STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335850	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hamptons Center for Rehabilitation and Nursing	64 County Road 39 South Hampton, NY 11968

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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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. Based on record review and interviews during survey, the facility failed to assess a resident using the quarterly review instrument specified by the State and approved by Center of Medicare and Medicaid Services not less frequently than once every three (3) months. This was identified for four (4) (Resident #25, Resident #35, Resident #36, Resident #184) of ten (10) sampled from 61 residents triggered for the resident assessment task. Specifically, Resident #184's Quarterly Minimum Data Set assessment with Assessment Reference Date of 02/06/2026 was not completed; Resident #35's Quarterly Minimum Data Set assessment was not completed until 77 days after the Assessment Reference Date of 02/06/2026; Resident #25's Quarterly Minimum Data Set assessment was not completed until 71 days after the Assessment Reference Date of 01/21/2026; and Resident #36's Quarterly Minimum Data Set assessment was not completed until 22 days after the Assessment Reference Date of 11/28/2025. The findings include but are not limited to:The facility's policy and procedure titled Minimum Data Set (MDS 3.0) Completion, last reviewed in October 2025, documented the facility will ensure that all Minimum Data Set assessments are completed, signed, and transmitted in accordance with federal requirements and the Resident Assessment Instrument Manual. All required assessments will be scheduled based on Assessment Reference Date and completed within 14 days. The assessment completion is defined as completion of the care area assessment process in addition to the Minimum Data Set items, and a Registered Nurse assessment coordinator has signed and dated both the Minimum Data Set and care area assessment completion attestation. The Center for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1 dated October 2025 documented assessment management requirements for quarterly assessments including the completion date (item Z0500B) must be no later than 14 days after the assessment reference date (ARD + 14 calendar days).Resident #184 was admitted with diagnoses including dementia (a progressive disease that affects memory, thinking and social ability), hypertension (high blood pressure) and hyperlipidemia (elevated lipid level). The Quarterly Minimum Data Set assessment with an assessment reference date of 02/06/2026 documented that Resident #184 had a Brief Interview for Mental Status score of 10, which indicated Resident #184 had moderately impaired cognition. The Quarterly Minimum Data Set assessment did not have a completion date indicated (item Z0500B). Resident #35 was admitted with diagnoses including nontraumatic subarachnoid hemorrhage (bleeding into the space surrounding the brain not caused by head injury), dysphagia (difficulty swallowing), and aphasia (inability to swallow). The Quarterly Minimum Data Set assessment with an assessment reference date of 02/06/2026 documented the Brief Interview for Mental Status was not completed because Resident #35 was unable to understand others. The Quarterly Minimum Data Set assessment was not completed until 04/24/2026, 77 days after the assessment reference date. Resident #25 was admitted with diagnoses including multiple sclerosis (a nervous system disease that affects the brain and spinal cord), tremor, and ulcerative colitis (a condition that cause inflammation and ulcers in the colon). The Quarterly Minimum Data Set assessment with an assessment reference date of 01/21/2026 documented Resident #25 had a Brief Interview for Mental Status score of 15, which indicated Resident #25 had intact cognition. The Quarterly Minimum Data Set assessment was not completed until 04/02/2026, 71 days after 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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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assessment reference date. During an interview on 04/28/2026 at 09:36 AM, the Minimum Data Set Assessor stated that they were responsible for the completion of all Minimum Data Set assessments. The Minimum Data Set Assessor stated the Minimum Data Set booklets should be completed within 14 days of the assessment reference dates. The Minimum Data Set Assessor stated they were unable to complete the assessments on time because they performed other duties such as managing care plan meetings and they have reported their concern to the Minimum Data Set Coordinator and were doing their best at this point. During an interview on 04/28/2026 at 10:30 AM, the Minimum Data Set Coordinator stated that quarterly Minimum Data Set assessments should be completed within 14 days of the assessment reference dates. The Minimum Data Set Coordinator stated they were on track with completing and submitting assessments until a sudden influx of new resident admissions in October 2025. Additionally, the minimum data set system to submit the assessments was changed during the past few months which affected compliance with assessment completion and submission timeline. The Minimum Data Set Coordinator stated the facility Administrator and the Director of Nursing Services were aware of the issues. During an interview on 04/28/2026 at 11:12 AM, the Assistant Director of Nursing Services, former Director of Nursing Services (until 04/20/2026), stated they were aware of late Minimum Data Set assessment completion and were unable to identify the root cause why the assessments were completed late. During an interview on 04/28/2026 at 11:31 AM, the current Director of Nursing Services stated all Minimum Data Set assessments should be completed on time. The Director of Nursing Services stated that timely completion of the Minimum Data Set assessment was crucial to ensure resident care was assessed and provided appropriately. During an interview on 04/28/2026 at 01:14 PM, the Administrator stated they were aware of late Minimum Data Set assessment completion; however, they did not implement any systemic changes that were implemented until the new Director of Nursing Services started. 10New York Code Rules and Regulations 415.11(a)(4)

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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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during survey, the facility failed to ensure that all completed Minimum Data Set assessments were electronically transmitted to the Center for Medicare and Medicaid Services within 14 days of the resident assessment completion. This was identified for three (3) (Resident #36, Resident #43, and Resident #178) of ten (10) residents sampled from 61 residents triggered for the resident assessment task. Specifically, Resident #178's Annual Minimum Data Set assessment was not electronically transmitted to the Center for Medicare and Medicaid Services until 56 days after the completion of the assessment; Resident #43's admission Minimum Data Set assessment was not electronically transmitted to the Center for Medicare and Medicaid Services until 42 days after the completion of the assessment; and Resident #36's Quarterly Minimum Data Set assessment was not electronically transmitted to the Center for Medicare and Medicaid Services until 27 days after the completion of the assessment.The findings include but were not limited to:The facility's policy and procedure titled Minimum Data Set (MDS 3.0) Completion, last reviewed on October 2025, documented the facility will ensure that all Minimum Data Set assessments are completed, signed, and transmitted in accordance with federal requirement and the Resdient Assessment Instrument Manual. All completed Minimum Data Set assessments are transmitted electronically to Center of Medicare and Medicaid Services via the approved submission system. The admission and annual comprehensive assessments and the quarterly assessments are transmitted no later than 14 calendar days from care plan completion date. Resident #178 was admitted with diagnoses including osteoporosis (a bone disease when bone mass and bone density decrease), type 2 diabetes mellitus, and retention of urine. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, which indicated that Resident #178 had intact cognition. The Minimum Data Set was completed on 02/10/2026. Resident #43 was admitted with diagnoses including seizures (abnormal electrical activity in the brain), postlaminectomy syndrome (failed back surgery syndrome where patient continues to have pain after spine surgery), and hypertension (high blood pressure). The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, which indicated that Resident #43 had intact cognition. The Minimum Data Set was completed on 11/26/2025. Resident #36 was admitted with diagnoses including Guillain-Barre syndrome (an autoimmune condition where the immune system attack the body's nerves), discitis in the thoracic region (infection of the disc space between vertebrae), and chronic obstructive pulmonary disease (a chronic lung condition caused by damages to the lungs). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated that Resident #36 had intact cognition. The Minimum Data Set was completed on 12/20/2025. A review of the Minimum Data Set (MDS) 3.0 Nursing Home Validation Report revealed the following:-Resident #178's 01/30/2026 admission Minimum Data Set assessment was completed on 02/10/2026, but not transmitted to the Center for Medicare and Medicaid Services (CMS) until 04/07/2026, that is 56 days after the assessment was completed. Additionally, the validation report indicated the assessment was rejected because Section X did not match the corresponding items of an existing record in the database. -Resident #43's 11/19/2025 admission Minimum Data Set assessment was completed on 11/26/2025, but was not transmitted to the Center for Medicare and Medicaid Services until 01/07/2026, that is 42 days after the assessment was completed. -Resident #36's 11/28/2025 Quarterly Minimum Data Set assessment was completed on 12/20/2025, but was not transmitted to the Center for Medicare and Medicaid Services until 01/16/2026, that is 27 days after the assessment was completed. During an interview on 04/28/2026 at 09:36 AM, the Minimum Data Set Assessor stated the Minimum Data Set coordinator and themself were responsible for transmitting the Minimum Data Set assessments to the (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Center of Medicare and Medicaid Services. The Minimum Data Set Assessor stated they usually transmit the Minimum Data Set assessments the same day they were completed. The Minimum Data Set Assessor stated they were unable to complete and transmitted assessments on time because they performed other duties such as managing care plan meetings. The Minimum Data Set Assessor has reported their concern to the Minimum Data Set Coordinator and was doing their best at this point. During an interview on 04/28/2026 at 10:30 AM, the Minimum Data Set Coordinator stated that quarterly Minimum Data Set assessments should be completed within 14 days of the assessment reference dates. The Minimum Data Set Coordinator stated they were on track with completing and transmitting assessments until a sudden influx of new resident admissions in October 2025. Additionally, the minimum data set system to submit the assessments was changed during the past few months which affected compliance with assessment completion and submission timeline. The Minimum Data Set Coordinator stated the facility Administrator and the Director of Nursing Services were aware of the issues. During an interview on 04/28/2026 at 11:31AM, the Director of Nursing Services stated they expected all Minimum Data Set assessments to be completed and transmitted timely.During an interview on 04/28/2026 at 01:14PM, the Administrator stated that they expected all Minimum Data Set assessments to be completed and transmitted timely. 10 New York Code Rules and Regulations 415.11

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews during surveys, the facility failed to ensure that each resident's environment remained free of accident hazards. This was identified for one (1) (Unit G) of seven (7) units reviewed for Accidents. Specifically, a free-standing E-Cylinder oxygen tank (a portable, high-capacity metal cylinder used to store compressed medical grade oxygen) was observed in the Unit G nursing station. The E-Cylinder tank was free standing and was not secured in a safety stand or a rack. The findings include: The facility's policy, titled Oxygen Tank Storage and Handling last revised on 02/2026, documented that all-oxygen tanks must be secured to a wall with a chain or heavy cable. No oxygen tanks will be left unattended on a transport dolly (a small, wheeled platform or cart used to move heavy items). Full oxygen tanks will be separated from empty oxygen tanks and identified as such. During an initial tour of the G Unit on 04/21/2026 at 12:15 PM, an unsecured E-Cylinder tank (a portable, high-capacity metal cylinder used to store compressed medical grade oxygen) was observed freely standing against the wall in the nurse's station. The E-cylinder tank was full and not in use. The E-Cylinder tank was not secure in a rolling caddy or a metal rack. During an interview on 04/21/2026 at 12:20 PM, Licensed Practical Nurse #1 stated they did not see the E-Cylinder tank in the nurse's station. Licensed Practical Nurse #1 stated that they were doing the medication administration for the residents in Unit G and did not notice the E-Cylinder oxygen tank was unsecured. Licensed Practical Nurse #1 stated oxygen tanks must be secured with a chain against the wall and on a dolly (a small, wheeled platform or cart used to move heavy items). During an interview on 04/21/2026 at 12:38 PM, Registered Nurse #2, stated the nurses in the unit for all shifts were responsible for ensuring that all oxygen tanks are secured properly. Registered Nurse #2 stated that oxygen tanks should not be freely standing. Registered Nurse #2 stated that all oxygen tanks must be chained to the wall and secure in a dolly for safety. During an interview on 04/22/2026 at 08:33 AM, Registered Nurse #1, the Unit G Manager, stated they were not aware that an unsecured E-Cylinder tank was in the nurse's station. Registered Nurse #1 stated they checked the tanks when they came in the morning of 04/21/2026 and did not see any tanks freely standing. Registered Nurse #1 stated they did not know who put the unsecured E-Cylinder tank in the nurse's station. Registered Nurse #1 stated that E-Cylinder tanks must be chained to the wall and secure in a dolly. During an interview on 04/22/2026 at 09:51 AM, the Director of Housekeeping stated that they were responsible for transporting the oxygen tanks to the unit. The Director of Housekeeping stated that they did visual rounds around 5:00 AM on 04/21/2026 and saw all the E-Cylinder oxygen tanks secured in a dolly. The Director of Housekeeping stated that an unsecured E-Cylinder oxygen tank is an accident hazard. The Director of Housekeeping stated that an unsecured E-Cylinder oxygen tank can fall and explode. During an interview on 04/27/2026 at 10:32 AM, the Director of Nursing Services stated all staff should be monitoring the oxygen tanks in the unit and resident rooms. The Director of Nursing Services stated all staff should make sure that the oxygen tanks are secure in a dolly and chained against the wall. The Director of Nursing Services stated that an unsecured E-Cylinder oxygen tank can be an accident hazard and cause injury if the tank falls and explodes. 10 New York Code Rules and Regulations 415.12(h)(1)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during a survey (Complaint #2962369), the facility failed to ensure all residents had the right to be treated with respect and dignity, including the right to retain personal possessions. This was identified for one (1) (Residents #266) of two (2) residents reviewed for resident rights. Specifically, Resident #266 was transferred to the hospital. The facility staff packed Resident 266's belongings. After the resident's was readmitted to the facility from the hospital, the facility did not return the resident's belongings. The findings include: The facility's Policy titled Personal Belongings last reviewed on 10/2025 documented upon discharge of residents to a hospital, the facility will send all valuables to the basement for storage. All clothing and other personal belongings may be left in the room if the door can be locked or the security of the items can be ensured. Property left in the facility for more than 30 days after discharge will be disposed of at the discretion of the facility. The resident was admitted with diagnoses including type two diabetes, cerebral infarction, and essential hypertension. The Minimum Data Set assessment dated [DATE] documented a Brief Interview of Mental Status score of 3, indicating the resident had severely impaired cognition. The resident required assistance with all activities of daily care and was always incontinent. The Facility Grievance form dated 04/13/2026 documented Resident #266's family member reported missing clothing. The resident's clothing could not be located. During an interview on 04/22/2026 at 01:08 PM, Resident #266's family member stated the resident was discharged to the hospital for an evaluation on 01/23/2026 and returned to the facility on [DATE]. The resident's belongings were never returned to the resident or the family after the resident's discharge to the hospital. Resident #266's family member stated the facility knew about the belongings and nobody informed them what happened until today, 04/22/2026 when they heard from the Director of Housekeeping and the Administrator. Resident#266's family stated the missing clothing had sentimental value and getting reimbursement for the belongings cannot compensate for what was lost. Resident #266's family member stated they were informed that the resident's personal possessions were accidentally given to a different resident with same last name. During an interview on 04/23/2026 at 01:24 PM, Certified Nursing Assistant #1 stated when a resident is discharged , they (Certified Nursing Assistant #1) place all the resident's belongings in a box labeled with the resident's name and the room number. Certified Nursing Assistant #1 stated the box is usually stored in the resident's closet until the unit manager tells them (Certified Nursing Assistant #1) to remove the box. Certified Nursing Assistant #1 stated they did not remember if they collected Resident #266's belongings when the resident was transferred to the hospital. During an Interview on 04/23/2026 at 01:26 PM, Housekeeper #1 stated all nurses and certified nursing assistants are responsible for packing the resident's belongings and the housekeepers are responsible for cleaning the rooms. Housekeeper #1 stated the Director of Housekeeping takes the boxes from the rooms to store them in the basement until the resident returns from the hospital, or the resident's family picks up the belongings. During an interview on 04/23/2026 at 03:33PM, the Administrator stated they were not made aware of Resident#266's belongings were missing until 4/13/2026. The Administrator stated they requested receipts of the missing clothing from the resident's family member and they received the receipts on 04/22/2026 and will reimburse the cost of the clothing. During an interview on 04/28/2026 at 12:15 PM, the Director of Housekeeping stated when the resident was discharged to hospital for evaluation on 01/23/2026, Resident #266's belongings were boxed and stored in the basement. The Director of Housekeeping stated there was another resident with the same last name who was assigned to Resident #266's room, and they thought the box belonged to the newly admitted resident. The Director of Housekeeping stated they did not realize until 04/22/2026 that Resident #266's belongings were given to the wrong resident. The Director of Housekeeping stated the resident (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who received Resident #266's belongings were no longer in the facility, and their belongings were not in the facility. 10 New York Code Rules and Regulations 415.5(h)(1)