STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335093	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Nursing Home	128 Beach 115th Street Rockaway Park, NY 11694

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observations, interviews, and record review during the Abbreviated Survey (NY00337011), the facility failed to protect residents' rights to be free from physical and verbal abuse by nursing home staff. This was evident in 2 out of 6 residents (Resident #1 and Resident #2) reviewed for abuse. Specifically, 1) On 03/25/24 between 5:00 am and 6:00 am, Certified Nurse Assistant #1 reported that they witnessed Certified Nursing Assistant #2 hit Resident #1 on their left cheek with a closed fit and used profanity at Resident #1 on 03/24/24 during care between 4:00 am and 5:00 am. 2) Certified Nursing Assistant #1 also reported on 03/25/24 at 8:00 am that they witnessed Certified Nursing Assistant #2 roughly washed Resident #2's testicle and hit Resident #2 on their hand with a lotion bottle during peri-care on 03/24/24 between 4:00 am and 5:00 am. The findings are: The Facility's Policy and Procedure entitled Abuse Prevention, last review date of 12/29/23, documented that the resident had a right to be free from abuse, neglect, misappropriation of resident property, and exploitation by anyone in this facility. Resident #1 was admitted to the facility with diagnoses including Alcoholic Cirrhosis of the Liver, Alzheimer's disease, and Paraplegia. A Minimum Data Set (a resident assessment tool) dated 01/29/24 documented that Resident #1 had short-term and long-term memory impairments and moderately impaired cognitive skills for daily decision-making. Resident #1 depends on staff (the helper makes all efforts) for turning, positioning, and transfer. Resident #1 had an Abuse Care Plan initiated on 06/17/19. The interventions documented monitoring for changes in mood and manner and addressed Resident #1's concerns as they arose. The abuse care plan was last updated on 02/08/24 and document that Resident #1 remained at risk for abuse. The care plan was not updated to reflect the allegation of abuse made on 03/25/24. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 128 Beach 115th Street Rockaway Park, NY 11694	

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Resident Nursing Instruction dated 06/05/20 documented Resident #1 yells, screams, and resists care. There were no instructions on what staff should do if Resident #1 resists care. An Investigation Summary dated 03/24/24 documented Certified Nursing Assistant #1, who worked with Certified Nursing Assistant #2 on the night shift of 03/23/24, reported that they witnessed Certified Nursing Assistant #2 being aggressive with Resident #1. Certified Nursing Assistant #2 held Resident #1's right arm and punched Resident #1 on the left side of their face while using profanity at Resident #1. Certified Nursing Assistant #1 also reported witnessing Certified Nursing Assistant #2 roughly washed Resident #2's testicle on 03/24/24 while they were providing care. Resident #2 was also hit on their hand with a lotion bottle by Certified Nursing Assistant #2. The investigation concluded that abuse, neglect, and mistreatment had occurred. A Late Entry Nursing Progress Note dated 04/02/24 at 12:54 pm (for 03/25/24 at 9:30 am), written by the Assistant Director of Nursing, documented Licensed Practical Nurse #1 reported an alleged abuse on 03/25/24. The Assistant Director of Nursing responded to the unit at approximately 9:30 am and assessed Resident #1. There were no visible signs of injury and Resident #1 denied pain and discomfort. The Director of Nursing and the Medical Doctor were notified. There was no documented physician's assessment for the allegation of abuse made on 03/25/24. Resident #2 was admitted to the facility with diagnoses including Dementia, Bipolar Disorder, and Depressive Disorder. A Minimum Data Set, dated dated dated [DATE] documented that Resident #2 had short-term and long-term memory impairment with moderately impaired cognitive skills for daily decision-making. Resident #2 required substantial/maximal assistance (the helper makes more than half the effort) with bed mobility and transfer. A Risk for Abuse Care Plan for Resident #2 was initiated on 02/08/19 and was last updated on 01/09/24. The interventions documented that staff should address Resident #2's concerns and observe Resident #2 during rounds and care. Late Entry Nursing Note dated 04/02/24 at 4:37 pm (for 03/25/24 at 10:30 am), written by the Director of Nursing, documented that on 03/25/2024, Licensed Practical Nurse #1 reported an alleged physical abuse. At approximately 10:30 am, this writer performed a physical body assessment on Resident #2. Resident #2 does not appear to be in pain or discomfort. There was no redness, bruising, swelling, or discoloration, and the skin was intact, with no injuries observed, specifically to the hands. The Medical Doctor was made aware. There was no documented physician's assessment for the allegation of abuse made on 03/25/24. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/24 at 12:21 pm, Certified Nursing Assistant #1 stated that they worked with Certified Nursing Assistant #2 for the first time on 03/23/24 on the night shift (11:00 pm to 7:00 am). Certified Nursing Assistant #1 stated that they assisted Certified Nursing Assistant #2 in caring for Resident #1 between 4:00 am and 5:00 am on 03/24/24. Certified Nursing Assistant #1 stated that Resident #1 refused care, and Certified Nursing Assistant #2 voiced that they needed the work to be done. Certified Nursing Assistant #1 stated that they and Certified Nursing Assistant #2 went to Resident #1's room, and Resident #1 began swinging their arm trying to punch them. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 grabbed Resident #1's right hand and pressed it against the left side of Resident #1's neck and directed Certified Nursing Assistant #1 to perform the incontinent care. Certified Nursing Assistant #1 stated that Resident #1's left hand is paralyzed. Certified Nursing Assistant #1 went on to say after Resident #1's care was completed Certified Nursing Assistant #2 let go of Resident #1 right hand, but Resident #1 started to swing their right hand at them. Certified Nursing Assistant #1 stated that Certified Nursing Assistant #2 then grabbed Resident #1's right arm and pressed it again at Resident #1's neck, and punched Resident #1 on the left side of Resident #1's face while saying, don't f--k with me. Certified Nursing Assistant #1 also reported that on 03/24/24 between 4:00 am and 5:00 am, they assisted Certified Nursing Assistant #2 in caring for Resident #2. Certified Nursing Assistant #1 went on to say that they also observed Certified Nursing Assistant #2 washed Resident #2's testicles roughly. Certified Nursing Assistant #1 stated that Resident #2 covered their groin area with their hands and had a facial expression like pain. Certified Nursing Assistant #1 said that Certified Nursing Assistant #2 yelled at Resident #2 three times telling Resident #2 to move their hands. When Resident #2 did not comply, Certified Nursing Assistant #2 hit Resident #2's hand with a lotion bottle. Certified Nursing Assistant #1 stated they reported the incident to Licensed Practical Nurse #1 on 03/25/24 between 5:00 am and 6:00 am. During an interview on 04/02/24 at 11:50 am, Certified Nurse Assistant #2 stated they were assigned to Resident #1 on 03/23/24 on the 11:00 pm to 7:00 am shift and Certified Nursing Assistant #1 assisted them in providing care to Resident #1. Certified Nursing Assistant #2 stated that Resident #1 was agitated, and they held Resident #1's hand while Certified Nursing Assistant #1 changed Resident #1's incontinent brief. Certified Nursing Assistant #2 stated that Resident #1 cursed and yelled at them to let go of their hand. Certified Nursing Assistant #2 stated that they explained to Resident #1 that they needed to complete their care, but they did not hit Resident #1. Certified Nursing Assistant #2 stated that Resident #2 was assigned to Certified Nursing Assistant #1, and they assisted Certified Nursing Assistant #1 with caring for Resident #2. Certified Nursing Assistant #2 stated that Resident #2 was resistive to care and that they did not roughly wash Resident #2's testicles. Certified Nurse Assistant #2 stated that the lotion bottle could have contacted Resident #2's skin while they were applying lotion to Resident #2. During an interview on 04/02/24 at 4:53 pm, Licensed Practical Nurse #1, who worked on 03/23/24 on the night shift (11:00 pm -7:00 am) on Resident #1 and Resident #2's unit, stated that on 03/24/24 (at the end of the shift) Certified Nursing Assistant #1 reported that they did not want to work with Certified Nursing Assistant #2 but did not specify the reason. Licensed Practical Nurse #1 went on to say Certified Nursing Assistant #1 approached them on 03/25/24 between 4:00 am and 5:00 am stating that they witnessed Certified Nursing Assistant #2 being physically and verbally abusive towards Resident #1 on 03/24/24. Licensed Practical Nurse #1 stated that they reported the allegation of abuse to the Assistant Director of Nursing on 03/25/24 at around 8:30 am. Licensed Practical Nurse #1 also stated they do not recall Certified Nurse Assistant #1 mentioning Resident #2's abuse. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 128 Beach 115th Street Rockaway Park, NY 11694	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/24 at 10:47 am, the Assistant Director of Nursing stated that Licensed Practical Nurse #1 informed them and the Director of Nursing on 03/25/24 at around 8:30 am that Certified Nursing Assistant #1 reported that Resident #1 was aggressive with them and Certified Nursing Assistant #2 during care on 03/24/24. The Assistant Director of Nursing stated that Licensed Practical Nurse #1 did not say anything about Resident #2, but Certified Nursing Assistant #1 reported to them that Resident #2 was also abused by Certified Nursing Assistant #2. The Assistant Director of Nursing stated that they performed a body assessment on Resident #1, and there was no redness, swelling, or bruising observed, and Resident #1 denied pain and discomfort. The Assistant Director of Nursing went on to say that Resident #2 was also assessed with no visible injury, and no signs of pain observed. During an interview on 04/02/24 at 10:15 am, the Director of Nursing stated they investigated the allegation of abuse and based on the witness's reports, they concluded that abuse did occur. The Director of Nursing stated that the police was not notified. 10 NYC RR 415.4(b)(1)(i)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 F609 S/S E Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00337011), the facility failed to ensure that an alleged violation involving abuse was reported immediately but not later than two hours after the allegation was made if the events that caused the allegation involve abuse or result in serious bodily injury to New York State Department of Health and to local law enforcement. This was evident in 2 out of 6 residents reviewed for abuse (Resident #1 and Resident #2). Specifically, 1) On 03/25/24 between 5:00 am and 6:00 am, Certified Nurse Assistant #1 reported that they witnessed Certified Nursing Assistant #2 hit Resident #1 on their left cheek with a closed fit and used profanity at Resident #1 on 03/24/24 during care between 4:00 am and 5:00 am. The facility did not report the abuse allegation to the New York State Department of Health within two hours and did not notify local law enforcement timely. 2) Certified Nursing Assistant #1 also reported on 03/25/24 at 8:00 am that they witnessed Certified Nursing Assistant #2 roughly washed Resident #2's testicle and hit Resident #1 on their hand during peri-care on 03/24/24 between 4:00 am and 5:00 am. The facility did not report the abuse allegation to the New York State Department of Health within two hours. The facility reported the abuse allegations to New York State Department of Health on 03/25/24 at 1:32 pm. Additionally, the facility did not report the allegations of abuse to local law enforcement timely. The facility reported the allegations of abuse to local law enforcement while New York State Department of Health Surveyor was onsite 04/02/24. The findings are: The Facility's Policy and Procedure titled Accident and Incident Investigation and Reporting, with the last review date of 12/29/23, documented the responsibility of all Registered Nurse Supervisors and department heads to report alleged violations of mistreatment, neglect, and abuse, including injuries of unknown origin and misappropriation of resident property, immediately to the Administrator and/or Director of Nursing. The responsibility of the Administrator/ Director of Nursing or designee is to report to the New York State Department of Health the above-listed violations immediately but no more than two hours after the allegation is made if the event that causes the allegation involves abuse or results in serious bodily harm. The responsibility of the Administrator/Director of Nursing and or designee is to report suspicions of crimes to the New York Department of Health and local police within 24 hours or two hours if the crime results in serious bodily harm. Resident #1 was admitted to the facility with diagnoses including Alcoholic Cirrhosis of the Liver, Alzheimer's disease, and Paraplegia. A Minimum Data Set (a resident assessment tool) dated 01/29/24 documented that Resident #1 had short-term and long-term memory impairments and moderately impaired cognitive skills for daily decision-making. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 was admitted to the facility with diagnoses including Dementia, Bipolar Disorder, and Depressive Disorder. A Minimum Data Set, dated dated dated [DATE] documented that Resident #2 had short-term and long-term memory impairments and moderately impaired cognitive skills for daily decision-making. An Investigation Summary dated 03/24/24 documented Certified Nursing Assistant #1, who worked with Certified Nursing Assistant #2 on the night shift of 03/23/24, reported that they witnessed Certified Nursing Assistant #2 being aggressive with Resident #1. Certified Nursing Assistant #2 held Resident #1's right arm, punched Resident #1 on the left side of their face and used profanity at Resident #1 while Certified Nursing Assistant #1 changed Resident #1's brief. Certified Nursing Assistant #1 also reported on 03/24/24 that they also witnessed Certified Nursing Assistant #2 roughly washed Resident #2's testicle and hit Resident #2 on their hand with a lotion bottle. The investigation concluded that abuse, neglect, and mistreatment had occurred. An addendum to the facility Investigation Summary dated 04/02/24 documented that the facility called the police on 04/02/24 at 10:40 am. Review of a Webform Submission from the Nursing Home Facility Incident Report showed that the facility submitted to allegation of abuse to New York State Department of Health on 03/25/24 at 1:32 pm. During an interview on 04/02/24 between 10:15 am and 5:30 pm, the Director of Nursing stated they became aware of the allegation at 8:30 am on 03/25/24. The Director of Nursing went on to say that they did not report the allegation of abuse to New York State Department of Health within two hours because they spoke with Certified Nursing Assistant #1 at 12:30 pm on 03/25/24. The Director of Nursing stated that they did not call the police when the allegation of abuse was initially reported on 03/25/24 and that they have five days to do an investigation. The Director of Nursing stated the allegation of abuse was substantiated based on Certified Nurse Assistant #1 witnessing the abuse and the police was notified on 04/02/24. During an interview on 04/02/24 at 3:25 pm, the Administrator stated that they were out of the country at the time the incident and that the allegation of abuse should have been reported within two hours to New York State Department of Health. 10 NYCRR 415.4(b)(2)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Nursing Home	128 Beach 115th Street Rockaway Park, NY 11694

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observations, record review, and interviews conducted during an Abbreviated Survey (NY00337011), the facility failed to ensure that a care plan was reviewed and revised by the interdisciplinary team after each assessment. This was evident in 2 out of 6 residents sampled (Resident #1 and Resident #2). Specifically, 1) On 03/25/24 between 5:00 am and 6:00 am, Certified Nurse Assistant #1 reported that they witnessed Certified Nursing Assistant #2 hit Resident #1 on their left cheek with a closed fit and used profanity at Resident #1 on 03/24/24 during care between 4:00 am and 5:00 am. Resident #1's care plan was not reviewed and revised to reflect the allegation of abuse. 2) Certified Nursing Assistant #1 also reported on 03/25/24 at 8:00 am that they witnessed Certified Nursing Assistant #2 roughly washed Resident #2's testicle and hit Resident #1 with a lotion bottle on their hand during peri-care on 03/24/24 between 4:00 am and 5:00 am. Resident #2's care plan was not reviewed and revised to reflect the allegation of abuse. The findings are: The Facility's Policy and Procedure titled Comprehensive Care Planning was last reviewed on 10/16/23. The policy documented that each resident would have a comprehensive person-centered care plan in compliance with Federal and State regulations. The facility will establish an interdisciplinary team care plan process to ensure that resident care and treatment are planned appropriately for the resident's needs and condition, impairment, disability, or disease process in a timely, systematic, and comprehensive manner. The policy also documented that the care plan should be revised when appropriate to reflect the resident's current needs based on evaluation and episodic changes to include but not limited to: Accidents and /or Incidents, Behaviors/Mood State Changes. Resident #1 was admitted to the facility with diagnoses including Alcoholic Cirrhosis of the Liver, Alzheimer's disease, and Paraplegia. A Minimum Data Set (a resident assessment tool) dated 01/29/24 documented that Resident #1 had short-term and long-term memory impairments and moderately impaired cognitive skills for daily decision-making. Resident #1's Risk for Abuse Care Plan was initiated on 02/08/19 and was last updated 01/09/24. The interventions documented for staff to address Resident #1's concerns as they arise, staff to observe Resident #1 during rounds and care. The Care Plan was last reviewed and revised on 02/08/24 and documented Resident #1 remained at risk for abuse. Resident #2 was initially admitted to the facility on [DATE] with diagnoses including Dementia, Bipolar Disorder, and Depressive Disorder. A Minimum Data Set, dated dated dated [DATE] documented that Resident #2 had short-term and long-term memory impairment and moderately impaired cognitive skills for daily decision-making. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 128 Beach 115th Street Rockaway Park, NY 11694	

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's Abuse Care Plan was initiated on 02/08/19 and was last reviewed on 01/09/24. The Care Plans for Resident #1 and Resident #2 were not updated to reflect on the allegations of abuse made on 03/25/24. An Investigation Summary dated 03/24/24 documented Certified Nursing Assistant #1, who worked with Certified Nursing Assistant #2 on the night shift of 03/23/24, reported that they witnessed Certified Nursing Assistant #2 being aggressive with Resident #1. Certified Nursing Assistant #2 held Resident #1's right arm, punched Resident #1 on the left side of their face and used profanity at Resident #1 while Certified Nursing Assistant #1 changed Resident #1's brief. Certified Nursing Assistant #1 also reported on 03/24/24 that they witnessed Certified Nursing Assistant #2 roughly washed Resident #2's testicle and hit Resident #2 on their hand with a lotion bottle. The investigation concluded that abuse, neglect, and mistreatment had occurred. During an interview on 04/02/24 at 10:47 am, the Assistant Director of Nursing stated that they did not update the care plans for Resident #1 and Resident #2 after the allegations of abuse were made. The Assistant Director of Nursing went on to say that the care plans should have been updated with new interventions to prevent a reoccurrence of abuse. The Assistant Director of Nursing stated that the Nursing Supervisors and Assistant Director of Nursing are responsible for updating care plans. 10 NYCRR 415.11(c)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review, and interview conducted during an Abbreviated survey (NY00335621), the facility failed to provide adequate supervision to a resident to prevent an accident. This was evident in 1 out of 6 residents (Resident #3) sampled for accidents. Specifically, on 03/11/24 at 9:50 am Resident #3 was assisted into a bathroom toilet stall by Certified Nursing Assistant #3, who was assigned to provide 1:1 monitoring of Resident #3. At 10:35 am, Resident #3 exited from the toilet stall and was noted with a linear laceration measuring 1 centimeter above their left eye. Subsequently, Resident #3 was transferred to the hospital on 03/11/24 at 12:12 pm and was diagnosed with a Left Proximal Humerus Fracture (breaking the bone in the upper arm). This resulted in actual harm to Resident #3 that was not Immediate Jeopardy. The findings are: The facility Policy and Procedure titled Resident Monitoring and Visual Checks dated 07/12/22 was last reviewed on 01/19/23. The policy states that all residents will be monitored by caregivers at the start and end of each shift. The residents need will be assessed for increased monitoring and closer supervision based upon individual needs and behaviors. The Interdisciplinary Team will determine when a resident needs additional monitoring. Caregivers will be informed regarding residents monitoring needs during the shift report, and specific Monitoring forms will be utilized to document the increased monitoring. The facility Policy and Procedure titled Fall Prevention dated 02/2022 states that each resident will be assessed for his/her risk for falls on admission, re-admission, quarterly, and for change in condition. Each resident will have an individualized care plan outlining their fall prevention measures. Residents who require dayroom monitoring or close supervision when out of bed will have this clearly documented on the Certified Nursing Assistant Accountability Record. Resident #3 was admitted to the facility with diagnoses including Paranoid Schizophrenia (a pattern of behavior where a person feels distrustful and suspicious of other people and acts accordingly), Generalized Anxiety Disorder, and a history of sacrum fracture (broken bone). A Minimum Data Set (a resident assessment tool) dated 02/07/24 documented Resident #3 had short-term and long-term memory impairments and moderately impaired cognitive skills for daily decision-making. Resident #3 required partial/moderate assistance for toileting hygiene (the ability to maintain perineal hygiene, adjust clothes, before and after voiding or having a bowel movement) which means - helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. The Minimum Data Set documented that Resident #3 uses a wheelchair. A Fall Prevention / Risk assessment dated [DATE] documented Resident #3 was assessed and identified with a score of 9. The form also documented that a score greater than 5 is high risk for fall. According to the form, a fall prevention protocol should be initiated. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A Care Plan for Falls initiated on 07/23/20 was last reviewed (quarterly) on 02/10/24. The interventions instructed to always place Resident #3 in an area closely supervised by staff, keep immediate necessities within easy reach, 1:1 monitoring for falls and behavior on the 7:00 am-3:00 pm and the 3:00 pm-11:00 pm shifts, and visual every 30 minutes during the 11:00 pm-7:00 am shift. Resident Nursing Instructions dated 12/04/23 documented 1:1 staff monitoring from 7:00 am-3:00 pm and every 30 minutes monitoring from 3:00 pm-11:00 pm, and 11:00 pm-7:00 am shifts. The Resident Nursing Instructions were not updated when the care plan was updated on 02/10/24 for Resident to be on 1:1 monitoring from 7:00 am - 3:00 pm and 3:00 pm - 11:00 pm shifts. The lesson plan titled Supervision and Safeguarding Resident related to 1:1 Monitoring states that 1:1 monitor must always be arm's length away from the resident that they are monitoring. The lesson plan also documents those certain residents on 1:1 monitoring requires that the monitor be always in proximity. This is for residents with suicidal ideation, fall risks, and unsafe behaviors. This means that the monitor must be present in the room with the resident and at arm's length away. Review of the above lesson plan with attached in-service sheets dated from 09/01/23 - 09/09/23, revealed that Certified Nursing Assistant #3 received in-service on 1:1 monitoring between 09/01/23 and 09/09/23 as indicated by Certified Nursing Assistant #3's signature. The One-to-One Resident Monitoring Documentation Form dated 03/11/24 documented Resident #3 was on 1:1 monitoring due to impulsive behaviors and fall risk. Certified Nurse Assistant #3 was assigned to provide 1:1 monitoring (must always have the resident in line of vision or be directly outside the door and follow when resident leaves) for Resident #3. The monitoring form 9:00 am entry documented Resident #3 was in the restroom, and at 10:00 am documented Resident #3 was sitting on their bed. The Toilet Use section of the Resident Nursing Instructions, last updated 10/05/23, had no instructions on what staff should do when Resident #3 is being toileted. A Nurse's Progress Note written by Registered Nurse Supervisor #1, dated 3/11/24 at 11:39 am, documented Licensed Practical Nurse #1 reported to them Resident #3 was observed with a cut above their eyebrow. Resident #3 was assessed with a linear laceration measuring 1 centimeter in length above their left eyebrow with no active bleeding. During palpation of the left arm/shoulder, Resident #3 complained of severe pain and had a decrease in Range of Motion. As per translator, Resident #3 verbalized having pain but does not recall any traumatic event. Resident #3 was assessed by the Medical Doctor. An order was obtained for an anti-bacterial ointment to apply to the left eyebrow and to transfer Resident #3 to the hospital for a STAT (immediate) x-ray to rule out a fracture. Diagnostic imaging done in the hospital on 03/11/24 documented the radiographs of Resident #3's shoulder showed an acute fracture through the surgical neck of the humerus with displacement of the shaft anterior/superiorly (broken bone in the upper arm). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 128 Beach 115th Street Rockaway Park, NY 11694	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Facility's Investigative Summary documented on 03/11/24 Resident #3 was on 1:1 monitoring and was assigned to be monitored by Certified Nursing Assistant #3. The investigation documented Certified Nursing Assistant #3 stated they took Resident #3 to the community bathroom (which has two stalls) at 9:50 am. Certified Nurse Assistant #3 stated Resident #3 had no injury prior to going to the bathroom. Certified Nurse Assistant #3 stated they remained in the bathroom, and they were able to see Resident #3's feet through the crack between the two stalls. Certified Nursing Assistant #3 stated at 10:35 am, Resident #3 came out of the toilet stall, and they noticed a cut over Resident #3's left eye. After entering Resident #3's room, Resident #3 was holding their arm /shoulder as if in pain. Certified Nurse Assistant #3 reported to Licensed Practical Nurse #1 that Resident #3 had a bump on the side of their eye. Nursing Supervisor #1 and the Medical Doctor were notified, and Resident #3 was transferred to the hospital and was diagnosed with Left Proximal Humerus Fracture. The facility concluded it was reasonable to believe Resident #3 was left unattended by Certified Nurse Assistant #3 and there is credible evidence to believe abuse, mistreatment, and neglect have occurred as a result of a violation of Resident #3's plan of care. A Nursing Progress Note written by the Assistant Director of Nursing, dated 03/22/24 at 3:57 pm documented the Orthopedic Consultant called and stated based on the imaging completed, if treatment only includes putting Resident #3's arm in a sling the arm will not properly heal, and without surgery the healing process will be prolonged. Surgery was recommended. An Orthopedic Consultation dated 03/26/24 documented Resident #3 had a Left Proximal Humerus Fracture, Resident #3 was not a good candidate for surgery, and should have no weight bearing for 3 more weeks. During an interview with Resident #3 on 04/03/24 at 1:00 pm, Resident #3 did not respond to surveyor's questions. During an interview on 04/10/24 at 1:56 pm, Certified Nursing Assistant #3 stated they were assigned to provide 1:1 monitoring for Resident #3 on 03/11/24 on the 7:00 am-3:00 pm shift. Certified Nursing Assistant #3 stated Resident #3 had wandering behavior and was on fall precautions. Certified Nursing Assistant #3 stated sometime between 9:30 am and 10:00 am (not sure of the time) they took Resident #3 in their wheelchair to the common restroom located in the hallway. Certified Nursing Assistant #3 stated they assisted Resident #3 with walking into one of the toilet stalls and Resident #3 pulled down their incontinence brief and sat down on the toilet independently while holding onto the hand bar. Certified Nursing Assistant #3 stated they left the toilet area and stood behind the door to the toilet where they could see Resident #3 from between the cracks of the door. Certified Nursing Assistant #3 stated Resident #3 got up, closed the door to toilet, and sat back down on the toilet. Certified Nursing Assistant #3 stated they stayed with Resident #3 until at approximately 10:35 am when they observed (through the door crack) Resident #3 bent over cleaning themselves. Certified Nursing Assistant #3 stated when Resident #3 opened the door to the toilet, they observed Resident #3 with a cut above their left eye with a few drops of fresh blood. Certified Nursing Assistant #3 stated they did not hear any crying, screaming, or noise while Resident #3 was in the toilet stall. Certified Nursing Assistant #3 stated Resident #3 did not fall because it would have been difficult for Resident #3 to pick themselves up. Resident #3 is a heavy person, and the toilet space is small. Certified Nursing Assistant #3 stated they escorted Resident #3 to the wheelchair and took Resident #3 back to their room when they observed Resident #3 holding their left arm saying oy, oy sounding as if they were in pain. Certified Nursing Assistant #3 stated they reported to Licensed Practical Nurse #1 immediately. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/15/24 at 10:00 am, Licensed Practical Nurse #1 stated sometime after 10:00 am and 10:30 am (not sure of the time), Certified Nurse Assistant #3 notified them Resident #3 had a bump on their head. Licensed Practical Nurse #1 stated they observed Resident #3 sitting on their bed, holding their left shoulder. They were observed to have a small, slightly bleeding cut above their left eye. Licensed Practical Nurse #1 stated they called Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated Certified Nurse Assistant #3 reported to them Resident #3 went to the bathroom by themselves, and they think Resident #3 hit their head. Licensed Practical Nurse #1 stated they told Certified Nursing Assistant #3 they were supposed to stay with Resident #3 inside of the bathroom the entire time. Licensed Practical Nurse #1 stated one-to-one monitoring means staff must see the resident 24 hours a day and be very close to the resident at arm's length in case something happens. Licensed Practical Nurse #1 stated they are responsible for overseeing if the staff are monitoring the residents. During an interview on 04/03/24 at 1:14 pm, Registered Nurse Supervisor #1 stated they assessed Resident #3 and observed an abrasion on Resident #3's left eyebrow. The abrasion was not bleeding, but Resident #3 was moaning while holding their left arm and verbalized pain via a translator. Attending Physician #1 was in the building and assessed Resident #3 who screamed out in pain when their arm was touched Resident #3 was transferred immediately to the hospital for an x-ray. Registered Nurse Supervisor #1 stated a synthetic opioid/narcotic that relieves pain was given to Resident #3 prior to the incident, for a different concern, so additional pain medication was not administered. Registered Nurse Supervisor #1 stated Resident #3 was on 1:1 monitoring for safety, wandering, and a history of falls. Registered Nurse Supervisor #1 stated the nurse on the unit is responsible for overseeing if the staff are monitoring residents properly. Registered Nurse Supervisor #1 stated staff who are assigned to do 1:1 is supposed to be at arm's length and always monitoring the resident visually. Registered Nurse Supervisor #1 stated they initiated an investigation and Certified Nurse Assistant #3's version of what happened does not make any sense. During an interview on 04/03/24 at 12:00 pm, Attending Physician #1 stated they assessed Resident #3 on 03/11/24 and observed a fresh superficial laceration above the left eyebrow which did not require any sutures. Attending Physician #1 went on to say Resident #3 was guarding their left arm, and there was no deformity, but tenderness to touch and pain as assessed via verbal cues was around 5-6 out of 10. Attending Physician #1 stated there was no other visible injury or swelling at the time of assessment. The Attending Physician #1 stated Resident #3 returned from the hospital with the diagnosis of a Left Proximal Humerus Fracture with an order to wear a sling because surgery was not an option. Attending Physician #1 stated it was not clear how Resident #3 sustained a fracture because there would be ecchymosis (a discoloration of the skin resulting from bleeding underneath) on the body if Resident #3 had fallen. Attending Physician #1 stated Resident #3 had declined physically after sustaining the fracture and had required more assistance because Resident #3 was unable to use their left arm. Resident #3 was seen by an Orthopedic doctor on 03/26/24 and was not a candidate for surgery at that time. During an interview on 04/03/24 at 12:30 pm, the Administrator stated they were part of the investigation and went to the restroom to check because Certified Nurse Assistant #3 said they did not leave Resident #3 unattended and could not explain how Resident #3 sustained the injuries. The Administrator stated they checked the sidebars in the toilet stall, and they were in working condition. There was no sign of trauma except a dry stain dark in color (looked like dry blood, but not sure) on the metal latch of the toilet door. The Administrator stated they suspect Resident #3 hit their head on that metal latch when they tried to get up. (continued on next page)

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	335093	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Nursing Home	128 Beach 115th Street Rockaway Park, NY 11694

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 04/03/24 at 1:45 pm, the Director of Nursing stated Resident #3 was on 1:1 monitoring since 2020 for safety, due to wandering behavior and falls. Staff, including Certified Nurse Assistant #3, were in-serviced previously on 1:1 monitoring, which means they should have known to be at arm's length from the resident and to always have the resident in sight. Certified Nurse Assistant #3 should not have closed the toilet door and should have stayed with Resident #3. Certified Nurse Assistant #3 told them they were behind the door all the time and saw Resident #3 through the crack in the door between stalls but were not able to explain how they did not hear or see how Resident #3 sustained a laceration over their eyebrow and injury to the left upper arm. According to Certified Nurse Assistant #3, Resident #3 was in the restroom for 40 minutes (according to Certified Nursing Assistant #3, this is Resident #3's usual behavior). The Director of Nursing went on to say they suspected Certified Nurse Assistant #3 left Resident #3 on the toilet for an extended time. The Director of Nursing stated due to the extent of the injury, they did not believe Certified Nurse Assistant #3 monitored Resident #3 properly and they suspended Certified Nursing Assistant #3. The Director of Nursing stated the investigation concluded abuse, neglect, and mistreatment had occurred. 10 NYCRR 415.12(h)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, interviews, and record review conducted during an Abbreviated Survey (NY00337011), the facility failed to maintain clinical records that are complete and accurately documented in accordance with accepted professional standards and practices. This was evident in 2 out of 6 residents (Resident #1 and Resident #2) reviewed for Abuse. Specifically, on 03/25/24, Certified Nurse Assistant #1 reported that they witnessed Certified Nurse Assistant #2 being verbally and physically abusive to Resident #1 and Resident #2. There were no assessments documented in Resident #1 and Resident #2's medical records prior to New York State Department of Health Surveyor's onsite visit on 04/02/24. Additionally, there were no physician's assessments documented in Resident #1 and Resident #2's medical record. The findings are: The facility's Policy and Procedure titled Documentation in the Medical Record with the last review date of 04/13/22, documented that the objective to ensure that the facility was incompliance with F842 and that the progress notes document all events pertaining to the resident's stay in the facility. The policy also documented that it is the policy of the facility to ensure that licensed professionals document changes in resident condition, accidents, incidents, transfers, expirations, and leave against medical advice to ensure that all events of the resident stay are included. Resident #1 was admitted to the facility with diagnoses including Alcoholic Cirrhosis of the Liver, Alzheimer's disease, and Paraplegia. A Minimum Data Set (a resident assessment tool) dated 01/29/24 documented that Resident #1 had short-term and long-term memory impairments and moderately impaired cognitive skills for daily decision-making. Resident #2 was initially admitted to the facility on [DATE] with diagnoses including Dementia, Bipolar Disorder, and Depressive Disorder. A Minimum Data Set, dated dated dated [DATE] documented that Resident #2 had short-term and long-term memory impairment and moderately impaired cognitive skills for daily decision-making. An Investigation Summary dated 03/24/24 documented Certified Nursing Assistant #1, who worked with Certified Nursing Assistant #2 on the night shift of 03/23/24, reported that they witnessed Certified Nursing Assistant #2 being aggressive with Resident #1. Certified Nursing Assistant #2 held Resident #1's right arm, punched Resident #1 on the left side of their face and used profanity at Resident #1 while Certified Nursing Assistant #1 changed Resident #1's brief. Certified Nursing Assistant #1 also reported on 03/24/24 that they also witnessed Certified Nursing Assistant #2 roughly washed Resident #2's testicle and hit Resident #2 on their hand with a lotion bottle. The investigation concluded that abuse, neglect, and mistreatment had occurred. An addendum to the facility Investigation Summary dated 04/02/24 documented that the facility called the police on 04/02/24 at 10:40 am. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/02/24 at 10:47 am, the Assistant Director of Nursing stated that they assessed Resident #1 and Resident #2 on 03/25/24 and there were no visible signs of injuries. Neither Resident #1 nor Resident #2 complained of pain. The Assistant Director of Nursing went on to say that they reported their findings to the Director of Nursing and the assessment was documented into the investigation summary report. The Assistant Director of Nursing stated that they should have documented the assessment findings into the Residents' medical records. The Assistant Director of Nursing stated that it is the supervisor's responsibility to assessed and document in the Resident's medical record, but the facility did not have a supervisor on duty, and that they were overwhelmed. During an interview on 04/02/24 at 2:50 pm, the Attending Physician stated they were notified of the abuse allegation by the Assistant Director of Nursing on 03/25/24. The Attending stated it was reported that Resident #1 and Resident #2 did not sustain any injury or have complaints of pain. The Attending Physician stated they examined Resident #2's private area during the monthly review on 03/27/24 and there were visible injuries or complaints of pain. The Attending Physician also stated they evaluated Resident #1 during their monthly review on 03/29/24, and there no visible injury or pain. 10 NYCRR 415.22(a) (1-4)