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	04/02/2024

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 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** 42101 Based on interviews and record review conducted during Recertification and Complaint investigations (NY00332356), the facility did not ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property were reported to the State Survey Agency. Specifically, the facility did not report suspected abuse that resulted in a resident sustained a 4-centimeter hematoma to right side of their forehead. This was evident for 2 of 2 residents reviewed for Abuse out of a sample of 30 residents. (Resident # 12 and Resident #68). The findings are: The facility policy and procedure titled Abuse Prevention and Reporting effective 11/7/2023 documented facility will investigate all incidents and complaints and report all occurrences promptly to the Department of Health when there is reasonable cause to believe abuse, neglect, or mistreatment (hereinafter abuse) has occurred. All employees and licensed health care professionals are required by the regulation to report any instance of physical abuse, neglect, or mistreatment to the New York State Department of Health Office. Professionals who care for Nursing Home residents and those employed by this facility as well as those who provide services to the residents are mandated reporters. All facility staff must notify the supervisor who will notify the registered Nurse Supervisor immediately of any observation or communication that abuse, neglect, or mistreatment has/may have occurred. All reports of alleged abuse, mistreatment or neglect will be investigated immediately by the Registered Nurse Supervisor and reported to the Director of Nursing/Designee. The facility will ensure that the Department of Health is notified of all reportable events. The Nursing Progress Note dated 1/28/2024 at 2:30 AM written by Licensed Practical Nurse #1 documented they were called to Resident #12's room and observed them with a bruise on their forehead and crying and when asked that stated their roommate Resident #68 [NAME] a plastic bottle that hit them on their forehead. The nurse supervisor was called to the floor, resident assessed, ice applied pack applied and pain medication given. Resident #68 was moved and family notified. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Progress Note dated 1/28/2024 at 3:39 AM was written by the Registered Nurse Supervisor #1 stated that they were called to see the resident at 12:45 AM on arrival observed Resident #12 crying in bed saying their roommate hurt them. Resident #12 pointed to resident #68. Resident #12 was noted with a hematoma measure 4 centimeters to their right forehead with small, bruised area in the center measuring 0.3 cm. Resident #68 admitted they were angry and because they were agitated, they threw a perfume bottle but they did not hit resident #12. A plastic perfume bottle was found on the floor near their doorway. Cold compress applied immediately, and pain medication given for pain. The medical provider called and pain medication cold compress and neuro checks ordered. An Accident Report dated 1/28/2024 at 12:48AM documented that Resident #12 was noted with a hematoma 4 centimeters on their forehead. Resident #12's roommate threw a plastic bottle and it hit Resident #12 on the forehead. Resident #12 was moved away from roommate and Resident #68 was moved out of the room to another unit. The Department of Health in the Health Electronic Response Data System (HERDS) confirmation email from the Department of Health dated 1/30/2024 at 3:06 PM documented the incident report has been received. The resident-to-resident incident was reported to the New York State Department of Health 1/30/2024 at 3:06 PM more than 48 hours after the incident occurred. During an interview on 4/01/2024 at 3:47 PM, Registered Nurse Supervisor #1 was interviewed and stated that they were called to the unit and the investigation revealed a bruise of the right forehead and assumed resident #68 threw a bottle at resident #12. The Director of Nursing was not notified right away but a few hours later. The incident occurred at approximately 1 AM or at the beginning of the shift 12AM-2AM. Registered Nurse Supervisor #1 also stated that there is a protocol in place and abuse should be reported immediately. During an interview on 04/02/2024 at 12:11 PM, the former Director of Nursing stated that they were called to the unit and informed of the incident but they could not recall the time of day that the incident was reported to them. The former Director of Nursing stated that they called the administrator to report the incident and that they have to report a major injury or abuse within 2 hours and all other incidents report within 24 hours. During an interview on 04/02/2024 at 11:43 AM, the Administrator was interviewed and stated that they are informed of the incidents and the Director of Nursing was in charge of reporting the incident to the Department of Health. The Administrator also stated that they have access to the reporting system. The Administrator further stated that the time frame for reporting for a resident-to-resident incident is 24 hours. During an interview on 4/2/2024 at 1:48 PM, the current Director of Nursing was interviewed and stated that if there is a resident-to-resident altercation with injury it needs to be reported within 2 hours and a resident-to-resident altercation with no injury needs to be reported within 24 hours. If there is an injury of unknown origin it needs to be reported within 2 hours. 10 NYCRR 415.4(b)(1)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observation, record review and staff interviews conducted during the Recertification/Complaint Survey from 3/26/24 to 4/2/24, the facility did not ensure that a person-centered comprehensive care plan (CCP) was developed and implemented to address the resident's medical, physical, mental, and psychosocial needs. Specifically, there was no comprehensive care plan developed and implemented for resident's use of anticoagulant therapy. This was evident for 1 of 5 residents reviewed for Unnecessary Medications out of 30 sampled residents (Resident #59). The findings are: The facility policy and procedure titled Comprehensive Care Planning dated 01/2008, last revised 03/2019, documented that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs is developed for each resident. The policy also documented that each resident's comprehensive care plan is designed to incorporate identified problem areas. Resident #59 was admitted to the facility with diagnoses that included Atrial Fibrillation, Coronary Artery Disease, Cerebrovascular Accident, and Non-Alzheimer's Dementia. The Admission Minimum Data Set assessment dated [DATE] documented the resident had severe impairment in cognition with long and short-term memory problems. The Minimum Data Set assessment also documented that resident received antidepressant, anticoagulant, and hypoglycemic medication. The Comprehensive Care Plan (CCP) titled Cardiovascular dated 01/30/2024 last updated 2/14/2024, documented that the resident is at risk for Cardiovascular dysfunction and resident will be free from signs/symptoms of cardiovascular dysfunction for 90 days. Interventions included monitor for signs/symptoms of cardiovascular dysfunction, mental status changes, headache, fatigue, weakness, palpitations, rapid weight gain cyanosis, shortness of breath, blurred vision, congestion, bradycardia, tachycardia. The Physician's order dated 3/27/2024 documented: Eliquis 2.5 mg tablet by g-tube route every 12 hours for unspecified Atrial Fibrillation which first became standing on 1/30/2024. There was no documented evidence a comprehensive care plan had been developed to address the resident anticoagulant therapy. On 03/28/24 at 02:30 PM, an interview was conducted with Registered Nurse Supervisor- Registered Nurse #1 who stated that Resident #59 is prescribed Aspirin 81mg daily and Eliquis 2.5 every 12 hours for Atrial Fibrillation. Registered Nurse #1 also stated that Resident #59 was prescribed Eliquis upon admission from the hospital. Registered Nurse #1 further stated that there is care plan for cardiovascular and psychotropic medication use but there was none for anticoagulant therapy. Registered Nurse #1 further stated that the Admission Nurse was supposed to initiate the care plan on admission as Resident #59 was prescribed anticoagulant medication when they first came to the facility. Registered Nurse #1 stated they are not sure why the care plan was not initiated since admission. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/28/24 at 02:38 PM, the Director of Nursing was interviewed and stated the Registered Nurse should be initiating the care plan upon admission, and the next day, the Registered Nurse Supervisor should review it for completion. The Director of Nursing also stated that the care plan for anticoagulant therapy could have been on the resident's cardiovascular care plan. 10 NYCRR 415.11(c)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42101 Based on observations and interviews conducted during the Recertification survey from 3/26/2024 to 4/02/2024, the facility did not ensure that drugs and biologicals were safe and secure to protect from unauthorized access. Specifically, 1) antibiotic solutions and intravenous fluids were located in unlocked cabinets in the nurse's station on the 3rd floor where authorized licensed staff and unauthorized staff were noted entering the nurses station area, and 2) medications were noted to be left out on the medication cart unsecured. This was evident for the Medication Storage Task on Unit 2 and Unit 3. The findings are: 1.The facility policy titled Storage of Drugs revised 12/14/2023 documented all drug s in the nursing station are to comply with the following conditions: Drugs are stored in an orderly manner in cabinets, drawers, or care of sufficient size to prevent crowding. All medications and other drugs including treatment items, are stored in locked cabinet or room, inaccessible to residents and visitors. Drugs are accessible only to personnel designated in writing by facility resident care policies. On 03/28/2024 at 11:57 AM, Registered Nurse #3 was observed taking 0.95 % Sodium chloride intravenous solution and Ampicillin 2-gram placed in a dark brown light protection bag from an unlocked drawer in the nurse's station on Unit 3 and walking down the hallway. Registered Nurse #3 stated that they were going to hang the intravenous antibiotic for Resident #62 after lunch. On 03/28/2024 at 12:56 PM, Registered Nurse #3 was observed administering the intravenous antibiotics to Resident #62. On 03/28/2024 at 03:42 PM, Registered Nurse #3 stated that intravenous medications are stored in the nurse's station and there is not any place else. They are in the process of reconstructing the building and they are doing this floor and unsure of the date maybe after the survey. The Director of Nursing and Administrator are aware of the lack of storage for the intravenous and intravenous antibiotics, and this issues has been brought up at morning meeting. Registered Nurse # 3 stated that the medications need to be secured. On 03/29/2024 at 10:20 AM, multiple medications were observed in the drawer in the nurse's station bellow the binders on the shelf that included 0.9% sodium chloride flush -1 flush, 11 bags of 1000 milliliters of intravenous fluids of 0.45% sodium chloride, 2 bags of 1000 milliliters bags of 5% dextrose intravenous fluids. Bags of intravenous fluids also were also observed labeled with resident's personal information stored in an unlocked drawer at the back of the nurse's station. On 03/29/2024 at 10:33 AM, Maintenance Worker #1 was observed on the unit putting locks on the nurse's station drawers. There was on lock on the top right side drawer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/29/2024 at 12:50 PM, Registered Nurse #5 was interviewed and stated they check the medication cart every shift with the medication nurses. We had supplies of intravenous fluids medication supplies and all antibiotics and items should be locked up because we have wandering residents. On 04/01/2024 at 11:56 AM, Maintenance Worker #1 was interviewed and stated that one side to the locks were done and the staff kept losing the keys. There were antibiotics and intravenous fluids which needed to be locked up so we repaired the broken lock and added locks to the other side on all 3 floors. On 04/01/2024 at 1:01 PM, Maintenance Worker #2 stated that the locks were not working properly, they were loose and they were replaced a month ago. Maintenance Worker #2 also stated that they were told that the locks were not working properly so they are in the process of repairing them. 40565 2. During multiple observations of the Unit 2 medication cart conducted from 3/26/24, the medication cart had been observed placed in hallway, sometimes unattended. On 03/29/24 at 09:57 AM, the facility Medication Storage task was performed on Unit 2 with Licensed Practical Nurse #1 and 2 bottles of Liquid Protein Supplement 960ml, one 510g bottle of Polyethylene Glycol 3350 powder, and one 473ml bottle of Docusate sodium liquid were placed unsecured, on top of the left side of the medication cart. Licensed Practical Nurse #2 was interviewed immediately and stated that there was not enough space in the medication cart to store the medications inside the cart. On 03/29/24 at 10:13 AM, Registered Nurse #2 was interviewed and stated that the medications on top of the cart should not have been there but there is no space to lock them up in the cart. Registered Nurse #2 also stated that they do not stock medication in their medication room on the unit, and all the stocked medications are collected from the storage downstairs as they are needed. 10 NYCRR 415.18(e)(1-4)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42101 Based on observations, record review, and interviews conducted during the Recertification survey from 3/26/2024 to 4/02/2024, the facility did not ensure food was prepared and served in accordance with professional standards for food service safety to prevent foodborne illness. This was evident for 1 of 3 dining rooms (2nd Floor). Specifically, Certified Nursing Assistant #6 was observed assisting multiple residents with hand hygiene with bare hands without performing hand hygiene in between residents and was also observed touching the inside of paper and plastic cups while preparing beverages for residents at the lunch meal on the 2nd floor. This was evident for 1 of 3 dining rooms during the Dining Task. The findings are: The facility policy titled Infection Surveillance revised 10/16/2023 documented employee, volunteer and contract employee infections will be tracked as appropriate, such as influenza and gastrointestinal outbreaks. The facility will collect data to properly identify possible communicable diseases or infections among residents and staff before they spread by identifying. Data to be collected, including how often and the type of data to be documented including observations of staff including the identification of ineffective practices, if any. On 03/26/2024 from 11:54 AM to 11:57AM, Certified Nursing Assistant # 1 was observed handing out hand wipes to residents on the 2nd floor to clean their hands before lunch. Certified Nursing Assistant #1 adjusted a resident's clothing, gave wipes to 3 other residents to clean their hands, assisted Resident # 14 to clean their hands, picked up the used hand wipe and proceeded to get a hand wipe for Resident #29 and wiped the hands of Resident #55 without performing hand hygiene between residents. On 03/26/2024 from 11:57 AM to 12:16 PM, Certified Nursing Assistant #1 was observed washing their hands at the sink. Certified Nursing Assistant #1 then handed out clothing protectors to residents and picking up used hand wipes in paper cloth protector and disposed of them. Certified Nursing Assistant #1 was then observed pouring beverages into paper and plastic cups for residents. Certified Nursing Assistant #1 was observed placing their fingers inside the cups while handling before placing lids on the cup. During an interview on 03/26/2024 at 12:59 PM, Certified Nursing Assistant #1 stated that they did wash their hands in-between residents and the resident's hands must be cleaned to protect the residents and the staff. During an interview on 4/01/2024 at 12:03 PM, Registered Nurse #2 was interviewed and stated when staff come into room, they utilize hand sanitizer to clean their hands. If helping residents with wiping their hands they should sanitize their hands in between residents. Registered Nurse #2 also stated that the aides should place the cups on the tray and serve to the residents and hands should not touch the inside of the cup, top of the cup or anywhere resident's mouth will make contact. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a subsequent interview on 04/01/2024 at 3:03 PM, Certified Nursing Assistant #1 stated that it is important that the beverage cups are handled correctly so residents do not get sick and there is not bacteria in anything they are going to drink. During an interview on 04/02/2024 at 11:52 AM, the Infection Preventionist stated that they do rounds once a day in the morning. Hand hygiene in-service was done in December 2023 by the Assistant Director of Nursing. They stated that they observe dining once a week to look for resident use of hand wipes, staff hand hygiene, handling of cups with bare hands and sanitizer before anything. 10 NYCRR 415.14(h)