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	05/08/2026

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to update the electronic medical record with a resident's Medical Order for Life-Sustaining Treatment (MOLST) after returning to the facility from a hospitalization. This was evident for one (1) out of six (6) residents (Resident #1) reviewed for advanced directives. Specifically, Resident #1 had a Do Not Resuscitate (DNR)/ Do Not Intubate (DNI) order in place dated [DATE]. On [DATE], the resident was hospitalized and returned to the facility on [DATE]. On [DATE] at 9:47 PM, Resident #1 was found to be unresponsive. Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 both could not locate the resident's advanced directive/code status in the Electronic Medical Record and initiated cardiopulmonary resuscitation against Resident #1's wishes and Emergency Medical Service was called and continued cardiopulmonary resuscitation until the resident was pronounced deceased . This resulted in Immediate Jeopardy Past Noncompliance.The findings include:The facility's policy and procedure titled Advanced Directives Specific to Do Not Resuscitate was last reviewed on [DATE] and states when a resident is admitted with a Medical Order for Life Sustaining Treatment, if the resident/family wishes to keep Medical Order for Life-Sustaining Treatment orders as is, the admitting nurse will communicate this with the physician and ensure that a physician's order is obtained.Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary edema (a progressive, treatable, but incurable lung disease), type 2 diabetes mellitus and heart failure (the heart muscle cannot pump enough blood to meet the body's needs).The Minimum Data Set (a resident assessment tool) dated [DATE] identified Resident #1 to have intact cognition. The Medical Order for Life Sustaining Treatment signed and dated [DATE] by the resident and physician, documented Do Not Resuscitate and Do Not Intubate.An Advance Directive Care Plan dated [DATE] identified Resident #1 as Do Not Resuscitate. The interventions included Physician's Order for advanced directive and document in chart. There is no documented evidence that the resident or their representative rescinded the [DATE] Do Not Resuscitate/Do Not Intubate directives, however, a review of the resident's Electronic Medical Record revealed the physician's order for the Do Not Resuscitate/Do Not Intubate had been de-activated while the resident was in the hospital.The facility's investigative summary dated [DATE], documented that on [DATE] at approximately 9:47 PM, the resident was observed by unit staff to be unresponsive. The assigned Licensed Practical Nurse #1 immediately notified Registered Nurse Supervisor #1 that the resident was unresponsive and had no palpable pulse. Registered Nurse Supervisor #1 promptly assessed the resident and confirmed unresponsiveness and absence of palpable pulse. A Code Stat (immediately or without delay) was immediately activated via overhead page and Registered Nurse Supervisor #2 responded at approximately 9:50 PM to assist with the emergency response. At the time of the emergency, Registered Nurse Supervisor #1 reviewed the electronic medical record to verify code status. No active/current physician order indicating Do Not Resuscitate was present in the physician order section of the chart. Based on the resident's clinical condition, cardiopulmonary resuscitation was initiated at approximately 9:53 PM. Emergency Medical Services arrived at approximately 10:02 PM and resuscitative efforts continued until approximately (continued on next page)

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

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	10:27 PM, when the resident was pronounced deceased by Emergency Medical Services. The investigation concluded that there was no evidence of abuse, neglect or intentional harm.During an interview on [DATE] at 12:30 PM, Certified Nursing Assistant #1 stated that during rounds on [DATE] at 8:45 PM, Resident #1 was alert, watching television and talking. They stated during their 9:45 PM rounding on [DATE], Resident #1 was unresponsive, and they immediately called Licensed Practical Nurse #1.During an interview on [DATE] at 1:00 PM, Licensed Practical Nurse #1 stated that on [DATE], Certified Nursing Assistant #1 notified them that Resident #1 was unresponsive. They went to Resident #1's room and noted they were unresponsive and without a palpable pulse. Licensed Practical Nurse #1 stated they left the room and notified Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated they and Registered Nurse Supervisor #1 went to Resident #1's room and they found Resident #1 unresponsive and without a palpable pulse. Licensed Practical Nurse #1 stated Registered Nurse Supervisor #1 left the room and called Code Stat. Licensed Practical Nurse #1 stated they remained with Resident #1 and continued to check for pulse and responsiveness. They stated that Registered Nurse Supervisors #1 and #2 came to Resident #1's room and Registered Nurse Supervisor #2 started chest compressions on Resident #1. Licensed Practical Nurse #1 stated they were assigned to Resident #1, they were in-serviced on advanced directives and that they were certified in cardiopulmonary resuscitation.During an interview on [DATE] at 1:45 PM, Registered Nurse Supervisor #1 stated that Licensed Practical Nurse #1 notified them that Resident #1 was unresponsive. They assessed Resident #1, left the room to check code status and called Code Stat. Registered Nurse Supervisor #1 stated Do Not Resuscitate was not noted in the electronic medical record and there was no purple binder with the Medical Order for Life Sustaining Treatment form. They stated that since there was no documentation, they activated a full code by calling Code Stat. Registered Nurse Supervisor #1 stated they left Licensed Practical Nurse #1 with Resident #1 while they went to the first floor to get the Automatic External Defibrillator (AED). They stated that they and Registered Nurse Supervisor #2 went to Resident #1's room and Registered Nurse Supervisor #2 initiated cardiopulmonary resuscitation. Registered Nurse Supervisor #1 stated on hire to the facility, they were inserviced on advanced directives and that they are certified in cardiopulmonary resuscitation. During an interview on [DATE] at 2:15 PM, Registered Nurse Supervisor #2 stated they were on the first floor when they heard the overhead page for Code Stat. They stated that on their way to Resident #1's room on the second floor, they met Registered Nurse Supervisor #1 exiting the second floor and stated they think Resident #1 is dead and that they were going to get the Automatic External Defibrillator. Registered Nurse Supervisor #2 stated they and Registered Nurse Supervisor #1 went to Resident #1's room and they (Registered Nurse Supervisor #2) found Resident #1 unresponsive and without a palpable pulse. They stated that they initiated chest compressions based on information from Registered Nurse Supervisor #1 that Resident #1 was a full code. Registered Nurse Supervisor #2 stated they continued chest compressions until Emergency Medical Services arrived. They stated that Emergency Medical Services continued chest compressions and that Resident #1's status was unchanged. Registered Nurse Supervisor #2 stated that Emergency Medical Services pronounced the resident deceased at 10:27 PM. Registered Nurse Supervisor #2 stated the physician and Resident #1's family were notified.During an interview on [DATE] at 3:30 PM, the Director of Nursing stated that Certified Nursing Assistant #1 found Resident #1 unresponsive on [DATE] at 9:47 PM and notified Licensed Practical Nurse #1 immediately. The Director of Nursing stated that Licensed Practical Nurse #1 went to Resident #1's room and found them unresponsive without a palpable pulse. They stated that that Licensed Practical Nurse #1 immediately notified Registered Nurse Supervisor #1 who assessed Resident #1, checked the Electronic Medical Record for code status and called Code Stat. The Director of Nursing stated Registered Nurse Supervisor #2 responded and initiated chest compressions. The Director of Nursing stated that Registered Nurse Supervisor #1 checked the Electronic Medical Record and did not find an order for Do Not Resuscitate. They stated that that the order was not re-entered when Resident #1 (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	returned from a hospitalization on [DATE]. The Director of Nursing stated they investigated the incident and identified that cardiopulmonary resuscitation was initiated against the resident's wish for Do Not Resuscitate. In addition, they stated the staff acted in good faith based on Resident #1's clinical condition.During a follow-up interview on [DATE] at 1:00 PM, the Director of Nursing stated staff stated they did not see a binder with the Medical Order for Life Sustaining Treatment (MOLST), at the nurses' station during the emergency on [DATE]. The Director of Nursing stated after the incident, the facility has changed the procedure for filing Medical Order for Life-Sustaining Treatment forms. They stated the Medical Order for Life Sustaining Treatment forms for all residents on each unit, are filed in one purple binder and secured with a chain at the nurses' station. The Director of Nursing stated they received Resident #1's Medical Order for Life-Sustaining Treatment paper copy from the Administrator who received it from the medical records staff on [DATE]. During an interview on [DATE] at 11:00 AM, Medical Records Staff #1 stated on [DATE], they found Resident #1's purple binder on a shelf at the nurses' station on the second floor. They stated the pink form Medical Order for Life Sustaining Treatment was in the binder, and they gave it to the Administrator.During an interview with the Medical Director on [DATE] at 11:51 AM, they stated staff should not have performed chest compressions on Resident #1. The Medical Director stated Resident #1 had a Medical Order for Life-Sustaining Treatment that indicated Do Not Resuscitate that was signed by them (Medical Director) on [DATE] and a physician order for Do Not Resuscitate/Do Not Intubate, signed by them [DATE]. The Medical Director stated the Administrator informed them of the incident on [DATE]. 10 New York Code, Rules, and Regulations 415.3(e)(2)(iii) Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the non-compliance and was in substantial compliance for this specific regulatory requirement prior to and during the time of this survey. A Plan of Correction is not required for this citation. The facility took immediate corrective actions and was found to be in substantial compliance on [DATE], prior to Surveyors' onsite visit on [DATE]. Immediate Corrective Actions[DATE] - [DATE] - facility wide audit done to ensure all residents' advanced directives are accurately reflected as active/current physician orders. All residents were audited to ensure that each resident has an active physician order reflecting their current advance directive/code status-Full Code and Do Not Resuscitate/Do Not IntubateXXX[DATE] - [DATE] - a comprehensive audit of all residents' advanced directives, including prior admissions and readmissions reviewedXXX[DATE] - [DATE] - Care plan review completed to ensure care plans are current, accurate, and aligned with each resident's advance directives and active/current physician ordersXXX[DATE] - [DATE] - Policy and procedure Advance Directives Specific to DNR was reviewed and updated to standardize advanced directive verification processes ensuring consistent, accurate alignment with active/current physician orders, clearly defined roles and responsibilities for nursing, social services and providersXXX[DATE] - Policy and procedure, Advance Directives Specific to Do Not Resuscitate, was revised to reinforce that during an emergency or code event, staff must rely on readily accessible, active physician orders in the electronic medical record to determine code status. Consistent with regulatory standards, the Medical Order for Life Sustaining Treatment (MOLST)form constitutes a valid and actionable medical order; therefore, in the absence of a clearly visible or active physician order in the electronic medical record, staff are directed to immediately locate and verify the most current signed Medical Order for Life-Sustaining Treatment or advance directive in the medical record. Lesson Plan and In-service Attendances on Code Status/Advance Directives/ Medical Order for Life-Sustaining Treatment dated [DATE]-[DATE] reviewed with no concerns.TOTAL EMPLOYEES ---195TitleCompleted % CompleteCertified nursing Assistants90100% - 5 staff on leave, 1 on vacation.Registered Nurses18100%Licensed Practical Nurses30100%Dietary Staff16100%Housekeeping Staff16100%Maintenance Staff2100%Recreation Staff5100%Administration Employees13100%Rehabilitation5100%

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on interview and record review conducted during the survey, the facility failed to maintain medical records on each resident that are complete, accurately documented, and readily accessible and systematically organized. This was evident for one (1) of six (6) residents reviewed for Advanced Directive. Specifically, Resident #1 had Do Not Resuscitate (DNR)/ Do Not Intubate (DNI) order in place dated [DATE]. On [DATE] the resident was hospitalized and returned to the facility on [DATE]. On [DATE] at 9:47 PM, Resident #1 was found to be unresponsive. Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 both could not locate the resident's advanced directive/code status in the Electronic Medical Record and initiated cardiopulmonary resuscitation against Resident #1's wishes and Emergency Medical Service was called and continued cardiopulmonary resuscitation and intubation until the resident was pronounced deceased . Findings are:The facility Policy on Advance Directive title Advance Directive Specific to DNR was last revised on [DATE]. The policy states to ensure that each resident's advanced directives, including code status, are accurately established, verified, clearly documented and consistently aligned with active physician orders in the electronic medical record.The facility recognizes the Medical Orders for Life Sustaining Treatment (MOLST) as a valid and actionable medical order under New York State law and requires that all advanced directives decisions are readily accessible and immediately actionable to guide clinical care particularly during emergencies.Resident #1 was admitted to the facility with diagnoses including chronic obstructive pulmonary edema (a progressive, treatable, but incurable lung disease), type 2 diabetes mellitus and heart failure (the heart muscle cannot pump enough blood to meet the body's needs).The Minimum Data Set (a resident assessment tool) dated [DATE] identified assessed Resident #1 to have had intact cognition and able to make medical decisions. The Medical Order for Life Sustaining Treatment (MOLST) signed and dated [DATE] by the resident and physician, documented Do Not Resuscitate and Do Not Intubate.An Advance Directive Care Plan dated [DATE] identified Resident #1 as Do Not Resuscitate. The interventions include physician's order for advanced directive and to document in chart. There is no documented evidence that the resident or their representative rescinded the [DATE] Do Not Resuscitate/Do Not Intubate directives, however, a review of the resident's Electronic Medical Record revealed the physician's order for the Do Not Resuscitate/Do Not Intubate had been de-activated while the resident was in the hospital.The facility's investigative summary dated [DATE], documented that on [DATE] at approximately 9:47 PM, the resident was observed by unit staff to be unresponsive. The assigned Licensed Practical Nurse #1 immediately notified Registered Nurse Supervisor #1 that the resident was unresponsive and had no palpable pulse. Registered Nurse Supervisor #1 promptly assessed the resident and confirmed unresponsiveness and absence of palpable pulse. A Code Stat (immediately or without delay) was immediately activated via overhead page and Registered Nurse Supervisor #2 responded at approximately 9:50 PM to assist with the emergency response. At the time of the emergency, Registered Nurse Supervisor #1 reviewed the electronic medical record to verify code status. No active/current physician order indicating Do Not Resuscitate was present in the physician order section of the chart. Based on the resident's clinical condition, cardiopulmonary resuscitation was initiated at approximately 9:53 PM. Emergency Medical Services arrived at approximately 10:02 PM and resuscitative efforts continued until approximately 10:27 PM, when the resident was pronounced deceased by Emergency Medical Services. The investigation concluded that there was no evidence of abuse, neglect or intentional harm.During an interview on [DATE] at 1:45 PM, Registered Nurse Supervisor #1 stated that Licensed Practical Nurse #1 notified them that Resident #1 was unresponsive. They assessed Resident #1, left the room to check code status and called Code Stat. Registered Nurse Supervisor #1 stated Do Not Resuscitate was not noted in the electronic medical (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record and there was no purple binder with the Medical Order for Life Sustaining Treatment form. They stated that since there was no documentation, they activated a full code by calling Code Stat. Registered Nurse Supervisor #1 stated they left Licensed Practical Nurse #1 with Resident #1 while they went to the first floor to get the Automatic External Defibrillator (AED). They stated that they and Registered Nurse Supervisor #2 went to Resident #1's room and Registered Nurse Supervisor #2 initiated cardiopulmonary resuscitation. Registered Nurse Supervisor #1 stated on hire to the facility, they were in-serviced on advanced directives and that they are certified in cardiopulmonary resuscitation. During an interview on [DATE] at 3:30 PM, the Director of Nursing stated that Certified Nursing Assistant #1 found Resident #1 unresponsive on [DATE] at 9:47 PM and notified Licensed Practical Nurse #1 immediately. The Director of Nursing stated that Licensed Practical Nurse #1 went to Resident #1's room and found them unresponsive without a palpable pulse. They stated that that Licensed Practical Nurse #1 immediately notified Registered Nurse Supervisor #1 who assessed Resident #1, checked the Electronic Medical Record for code status and called Code Stat. The Director of Nursing stated Registered Nurse Supervisor #2 responded and initiated chest compressions. The Director of Nursing stated that Registered Nurse Supervisor #1 checked the Electronic Medical Record and did not find an order for Do Not Resuscitate. They stated that that the order was not re-entered when Resident #1 returned from a hospitalization on [DATE]. The Director of Nursing stated they investigated the incident and identified that cardiopulmonary resuscitation was initiated against the resident's wish for Do Not Resuscitate. In addition, they stated the staff acted in good faith based on Resident #1's clinical condition.During a follow-up interview on [DATE] at 1:00 PM, the Director of Nursing stated staff stated they did not see a binder with the Medical Order for Life Sustaining Treatment (MOLST), at the nurses' station during the emergency on [DATE]. The Director of Nursing stated after the incident, the facility has changed the procedure for filing Medical Order for Life-Sustaining Treatment forms. They stated the Medical Order for Life Sustaining Treatment forms for all residents on each unit, are filed in one purple binder and secured with a chain at the nurses' station. The Director of Nursing stated they received Resident #1's Medical Order for Life-Sustaining Treatment paper copy from the Administrator who received it from the medical records staff on [DATE]. During an interview on [DATE] at 11:00 AM, Medical Records Staff #1 stated on [DATE], they found Resident #1's purple binder on a shelf at the nurses' station on the second floor. They stated the pink form Medical Order for Life Sustaining Treatment was in the binder, and they gave it to the Administrator.During an interview with the Medical Director on [DATE] at 11:51 AM, they stated staff should not have performed chest compressions on Resident #1. The Medical Director stated Resident #1 had a Medical Order for Life-Sustaining Treatment that indicated Do Not Resuscitate that was signed by them (Medical Director) on [DATE] and a physician order for Do Not Resuscitate/Do Not Intubate, signed by them [DATE]. The Medical Director stated the Administrator informed them of the incident on [DATE]. 10 New York Code, Rules, and Regulations 415.22(a)(1-24) Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the non-compliance and was in substantial compliance for this specific regulatory requirement prior to and during the time of this survey. A Plan of Correction is not required for this citation. The facility took immediate corrective actions and was found to be in substantial compliance on [DATE], prior to Surveyors' onsite visit on [DATE]. Immediate Corrective Actions[DATE] - [DATE] - facility wide audit done to ensure all residents' advanced directives are accurately reflected as active/current physician orders. All residents were audited to ensure that each resident has an active physician order reflecting their current advance directive/code status-Full Code and Do Not Resuscitate/Do Not IntubateXXX[DATE] - [DATE] - a comprehensive audit of all residents' advanced directives, including prior admissions and readmissions reviewedXXX[DATE] - [DATE] - Care plan review completed to ensure care plans are current, accurate, and aligned with each resident's advance directives and active/current physician ordersXXX[DATE] - [DATE] - Policy and procedure Advance Directives Specific to DNR was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed and updated to standardize advanced directive verification processes ensuring consistent, accurate alignment with active/current physician orders, clearly defined roles and responsibilities for nursing, social services and providersXXX[DATE] - Policy and procedure, Advance Directives Specific to Do Not Resuscitate, was revised to reinforce that during an emergency or code event, staff must rely on readily accessible, active physician orders in the electronic medical record to determine code status. Consistent with regulatory standards, the Medical Order for Life Sustaining Treatment (MOLST) form constitutes a valid and actionable medical order; therefore, in the absence of a clearly visible or active physician order in the electronic medical record, staff are directed to immediately locate and verify the most current signed Medical Order for Life-Sustaining Treatment or advance directive in the medical record. Lesson Plan and In-service Attendances on Code Status/Advance Directives/ Medical Order for Life-Sustaining Treatment dated [DATE]-[DATE] reviewed with no concerns.TOTAL EMPLOYEES ---195TitleCompleted % CompleteCertified nursing Assistants90100% - 5 staff on leave, 1 on vacation.Registered Nurses18100%Licensed Practical Nurses30100%Dietary Staff16100%Housekeeping Staff16100%Maintenance Staff2100%Recreation Staff5100%Administration Employees13100%Rehabilitation5100%