STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335143	A. Building B. Wing	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadow Park Rehabilitation and Health Center L L C	78-10 164th Street Flushing, NY 11366

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 - Few	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** Based on observation, record review, and interviews conducted during an abbreviated survey (NY00336488), the facility did not ensure the resident's right to be free from abuse and neglect. This was evident for one (1) out of four (4) residents (Resident #1). Specifically, on 03/19/2024 at 9:45 PM Licensed Practical Nurse #1 responded to a loud noise coming from Resident #1 and Resident #2's room. When Licensed Practical Nurse #1 approached the room they observed Resident #2 standing in the doorway holding a wheelchair leg rest in their hand and Resident #1, who was Resident #2's roommate, sitting on the floor in the room. Resident #1 had a laceration to the left side of their forehead and was transferred to the hospital on [DATE]. The hospital Discharge summary dated [DATE] documented left facial and periorbital soft tissue swelling/hematoma. Laceration repaired. Facility staff was not able to state how Resident #2 was able to come into possession of a wheelchair leg rest. The findings are: The facility's policy titled Abuse Prevention and Reporting effective 11/07/2023 documented, each resident had the right to be free from abuse, corporal punishment, and involuntary seclusion. Physical abuse is defined as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. Resident #1 was admitted to the facility with diagnoses including Dementia without Behaviors, Depression, and Legal Blindness. The Minimum Data Set Assessment, an assessment tool, dated prior to 02/24/2024 documented Resident #1 had severe cognitive impairment. Resident #1 had a potential for abuse care plan in place dated 02/17/2023. The interventions dated 02/21/2024 documented for ongoing assessment and reporting of any unusual markings on the resident body to nurse charge. Monitoring for any signs or symptoms of distress and sadness. Monitoring body language and facial expression for any signs/symptoms of distress. The care plan was updated to reflect on the abuse incident. Resident #2 was admitted to the facility with diagnoses including vascular Dementia without Behaviors, Anxiety Disorder, and recurrent Major Depressive disorder. The Minimum Data Set assessment dated [DATE] documented Resident #2 had severe cognitive impairment. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Few	A Behavior Care Plan (Actual) dated 10/16/2023 that documented as evidenced by verbally abusive, wandering, physically aggressive, aggressive/destructive behavior, screaming/crawling on the floor looking for their children, throwing food, related to new admission, cognitive deficits, and psychiatric history. The interventions documented for staff to identify possible triggers of negative behavior, refer for psychiatry evaluation, administer medications as ordered, and document in the medical record the frequency, intensity, and duration of negative behaviors. A Nursing Progress Note dated 03/19/2024 documented Registered Nurse Supervisor #5 assessed Resident #1, who was alert, but confused. Resident #1 had a small bump on their left lower eye and a small laceration with minimal bleeding. Resident #1's vitals were taken, and Resident #1 was not in any respiratory distress, did not complain of pain and denied dizziness. 911 was called and Resident #1's Nurse Practitioner and Power of Attorney, as well as a family member were notified. At approximately 10:00 PM, the police and the Emergency Medical Services arrived. Resident #1 left the facility at 10:33 PM with the police, Emergency Medical Services, and their family. The facility's Investigative Summary dated 03/22/2024 documented, a physical altercation occurred between Resident #1 and Resident #2 on 03/19/2024 at approximately 9:45 PM. Licensed Practical Nurse #1 heard a loud disagreement coming from the joint room of Resident #1 and Resident #2 and immediately responded to the room. Licensed Practical Nurse #1 observed Resident #2 holding a wheelchair leg rest and removed it from Resident #2. Licensed Practical Nurse #1 also observed Resident #1 sitting on the floor of their room with swelling to the left eye and a small laceration under the left eye, at the lateral side of the face. Resident #1 and Resident #2 were transferred to the hospital for evaluation. Resident #1's hospital discharge paperwork dated 03/20/2024 documented that a computer tomograph revealed no acute fracture and the presence of left facial and periorbital soft tissue swelling/hematoma. Resident #2's emergency room discharge paperwork documented no physical injury. The facility's Investigative Summary documented that the incident was unpredictable and unforeseeable as both residents involved in the incident had been roommates since 01/31/2024, and there was no previous history of altercation. The facility's finding was that there was no reason to believe that abuse, neglect, or mistreatment occurred. A Statement of Accident, by Registered Nurse Supervisor #4, dated 03/19/2025, documented that Registered Nurse Supervisor #4 was summoned at approximately 9:45 PM on 03/19/2024 to Resident #1 and Resident #2's room. Resident #1 was observed sitting on the floor of their room with moderate amount of swelling and small laceration to their left lower eye. Resident #2 (roommate) was standing in the doorway holding a wheelchair leg rest in their hand. Resident #2 said can you believe Resident #1 took their spouse away from them and that Resident #1 was not their spouse's type. They are their spouse's type. Resident #1's hospital Discharge summary dated [DATE] documented that Resident #1 was evaluated, and a maxillofacial computer tomograph was done. It revealed no acute fracture and the presence of left facial and periorbital soft tissue swelling/hematoma. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 05/20/2025 at 1:32 PM, Licensed Practical Nurse #1 stated that they heard a noise in the hallway that was coming from Resident #1 and Resident #2's room. Licensed Practical Nurse #1 stated that they responded to the room and observed Resident #2 standing in the doorway of their room holding a wheelchair leg rest and Resident #1 sitting on the floor in the room. Licensed Practical Nurse #1 stated that Resident #2 was standing less than 6 feet away from Resident #1. Licensed Practical Nurse #1 stated that they screamed for help and removed the leg rest from Resident #2. Licensed Practical Nurse #1 stated that Registered Nurse Supervisor #4 came into the room, and they took Resident #2 out of the room to keep the residents separated. Licensed Practical Nurse #1 stated that they continued with their daily duties while Registered Nurse Supervisor #4 called 911. Licensed Practical Nurse #1 stated that Resident #1 was sent to the hospital. Registered Nurse Supervisor #4 are no longer working at the facility and could not be reached. During a telephone interview on 06/18/2025 at 9:24 AM, Certified Nursing Assistant #4 stated that both Residents #1 and #2 were ambulatory and that they do not know where Resident #2 get the wheelchair leg rest. Certified Nursing Assistant #4 stated after putting the wheelchair bound residents in bed they stationed the wheelchair out of the room, if there are no space in the room to keep the wheelchair. During a telephone interview on 06/23/2025 at 10:08 AM, Certified Nursing Assistant #5 stated they do not know where Resident #2 get the wheelchair leg rest from. Certified Nursing Assistant #5 stated after putting a wheelchair bound resident in bed, the wheelchair would either stay in the room or be taken out of the room and stored in a corner in the hallway. Certified Nursing Assistant #2 stated that a resident would not be able to take off the leg rests from the wheelchair as the wheelchairs are parked with the legs facing the wall. During a telephone interview on 05/29/2025 at 3:09 PM, the Director of Nursing stated prior to current incident, there has never been an altercation between Resident #1 and Resident #2. The Director of Nursing stated that the incident was unpredictable and unforeseeable. The Director of Nursing stated that Resident #2 reported that Resident #1 had taken away their spouse, even though Resident #1 was not the spouse's type. During a follow up telephone interview on 06/23/2025 at 2:00 PM, the Director of Nursing stated there were three residents in a 4-beded room and that one of the residents used a wheelchair. The Director of Nursing stated that they were unsure of how Resident #2 got ahold of the wheelchair leg rest. Further stated that this was the facility's first and only incident involving a wheelchair leg rest. During a follow up telephone interview on 06/26/2025 at 9:25 AM, the Director of Nursing stated that they investigated the incident, but did not think to investigate how Resident #2 was able to get ahold of the wheelchair leg rest. The Director of Nursing stated that they did not implement any interventions to prevent this incident from happening again. The Director of Nursing stated at times they observed that the wheelchair leg rests stayed attached to the wheelchairs but sometimes, the leg rests are placed on the seat of the wheelchair. (continued on next page)

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Meadow Park Rehabilitation and Health Center L L C	78-10 164th Street Flushing, NY 11366

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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 - Few	During a telephone interview on 07/07/2025 at 12:05 PM, Registered Nurse Supervisor #5 stated that when they arrived on the unit, they observed Resident #1 sitting at a dining table in front of the nurse's station for safety, as Resident #2 was holding a wheelchair leg rest. Registered Nurse Supervisor #5 stated that Resident #1 had a small laceration below their left eye and that there were no witnesses to the incident. Registered Nurse Supervisor #5 stated that they do not know where Resident #2 get the leg rest from. Registered Nurse Supervisor #5 stated that they looked at the leg rest but did not see any blood on the leg rest. Registered Nurse Supervisor #5 stated that the wheelchairs are either stored in a small storage room on the unit, in the hallways, or in the residents' rooms. Registered Nurse Supervisor #5 stated that some of the staff members remove the wheelchair leg rests off the wheelchairs when they put the residents in bed, and they store them on the seats of the wheelchair. 10NYCRR 415.4(b)(1)(ii)

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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 - Few	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** Based on record review, and interviews conducted during an Abbreviated Survey (NY00336488), the facility did not ensure that the results of all investigations pertaining to alleged violations involving abuse, neglect, exploitation or mistreatment, were reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident for one out of four residents (Resident #1) sampled for abuse. Specifically, on 03/19/2024 at approximately 9:45 PM Licensed Practical Nurse #1 responded to a loud verbal disagreement into Resident #1 and Resident #2's room. Licensed Practical Nurse #1 observed Resident #2 standing at their room door holding the leg rest of a wheelchair in their hand and Resident #1 was sitting on the floor in their room with swelling and a laceration to their left eye. The facility submitted their five-day investigation results to the New York State Department of Health on 03/27/2024 at 4:08 PM. The findings are: The facility's Policy and Procedure titled Abuse Prevention and Reporting with an effective date of 11/07/2023 documented under the heading Investigation: The Director of Nursing/Designee will complete the investigation summary and attach it to the occurrence report and collected statements, oversee the investigation process, determine need for further information, collect all facts and ensure all alleged abuse is reported to the Department of Health, and report all occurrences immediately to the Administrator. Resident #1 was admitted to the facility with diagnoses including Dementia, Depression, and Legal Blindness. The Minimum Data Set, an assessment tool, dated 11/24/2024 documented Resident #1 had severe cognitive impairment. Resident #2 was admitted to the facility with diagnoses including Vascular Dementia, Stroke and Hypertension. The Minimum Data Set, dated [DATE] documented Resident #3 had severe cognitive impairment. The facility's Investigative Summary dated 03/22/2024 documented that Licensed Practical Nurse #1 heard a loud verbal disagreement coming from Resident #1 and Resident #2's joint room. As Licensed Practical Nurse #1 entered the residents' room, they observed that Resident #2 was holding a wheelchair leg rest in their hand and Resident #1 was sitting on the floor with swelling and a laceration to the left eye. The facility's Investigative Summary dated 03/22/2024 documented that the incident was unpredictable and unforeseeable as both residents involved in the incident had been roommates since 01/31/2024, and there was no previous history of altercation. The facility's finding was that there was no reason to believe that abuse, neglect, or mistreatment occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility reported the incident to the Department on 03/19/2024 at 11:06 PM and received an email from the Department of Health that the report was received on 03/20/2024 at 12:51 PM. The facility however, submitted their final facility investigation results on 03/27/2024 at 4:08 PM. During an interview on 05/21/2025 at 3:43 PM, the Director of Nursing stated that the facility had five business days from the date the facility received the Department's email that the incident was received, to submit the final facility investigation to the Department. The Director of Nursing stated after they reviewed the March 2024 calendar, the facility's final investigation should have been submitted on 03/26/2027. 10 NYCRR 415.4(b)(2)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (NY00336488), the facility did not ensure that all incidents were thoroughly investigated. This was evident for (1) out of (4) residents (Resident #1). Specifically, on 03/19/2024 at 9:45 PM Licensed Practical Nurse #1 responded to a loud noise that was coming from Resident #1 and Resident #2's room. When Licensed Practical Nurse #1 approached the room, they observed Resident #2 standing in the doorway to their room holding a wheelchair leg rest in their hand and Resident #2's roommate, Resident #1, sitting on the floor in their room. Registered Nurse Supervisor #5 assessed Resident #1 who had a laceration to the left side of their forehead. Resident #1 was transferred to the hospital for an evaluation on 03/19/2024. The Hospital Discharge paperwork dated 03/20/2024 documented that Resident #1 had a soft tissue swelling and hematoma to the left facial and periorbital area. The facility's investigation did not identify where Resident #2 found the wheelchair the leg rest, and there were no interventions implemented to prevent this type of incident from reoccurring. The findings are: The facility's policy titled Abuse Prevention and Reporting effective 11/07/2023 documented, each resident had the right to be free from abuse, corporal punishment, and involuntary seclusion. All reports of alleged abuse, mistreatment, or neglect will be investigated immediately by the Registered Nurse (Assistant Director of Nursing or House Supervisor) and reported to the Director of Nursing/Designee. The Investigation shall include .Registered Nurse Supervisor (Assistant Director of Nursing or House Supervisor) at the time of the occurrence or when reported will: Examine the scene/environment for obstacles, items that may be involved (i.e., tied linens, restraints) equipment in need of repair, wet surfaces, etc. Resident #1 was admitted to the facility with diagnoses included Dementia without Behaviors, Depression, and Legal Blindness. The Minimum Data Set assessment dated [DATE] documented Resident #1 had severe cognitive impairment. Resident #2 was admitted to the facility with diagnoses included Vascular Dementia without Behaviors, Anxiety Disorder, and Recurrent Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented Resident #2 had severe cognitive impairment. A Nursing Progress Note dated 03/19/2024 documented Registered Nurse Supervisor #5 assessed Resident #1, who was awake, alert, and confused with a small bump on their left lower eye and a small laceration with minimal bleeding. Resident #1's vitals were taken, the resident was not in any respiratory distress, did not complain of pain and denied dizziness. 911 was called along with the Nurse Practitioner, Resident #1's Power of Attorney, and a family member. At approximately 10:00 PM, the police and emergency medical team arrived, and Resident #1 left the facility at 10:33 PM with the police, the emergency medical team, and Resident #1's family member. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's hospital discharge paperwork dated 03/19/2024 documented that Resident #1 was evaluated, and a Maxillofacial computer tomograph was done. It revealed no acute fracture and the presence of left facial and periorbital soft tissue swelling/hematoma. The facility's Investigative Summary dated 03/22/2024 documented that a physical altercation occurred between Resident #1 and Resident #2 on 03/19/2024 at approximately 9:45 PM. Licensed Practical Nurse #1 heard a loud disagreement coming from the joint room of Resident #1 and Resident #2 and immediately responded to the room. Licensed Practical Nurse #1 observed Resident #2 holding a wheelchair leg rest and removed it from Resident #2. Licensed Practical Nurse #1 also observed Resident #1 sitting on the floor of their room with swelling to the left eye and a small laceration under the left eye, lateral side of the face. Resident #1 and Resident #2 were transferred to the hospital for evaluation. Resident #1's hospital discharge paperwork dated 03/20/2024 documented that a computer tomograph revealed no acute fracture and the presence of left facial and periorbital soft tissue swelling/hematoma. Resident #2's emergency room discharge paperwork documented no physical injury. The facility's finding was that there was no reason to believe that abuse, neglect, or mistreatment occurred. There was no documented evidence that the facility addressed the wheelchair leg rest and implemented preventive measures. During a telephone interview on 05/20/2025 at 1:32 PM, Licensed Practical Nurse #1 stated that they heard a noise in the hallway coming from Resident #1 and Resident #2's room. Licensed Practical Nurse #1 stated that they responded to the room and observed Resident #1 sitting on the floor in the room and Resident #2 standing less than 6 feet away from Resident #1 holding a wheelchair leg rest. Licensed Practical Nurse #1 stated that they screamed for help and removed the leg rest from Resident #2. Licensed Practical Nurse #1 stated that Registered Nurse Supervisor #4 came into the room, and they took Resident #2 out of the room to keep the residents separated. Licensed Practical Nurse #1 stated that they continued with their daily duties while Registered Nurse #4 called 911. Licensed Practical Nurse #1 stated that Resident #1 was sent to the hospital. Registered Nurse Supervisor #4 are no longer working at the facility. During a follow up telephone interview on 06/23/2025 at 2:00 PM, the Director of Nursing stated there were three residents in a 4-beded room and that they were unsure if one of the residents used a wheelchair. The Director of Nursing stated that they were unsure of how Resident #2 got ahold of the wheelchair leg rest. Further stated that this was the facility's first and only incident involving a wheelchair leg rest. During a follow up telephone interview on 06/26/2025 at 9:25 AM, the Director of Nursing stated that they investigated the incident, but did not think to investigate how Resident #2 was able to get ahold of the wheelchair leg rest. The Director of Nursing stated that they did not implement any interventions to prevent this incident from happening again. The Director of Nursing stated at times they observed that the wheelchair leg rests stayed attached to the wheelchairs but sometimes, the leg rests are placed on the seat of the wheelchair. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 07/07/2025 at 12:05 PM, Registered Nurse Supervisor #5 stated that when they arrived on the unit, they observed Resident #1 sitting at a dining table in front of the nurse's station for safety, as Resident #2 was holding a wheelchair leg rest. Registered Nurse Supervisor #5 stated that Resident #1 had a small laceration below their left eye and that there were no witnesses to the incident. Registered Nurse Supervisor #5 stated that they do not know where Resident #2 get the leg rest from. Registered Nurse Supervisor #5 stated that they looked at the leg rest but did not see any blood on the leg rest. Registered Nurse Supervisor #5 stated that the wheelchairs are either stored in a small storage room on the unit, in the hallways, or in the residents' rooms. Registered Nurse Supervisor #5 stated that some of the staff members remove the wheelchair leg rests off the wheelchairs when they put the residents in bed, and they store them on the seats of the wheelchair. 10NYCRR 415.4(b)(1)(ii)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, and interviews conducted during an abbreviated survey (NY00355163), the facility failed to ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and their needs, and that each resident and resident representative, if applicable, is involved in the developing the care plan and making decisions about their care. This was evident for one (1) out of four (4) residents (Resident #4). Specifically, on 08/06/2024 at 10:25 PM Resident #4 was observed on the floor next to their bed. The Physical Therapist evaluated the resident on 08/07/2024, as ordered by the physician, and recommended a floor bed. There was no documented evidence that the care plan was reviewed and revised to reflect the fall of 08/06/2024. The findings are: The facility policy titled Comprehensive Care Planning, revised 03/2019, documented that assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. The facility policy titled Fall Prevention Program, revised 04/01/2024, documented that each resident's risk factors, and environmental hazards will be evaluated when developing the residents comprehensive plan of care. Interventions will be monitored for effectiveness and the plan of care will be revised as needed. When any resident experiences a fall, the facility will, among other actions, review the resident's care plan and update as indicated, Resident #4 was admitted to the facility with diagnoses including Acute Respiratory Failure with Hypoxia, Dementia, and Hypertension. The Minimum Data Set, an assessment tool, dated 07/03/2024 documented Resident #4 had a short-term memory problem. The Fall Risk assessment dated [DATE] documented under History of falls (past three months) that Resident #4 had one-two falls and a total fall risk assessment score of eight (8) denoting low to moderate fall risk. A review of Resident #4's Comprehensive Care Plan dated 06/14/2024 documented Resident #4 was at Risk for Falls/Injury. The interventions documented reducing environmental hazards, i.e., keep floors dry and clear; instruct/reinforce safety measures with resident/family, i.e., transfer techniques, proper footwear, locking wheelchair; providing resident/family with information on safety risk factors; advising staff/resident/family to keep personal items within reach; call bell within reach. Encouraging resident to ask for assistance as needed, monitoring for changes in Activities of Daily Living. Resident #4's Certified Nursing Assistant Accountability and Nursing Instructions for July 2024 documented no bed rails; precautions for fall and keep at nursing station. (continued on next page)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse #2's nursing progress note dated 08/06/2024 documented that Resident #4 was observed sitting on the floor mat next to their bed. Resident #4 could not explain what had happened. Resident #4 was assisted back to their bed with the assistance of two staff members. Resident #4 was assessed by Registered Nurse #3 with no visible injuries observed. Resident #4 did not complain of pain or discomfort. The emergency contact and primary medical doctor were notified. Primary Medical Doctor #1 ordered on 08/07/2024 a Physical Therapy Screen to evaluate and treat for fall. A Fall Risk Assessment completed by Registered Nurse #3 on 08/06/2024 following Resident #4's fall documented under the section History of Falls (past three months): No falls and a total fall risk assessment score of 8 (low to moderate fall risk). Physical Therapist #1's Progress Note dated 08/07/2024 documented that Resident #4 was seen following their fall and denied any pain. Range of motion to bilateral lower extremities was within functional limits. Resident #4 required constant assist of one (1) person for all transfers and a floor mat was noted. Physical Therapist #1 recommended a floor bed and made Registered Nurse #2 aware. There was no documented evidence that the care plan was updated to reflect on the fall of 08/06/2024. There was no documented evidence Resident #4 received or did not receive a floor bed. Registered Nurse #3 stated during a telephone interview on 05/21/2024 at 12:32 PM that it might have been a mistake that they did not click 1-2 falls on the fall assessment following the resident's first fall on 08/06/2024. Registered Nurse #3 further stated that they might have just clicked through the assessment and missed that 08/06/2024 accident. During an interview on 05/21/2025 at 3:43 PM, the Director of Nursing stated, if the Physical Therapist evaluated Resident #4 and recommended a floor bed, then it should have been listed as an intervention on the resident's fall risk care plan. The Director of Nursing stated during a follow up telephone interview on 06/10/2025 at 1:21 PM that any Registered Nurse can update a resident's care plan and the nursing instruction on the Certified Nursing Assistant Accountability, but that the person ultimately responsible for supervision is the Minimum Data Set coordinator. The Director of Nursing stated that the Physical Therapist discussed during morning meeting that they have recommended a floor bed. The Director of Nursing stated that the Director of Building Services, who was at the morning meeting stated that they would take care of it. The Director of Nursing stated that the nurse did not document in Resident #4's progress notes that a floor bed was delivered. The Director of Nursing stated that they were now aware that it was an omission that the floor bed was not added to Resident #4's care plan and that it should have been updated as an intervention on 08/06/2024 after the resident's first fall. 10 NYCRR 415.11(c)(1)