

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 09/30/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>34798</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that each resident was treated with respect and dignity and in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. This was identified for one (Resident #5) of three residents reviewed for Dignity. Specifically, on 9/23/2024 Resident #5's room was observed with a strong urine odor. A disposable bed pad with a large urine stain was observed on the floor adjacent to the resident's bed with three urinals one of which was full. Resident #5 stated they wanted the area to be clean.</p> <p>The finding is:</p> <p>The facility's policy titled Dignity, last reviewed May 2024, documented it is the policy of the facility to promote an environment in which the resident's dignity is evident in all interactions between caregivers and residents. Dignity means staff carry out activities that assist the resident to maintain and enhance their self-esteem and self-worth.</p> <p>Resident #5 was admitted with diagnoses including Asperger's Syndrome, Depression, and Cerebrovascular Accident. The 9/19/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented the resident required substantial/maximal assistance for toileting and had functional limitation in range of motion to the upper and lower extremities.</p> <p>On 9/23/2024 at 11:43 AM, Resident #5 was observed in bed. The resident appeared to be sleeping but was easily arousable. There was a disposable bed mat on the floor with three urine bottles on it. One of the urine bottles was full and the other two were empty. The bed mat on the floor was soiled with a large urine stain and there was a strong urine odor in the room. The resident stated the staff needed to empty the full urine bottle.</p> <p>Certified Nursing Assistant #1 was notified of the observation on 9/23/2024 at 11:45 AM. Certified Nursing Assistant #1 observed the soiled bed mat on the floor and the full bottle of urine and stated the resident does not like to get out of bed until after lunch. Certified Nursing Assistant #1 stated it is difficult for the resident to use the bathroom because the resident has to wear braces on their legs, and having the urine bottles on the floor next to the bed is the resident's preference. Certified Nursing Assistant #1 stated they would get the resident out of bed after lunch and then they left the room without emptying the urine bottle or removing the soiled bed mat.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 9/23/2024 at 12:45 PM, Resident ##5's room was observed with a soiled bed mat that was placed on the floor. A full urinal was still present next to the resident's bed. The resident was sitting up in their bed and had just finished their lunch meal. This observation was brought to the attention of Licensed Practical Nurse #1 (unit manager). Licensed Practical Nurse #1 stated the urinal should have been emptied when the full urinal was observed by Certified Nursing Assistant #1 an hour ago and the disposable bed mat should have been removed.</p> <p>The Director of Nursing Services was interviewed on 9/26/2024 at 1:46 PM and stated having the urinals on the floor is the resident's preference and we have to honor their wishes, but the resident area should be kept clean and odor-free.</p> <p>Resident #5 was interviewed On 9/26/2024 at 2:26 PM and stated the urinals are kept on the floor because they are easy to reach that way and they urinate a lot. The resident stated it is difficult for them to get out of bed and the aides are too busy to get them up. The resident stated, I want the area to be clean.</p> <p>10NYCRR 415.3(d)(1)(i)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>34798</p> <p>Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00354353) initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that each resident's primary representative was immediately informed when a resident had an accident resulting in injury that had the potential for requiring Physician intervention. This was identified for one (Resident #230) of four residents reviewed for Accidents. Specifically, on 9/17/2024 Resident #230 fell from the bed and sustained bruising to their face. The resident's representative was not informed of the fall.</p> <p>The finding is:</p> <p>The facility's policy titled Change in Condition, last reviewed 10/2023, documented any deterioration in health, mental, or psychosocial status causing either life-threatening conditions or clinical complications, as well as any deviation from the resident's baseline medical condition, which constitutes an abnormal condition, will be reported to the Nursing Supervisor and Physician. Criteria for reporting a change in condition include incident/accident with or without injury. At the time the change in condition is identified, the nurse will notify families/next of kin.</p> <p>Resident #230 was admitted with diagnoses including Cerebral Palsy, Quadriplegia, and Seizure Disorder. The 9/3/2024 Admission Minimum Data Set assessment documented no Brief Interview for Mental Status score because the resident had severely impaired cognitive skills for daily decision-making.</p> <p>An Accident and Incident report dated 9/17/2024 at 1:00 PM documented the resident fell from the bed and was found on the floor adjacent to their bed by a housekeeper. The resident was non-verbal and could not explain what happened. The resident sustained a 3-centimeter round ecchymotic (bruise) abrasion to the right forehead and an abrasion to the right cheek. The Physician and the resident's group home manager were notified.</p> <p>A review of the electronic medical record revealed that the resident's family member was listed as the primary contact and the group home was listed as the secondary contact.</p> <p>The resident's family member (primary contact) was interviewed on 9/27/2024 at 12:32 PM and stated the facility did not notify them when the resident fell from the bed on 9/17/2024. The family member stated they found out about the fall the next day when they were notified by another organization that supports the group home.</p> <p>On 9/27/2024 and 9/30/2024 multiple calls were made to Registered Nurse #1 (nursing supervisor) who prepared the accident and investigation report. Calls were not returned.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/30/2024 at 9:37 AM, Assistant Director of Nursing Services #1 (Risk Manager) stated the group home was providing care to the resident before the resident was admitted to the facility for short-term treatment. The facility staff did not call or notify the family member who was listed as the primary contact instead, they called the group home regarding the resident's fall. Assistant Director of Nursing Services #1 stated that the facility should have notified the family member of the resident's fall on 9/17/2023.</p> <p>During an interview on 9/30/2024 at 10:14 AM, Licensed Practical Nurse #2 (unit nurse) stated they did not notify the resident's family to inform them of the resident's fall on 9/17/2024. Licensed Practical Nurse #2 stated when the resident fell , they contacted the group home staff because the group home staff were the ones who were visiting the resident.</p> <p>During an interview on 9/30/2024 at 10:22 AM, the Director of Nursing Services stated that the facility staff should have called the resident's family member first because the resident's medical record contact list documented the family member as the first contact.</p> <p>10 NYCRR 415.3(f)(2)(ii)(a)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925</p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that each resident was provided a safe, clean, comfortable, and homelike environment. This was identified for one (Unit E) of four units observed during the environmental task. Specifically, during an environmental tour of Unit E, Resident#144's bathroom door was observed with broken hinges and was not able to be closed; Resident#56's privacy curtains were observed with dark brown and yellow stains, and the bathroom floor was soiled with dark grayish stains.</p> <p>The findings are:</p> <p>The facility's policy for Cleaning Resident Bathrooms and Public Bathrooms, dated February 2024, documented that daily cleaning will ensure optimum levels of cleanliness and sanitation, prohibit the spread of infection, and maintain the outward appearance of the facility.</p> <p>The facility's policy for Cleaning Resident Rooms, dated March 2024, documented the purpose of this policy was to provide a detailed description of the steps that are to be completed daily in the cleaning of a resident room. The steps included cleaning and dusting all vertical surfaces including doors, door trim, molding, walls, light switch plates, and curtains using a clean cloth soaked in or sprayed with disinfectant cleaner.</p> <p>-Resident#144 had diagnoses that included Dementia, Arthritis, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The resident utilized a walker and wheelchair as a mobility device.</p> <p>During an environmental tour of Unit E on 9/23/2024 at 12:41 PM, Resident #144's bathroom door was observed with a loose upper hinge and was unable to be closed.</p> <p>During an observation on 9/30/2024 at 10:00 AM, Resident #144's bathroom door was observed with a loose upper hinge and was unable to be closed.</p> <p>During an interview on 9/30/2024 at 10:42 AM, Certified Nursing Assistant #9 stated Resident #144's bathroom door had been broken for months and the broken door concern was reported by them in the maintenance log book approximately seven months ago.</p> <p>During an interview on 9/30/2024 at 11:37 AM, Maintenance Worker#1 stated they always check the resident rooms after the resident gets discharged and before a new resident gets admitted to make sure that all maintenance concerns are addressed. Maintenance Worker#1 observed Resident#144's bathroom door and stated the door hinge was broken and needed to be fixed. Maintenance Worker#1 stated that according to the maintenance book Resident#144's bathroom door was fixed on 9/11/2024 and the door hinges must have broken again after it got fixed on 9/11/2024.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/30/2024 at 2:40 PM, Unit Manager #3 stated Resident#144's bathroom door had been broken for a while and the concern was documented in the maintenance log book.</p> <p>-Resident#56 had diagnoses including Cardiomegaly, Major Depression, and Type 2 Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident was cognitively intact. The resident required supervision and contact guard assistance with toileting and was frequently incontinent of bowel and bladder.</p> <p>During an observation on 9/23/2024 at 12:19 PM, Resident #56's privacy curtain was observed to have multiple yellowish-brown stains all over the curtain, and the bathroom floor was observed with grayish-brown stains.</p> <p>Resident #56 was interviewed immediately after the observation on 9/23/2024 and stated It would be nice to have clean curtains.</p> <p>During an observation on 9/30/2024 at 3:08 PM, Resident #56's privacy curtain was observed with multiple yellowish-brown stains all over the curtain, and the bathroom floor was observed with grayish-brown stains.</p> <p>During an interview on 9/30/2024 at 11:07 AM, Certified Nursing Assistant #10 stated the housekeepers were responsible for cleaning the bathroom floors and the privacy curtains. The housekeepers were cleaning the bathrooms every day and they did not know why there were stains on the curtains.</p> <p>During an interview on 9/30/2024 at 11:45 AM, Housekeeper #1 stated the privacy curtain in Resident #56's room was changed last week, the curtain is not dirty it is just stained. Housekeeper #1 stated Resident #56's bathroom floors needed cleaning.</p> <p>During an interview on 9/30/2024 at 4:17 PM, the Director of Housekeeping stated the residents should not have stained privacy curtains and dirty bathroom floors and they will make sure that Resident #56's privacy curtain is changed and the bathroom floors are cleaned.</p> <p>During an interview on 9/30/2024 at 4:35 PM, the Director Of Nursing Services stated it was not acceptable to have dirty, stained bathroom floors, broken bathroom doors, and or stained privacy curtains in any resident room.</p> <p>10 NYCRR 415.5(h)(2)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670</p> <p>Based on record review, and interviews during the Recertification Survey and Abbreviated Survey (NY 00351219) initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that accidents were thoroughly investigated to rule out abuse, neglect, or mistreatment. This was identified for one (Resident #161) of four residents reviewed for Accidents. Specifically, Resident #161 was found on the floor in their room near the bed on 7/28/2024 and sustained a six-centimeter laceration (cut or tear) with bruising to the left side of their face. The facility did not obtain statements from each staff member involved with the resident to identify the root cause of the accident.</p> <p>The finding is:</p> <p>The facility's Accident and Incident policy and procedure reviewed on 8/2024 documented that the charge nurse or supervisor will initiate the collection of statements from staff. The statement will be collected from Certified Nursing Assistants, caregivers, Licensed nurses working that shift, and all others assigned to the unit that day, including other departments. The resident's roommate, other residents, or visitor's statements should be obtained as applicable. As necessary, statements are obtained from staff involved with the resident in the last 24 hours. The statements should be obtained from necessary personnel prior to the end of the shift on which the accident was first noted.</p> <p>Resident #161 was admitted with diagnoses that included Dementia, Difficulty walking, and Left Femur (leg bone) Fracture. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 5, which indicated the resident had severe cognitive impairment. The resident required moderate assistance from staff for transfers, and ambulation and had one fall with injury prior to this assessment.</p> <p>A Comprehensive Care Plan for falls dated 7/15/2023 and last updated on 7/28/2024 documented the resident was at risk for falls related to falls in the last six months. Since admission, the resident has fallen on 2/17/2024, 4/3/2024, 6/20/2024, and 7/28/2024. The resident with impaired balance, impaired gait, muscle weakness, impulsiveness, and poor safety awareness. The interventions included keeping the call bell and personal items within reach, encouraging the use of proper footwear, and reminding the resident to ask for assistance for difficult maneuvers.</p> <p>An Accident and Incident Report dated 7/28/2024 documented that at 7:15 PM the Certified Nursing Assistant #6 checked on the resident and observed the resident sitting upright on the floor next to their bed. The resident was unable to recall how the incident happened due to baseline confusion. The resident sustained a 6-centimeter laceration with bruising on the left side of their face and bleeding was noted.</p> <p>A nursing progress note dated 7/28/2024 documented the resident was found on the floor near the bedside, physical assessment revealed a 6-centimeter laceration with bruising to the left side of the resident's face.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/30/2024 at 10:21 AM, Certified Nursing Assistant #6 stated they were assigned to care for Resident #161 on 7/28/2024. Certified Nursing Assistant #6 stated the Kitchen transporter first observed the resident on the floor and called them. Certified Nursing Assistant #6 stated when they went to the resident's room, the resident was sitting on the floor in an upright position next to the bed. Certified Nursing Assistant #6 stated when they provided a statement regarding the accident, they did not tell the Nursing Supervisor that the Kitchen transporter was the one who found the resident on the floor.</p> <p>During an interview on 9/30/2024 at 10:55 AM, the Risk Manager stated the Registered Nurse Supervisor was responsible for interviewing the staff and obtaining statements that included all relevant information regarding the fall. The Risk Manager stated that Certified Nursing Assistant #6 should have reported to the Supervisor that the Kitchen transporter identified the resident on the floor. The Risk Manager stated that the Kitchen transporter's statement should have been obtained and included in the Accident and Incident Report.</p> <p>During an interview on 9/30/2024 at 11:15 AM, Registered Nurse #2 stated they were responsible for obtaining statements from all staff that were involved with the care of the resident. Registered Nurse #2 stated Resident #161 was found on the floor on 7/28/2024; however, they did not recall obtaining a statement from the Kitchen transporter and did not recall that it was the Kitchen transporter that first identified the resident on the floor. Registered Nurse #2 stated that if they knew they would have obtained a statement and included it in the Accident and Incident Report.</p> <p>During an interview on 9/30/2024 at 1:22 PM, the Director of Nursing Services stated that the Registered Nurse Supervisors were responsible for starting the Accident Incident Report and following up with obtaining statements from all involved staff. The Director of Nursing Services stated that if the Kitchen transporter identified the resident on the floor and brought it to the nursing staff's attention, a statement should have been obtained from the Kitchen transporter.</p> <p>10 NYCRR 415.4 (b) (3)</p>		

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<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45349</p> <p>Based on record review and interview during the recertification survey initiated on 9/23/2024 and completed on 9/30/2024, the facility failed to ensure that a Minimum Data Set Assessment was completed within the prescribed time frames. This was evident during the Resident Assessment task. Specifically, Resident #486 was admitted to the facility on [DATE]. The admission Minimum Data Set Assessment was completed on date 7/25/2024. The Minimum Data Set assessment was completed six days beyond the required timeframe.</p> <p>The finding is:</p> <p>The facility policy titled Minimum Data Set Version 3.0, last reviewed March 2024, documented the facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>Resident #486 was admitted on [DATE] with diagnoses of Congestive Heart Failure and Diabetes Mellitus. An admission Minimum Data Set assessment was initiated on 7/7/2024 and was completed on 7/25/2024.</p> <p>The Minimum Data Set Coordinator was interviewed on 9/30/2024 at 9:44 AM and stated the Minimum Data Set assessment for each resident should be completed within 14 days after the resident's admission to the facility. The Minimum Data Set Coordinator stated that Resident #486's assessment was not completed on time and was six days late. The Minimum Data Set Coordinator stated they were responsible for ensuring the timely completion of each Minimum Data Set assessment and were not sure why the admission assessment for Resident #486 was late.</p> <p>During an interview on 9/30/2024 at 3:27 PM, the Administrator stated the Minimum Data Set Coordinator is responsible for ensuring the Minimum Data Set assessments are completed on time. The Administrator stated they were not aware that the Minimum Data Set assessments were not being completed timely.</p> <p>10 NYCRR 415.11</p>		

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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>45349</p> <p>Based on interviews and record review during the Recertification Survey initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that all completed Minimum Data Set assessments were electronically transmitted to the Centers for Medicare and Medicaid Services within the required timeframe. This was identified for six (Residents #52, #148, #13, #105, #206, and 486) of 12 residents reviewed for the Resident Assessment Facility Task. Specifically, the Minimum Data Set assessment for Residents #52, #148, #13, #105, #206, and #486 were not transmitted to the Centers for Medicare and Medicaid Services within 14 days of the assessment completion date.</p> <p>The finding is:</p> <p>The facility's policy titled Minimum Data Set Version 3.0, last reviewed March 2024, documented the facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report dated 9/26/2024 documented the following Minimum Data Set assessments were transmitted to Centers for Medicare and Medicaid Services on 9/26/2024:</p> <ul style="list-style-type: none"> -Resident #52's quarterly Minimum Data Set assessment, with an assessment reference date of 7/17/24, was completed on 7/25/2024. The assessment was transmitted and accepted on 9/26/2024. Resident #52's Minimum Data Set assessment was transmitted 63 days late. -Resident #148's quarterly Minimum Data Set assessment, with an assessment reference date of 7/17/24, was completed on 7/23/2024. The assessment was transmitted and accepted on 9/26/2024. Resident #148's Minimum Data Set assessment was transmitted 65 days late. -Resident #13's quarterly Minimum Data Set assessment, with an assessment reference date of 7/17/24, was completed on 7/23/2024. The assessment was transmitted and accepted on 9/26/2024. Resident #13's Minimum Data Set assessment was transmitted 65 days late. -Resident #105's quarterly Minimum Data Set assessment, with an assessment reference date of 8/1/24, was completed on 8/11/2024. The assessment was transmitted and accepted on 9/26/2024. Resident #105's Minimum Data Set assessment was transmitted 46 days late. -Resident #206's quarterly Minimum Data Set assessment, with an assessment reference date of 7/26/24, was completed on 8/3/2024. The assessment was transmitted and accepted on 9/26/2024. Resident #206's Minimum Data Set assessment was transmitted 54 days late. -Resident #486's admission Minimum Data Set Assessment, with an assessment reference date of 7/7/2024, was completed on 7/25/2024. The assessment was transmitted and accepted on 9/26/2024. Resident #486's Minimum Data set assessment was transmitted 63 days late. <p>(continued on next page)</p>		

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<p>F 0640</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>The Minimum Data Set Coordinator was interviewed on 9/30/2024 at 1:28 PM and stated the Minimum Data Set assessment for each resident should be transmitted to the Centers for Medicare and Medicaid Services within 14 days of the assessment completion. The Minimum Data Set Coordinator stated they thought had previously submitted the Minimum Data Set assessment for all six residents; however, they did not receive the validation report. The Minimum Data Set Coordinator stated that based on not having the validation report, the assessments had not been previously submitted. The Minimum Data Set Coordinator stated they then resubmitted the Minimum Data Set assessments again on 9/26/2024.</p> <p>During an interview on 9/30/2024 at 3:27 PM, the Administrator stated the Minimum Data Set Coordinator is responsible for ensuring the Minimum Data Set assessments are completed and transmitted to the Centers for Medicare and Medicaid Services on a timely basis. The Administrator stated they were not aware that the Minimum Data Set assessments were not being transmitted timely.</p> <p>10 NYCRR 415.11</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585</p> <p>Based on observation, record review, and interviews conducted during a Recertification and Abbreviated survey (NY 00326995) completed on 9/30/24, the facility did not ensure a resident who required respiratory care, including tracheostomy (an opening into the windpipe to help air reach the lungs) care, provided such care consistent with professional standards of practice. This was identified for one (Resident #129) of one resident reviewed for respiratory care. Specifically, 1) during observation of Resident #129's tracheostomy care on 9/27/2024, Registered Nurse #6 did not change the inner tracheostomy tube (cannula) as ordered by the Physician and 2) there was no documented evidence the resident's tracheostomy outer cannula was routinely being changed as per the manufacturer's specifications from March 2023 to October 2023.</p> <p>The finding is:</p> <p>The policy and procedure titled Tracheostomy Care, revised May 2023, documented that the tracheostomy cannula, stomas, and surrounding areas shall be aseptically cleaned. Nurses may change the inner cannula. Only physicians may change/replace the outer cannula. Universal precautions are indicated with all tracheotomy procedures. The facility policy did not indicate a timeframe for changing the outer tracheostomy cannula.</p> <p>Resident #129 was admitted with a tracheostomy and Anoxic Brain Damage (a disorder of the brain caused by decreased oxygen). The Quarterly Minimum Data Set assessment dated [DATE], documented that the resident had severe cognitive impairment and was dependent on staff for all care. The Minimum Data Set assessment documented the resident required tracheostomy care.</p> <p>The Comprehensive Care Plan titled Respiratory: Tracheostomy, revised on 8/24/2024, documented Resident #129 was to receive tracheostomy care every shift and as needed. The Comprehensive Care Plan did not include directions related to changing the inner or outer cannula for the tracheostomy tube.</p> <p>The tracheostomy tube (utilized by Resident #129) manufacturer brochure documented under the warning section: The disposable inner cannula is designed for single use and should not be cleaned or reused and the outer cannula should be changed every 28 days. Under the cautions section: The tracheostomy tube and obturator are single patient-use medical devices. Duration of single-patient use should not exceed 29 days. The manufacturer does not recommend and has not substantiated the use of these devices beyond the 29-day time frame. Decisions about tracheostomy tube changes should be made by the responsible physician or designate using accepted medical techniques and judgment.</p> <p>A review of the resident's medical records indicated there were no physician orders to change the outer cannula from March 2023 to October 2023.</p> <p>A Nursing progress note dated 10/27/2023 documented the resident was seen on 10/25/2023 by the Ear Nose and Throat Specialist and the outer cannula was changed.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Physician's order dated 2/18/2024 (original order date 1/26/2024) documented to schedule an appointment with the Ear Nose and Throat consult for a tracheostomy change on 04/10/2024 at 10:00 AM.</p> <p>The physician's orders dated 9/25/2024 documented Resident #129 had a tracheostomy tube; and to change the disposable tracheostomy inner cannula daily and as needed for secretion maintenance.</p> <p>During an observation on 9/27/2024 at 10:20 AM, Registered Nurse #6 performed tracheostomy care for Resident #129 with the assistance of Registered Nurse #5. Registered Nurse #6 performed hand hygiene and gathered supplies. Registered Nurse #6 did not include a new disposable inner cannula while gathering the supplies. Registered Nurse #6 removed the dirty inner cannula and placed the dirty inner cannula in a tray to rinse with sterile saline. Registered Nurse #6 stated they would reuse the rinsed inner cannula and would place it back into the resident's tracheostomy. Registered Nurse #6 stated they did not know that there was a physician's order to change the inner cannula daily.</p> <p>During an interview on 9/27/2024 at 11:34 AM, Nurse Practitioner # 1 stated the tracheostomy inner cannula is disposable and should not have been washed and re-used. The disposable inner cannula should have been replaced. The resident can develop respiratory infections if the inner cannula is not replaced daily. The outer tracheostomy tube should also be changed every three months and there should have been a physician's order in 2023. The Respiratory Therapist is now responsible for tracheostomy tube changes every 3 months since January 2024. Nurse Practitioner #1 stated when the resident returned from the hospital in December 2023, we ensured the outer tracheostomy tube was changed as per protocol.</p> <p>During an interview on 9/30/2024 at 11:26 AM, the Medical stated Registered Nurse #6 should have changed the inner cannula as per the physician's orders. The resident is at risk for infections if the inner cannula is not changed daily or if the tracheostomy tube is not changed every 3 months. The tracheostomy tube should have been changed every 3 months. The attending physician should have ordered the tracheostomy tube replacement every 3 months.</p> <p>During an interview on 9/30/24 at 1:41 PM, the Director of Nursing Services stated cleaning the inner cannula and reinserting it back into the tracheostomy tube is not acceptable. The Director of Nursing Services stated that reusing the disposable inner cannula would increase the risk of infection. Resident #129's tracheostomy was not being changed on a routine basis in 2023 and this was identified when the resident went out to the Ear Nose and Throat Specialist in October 2023. The Director of Nursing Services stated the tracheostomy tube should have been changed on a routine basis.</p> <p>During a telephone interview with the Respiratory Therapist on 9/27/2024 at 1:20 PM, they stated Registered Nurse # 6 should have removed the disposable inner cannula and replaced it with a new inner cannula as per physician orders. The Respiratory Therapist stated reusing the disposable inner cannula places the resident at high risk for infection. The Respiratory Therapist stated they have been taking care of Resident #129 since January 2024 and have been changing their tracheostomy tube every 90 days. The Respiratory therapist stated they did not care for the resident before January 2024 and that the tracheostomy tube should have been changed every three months.</p> <p>10NYCRR 415.12(k)(4)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that all residents were free of significant medication errors. This was identified for one (Resident #106) of 25 residents reviewed during medication pass observation. Specifically, Resident #106 had a physician's order for Ampicillin 1 Gram (antibiotic) Intravenous solution every 6 hours at 12:00 AM; 6:00 AM; 12:00 PM; and 6:00 PM for Cellulitis (skin infection). The Medication Administration Record lacked documented evidence that Resident #106 received their 12:00 AM and 6:00 AM dosage of the Physician-ordered antibiotic on 9/23/2024.</p> <p>The finding is:</p> <p>The facility's policy for Medication Administration and Documentation, last reviewed 10/2023, documented administering medication at the time it is prepared. If there are any missed doses, notify the Physician and or the Nurse Practitioner immediately and follow the recommendations/orders. Upon completion of the medication pass and before the end of the shift, the medication nurse will check the electronic medical record dashboard to ensure all medications and monitoring are completed.</p> <p>Resident #106 was admitted with diagnoses of Acute Osteomyelitis (bone infection) of the left ankle and foot and Cellulitis (skin infection). The Minimum Data Set assessment dated [DATE] documented that Resident #106 had severely impaired cognitive skills for daily decision-making. The Minimum Data Set documented the resident received antibiotic therapy during the assessment look-back period.</p> <p>The Comprehensive Care Plan for Antibiotic Therapy dated 8/21/2024 documented the resident needs intravenous antibiotics therapy due to Cellulitis. The interventions included administering intravenous medication via a pump as per the physician's orders and documenting the administration on the resident's Medical Administration Record.</p> <p>The physician's order dated 8/22/2024 documented to administer Ampicillin 1 Gram solution with Sodium Chloride 0.9 % (flush). Infuse 1 Gram by injection route every 6 hours for 6 weeks every day at 12:00 AM; 6:00 AM; 12:00 PM; and 6:00 PM for 6 Weeks for Cellulitis.</p> <p>During a medication pass observation on 9/23/2024 at 11:20 AM, Resident #106 was observed lying in their bed. An intravenous pole was observed by the resident's bedside with an empty Ampicillin 1 Gram vial attached to an intravenous solution bag containing 50 milligrams of normal saline. The Ampicillin vial or the normal saline intravenous bag did not include a label indicating when the medication was reconstituted (mixed with normal saline) and the time the medication was supposed to be administered.</p> <p>A review of the Medication Administration Record dated 9/23/2024 indicated Ampicillin 1 Gram intravenous medication was not signed for as administered at 12:00 AM and at 6:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/23/2024 at 11:22 AM, Nurse Manager #3 stated they work on another unit and came to Resident #106's unit to administer the 12:00 PM intravenous antibiotic dose for the resident. Nurse Manager #3 confirmed an empty Ampicillin 1 Gram vial was attached to the 50 milligrams normal saline intravenous bag and the Ampicillin vial or the normal saline intravenous bag had no label that indicated when the medication was reconstituted and the time the medication was supposed to be administered. Nurse Manager #3 stated that the observed medication was most likely the 6:00 AM Ampicillin antibiotic dose not administered to the resident and did not know why.</p> <p>During an interview on 9/30/2024 at 10:13 AM, Registered Nurse Supervisor#1 stated they worked during the 9/22/2024 to 9/23/2024 night shift. They prepared the antibiotic medication for Resident #106 on 9/23/2024 at 6:00 AM; however, they forgot to administer the medication to Resident#106. Registered Nurse Supervisor#1 stated they administered the 12:00 AM intravenous antibiotic to Resident #106 and forgot to sign the Medication Administration Record.</p> <p>During an interview on 9/30/2024 at 11:57 AM, the Director of Nursing Services stated Nurse Manager #3 informed them that the 6:00 AM antibiotic medication dose was not administered to Resident #106 and that the 12:00 AM and 6:00 AM doses were not signed for as administered on the Medication Administration Record. The Director of Nursing Services stated that it is extremely important that antibiotics are administered as per the physician's orders.</p> <p>During an interview on 9/30/2024 at 1:00 PM, Medical Doctor#1 stated that residents should not miss any antibiotic doses to maintain the effectiveness of the medication and the staff must sign for the medication administration.</p> <p>10 NYCRR 415.12(m)(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45349</p> <p>Based on observations, interviews, and record review during the Recertification Survey initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that food was prepared and served in accordance with professional standards for food service safety. This was identified during the Kitchen observation task. Specifically, Dietary Aide #1 was observed handling peeled, hard-cooked eggs wearing the same gloves that were used while entering and exiting the walk-in refrigerator; and the cold food temperatures were above the safety zone.</p> <p>The finding is:</p> <p>The undated facility policy and procedure for Food Service Hand Washing, documented that hands are frequently and properly washed throughout the day. The purpose is to remove bacteria that may cause infection. Employees must always wash their hands before starting work in the kitchen, after handling soiled dishes and utensils, before and after performing cleaning procedures, and before and after handling food.</p> <p>The facility's policy and procedure for Food Service Department Infection Control Procedures, last reviewed February 2024, documented the facility maintains strict sanitary conditions in the food service department to eliminate food contamination and prevent the growth of disease-producing organisms and the production of bacterial toxins. All employees are required to wash their hands for the following: start of a new work assignment or procedure and when come into contact with any soiled object or matter. For glove use, if preparation requires direct food contact, put gloves on after hand washing. Change gloves as necessary such as if the employee is interrupted and required to perform another task.</p> <p>The facility's policy and procedure for Food temperatures, last reviewed in March 2024, documented that foods will be maintained at temperatures sufficient to preserve nutritive value and avoid bacterial growth before and during meal service. All foods, being held for any length of time, will be kept above 135 degrees Fahrenheit or below 41 degrees Fahrenheit.</p> <p>During a Kitchen observation on 9/23/2024 at 10:02 AM, with the Food Service Director, Dietary Aide #1 was observed entering a walk-in refrigerator wearing a pair of gloves. Dietary Aide #1 was observed exiting the refrigerator with the same gloves and then handling peeled, hard-cooked eggs.</p> <p>Dietary Aide #1 was immediately interviewed and stated they should have washed their hands and put on new gloves before handling any food. Dietary Aide #1 stated there was an increased risk of food contamination since they did not change their gloves.</p> <p>During a lunch meal tray line observation on 9/23/2024 at 11:21 AM with the Food Service Director, food temperatures were taken by the Food Service Supervisor. The egg salad sandwich temperature measured 60 degrees Fahrenheit, and the health shake temperature measured 45 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Food Service Supervisor was interviewed immediately after the observation on 9/23/2024 and stated the temperature of cold food items should be at or below 40 degrees Fahrenheit. The Food Service Supervisor stated that food temperatures over 40 degrees Fahrenheit have increased potential for bacterial growth and the residents could potentially get sick. The Food Service Supervisor stated they do not take the temperature of the cold food items before meal services. The facility tray line temperature log reflected only hot food temperatures.</p> <p>The Food Service Director was interviewed on 9/30/2024 at 9:37 AM and stated Dietary Aide #1 was in training on 9/23/2024 and was not supposed to be handling food. The Food Service Director stated if the food got contaminated, it potentially could spread illness to the residents. The Food Service Director further stated that they were not taking the temperatures of the cold food items on the tray line as they were using the temperature of the refrigerator as the basis for the food temperature, assuming that the cold food would remain as cold as the refrigerator temperature.</p> <p>10 NYCRR 415.14(h)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>34798</p> <p>Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00354353) initiated on 9/23/2024 and completed on 9/30/2024, the facility did not ensure that timely arrangements were made for outside services that met professional standards. This was identified for one (Resident #230) of four residents reviewed for Accidents. Specifically, Resident #230 with severely impaired communication was transferred to the Neurologist's office for a medical appointment on 9/11/2024. The resident was not accompanied by the facility staff or the resident representative who could speak on behalf of the resident; therefore, the appointment was canceled and the resident was returned to the facility. There was no documentation in the resident's medical record that the appointment was canceled; no documentation regarding how to coordinate future medical appointments; and no documentation from the resident's primary care provider regarding the missed medical appointment.</p> <p>The finding is:</p> <p>The facility policy titled Transport Policy for Medical Appointments, last reviewed March 2024, documented a qualified staff member or family member/designated representative will accompany residents during transport to provide assistance if needed and ensure comfort and safety; all transport requests, confirmations, and incidents must be documented in the resident's medical record; staff will record details of each transport, including date, time, destination, and any issues encountered during the transport; compliance with state and federal regulations regarding resident transport must be maintained at all times.</p> <p>Resident #230 was admitted with diagnoses including Cerebral Palsy, Quadriplegia, and Seizure Disorder. The 9/3/2024 Admission Minimum Data Set assessment documented no Brief Interview for Mental Status score because the resident had severely impaired cognitive skills for daily decision-making.</p> <p>A Social Work progress note dated 9/2/2024 documented that Resident #230 was non-verbal and was admitted to the facility for short-term intravenous antibiotic treatment. The discharge plan was for the resident to return to the group home setting.</p> <p>A physician's order dated 8/30/2024 documented Phenytoin (antiseizure medication) 50-milligram tablet, one tablet by oral route once daily for unspecified convulsions.</p> <p>A nursing progress note, written by Licensed Practical Nurse #1 (unit manager), dated 9/11/2024 at 9:14 AM documented the resident left the unit in stable condition via stretcher to a Neurology appointment.</p> <p>There was no further documentation in the medical record regarding the Neurology appointment.</p> <p>During an interview on 9/25/2024 at 11:01 AM, Receptionist #1 from the Neurologist's office stated Resident #230 came to the office for a Neurology consult on 9/11/2024. The resident was nonverbal and was not accompanied by the facility staff or a family member; therefore, the appointment was canceled.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/25/2024 at 11:50 AM, Resident #230's group home representatives including the house manager, the Director of Nursing, and the Assistant Director of Nursing, stated the resident's family member did not want the group home staff to accompany the resident for any outside consultant appointments. The group home house manager stated they told the resident's family member that the group home staff was not going to accompany the resident on 9/11/2024 for the Neurology appointment.</p> <p>During an interview on 9/25/2024 at 12:17 PM, Licensed Practical Nurse #1 (unit manager) stated the hospital recommended a Neurology consult for Resident #230 for seizure management. Licensed Practical Nurse #1 made an appointment for 9/11/2024. Licensed Practical Nurse #1 stated they spoke to the resident's group home manager on 9/10/2024, who said that the group home staff would not accompany the resident to the appointment as per the resident's family's direction. Licensed Practical Nurse #1 stated they had also told the resident's family member about the appointment; however, they could not recall when. Licensed Practical Nurse #1 stated to their knowledge, the family member was going to be at the appointment on 9/11/2024. Licensed Practical Nurse #1 stated they did not document their discussion with the resident's family member or the group home in the resident's medical record. Licensed Practical Nurse #1 stated they did not know the facility's policy for sending a non-verbal resident out for an appointment.</p> <p>During an additional interview on 9/26/2024 at 11:03 AM, Licensed Practical Nurse #1 stated when Resident #230 returned from the Neurologist's office on 9/11/2024, they (Licensed Practical Nurse #1) did not document in the resident's medical record and did not inform the resident's family of the appointment cancellation. Licensed Practical Nurse #1 stated they did not reschedule the appointment. Licensed Practical Nurse #1 stated the Nurse Practitioner was aware of the appointment cancellation.</p> <p>During an interview on 9/26/2024 at 1:50 PM, the Director of Nursing Services stated all conversations with the group home and the resident's family should have been documented including the appointment cancellation. The Director of Nursing Services stated that they expected staff to follow up regarding rescheduling the Neurology consult.</p> <p>During an interview on 9/27/2024 at 12:32 PM, the resident's family member stated they were not informed of the resident's 9/11/2024 Neurology appointment. They became aware of the appointment when they got a call from the Neurologist's office that the resident was brought in and was alone. The resident's family member stated they would have never agreed to the Neurology appointment because the transport would have been painful and distressing for the resident.</p> <p>During an interview on 9/30/2024 at 9:03 AM, Nurse Practitioner #1 stated they knew that Resident #230's Neurology appointment was canceled and the resident's family member did not want to reschedule the appointment. Nurse Practitioner #1 stated they could not recall if they documented their communication with the resident's family member in the resident's medical record.</p> <p>10 NYCRR 415.26(e)(1)(i-iv)</p>		