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	12/02/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review, and interviews conducted during an abbreviated survey (2616957), the facility did not ensure that each resident received adequate supervision to prevent accidents. This was evident for one (1) of three (3) residents (Resident #1) sampled. Specifically, on 09/13/2025, during morning care, Resident #1 sustained a fall when Certified Nursing Aide #1 provided care without another staff as per the plan of care. Resident #1 was transferred to the hospital and diagnosed with a nasal fracture.The finding is:The facility policy and procedure titled 'Accident/Incident' revised 12/04/2023 documented the facility will ensure the resident's environment remains as free of accident hazards as is possible. The policy also documented all accidents will be investigated, documented and reported to the New York State Department of Health as appropriate.Resident #1 was admitted to the facility with diagnoses that included Stroke, Cerebrovascular Accident, and Hemiplegia (weakness on one side of the body) affecting left non dominant side.The Minimum Data Set (an assessment tool) dated 07/04/2025 documented Resident had moderately impaired cognition, and upper extremity impairment on one (1) side and they required supervision or touching assistance for rolling left and right. The Resident Nursing Instructions dated 07/18/2025 documented one-person physical assist was changed to two+ person physical assist.The Resident CNA (Certified Nurse Accountability) Documentation for Bed Mobility dated 09/12/2025 and 09/13/2025 on the 11:00 PM - 7:00 AM shift documented Support Provided: one (1) person physical assist was signed off by Certified Nurse Aide # 1.The Hospital After Visit Summary dated 09/13/2025 documented reason for visit: fall. Diagnosis Closed fracture of nasal bone, closed fracture of left maxillary sinus.The undated, untitled facility's investigation documented Certified Nursing Assistant #1 was providing incontinent care, on 09/13/2025 at approximately 6:10 AM for Resident #1. Resident # 1 required two (2) person physical assist for bed mobility (turning from right side to left side). Interview with Resident # 1 stated they were lying too close to the edge of the bed during care, when they fell off the bed when turned. Resident #1 sustained a nasal fracture. The facility determined Certified Nurse Aide #1 did not follow the plan of care for bed mobility.The Nurse Progress note dated 09/13/2025 at 9:03 AM written by Registered Nurse Supervisor #1 documented Resident #1 was being changed before the fall and rolled out of bed during care. Resident #1 was lying face down on the floor at the bed side. Significant amount of blood coming from their face. Gauze applied; medical doctor notified transferred to hospital.On 11/01/25 at 9:46 AM, Charge Nurse #1 was interviewed and stated on 09/13/2025 at around 6:00 AM, Certified Nurse Aide #1 ran toward them and informed them Resident #1 jumped off the bed. Charge Nurse #1 also stated they saw Resident #1 lying face down, on the floor, on the right side of the bed, between the closet and the bed. Charge Nurse #1 further stated staff are responsible for checking in to the electronic medical record to become familiar with the care needs of their residents, and they just check to see if tasks have been signed off at the end of the shift.On 11/02/2025 at 10:00 AM, an interview was conducted with Certified Nurse Aide #1 who stated they had been assigned to Resident #1 once before and this was their second time being assigned to them. Certified Nurse Aide #1 also stated they are supposed to log into the electronic medical record system to see what care is needed for their assigned residents, but they did not log into the electronic medical record on 09/13/2025 because they did not have time to do so. Certified Nurse Aide #1 further stated they turned Resident #1 to one side, cleaned them, and then turned them over to the other side and they rolled out of bed. Certified Nurse Aide #1 stated they did not log into the electronic medical record at the start of, or at the end of their shift so they did not know Resident #1 needed one (1) or two (2) persons assist for turning and positioning. On 11/03/2025 at 12:52 PM, the Director of Nursing stated the expectation is for the certified nurse aide to log into electronic medical record kiosk before providing hands on care, and after receiving their unit assignments, to ensure the correct and proper level of care is provided. The Director of Nursing also stated no resident care is to be provided care before this step is completed. The Director of Nursing further stated the charge nurse provides reports to staff on newly admitted residents and any change in resident's condition. The Director of Nursing stated during orientation certified nurse aides are taught to log into electronic medical record and check the level of care needed for their residents. The Director of Nursing also stated Resident #1 required two (2) person physical assist for bed mobility, and Resident #1's care level needs were not followed. 10 NYCRR 415.12(h)(2)