

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335130	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/31/2025
NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nursing at Queens		STREET ADDRESS, CITY, STATE, ZIP CODE 157 15 19th Avenue Whitestone, NY 11357	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565</p> <p>Based on observations, record review and interviews conducted during the Recertification Survey from 01/26/2026 to 01/31/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Specifically, the facility failed to exercise reasonable care for the protection of the resident's property from loss or theft. This was evident for 1 resident investigated for personal property out of 38 residents sample investigated, (Resident # 30).</p> <p>The findings are:</p> <p>The facility policy and procedure for Personal Property dated 01/2023, last revised 01/2025 documented that The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.</p> <p>On 01/26/25 at 10:44 AM during the initial pool process, Resident #30's Spouse was interviewed and stated that resident keeps on missing blankets brought from home, it has been reported to the staff who say they sent them to a place for laundry and they never came back. Resident's spouse stated that they make sure that all the items are labeled with resident's name when they brought them. Resident's spouse also stated that the golden color blanket that is used to keep the resident warm has been missing for over 4 weeks.</p> <p>Resident was admitted to the facility 08/23/2023, with diagnoses that included Cancer, Anemia, Cerebrovascular Accident (CVA).</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident had severe impairment in cognition and requires Substantial/maximal assistance of staff for most activities of daily living. Minimum Data Set also documented that Resident and resident's family participated in Assessment and Goal Setting.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Comprehensive Care Plan (CCP) for Abuse dated 3/15/23 documented that Resident is at risk for potential abuse, neglect related to cognitive impairment, dependence on others for Activity of Daily Living care with the goals including Resident will not experience any form of abuse or neglect through review date, with interventions Assess resident for sign/symptoms of abuse and / or neglect (example psychosocial status) and report to appropriate resources; Investigate all allegations of abuse and neglect promptly; Provide support and ensure resident is free from abuse.</p> <p>Facility's Grievances/Complaint dated 01/31/25 9:30 am documented that Resident #30's spouse stated that one of the two resident's blankets was missing. Housekeeping staff interviewed claimed that the missing blanket was sent to the outside laundry company a few weeks ago but failed to notify the supervisor of the resident's missing blanket.</p> <p>On 01/30/25 at 09:13 AM, Certified Nursing Assistant #3 was interviewed and stated that Resident #30's dirty clothing is placed in the bin, the laundry staff comes twice a week to take down the dirty clothing for washing and return clean clothing Mondays and Wednesdays. Certified Nursing Assistant #3 stated that the family sometimes reported that resident's blanket was missing which was believed to have been sent down for laundry and they thought the blanket has been returned from laundry. Certified Nursing Assistant #3 stated that they did not know that resident is still missing the blanket and would have reported it to the charge nurse.</p> <p>On 01/31/25 at 08:48 AM, Laundry staff was interviewed and stated that when Resident #30 was transferred to the hospital, resident's belonging is packed and taken down to the trailer, and the belongings were returned to the resident's current room when resident was readmitted . Laundry staff was unable to recall if the missing blanket was among the clothing returned when resident was readmitted and is not able to explain the last time that resident's blanket was sent to the laundry.</p> <p>On 01/31/25 at 09:00 AM, Registered Nurse/Unit Manager, (Registered Nurse #1) was interviewed and stated that they are not aware that Resident #30 is missing a blanket but will investigate from the laundry department to find out if any of the resident's clothing sent down for laundry that have not been returned included the resident's blanket. Registered Nurse #1 was not able to explain when Resident #30 was transferred/readmitted to the unit.</p> <p>On 01/31/25 at 09:10 AM, the Housekeeping Director was interviewed and stated that they are not aware that resident has been missing a blanket. Housekeeping Director stated that they will check and investigate if resident has the blanket that have not been returned after laundry. Housekeeping Director further stated that Outside laundry company was contacted when they were informed of the resident's missing blanket this morning, but they are yet to hear any response from any of the company's staff.</p> <p>On 01/31/25 at 10:05 AM, the Director of Nursing was interviewed and stated that they have started investigation by interviewing the Certified Nursing Assistants and Housekeeping staff to find out how resident's blankets got missing and when they were made aware of the missing blanket.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/31/25 at 11:49 AM, the Assistant Director of Nursing was interviewed and stated that upon investigation, it was found that when the family brought the blanket on which resident's name was written, it was placed in the resident's closet, and sent to the laundry with other resident's dirty clothing, the Laundry staff acknowledged sending out the resident's blanket to the outside company about 3 weeks ago and stated that the blanket never returned. Assistant Director of Nursing stated that they were informed that resident's family reported the missing blanket to the staff, and has been asking the laundry staff about the missing blanket anytime resident's laundry was delivered to resident's room, but laundry staff failed to report the missing blanket to the Housekeeping Director for the facility to have addressed it immediately.</p> <p>10 NYCRR415.5(h)(2).</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864</p> <p>Based on observation, record review and staff interview during the Recertification /Complaint survey (NY00347053) conducted between 01/26/2025 and 01/31/2025, the facility did not ensure that all alleged violations involving abuse and injury of unknown origin were reported immediately to the New York State Department of Health, but not later than 2 hours after the allegation of abuse was reported. Specifically, the facility did not report within 2 hours when a resident (Resident #94) alleged that another resident (Resident #83) touched their breast. This was evident in 2 out of 37 residents sampled for Abuse.</p> <p>The findings are:</p> <p>The facility's policy titled Abuse - Prohibition Protocol, Types of Abuse, Response/Reporting, last reviewed 1/25, documented that it is the policy of the Grand Rehabilitation and Nursing Center that every resident has the right to be free from abuse, mistreatment, neglect and misappropriation of property.</p> <p>The facility's policy titled, Accident and Incident, Investigating and Reporting-Resident last reviewed 1/25, documented that the facility will report allegations and results of the investigations of alleged violations involving mistreatment, neglect or abuse.</p> <p>The facility investigation report dated that at 6/30/24 at 9:15PM, documented that Resident #94 stated that Resident #83 allegedly touched their breasts. Investigation revealed that on 6/30/24 at approximately 9:15PM, Resident #94 reported to the charge nurse, who notified the Registered Nurse Supervisor, that a resident who was identified as Resident #83, was passing by the hallway. Resident #94 was standing by the sink when Resident #83 allegedly touched their breast. The investigation also documented, that Resident #94 will be seen by the Psychiatrist and Psychologist to follow up on any behavioral changes, and that Resident #94 had a prior history of unfounded accusatory allegation against a staff member, which was investigated and ruled out.</p> <p>The Incident reporting to the New York State Department of Health Intake #NY0047053, documented that the incident occurred on 06/30/24 at 9:15PM, and was reported by the Administrator on 07/01/24 at 2:13PM. The investigation revealed that upon review of camera video on that side of the hallway, it was noted that around 6:35 PM, Resident #83 was wheeling themselves in the hallway and passed by Resident #94's room. From the camera angle, they appeared to shake /held hands for few seconds then upon wheeling back, Resident #83 again held hands with Resident #94.</p> <p>1) Resident #83 was admitted to the facility with diagnoses that include Cancer, Neurogenic Bladder and Paraplegia.</p> <p>The Annual Minimum Dats Set dated 06/01/24, documented that Resident #83's cognition as intact, Brief Interview of Mental Status of 14, no behaviors and impairment on both sides to lower extremities.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Comprehensive Care Plan focus titled Resident is at risk for potential abuse, neglect related to dependence on others for activities of daily living care, language barrier, created 2/15/23. Goals include Resident #83 will not experience any form of abuse or neglect through review date, 6/20/24. Interventions include Investigate all allegations of abuse and neglect promptly, assess resident for signs and symptoms of abuse and / or neglect and report to appropriate resources.</p> <p>A Nursing Note dated 06/30/24 documented that as per Resident #94, complained that Resident #83 allegedly touched their breast. Resident #94 stated they did not touch Resident #94's breast, but that they touched Resident #94's hand like 'Hi five', as per interpreter.</p> <p>A Nursing Note dated 07/01/24 documented that Resident #83 was moved to another unit to prevent further interaction, family in agreement with plan of care.</p> <p>A Physician's Note dated 7/1/24 documented Resident #83 was alleged by Resident #94, that they touched Resident #94's breasts while they were in their room. Resident #83 said they never touched nor went into Resident #94's room, Resident #83 was wheeling only in the hallway and was blindly accused by Resident #94. Will order Psychiatry and Psychologist evaluation.</p> <p>2) Resident # 94 was admitted to the facility on [DATE] with diagnoses that include Depression, Bipolar Disorder, and Schizophrenia.</p> <p>The Annual Minimum Data Set, dated dated [DATE] documented resident's cognition as intact, Brief Interview of Mental Status of 13, no behaviors, no impairments, that Resident #94 participates in assessment and goal setting.</p> <p>The Comprehensive Care Plan created on 7/3/24 documented Resident #94 is at risk for abuse related to diagnosis of Major Depressive and Bipolar Disorder. Goals include Resident will not experience any form of abuse or neglect through review date, 7/16/24. Interventions include assess resident for signs and symptoms of abuse and report to appropriate resources.</p> <p>The Comprehensive Care Plan created 1/16/24, documented Resident #94 exhibits behavior symptoms such as accusatory behavior. Goals include Resident #94 will verbalize understanding of need to control inappropriate behavior through the review date, 7/16/24. Interventions include to provide resident an opportunity to express themselves.</p> <p>A Nursing Note dated 6/30/24, documented that Registered Nurse Supervisor was called to assess Resident #94 by unit nurse that resident who was in wheelchair by nursing station that Resident #94 alleged another male resident touched their breast. Resident #94 had fully dressed up with shirt and pant.</p> <p>A Physician's Progress Note dated 7/1/24, documented nurse reported Resident #94 alleged that they were touched by Resident #83. Upon examination, there were no signs of bruises or scratches over the body and denies any pain over the body. The note documented that Resident #94 will be seen by Psychiatrist and Psychologist.</p> <p>On 01/30/25 at 10:32 AM the Director of Nursing was interviewed and stated that they were not employed at the facility at the time of the incident.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 01/30/25 at 10:34 AM, the Administrator was interviewed and stated that they were made aware on 06/30/24 that the allegation occurred, and once they were able to gain access in the Health Commerce System, they submitted the incident to the New York State Department of Health, later in the afternoon on 7/1/24. The Administrator also stated that they were not able to say why the previous Director of Nursing did not submit the investigation within the 2 hours, but that they were aware that an allegation of any abuse is supposed to be submitted within 2 hours.</p> <p>10 NYCRR 415.4 (b)(2)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>40565</p> <p>Based on observation, record review, and staff interviews during the Recertification survey, the facility did not conduct an annual review of the water management plan and did not complete an annual risk assessment form.</p> <p>The findings are:</p> <p>A record review of the Legionella Management Plan, revealed a risk assessment form, dated 6/19/2019.</p> <p>Item #6 of the policy is The Water Management Program will be reviewed at least once a year, or sooner. A record review of the policy and procedure on Legionella revealed that it was last reviewed in 3/2019.</p> <p>Meeting agendas, minutes, or documentation of Program Team meetings were not provided at the time of the survey.</p> <p>In an interview on January 31, 2025, at approximately 10:00 AM, the Facilities Maintenance Coordinator stated that he had not participated in an annual review in the past year.</p> <p>On January 31, 2025, at approximately 2:00 PM, during the exit interview, the Administrator stated the water management plan was not reviewed in the previous 12 months. When asked why it was not done, the Administrator did not respond.</p> <p>415.19(a)(1-3)</p>