STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, IN	**5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I310	415.29 Physical Environment This Regulation is not met as evidenced by: (j) Housekeeping (1) The entire nursing home, including but not limited to the floors, walls, windows, doors, ceilings, fixtures, equipment and furnishings, shall be clean. The facility shall be maintained in good repair including, but not limited to buildings, utilities, fixed equipment, resident care equipment and furnishings. Based on observation and staff interview during the annual survey, it was determined that the facility did not ensure that 6 ventilation grilles in the kitchen were maintained in good repair. The finding is: During the inspection of the kitchen, conducted on 3/25/08 between 8:30 AM and 9:30 AM, it was observed that 6 ventilation grilles exhibited signs of rust on their outer surfaces. In an interview on the same day at approximately 9:30 AM, the Director of Maintenance stated that he was waiting for weather permitting conditions in order to remove and repaint the ventilation grills. On 3/27/07, the Director of Maintenance told the team leader that the identified ventilation grilles were replaced with new ones. 415.29 (j)(1)	I310		3/29/08

Office of Health Systems Management / Office of Long Term Care

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility did not accommodate the needs of one of 23 sampled residents. Specifically, for Resident #13 the facility did not provide the resident with a gerichair. This resulted in no actual harm but had the potential for more than minimal harm. The Finding is: Resident #13 has diagnoses which include Spinal Stenosis, Osteoarthritis, and Dehydration. The Interim Physician's Orders dated 3/17/08 documented that the resident was to be out of bed to a gerichair and that the wheelchair was to be discontinued due to the resident being uncomfortable in their wheelchair. The admission Minimum Data Set (MDS) Assessment dated 3/23/08 documented that the resident had moderate pain. Resident #13 was observed on 3/25/08 and 3/28/08 at 12:30 PM sitting in a wheelchair in the dining room during lunch.	F 246		5/15/08

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ____ B. WING ____	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 1 During an interview with Resident #13 on 3/27/08 at 11:10 AM, while seated in a wheelchair, the resident stated that he was uncomfortable in his wheelchair due to falls he had at home. The resident stated he had fallen while attempting to sit in a chair at home and missed the chair, fracturing his pelvis, and that he had also fallen out of bed fracturing a rib. The resident stated that he was told by someone in the facility that they did not have a recliner chair (gerichair) for him to use. The resident was observed on the same day at 1:00 PM seated in the dining room in a wheel chair. The resident stated that he was still uncomfortable and wanted to lie down. At 2:20 PM, the same day, the resident was observed in bed with the head of his bed elevated approximately 60 degrees. At this time, the resident stated that he felt more comfortable now that he could stretch his back out. The Registered Nurse (RN) Unit Manager was interviewed on 3/28/08 at 11:45 AM and stated that the resident should be in a gerichair as the Physician ordered. The RN Unit Manager further stated that the order was picked up by the RN Desk Nurse. The RN Desk Nurse was interviewed at the same time and again at 1:20 PM and stated that she picked up the Physician's Order for the gerichair on 3/17/08 and obtained one for the resident that day. The RN Desk Nurse further stated that the resident was placed in a gerichair at that time, but did not know what happened to the gerichair since then. The Nurse's Progress Note dated 3/17/08 documented that Resident #13 complained of discomfort and was unable to sit in the wheelchair, as per therapy. The Nurse's note further documented that the wheelchair was	F 246		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ____ B. WING ____	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 246	Continued From page 2 discontinued and changed to a gerichair. The Director of Physical Therapy was interviewed on 3/28/08 at 1:10 PM and stated that Physical Therapy had requested that the resident be placed in a gerichair due to the fact that he was uncomfortable in his wheelchair. The Occupational Therapist who had worked with Resident #13 was interviewed on 3/28/08 at 1:15 PM and stated that she had seen Resident #13 in a gerichair last week and that she was aware that the wheel chair had been discontinued. She further stated that the resident was in a wheelchair this week when he attended occupational therapy. An interview with two 7 AM-3 PM shift Certified Nursing Assistants (CNAs) on 3/28/08 at 1:00 PM, who worked with the resident from 3/25/08 through 3/28/08 revealed that they knew the resident. Both CNAs stated that they were not aware that the resident had a gerichair because when they transferred the resident out of bed it was into a wheelchair. 415.5(e)(1)	F 246		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews during the annual survey, the facility did not ensure that medication ordered by a Physician was picked up and transcribed in a manner	F 281		5/15/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 3	F 281		

meeting professional standards of quality for one of twenty-three sampled residents. This resulted in no actual harm with the potential for more than minimal harm. (Resident #20)

The findings is:

Resident #20 has diagnoses which include Dementia and Arthritis.

The monthly Physician's Orders dated 3/13/08 revealed an order for the resident to receive Seroquel (an antipsychotic medication) 100 milligrams (mg) by mouth at hour of sleep.

The March 2008 Medication Administration Record revealed that the Physician's Order was not transcribed to the MAR and that the resident was currently receiving Seroquel 50 mg at hour of sleep (10:00 PM).

The Registered Nurse (RN) Nurse Manager was interviewed on 3/28/08 at 9:50 AM and stated that the Nurse picking up the order should have transcribed the order to the MAR and also write the change in medication on the facility's "Daily Audit Form". The RN further stated that the Physician's Orders written on the form would then be double checked by the 11:00 PM - 7:00 AM shift Night Nurse. The RN reviewed the "Daily Audit Forms" dated 3/13/08 and 3/14/08 and stated that there was no notation of the Seroquel being changed to 100 mg at hour of sleep. The RN stated that the Licensed Practical Nurse (LPN) who picked up the order on 3/13/08 was a per diem Nurse who only worked for a few months at that time and she may have forgotten to write the new order on the "Daily Audit Form".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 4 415.11(c)(3)(i)	F 281		
F 282 SS=D	483.20(k)(3)(ii) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and family interviews during the annual survey, the facility did not ensure that care was provided in accordance with Comprehensive Care Plans (CCPs) and/or Physician's orders for two of twenty-three sampled residents. Specifically, Resident #2 did not have a right resting hand splint in place and Resident #14 did not receive ace bandage wraps as ordered by a Physician. This resulted in no actual harm with the potential for more than minimal harm. The findings are: 1) Resident #2 has diagnoses including Dementia and an Impaired Right Hand Flexor Tone. The resident's CCP dated 1/7/08 documented that as an intervention for care the resident was to wear a right resting hand splint at night and then again for four hours during the day, approximately from 1:00 PM to 5:00 PM. The resident's Physician's Orders dated 1/7/08, 2/7/08, and 3/13/08 documented that the resident should be wearing a right resting hand splint at night and again at approximately from 1:00 PM to	F 282		5/15/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH** **HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 5 5:00 PM. The resident was observed on 3/26/08 at 3:30 PM, while in an activity, without any hand splint in place. Two members of the resident's family were interviewed on 3/25/08 at 12:45 PM, on 3/26/08 at 3:35 PM, and on 3/28/08 at 12:48 PM. As per their statements, one family member visited five days a week from about 9:00 AM to 1:30 PM and the other family member visited three times a week, arriving in the early afternoon and usually leaving the facility between 3:30 PM and 4:00 PM. Both family members stated that they had not seen a hand splint used for this resident in about two months. The Registered Nurse (RN) Unit Nurse Manager of the resident's unit was interviewed on 3/28/08 at 11:55 AM. The RN stated that a couple of days ago, the resident was not wearing the right resting hand splint during the day when it should have been in place. The RN stated that she questioned the resident's Certified Nursing Assistant (CNA) about it and the CNA stated that she was not applying the right resting hand brace to the resident because she was refusing to wear it. The RN stated that she had not been aware that the resident was refusing to wear the brace, or for how long the resident was not wearing it. The RN further stated that it was the CNA's responsibility to tell her that the resident had been refusing to wear the splint, and if she had known, she might have revised the resident's CCP to address her non-compliance with this treatment modality. Attempts to contact the resident's regular day	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 6 shift CNA via telephone were not successful. The Director of Rehabilitation Services was interviewed on 3/28/08 at 12:30 PM. She stated that it was her department that recommended that the resident's Physician order the right resting hand splint be used by the resident during the afternoon, in addition to it being on at night. She was not aware that the resident was refusing to use the hand splint felt that the resident would benefit from the use of the splint as currently ordered by the Physician. 2) Resident # 14 has diagnoses including Cerebral Vascular Accident, Chronic Renal Insufficiency, and Dementia. The resident's CCP dated 1/7/08, included as an intervention that the resident was to have ace wraps applied to the left posterior calf and leg in the morning and removed at the hour of sleep. The Physician's Orders dated 3/26/08 documented that the resident was to have ace wraps to the left lower extremity on in the morning and removed at bedtime. The resident was observed to be well groomed, dressed, and in bed on 3/27/08 at 10:25 AM. The Certified Nursing Assistant (CNA) that cared for the resident stated that she was preparing to transfer the resident out of bed. The resident did not have ace wraps on her left lower leg at that time. Resident #14 was observed again at 3:05 PM seated in a recliner chair in the hallway. The resident did not have ace wraps on her left lower leg. The Registered Nurse (RN) Manager was	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 7 interviewed on 3/27/08 at 3:05 PM and stated that the resident should have had ace wraps applied to her legs and that it was the Treatment Nurse's job to apply them. The Treatment Sheet dated March 2008 documented that the resident was to have a 6 inch elastic bandage applied to the left calf on in the morning and removed at bedtime. There was no Nurse's signature for the ace wraps on 3/27/08 to verify application. The 7 AM to 3 PM shift Licensed Practical Nurse (LPN) Treatment Nurse stated during an interview at 3:10 PM on 3/27/08 that she had not completed her treatments yet and that she would check to see when the ace wraps were to be applied. 415.11(c)(3)(ii)	F 282		
F 323 SS=D	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview during the annual survey, it was determined that the facility did not ensure that the resident environment remained as free of accident hazards as possible in that wall mounted heating units were noted in resident common shower	F 323		3/29/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ______ B. WING ______	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH** **HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 rooms on 1 of 3 resident floors. The exposed metal grilles were uncomfortably hot to the touch. This resulted in no actual harm with the potential for more than minimal harm. The findings are: On 03/25/08 between 9:00 AM and 2:00 PM, the following was noted: Wall mounted heating units were noted in two resident common shower rooms on the North and East wings of the 3rd floor. The heating units were noted to be off during the tour, but when turned on high, the surface of the exposed metal grille was uncomfortably hot to the touch. The heating units were immediately disabled by the facility. In an interview on the same day at approximately 10:30 AM, the Director of Maintenance stated that the two identified heaters had been shut off at the circuit breaker panels to prevent the units from being turned back on. He further stated that he would either try to install cages around the units or replace them with another type of safe design. 415.12(h)(1)	F 323		
F 364 SS=E	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by:	F 364		5/2/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ____ B. WING ____	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 9	F 364		

Based on resident (8 of 12 residents in Group Interview) and staff interviews, observation, test tray results, and review of Resident Council Meeting Minutes (2 of 3 minutes reviewed) during the annual survey, the facility did not consistently serve hot food items to assure palatability. This was evident on one of three units where test tray temperatures were taken. This resulted in no actual harm with the potential for more than minimal harm.

The finding is:

On 3/26/08 at 10:45 AM, the Resident Group Interview was conducted. Eight of twelve residents present, identified by the facility as being alert and lucid, complained that food intended to be served hot, was often served cold and unappetizing. The eight residents represented all three of the facility units. Three of the twelve residents present complained that the tea and coffee they received with their meals was also often cold and unappetizing.

On 3/28/08, test trays were requested for the Breakfast meal for each of the three resident units.

A test tray was put on the last (second) meal truck for the third floor unit, which arrived on the unit at 7:04 AM. The last meal tray was observed to be given at 7:29 AM. The test tray food temperatures were taken at that time in the presence of the Registered Nurse (RN) Unit Manager and the following was found:
1) Cheese Omelet - 116 degrees Fahrenheit (F);
2) Farina - 112 degrees F.

The Resident Council Meeting Minutes for three

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ___ B. WING ___	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 10 months (12/20/07, 1/31/08, and 2/26/08) were reviewed and in two of the three meetings (1/31/08 and 2/26/08) residents complained of cold food at meals. On 3/28/08 at 2:25 PM, the Administrator and the Food Service Director were interviewed. They stated that they were aware of some resident complaints of cold food at meals. 415.14(d)(1)(2)	F 364		
F 502 SS=D	483.75(j)(1) LABORATORY SERVICES The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview during the standard survey the facility did not ensure that one of twenty-four sampled residents received timely laboratory services as ordered by the Physician (Resident #15). This resulted in no actual harm with the potential for more than minimal harm. The finding is: Resident #15 has diagnoses including Multiple Sclerosis and Small Bowel Reconstruction. A Physician's Order dated 2/5/08 documented that stool for guiac (a test for evidence of blood in the stool), three samples, were to be collected. There were no laboratory results present in the	F 502		5/15/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING ____ B. WING ____	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 502	Continued From page 11 resident's medical record for stool for guiac ordered 2/5/08. An interview was held on 3/27/08 at 3:10 PM with the Registered Nurse (RN) Manager. The RN stated that the laboratory was contacted on 3/27/08 and stated that they had no record of stool for guiac for Resident #15. The RN stated that the Nurse who originally picked up the Physician's Order should have completed a lab slip and transcribed the order to the Treatment Administration Record (TAR). Additionally, the RN stated that the stool tests were not done and that the Nurse who picked up the Physician's Order on 2/5/08 no longer worked at the facility. 415.20	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING **01 - ISLAND NURSING AND REHAB** B. WING ______	**03/28/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH** **HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a): The facility must meet the applicable provisions of The 2000 Edition of The Life Safety Code (LSC) of The National Fire Protection Association (NFPA).	K 000		
K 050 SS=B	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 2000 NFPA 101 Chapter 19.7.2.1- For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan. 2000 NFPA 101 Chapter 19.7.2.2- A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms	K 050		4/3/08

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING 01 - ISLAND NURSING AND REHAB B. WING	03/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 1 (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire 2000 NFPA 101 Chapter 19.7.2.3- All health care occupancy personnel shall be instructed in the use of and response to fire alarms. In addition, they shall be instructed in the use of the code phrase to ensure transmission of an alarm under the following conditions: (1) When the individual who discovers a fire must immediately go to the aid of an endangered person (2) During a malfunction of the building fire alarm system Personnel hearing the code announced shall first activate the building fire alarm using the nearest manual fire alarm box and then shall execute immediately their duties as outlined in the fire safety plan. Based on observation, and staff interview, it was determined that the facility did not ensure that all staff are familiar with the fire safety plan in that 2 of 2 housekeeping staffs were not familiar with the location and identification of the manual fire alarm box (pull station) on the first floor. This resulted in no actual harm with potential for minimal harm. The findings are: On 03/25/08 at approximately 2:00 PM, during	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335835	A. BUILDING **01 - ISLAND NURSING AND REHAB** B. WING ______	**03/28/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ISLAND NURSING AND REHABILITATION CENTER, INC	**5537 EXPRESSWAY DRIVE NORTH** **HOLTSVILLE, NY 11742**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 050	Continued From page 2 evaluations of the facility's fire safety plan, 2 of 2 interviewed housekeeping staffs could not identify the location and were not familiar with the identification of the manual fire alarm box (pull station) on the first floor. The two interviewed housekeeping staffs pointed to the door access push button located in the inner stairwell instead of the manual fire alarm box (pull station) when asked to locate it. In an interview at this time, the Director of Maintenance stated that all housekeeping staff do attend fire safety classes and that he would contact the housekeeping department to in order to familiarize all housekeeping staff on the identification and location of the manual fire alarm box (pull station). 2000 NFPA 101 LSC; 19.7.1 NYCRR 415.26	K 050		

AH Form Approved

6/26/2008

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
2	A. Building B. Wing	5/29/2008

Name of Facility	Street Address, City, State, Zip Code
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix I310 Reg. # 415.29 LSC	Correction Completed 05/15/2008	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/28/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335835	A. Building B. Wing	5/29/2008

Name of Facility	Street Address, City, State, Zip Code
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	**05/15/2008**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	**05/15/2008**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**05/15/2008**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	**05/15/2008**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	**05/15/2008**	ID Prefix **F0502** Reg. # **483.75(j)(1)** LSC	**05/15/2008**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/28/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction		(Y3) Date of Revisit
335835	A. Building B. Wing	01 - ISLAND NURSING AND REHABILTATION CE	6/3/2008

Name of Facility	Street Address, City, State, Zip Code
ISLAND NURSING AND REHABILITATION CENTER, INC	5537 EXPRESSWAY DRIVE NORTH HOLTSVILLE, NY 11742

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	05/15/2008	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:
3/28/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO