident #1 was rarely understood and rarely understands.</p> <p>Resident #1's Comprehensive Care Plan titled, Falls/Potential for Falls, effective 3/26/2017 and reviewed on 1/4/2025 documented an intervention to keep the call bell within reach.</p> <p>During four observations on 2/26/2025 at 8:45 AM, 9:03 AM, 9:36 and 9:45 AM Resident #1 was observed in bed and the resident's call bell was observed hanging on the knob of the nightstand to the right of Resident #1's bed. The call bell was out of reach of Resident #1. The final observation at 9:45 AM was conducted with Certified Nursing Assistant #1. Certified Nursing Assistant #1 observed the call bell positioned hanging on the knob of the nightstand, and then left the room without placing the call bell within reach of Resident #1.</p> <p>During an interview on 2/26/2025 at 9:45 AM, Certified Nursing Assistant #1, who was assigned to Resident #1, stated they did not see Resident #1 today and they were not aware that the call bell was out of reach of Resident #1 but that the call bell should be where the resident can reach it.</p> <p>During an interview on 2/26/2025 at 2:41 PM, with the Director of Nursing Services they stated they didn't know why the call bell for Resident #1 was behind the residents headboard but they (the call bells) should be clipped to the bed sheet and with-in reach of the resident.</p> <p>2) Resident #2 had diagnoses that included Cerebral Infarction (ischemic stroke), Hemiplegia (paralysis that affects only one side of your body), and Dementia. Resident #2's Minimum Data Set assessment dated [DATE] documented Resident #2's Brief Interview for Mental Status was not conducted because Resident #2 was rarely/never understood.</p> <p>Resident #2's Comprehensive Care Plan titled: Falls/Potential for Falls, effective 2/16/2024 documented an intervention for the call bell to be within reach.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During three observations on 2/26/2025 at 8:47 AM, 9:05 AM, and 9:37 AM Resident #2 was observed in bed and Resident #2's call bell was observed hanging from the call bell jack in the wall, down behind the headboard and on the floor and out of the resident's reach restricting the resident from calling for assistance</p> <p>During an observation and interview on 2/26/2025 at 9:37 AM, with Certified Nursing Assistant #2 they stated they checked in on Resident #2 this morning but had not provided care yet. Certified Nursing Assistant #2 stated they could not recall where the call bell was when they checked on Resident #2. During this observation with the surveyor and Certified Nursing Assistant #2 stated they observed the call bell on the floor behind Resident #2, s headboard. They stated the call bell was not in reach of the resident and should always be.</p> <p>During an interview on 2/26/2025 at 9:54 AM, Licensed Practical Nurse #1, they stated they saw Resident #2 this morning but could not recall the location of the call bell. Licensed Practical Nurse #1 stated the call bell should be within arm's reach of the resident and not have been on the floor behind the headboard. Licensed Practical Nurse #1 stated that the call bell accessibility was the responsibility of all staff to check.</p> <p>During an interview on 2/26/2025 at 1:24 PM, Certified Nursing Assistant #3 stated they worked the overnight shift that ended at 7:00 AM. Certified Nursing Assistant #3 stated they provided care for Resident #2 at about 5:00 AM and they could not recall where the call bell was. Certified Nursing Assistant #3 stated the call bell should always be within the reach of a resident.</p> <p>During an interview on 2/26/2025 at 2:27 PM, Licensed Practical Nurse #3 stated they gave Resident #3 medication at about 5:00 AM and observed Resident #3's call bell on the resident's bed, within reach of the resident.</p> <p>During an interview on 2/26/2025 at 2:41 PM, with the Director of Nursing Services they stated they didn't know why the call bell for Resident #2 was behind the residents headboard but they (the call bells) should be clipped to the bed sheet and with-in reach of the resident</p> <p>3) Resident #3 had diagnoses including Dementia, Alzheimer's Disease, and Aphasia. Resident #3's Annual Minimum Data Set assessment dated [DATE] documented Resident #3's Brief Interview for Mental Status was not conducted because Resident #3 was rarely understood and rarely understands.</p> <p>Resident #3's Comprehensive Care Plan titled, Falls/Potential for Falls, effective 11/7/2017 and reviewed on 2/1/2025 documented an intervention for the call bell to be within reach.</p> <p>During three observations on 2/26/2025 at 8:49 AM, 9:08 AM, and 9:21 AM Resident #2 was observed in bed and their call bell was observed hanging from the call bell jack in the wall, down behind the headboard and on the floor and out of the resident's reach. During the 9:08 AM observation Certified Nursing Assistant #1 was bedside assisting Resident #3 with breakfast.</p> <p>During an interview on 2/26/2025 at 9:21 AM Certified Nursing Assistant #1, stated they checked on Resident #3 before breakfast and then returned to assist Resident #3 with their meal. Certified Nursing Assistant #1 stated they could not recall where the call bell was at those two times or that the call bell was out of reach. Certified Nursing Assistant #1 stated the call bell should always be where the resident could reach it.</p> <p>(continued on next page)</p>		

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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 1:24 PM, Certified Nursing Assistant #3 they stated they worked the overnight from 11:00 PM to &amp; 7:00 AM. Certified Nursing Assistant #3 stated they provided care for Resident #3 at about 5:30 AM and they placed the call bell across the chest of Resident #3.</p> <p>During an interview on 2/26/2025 at 2:41 PM, with the Director of Nursing Services they stated they didn't know why the call bell for Resident #1 was behind the residents headboard but they (the call bells) should be clipped to the bed sheet and with-in reach of the resident.</p> <p>10NYCRR 415.29</p>		