STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335146	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Nursing Care Center Inc	69 70 Grand Central Parkway Forest Hills, NY 11375

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Based on observation, record review, and interviews, the facility failed to maintain each resident's right to a safe, clean, comfortable, and homelike environment. This was evident in 3 of 5 units (Unit 1, Unit 4, and Unit 3.) observed. Specifically, resident's rooms were noted with torn window screen, ceiling tiles not firmly affixed to ceiling, paint plastered on wall, dining room furniture in disrepair, shower room with stains and shower curtains that were soiled and in disrepair. The findings included but were not limited to: The facility policy titled 'General Housekeeping Policy' dated revised 01/10/2025 documented it is the policy of the facility to provide a clean, safe, orderly comfortable and attractive home-like environment both indoors and outdoors, including walls and floors are to be maintained in accordance with state and federal codes and regulations. 1.During multiple observations from 12/01/2025 at 11:16 AM to 12/03/2025 at 10:01 AM, on Unit 1, two blue chairs were observed with ripped seat cushions in the resident's day room. 2. During multiple observations from 12/01/2025 to 12/08/2025, the following was observed in room [ROOM NUMBER]. Ceiling tiles above upon entering and between two beds in room [ROOM NUMBER] were not firmly affixed to the ceiling. Window screens were torn. Wall noted with white paint patches and chipped broken wallpaper. The review of maintenance log on unit 5 revealed no work related to the above concerns were requested. On 12/08/2025 at 12:30 PM, the Director of Environmental and Maintenance Services was interviewed and stated they are doing maintenance round of the rooms daily so the concerns in room [ROOM NUMBER] should have been addressed. The Director of Environmental and Maintenance Services stated they do not know why these were missed but they will repair them right away. 3. During multiple observations from 12/01/2025 to 12/08/2025, the following were observed on Unit 4: 1. Dining Room: (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. nine (9) torn vinyl seat chair cushions. b. ceiling tile not firmly affixed to ceiling, and brownish colored stained ceiling tiles. c. a hung framed cork board torn and in disrepair. d. five (5) round dining room tables with sharp and broken chipped edges all around the base of the tables. 2. Resident Shower Room: a. two (2) of two (2) shower room curtains had a black substance and were stained and frayed. b. one (1) of two (2) shower room across from room [ROOM NUMBER], with a large square opening on wall. c. toilet bowl heavily scratched with yellowish stains. d. surrounding sink area heavily stained with an accumulation of dirt and debris around faucet. e. shower room stall across from room [ROOM NUMBER] with cracked ceiling broken ceiling. f. toilet grab bars not firmly affixed to the wall. On 12/08/2025 at 1:00 PM, the Director of Environmental and Maintenance Services was interviewed and stated a clean safe and homelike environment makes people feel good, specifically residents, staff and visitors and prevents the spread of infection. The Director of Environmental and Maintenance Services also stated their role is to ensure the facility is clean, orderly and functions safely and they make multiple rounds each day on all floors to observe for cleanliness of the high touch areas like resident rooms, sinks areas, floors, dining rooms, shower rooms and that trash is being emptied. The dining room is swept and mopped every day before breakfast and again after supper, and the tables are also wiped clean and disinfected. The Director of Environmental and Maintenance Services further stated the logbook is checked daily, and they have come across issues of debris on floors or other areas, and they address this on the spot with their staff, however at times there is a communication problem with staff due to a language barrier. The Director of Environmental and Maintenance Services stated they ordered and replaced two hundred (200) resident room chairs, and while there are no orders for dining room chairs, they are planning to continue to renovate the entire facility. The Director of Environmental and Maintenance Services also stated they recently removed the vent in the shower room because it was dusty, and they did not replace it right away, and the shower curtains are changed when necessary. 10 NYCRR 415.5(h)(2)

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	335146	A. Building B. Wing	12/08/2025

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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 - Some	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** Number of residents sampled:37Number of residents cited:4 Based on observations, record review and interviews, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards and practices. This was evident for one (1) resident (Resident #86) of three (3) residents reviewed for Activities of Daily Living out of a sample of 38 residents. Specifically, 1). Resident #86 was not assisted out of bed, but documentation reflected that resident was taken out of bed, 2). Requested documents for Residents #79, Resident #221 and Resident #220 and access to the facility electronic medical record were not provided in a timely manner. The findings are: 1. Resident #86 was admitted to the facility with diagnoses include Coronary Artery Disease, Hypertension, and Opioid Dependence. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #86 has intact cognition, did not refuse care, was dependent on staff for sit to stand, chair to bed transfer, and uses a wheelchair for mobility. On 12/01/2025 at 10:05 AM, Resident #86 was interviewed and stated they have been at the facility since June 2025 and was being taken out of bed daily to attend therapy. Resident #86 also stated therapy ended few months ago and has only been out of bed a few times to go out for appointments. Resident #86 further stated they are very heavy and understands it is difficult for staff to get them out of bed. Resident #86 stated when they asked nursing assistants for assistance getting out of bed, they were told that there were no instructions for Resident #86 to get out of bed. The Physician Order revised 09/05/2025, last renewed 10/23/2025 documented transfer out of bed to standard wheel chair with gel-foam cushion and bilateral leg rests via mechanical lift. The Resident Nursing Instruction for Transfer revised on 09/05/2025 documented resident to transfer out of bed to standard wheelchair with gel-foam cushion and bilateral leg rests via mechanical lift every day at 7 AM to 3 PM, 3 PM to 11 PM and 11 PM to 7 AM. On 12/01/2025 from 10:05 AM to 1:15 PM, Resident #86 was observed in bed and was not taken out of bed during these times. Review of Certified Nursing Assistant Accountability Record dated 12/01/2025 documented for the 7 AM to 3 PM shift, Resident #86 transfer out of bed was performed on 12/01/2025. For 3 PM to 11 PM, Resident #86 transfer out of bed was performed on 12/01/2025, 12/02/2025, 12/03/2025. leg rests via mechanical lift every day at 7AM to 3PM, 3PM to 11PM and 11PM to 7AM. Following observations were also made on 12/01/2025 at 10:05 AM to 1:15 PM, on 12/02/2025 from 9:30 AM to 1:30PM, on 12/03/2025 from 9 AM to 1:05 PM and revealed that Resident #86 was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed in bed and was not out of bed. Review of Certified Nursing Assistant Accountability Record from 12/01/2025 to 12/03/2025 documented the following: For 7AM to 3PM shift, Resident #86 transfer out of bed was performed on 12/01/2025 and not performed on 12/02/2025 and 12/03/2025. For 3 PM to 11 PM, Resident #86 transfer out of bed was performed on 12/01/2025, 12/02/2025, 12/03/2025. On 12/04/2025 at 12:49 PM, Certified Nursing Assistant #2 stated they were assigned to Resident #86 only few times and they have not assisted Resident #86 to get out of bed but have assisted in other care needs. Certified Nursing Assistant #86 also stated they documented as performed for transfer out of bed on 12/01/2025 during 7 AM to 3 PM shift because the therapist transferred Resident #86 to the main floor for therapy. On 12/08/2025 at 10:02 AM, Certified Nursing Assistant #1 stated they cared for Resident #86 during 3 PM to 11 PM shift on 12/01/2025 and 12/02/2025. Certified Nursing Assistant #1 also stated Resident #86 was not taken out of bed on 12/01/2025 and 12/02/2025 during their shift so they do not recall why they documented as performed in their documentation. On 12/04/2025 at 12: 58 PM, Registered Nurse #3 stated Resident #86 reported pain and refused when staff attempted transfer using the mechanical lift. Resident #86 has been refusing to get out of bed when staff asks. Registered Nurse #3 stated they could not explain why staff documented performed when Resident #86 was not taken out of bed. On 12/04/2025 at 10:10 AM, Registered Nurse #4 stated they are newly hired and has worked been working on the unit for two weeks. Registered Nurse #4 stated Resident #86 is very pleasant and has never refused any care/treatment. Registered Nurse #4 stated they have only seen Resident #86 lying in bed and have not seen coming out of bed during their shift. The Director of Nursing was out of the country and unavailable for the interview. The Assistant Administrator was new to the role and could not give any information related to this deficiency. 2 a). On 12/03/2025 at 9:05 AM, the following documents for Resident #79 were requested: face sheet, current medical orders, current Medication Administration Record, policies and procedures for Gastric Tube Medication Administration, Standards of Professional Practice, Role of the Registered Nurse, List of Non Crushable Medications, Handwashing, staff in service records, Lesson Plan on Medication Administration via gastric tube and Comprehensive Care Plan for Tube Feed, and were not provided until 12/04/2025 at 3:00 PM. b). On 12/03/2025 at 3:30 PM, the following documents were requested for Resident #221: face sheet Minimum Data Set assessments, physician orders, nurse notes, investigation report for a fall, and a medication administration record which was not received until 12/04/2025 at 2:30 PM. c). On 12/01/2025 at 9:30 AM, the Entrance Conference was held with the Acting Administrator, and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility was provided with information on the documents that would be needed within the hour, the next 4 hours, by the end of the first day of survey and within 24 hours. The Acting Administrator stated the Director of Nursing Services was out on vacation and they did not have a replacement. On 12/01/2025 at 1:30 PM, the Facility Matrix for all floors had not been received. On 12/01/2025 between 2 PM and 3 PM, the matrix for two floors were provided. The Acting Administrator further stated that the matrix for the remaining floors would be left in the conference room the same day. On 12/02/2025 at 11:37 AM, the Acting Administrator was notified that the team still had not received access to the Medication Administration Record or the Treatment Administration Records in the facility's electronic medical record. The Acting Administrator stated the Quality Assurance Staff had been in contact with the customer service department for the electronic medical record and they were not sure why this problem was still occurring. On 12/03/2025 at 11:30 AM, the Acting Administrator was notified that the team still did not have access to the Medication Administration Record, Treatment Administration Record and notes in the care plan. The Acting Administrator stated that they have been in contact with electronic medical record company and was disappointed about the delay. On 12/03/2025 at 12:52 PM, the Acting Administrator and Quality Assurance Staff was informed that the survey team was still having limited access to the Electronic Health Record. On 12/03/25 at 1:45 PM, the survey team held a meeting with the Acting Administrator and Quality Assurance Staff Member. The facility was notified that the survey team still had not received access to the Medication Administration Record, Treatment Administration Record and care plan notes in electronic medical record. The customer service department for the electronic medical record was contacted from the main conference room in the presence of the surveyors, and access to all areas of the medical record requested was provided within 25 minutes. The Quality Assurance Staff Member stated that they were unsure of the system and was informed the vendor on previous calls that surveyors had access to everything on the electronic medical record, but they failed to follow up by checking with the surveyors themselves. On 12/04/25 at 1:30 PM, the Acting Administrator was informed that multiple surveyors who had submitted lists for printed medical records the previous day, still had not received them. The Acting Administrator stated there was only one person working in Medical Records and that person was also responsible for printing the requested documents. The Acting Administrator further stated that more people would be put in place to assist Medical Records in printing documents. On 12/08/2025 at 12:25 PM, the Acting Administrator was interviewed and stated usually the Director of Nursing Services prepares the survey binder where everything is in place for the surveyor. The Acting Administrator also stated the Director of Nursing Services was out of the country and the facility could not get in touch with them to locate the binder. The Acting Administrator further stated they were aware that they did not provide the matrix within the 4 hours as required, and the electronic medical record vendor informed them that surveyors had access to the record, but the Quality Assurance Staff failed to follow up with the surveyors to ensure access. The Acting Administrator. Stated the delay in getting documents over to the respective surveyors was due to there being only one person responsible for printing and scanning the documents. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 NYCRR 415.22(a)(1-4)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Number of residents sampled:Number of residents cited:Based on observations and staff interviews, the facility did not ensure that it provided a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This was evidenced by multiple observations of the staff bathrooms, elevators, lobby area and nursing stations.This was evident in the Lobby Area including on one (1) of five (5) units. Unit 4.The findings include but are not limited to: The facility policy titled General Housekeeping Policy dated 01/10/2025 documented that is the policy of this facility to provide a clean safe orderly comfortable and attractive homelike environment both indoors and outdoors.On multiple occasions from 12/01/2025 - 12/08/2025 the following was observed: 1. Lobby Area: a. three (3) of three (3) wall light fixtures located in the lobby wall area dusty shades, each missing one (1) of two (2) tear shaped crystal ornament.b. area located near kitchen area: corner panels missing and broken. c. ice machine located outside kitchen area with black and silver tape. d. broken ice tray rack2. Elevators A and B:a. two (2) of two (2) elevators with broken, wall panels in disrepair.b. floor embedded with accumulation of dirt dust and debris.3. 4th floor staff bathroom:a. loose sink faucet.b. floor corners embedded with ground in dirt.4. 4th floor Nurse Station:a. two (2) of two (2) torn vinyl seat cushion.b. floors with accumulation of layered dirt dust and debris.c. nurse station desk with Formica panels in disrepair.On 12/08/2025 at 1:00 pm the Director of Environmental and Maintenance Services was interviewed and stated that a clean safe and homelike environment makes people feel good, specifically residents, staff and visitors and prevents the spread of infection. I make multiple rounds a day of all floors including the basement. My role is to ensure that the facility is clean, orderly and functions safely. I observe for cleanliness of the high touch areas like resident rooms, sinks areas, light switches, floors, nurse stations, dining rooms, shower rooms and trash are being emptied and more. When making my daily rounds I have come across issues of debris on floors or other areas. I address this on the spot with my staff. I have a housekeeper on every resident floor. The nurse station is to be swept and mopped daily. The nurses are working at the nurse station, and we cannot always get to clean that space. There is a maintenance logbook on the units, for any staff to log in issues like loose bathroom sinks, broken ice machines, loose faucets. We are planning to purchase chairs for the nurse station. The lobby area ceiling light fixtures have been replaced, but not the wall light fixtures. There is a logbook on each unit for any Maintenance workorder that needs to be addressed. Staff can call or fill in a request. The logbook is checked daily. 10 NYCRR 415.29

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure residents remained free from chemical restraints. This was evident for one (1) of five (5) residents (Resident #162) reviewed for Unnecessary Medication out of a sample of 38 residents. Specifically, the facility did not rule out underlying medical conditions prior to initiating and increasing a dose of an antianxiety medication. In addition, there was no evidence the continued need for the medication was evaluated after Resident #162 was treated for a urinary tract infection and no longer displayed behaviors that were present when the medication was initiated. The findings are: The facility's policy and procedure titled ?Use of Psychotropics' reviewed 4/2025 documented physicians use psychotropic medications appropriately working with the interdisciplinary team to ensure appropriate use, evaluation and monitoring. Evaluate the ongoing effectiveness, benefits as well as risks of non-pharmacological approaches and psychotropic medications. Monitoring and accurate documentation of resident's response to any treatment such as laboratory results, vital signs, progress notes, behavior flow sheets, medication administration records, and consultant pharmacist's drug regimen review. Resident #162 was admitted to the facility with diagnoses which included Non-Alzheimer's Dementia, Hyperlipidemia and Traumatic Brain Injury. The Quarterly Minimum Data Set, dated [DATE] documented Resident #162 had severely impaired cognition and received antianxiety medication seven (7) out of seven (7) days. The Comprehensive Care Plan for Psychotropic initiated 08/09/2025 reviewed 11/09/2025 documented resident on Buspirone 5mg tab for anxiety disorder. Interventions were to monitor behavior and intervene appropriately, monitor drug effectiveness.The Psychiatry Consultations completed 01/14/2025, 03/18/2025, 03/25/2025, 04/17/2025, 04/22/2025 and last completed 05/13/2025 documented Resident #162 with history of Dementia, Insomnia was seen. Chart reviewed. Discussed with nursing staff. Resident has no complaints and denies symptoms of depression or anxiety. Patient denies side effects from medications. Resident to continue current medications Donepezil 10mg at bedtime, Melatonin 5mg at bedtime and Namenda 10mg twice a day.The Physician Note dated 08/09/2025 documented Resident #162 was seen and examined at the bedside for evaluation of reported agitation. Buspirone was ordered. Labs reviewed. Will monitor clinically. The Physician Order initiated 08/09/2025 documented to administer Buspirone 5mg tab once daily at 4 PM for anxiety disorder. There was no documented evidence nonpharmacological interventions were attempted or that underlying medical conditions were ruled out prior to initiating Buspirone on 08/09/2025. The Physician Note dated 08/27/2025 documented Resident #162 was evaluated at bedside for reportedly feeling anxious. Resident is on Buspirone and offered alternative medication, but resident declined it. Psychiatry consultation was advised.There was no documented evidence that a psychiatry consultation was ever completed since 05/13/2025. The Behavior Note dated 09/21/2025 documented Resident #162 noted with agitation and noncompliance with care. Resident becomes physically aggressive during activity of daily living, needs a lot of encouragement and assistance during care. Will continue to monitor. The Physician Note dated 09/30/2025 documented Resident #162 evaluated after staff noted agitation, pacing, and having verbal outbursts. Also, restless. Resident #162 responded to calm counseling and redirection. Continue reinforce verbal redirection, low stimulation setting. There was no documented evidence that a psychiatry consultation was requested to evaluate increased behaviors or that underlying medical conditions were ruled out. The facility Discharge Summary Note dated 10/03/2025 and completed prior to Resident #162's transfer to the emergency room, documented Resident #162 noted with increased agitation and refusing evaluation after multiple redirections. Upon conversation with resident's spouse to increase Buspirone. Buspirone was later increased to manage resident's agitation so resident would be more compliant with hospital transfer for further evaluation and possible extension (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or modification to treatment (due to persistent refusal of facility evaluation). The Physician Order for Buspirone 5mg tab once daily at 4 PM for anxiety disorder was discontinued on 10/03/2025. The Physician Order dated 10/03/2025, renewed 10/23/2025 and last renewed 12/05/2025 documented Buspirone 5mg tab twice daily at 9 AM and 9 PM for anxiety disorder. The Nursing Note dated 10/03/2025 documented physician order Buspirone 5mg every 12 hours, order carried out. Buspirone 5mg once daily was increased to 5mg twice a day at 9 AM and 9 PM on 10/03/2025. The Physician Note dated 10/03/2025 documented Resident #162 was transferred to the hospital for further evaluation.The Hospital Discharge Summary Note dated 10/04/2025 documented Resident #162 was diagnosed with acute urinary tract infection, a dose of Ceftriaxone 1gram was administered. Resident #162 to complete antibiotic medication upon returning to the nursing facility. The Physician Orders for Ceftriaxone 1 GM in 100 ml by intravenous route once daily for 5 days was initiated and Buspirone 5 PM twice a day was continued upon readmitting to the nursing facility on 10/04/2025. There was no documented evidence in Physician Notes dated 10/05/2025 and 10/09/2025 that resident was evaluated upon readmission from hospital for necessity of the increased dose of Buspirone 5 MG twice a day. The Physician Monthly assessment dated [DATE] documented Resident #162 evaluated for monthly review. Consultations and labs were reviewed. Resident with anxiety, continue Buspirone, continue clinical monitoring, follow up with labs. The Physician Note dated 10/14/2025 documented Resident #162 expressed hesitancy regarding the need for certain medication, citing concerns about side effects and feeling fine without them. Resident counseled at length regarding purpose and importance of adherence. Will follow up to reassess compliance and evaluate any emerging concerns or side effects. There was no documented evidence of ongoing behaviors to support use of an antianxiety medication following completion of antibiotic therapy for a urinary tract infection for Resident #162. In addition, there was no documented evidence that the necessity of the medication was evaluated, or adjustments made after Resident #162 expressed concerns about continued use of the medication. The Physician Monthly assessment dated [DATE] documented Resident #162 evaluated for monthly review. Previous consultations and labs were reviewed. Resident with anxiety, continue Buspirone, and continue with behavioral pattern monitoring. The Behavior Notes dated 10/18/2025 and 11/27/2025 documented Resident #162 is verbally responsive, calm and quiet. Resident is being monitored for Dementia without behavioral disturbances and Insomnia. Resident was last seen by the psychiatrist on 05/13/25, there is no new recommendation. No noted behavior at this time. Resident is currently on Donepezil 10 mg for dementia, Melatonin 5 mg at bedtime for insomnia and Namenda 10 mg twice a day for dementia. No side effects noted. Will continue to monitor. The behavior notes did not document Resident #162 was also receiving on Buspar also at this time. On 12/05/2025 at 10:48 AM, Registered Nurse #5 stated Resident #162 has dementia, and was evaluated by the Psychiatrist upon admission with last follow up done in May 2025. Registered Nurse #5 also stated they were informed of the increased order for Buspirone 5mg to twice daily by the covering physician on 10/03/2025. Registered Nurse #5 stated resident with any change in medication regimen are monitored especially for antipsychotic medication. Unit nurses will create behavior note documenting an episode or event when resident was noted with change in behavior. On 12/08/2025 at 12:35 PM, Medical Doctor #3 was interviewed by telephone and stated they were covering physician who saw Resident #162 on 10/03/2025. Resident #162 was agitated, refusing to transfer for hospital evaluation. Medical Doctor #3 stated after discussing with Resident #162's spouse they decided to increase Buspirone for Resident #162 to comply in hospital transfer for further evaluate resident's condition. Medical Doctor #3 could not explain why the increased dose of Buspar was continued after Resident #162 was treated for a urinary tract infection and was no longer displaying behaviors. On 12/08/2025 at 12:05 PM, Medical Doctor #2 was interviewed by telephone and stated they were covering doctor on 10/23/2025 and renewed Resident #162's medications because they were due to be renewed on 10/23/2025. Medical Doctor #2 also stated they were not aware that of any prior changes in medication dosage or frequency. On 12/08/2025 at 12:15 PM, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical Doctor #1 was interviewed by telephone and stated there is no assigned doctor for Unit 5, so all doctors are responsible to oversee and supervise resident's care and treatment. Medical Doctor #1 also stated they review previous consultant/physician notes and speak to unit nurses for any changes in condition or treatment. Medical Doctor #1 further stated they saw the increase dosage for Buspirone when they renewed the monthly medications in December 2025. Medical Doctor #1 stated if there were any changes in medication treatment, there would be ongoing evaluation and monitoring of the effectiveness, and it is the responsibility of all physicians to monitor the effects of medication change regularly and determine if treatment/interventions remain as appropriate. 10 NYCRR 415.4(a)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335146	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview Nursing Care Center Inc	69 70 Grand Central Parkway Forest Hills, NY 11375

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 35Number of residents cited:1Based on observation, staff interview and record review, the facility failed to ensure needed care and services that are resident centered, in accordance with the professional standards of practice that will meet resident's physical, mental, and psychosocial needs are provided to a resident. This was evident for one (1) of two (2) residents (Resident #79) reviewed for Tube Feeding out of 38 sampled residents. Specifically, 1). functioning of a gastrostomy tube was not checked prior to the administration of medications, and 2). Multiple medications were crushed and administered together. The findings included but were not limited to:The facility policy and procedure titled ?Medication Administration via Gastrostomy, Nasogastric or Jejunostomy Tube' dated 06/2025 documented pour medication into individual plastic bag and crush medications individually, pour powdered medications into a plastic calibrated medication cup and dilute with sufficient amount of water usually 10 cubic centimeters to facilitate administration. Stir the medications until totally dissolved. Keeps medications separate. To ensure tube is in proper place, place stethoscope with 10 -15 cubic centimeter of air and listen for swish sound OR draw back plunger and observe aspiration of stomach contents and returns to stomach. Flush the tube with approximately 10 cubic centimeters of water after each medication, final medication flush of 30 cubic centimeters of water (or otherwise indicated). Resident #79 was admitted to the facility with diagnoses that included Amyotrophic lateral sclerosis (a progressive disease that leads to muscle weakness and loss of voluntary muscle control), Gastrostomy status, and Dysphagia (difficulty swallowing). The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #79 was severely cognitively impaired. The Medical orders dated 12/05/2025 documented the following:crush medications to facilitate administration, gastrostomy tube, check placement prior to start of feeds, call medical doctor if return is greater than 100 cubic centimeters (cc). Ferrous sulfate (iron) 325 milligram by gastric tube daily, glycopyrrolate (reduces salivary secretions) 1 milligram by gastric tube twice daily, baclofen (control muscle spasm) 10 milligrams via gastric tube, folic acid (vitamin B) 1 milligram via gastric tube daily. On 12/03/2025 at 8:45 AM, Registered Nurse #1 was observed conducting medication administration for Resident #79. Registered Nurse #1 placed (1) Folic acid 100 mg tablet, one (1) ferrous sulfate 325 mg tablet, one (1) baclofen 10 mg tablet, and one (1) glycopyrrolate tablet 1 mg in a plastic medication cup. Registered Nurse #1 then placed all four (4) medications in a clear plastic pouch and crushed them together, using a medication crusher. Registered Nurse #1 entered Resident #79's room and placed the powdered medications into a five (5) ounce (approximately 150 cubic centimeters) clear plastic cup and added water. Registered Nurse #1 filled a second five (5) ounce clear plastic cup with water and placed it at the bedside table. Registered Nurse #1 then proceeded to administer a water flush of 60 cubic centimeters into the gastric tube. Registered Nurse #1 continued by withdrawing 60 cubic centimeters of the medications mixed with water solution and pushed this into the gastric tubing. An additional 40 cubic centimeters of the remaining medication mixed with water solution was then administered into the gastric tube. Registered Nurse #1 completed the medication administration process by flushing 35 cubic centimeters of water into the gastric tube.Registered Nurse #1 did not verify that the tube was functioning before they administered medication, and they did not give each medication individually and flush with 10 cubic centimeters between each medication. On 12/03/2025 at 11:29 AM, Registered Nurse #1 was interviewed and stated they were nervous, and they do not administer medications to residents with gastric tubing in this manner. Registered Nurse #1 also stated they have received training on how to administer medications to residents with a gastric tube in place, and medications need to be given separately because they each have a side effect and can cause a side effect reaction. On 12/05/2025 at 10:06 AM, the Attending Physician was interviewed and stated Resident #79 has a gastric tube due to their diagnosis of Amyotrophic Lateral Sclerosis, which is a (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	serious disease that kills muscles, and leads to an inability to swallow. The Attending Physician also stated medications are to be administered separately, one at a time and slowly as the body needs time to absorb them as the Resident #79 has a slow absorption rate due to their diagnosis. The Attending Physician further stated checking for patency prior to administering medications is necessary to ensure the stomach is not full which can cause bloating, vomiting and discomfort, and if too much fluid is administered, it can cause the resident discomfort. On 12/08/2025 at 8:28 AM, Registered Nurse Supervisor #2 was interviewed and stated frequent rounds are conducted every day on every floor, after reports are obtained from prior shifts to ensure that continuity of care and services and needed follow ups are done. Registered Nurse Supervisor #2 also stated medications given to residents who have a gastric tube are to be crushed and administered separately, and checking for stomach contents is important to ensure placement stomach filling amount. Registered Nurse Supervisor #2 further stated the facility policy is to flush the gastric tube with 30 cubic centimeters of water after checking for patency. If there is 100 cubic centimeters of stomach content of more, then the feeds and medications are to be held, and the medical doctor is to be notified. Registered Nurse Supervisor #2 stated we dilute each medication with ten cubic centimeters of water for dilution of each medication, and flush with thirty cubic centimeters of water once all medication has been given. Registered Nurse Supervisor #2 also stated the nurse did not follow standards of practice and this could have had consequences for Resident #79. 10 NYCRR 415.11 (c) (3)(i)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure that residents who are unable to carry out activities of daily living receive the necessary services and assistance to maintain grooming, and personal hygiene. This was evident for one (1) of three (3) residents (Resident #86) reviewed for Activities of Daily Living out of a sample of 38 residents. Specifically, Resident #86 was not assisted out of bed as per physician's order and their plan of care. The findings are:The facility's policy and procedure titled ?Activities of Daily Living Supporting' reviewed 01/10/2025 documented residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Resident #86 was admitted to the facility with diagnoses include Coronary Artery Disease, Hypertension, and Opioid Dependence. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #86 has intact cognition, did not refuse care, was dependent on staff for sit to stand, chair to bed transfer, and uses a wheelchair for mobility. On 12/01/2025 at 10:05 AM, Resident #86 was interviewed and stated they have been at the facility since June 2025 and was being taken out of bed daily to attend therapy. Resident #86 also stated therapy ended few months ago and has only been out of bed a few times to go out for appointments. Resident #86 further stated they are very heavy and understands it is difficult for staff to get them out of bed. Resident #86 stated when they asked nursing assistants for assistance getting out of bed, they were told that there were no instructions for Resident #86 to get out of bed. The Comprehensive Care Plan for Mobility dated 06/02/2025 revised 09/24/2025 documented Resident #86 is dependent for bed mobility from lying to sit to stand and transfer from bed to chair. Intervention included transfer out of bed to standard wheelchair with gel-foam cushion and B leg rests via mechanical lift.The Comprehensive Care Plan for Noncompliance dated 06/02/2025 documented Resident #86 failure to follow therapeutic plan of care, refusal of optometrist. Interventions included to allow the resident to make decisions about treatment regime, to provide sense of control, and if possible, negotiate a time for activities of daily living so that the resident participates in the decision-making process, return at the agreed upon time.There was no documented evidence Resident #86 was noncompliant with getting out of bed or had refused to get out of bed.The Physical Therapy note dated 09/05/2025 documented Resident #86 was discharged from physical therapy at maximum for transfers. However, for safety of both the resident and staff on unit, transfers recommended to be updated to include dependent on two staff with Hoyer lift. This plan will be implemented to ensure safe and consistent transfer practices. Patient and interdisciplinary team verbalized understanding and in agreement.The Physician Order revised 09/05/2025, last renewed 10/23/2025 documented transfer out of bed to standard wheelchair with gel-foam cushion and bilateral leg rests via mechanical lift.The Resident Nursing Instruction for Transfer revised on 09/05/2025 documented resident to transfer out of bed to standard wheelchair with gel-foam cushion and bilateral leg rests via mechanical lift every day at 7 AM to 3 PM, 3 PM to 11 PM and 11 PM to 7 AM. On 12/01/2025 from 10:05 AM to 1:15 PM, on 12/02/2025 from 9:30 AM to 1:30 PM, on 12/03/2025 from 9:00 AM to 1:05 PM Resident #86 was observed in bed and was not taken out of bed during these times. Review of Certified Nursing Assistant Accountability Record from 12/01/2025 to 12/03/2025 documented the following: For 7 AM to 3 PM shift, Resident #86 transfer out of bed was performed on 12/01/2025 and not performed on 12/02/2025 and 12/03/2025. For 3 PM to 11 PM, Resident #86 transfer out of bed was performed on 12/01/2025, 12/02/2025, 12/03/2025.For 11 PM to 7 AM, Resident #86 transfer out of bed was not performed on 12/01/2025, 12/02/2025 and 12/03/2025. On 12/03/2025 at 11:04 AM, the Director of Rehabilitation stated when Resident #86 was on therapy, the therapist assisted Resident #86 to get out of bed and into the wheelchair to go down to the gym five (5) to six (6) times per week. The Director of Rehabilitation also stated therapy ended sometime in September 2025, and on 09/05/2025, there is discharge (continued on next page)

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	335146	A. Building B. Wing	12/08/2025

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Fairview Nursing Care Center Inc	69 70 Grand Central Parkway Forest Hills, NY 11375

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recommendation to transfer resident out of bed with two staff using mechanical lift on the unit which has not changed and is currently still active for staff to follow for transfer.On 12/04/2025 at 12:49 PM, Certified Nursing Assistant #2 stated they were assigned to Resident #86 only few times and they have not assisted Resident #86 to get out of bed but have assisted in other care needs. Certified Nursing Assistant #86 also stated they documented as performed for transfer out of bed on 12/01/2025 during 7 AM to 3 PM shift because the therapist transferred Resident #86 to the main floor for therapy.On 12/03/2025 at 12:35 PM, Certified Nursing Assistant #3 stated they regularly taking care of Resident #86, so they are familiar with resident's care needs. Certified Nursing Assistant #3 also stated that in the past they attempted transferring Resident #86 out of bed using the Hoyer lift, but this could not be done because Resident #86 reported having pain on their left right leg. Certified Nursing Assistant #3 further stated they permanently stopped transferring Resident #86 out of bed after that, and documented not performed for the transfer out of bed task On 12/08/2025 at 10:02 AM, Certified Nursing Assistant #1 stated they cared for Resident #86 during 3 PM to 11 PM shift on 12/01/2025 and 12/02/2025. Certified Nursing Assistant #1 also stated Resident #86 was not taken out of bed on 12/01/2025 and 12/02/2025 during their shift so they do not recall why they documented as performed in their documentation.On 12/04/2025 at 12: 58 PM, Registered Nurse #3 stated Resident #86 reported pain and refused when staff attempted transfer using the mechanical lift. Registered Nurse #3 also stated Resident #86 has been refusing to get out of bed when asked by staff. Registered Nurse #3 further stated Resident #86 is cognitively intact and was spoken to when they refused to get out of bed and all refusals and related documentation is done by the nursing supervisors. Registered Nurse #3 stated they could not explain why staff documented ?performed' when Resident #86 was not taken out of bed.On 12/04/2025 at 10:10 AM, Registered Nurse #4 stated they are newly hired and has worked been working on the unit for two weeks. Registered Nurse #4 stated Resident #86 is very pleasant and has never refused any care/treatment. Registered Nurse #4 stated do medication pass on the unit and they have only seen Resident #86 lying in bed and have not seen them being taken out of bed during their shift.On 12/08/2025 at 11:02 AM, Registered Nurse #5, who is the supervisor on the unit, stated Resident #86 has a history of refusing care and treatments which have been documented in the medical record. Registered Nurse #5 also stated Resident #86 complained of pain during transfer in the past and did not want to come out of bed, however, they were not aware that Resident #86 had not been out of bed for some time. Registered Nurse #5 further stated the certified nursing assistants are responsible to provide care as per resident needs and inform nurses of any care refusal/concerns so the team can evaluate and find a solution in timely manner. 10 NYCRR 415.12(a)(3)

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	335146	A. Building B. Wing	12/08/2025

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview and record review conducted during the Recertification survey, the facility failed to ensure that a resident fed by enteral means receives the appropriate treatment to prevent complications of enteral feeding. This was evident for one (1) of two (2) residents (Resident #79) reviewed for Tube Feeding out of a 38 sampled residents. Specifically, 1). The functioning of a gastrostomy tube was not checked prior to the administration of medications, and 2). Multiple medications were crushed and administered together.The findings included but were not limited to:The facility policy and procedure titled 'Quality of Care' dated 02/15/2025 documented the facility will deliver high quality, person-centered care based on accurate assessment, individualized care plans, resident rights, professional standards and evidenced based clinical practices.The facility policy and procedure titled ?Medication Administration via Gastrostomy, Nasogastric or Jejunostomy Tube' dated 06/2025 documented pour medication into individual plastic bag and crush medications individually, pour powdered medications into a plastic calibrated medication cup and dilute with sufficient amount of water usually 10 cubic centimeters to facilitate administration. Stir the medications until totally dissolved. Keeps medications separate. To ensure tube is in proper place, place stethoscope with 10-15 cubic centimeters of air and listen for swish sound OR draw back plunger and observe aspiration of stomach contents and returns to stomach. Flush the tube with approximately 10 cubic centimeters of water after each medication, final medication flush of 30 cubic centimeters of water (or otherwise indicated). Resident #79 was admitted to the facility with diagnoses that included Amyotrophic lateral sclerosis (a progressive disease that leads to muscle weakness and loss of voluntary muscle control), Gastrostomy status, and Dysphagia (difficulty swallowing). The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #79 was severely cognitively impaired. The Medical orders dated 12/05/2025 documented the following:crush medications to facilitate administration, gastrostomy tube, check placement prior to start of feeds, call medical doctor if return is greater than 100 cubic centimeters (cc). Ferrous sulfate (iron) 325 milligram by gastric tube daily, glycopyrrolate (reduces salivary secretions) 1 milligram by gastric tube twice daily, baclofen (control muscle spasm) 10 milligrams via gastric tube, folic acid (vitamin B) 1 milligram via gastric tube daily. The Comprehensive Care Plan for Tube Feeding effective date 10/03/2025, documented check for placement, patency and residual prior feeding. There is no documented interventions about medication water flushes that are to be administered during the medication administration process. On 12/03/2025 at 8:45 AM, Registered Nurse #1 was observed conducting medication administration for Resident #79. Registered Nurse #1 placed (1) Folic acid 100 mg tablet, one (1) ferrous sulfate 325 mg tablet, one (1) baclofen 10 mg tablet, and one (1) glycopyrrolate tablet 1 mg in a plastic medication cup. Registered Nurse #1 then placed all four (4) medications in a clear plastic pouch and crushed them together, using a medication crusher. Registered Nurse #1 entered Resident #79's room and placed the powdered medications into a five (5) ounce (approximately 150 cubic centimeters) clear plastic cup and added water. Registered Nurse #1 filled a second five (5) ounce clear plastic cup with water and placed it at the bedside table. Registered Nurse #1 then proceeded to administer a water flush of 60 cubic centimeters into the gastric tube. Registered Nurse #1 continued by withdrawing 60 cubic centimeters of the medications mixed in the water solution and pushed this into the gastric tubing. An additional 40 cubic centimeters of the remaining medication mixed in the water solution was then administered into the gastric tube. Registered Nurse #1 completed the medication administration process by flushing 35 cubic centimeters of water into the gastric tube.Registered Nurse #1 did not verify that the tube was functioning before they administered medication, and they did not give each medication individually and flush with 10 cubic centimeters between each medication. On 12/03/2025 at 11:29 AM, (continued on next page)

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	335146	A. Building B. Wing	12/08/2025

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #1 was interviewed and stated they were nervous, and they do not administer medications to residents with gastric tubing in this manner. Registered Nurse #1 also stated they have received training on how to administer medications to residents with a gastric tube in place, and medications need to be given separately because they each have a side effect and can cause a side effect reaction. On 12/05/2025 at 10:06 AM, the Attending Physician was interviewed and stated Resident #79 has a gastric tube due to their diagnosis of Amyotrophic Lateral Sclerosis, which is a serious disease that kills muscles, and leads to an inability to swallow. The Attending Physician also stated medications are to be administered separately, one at a time and slowly as the body needs time to absorb them as the Resident #79 has a slow absorption rate due to their diagnosis. The Attending Physician further stated checking for patency prior to administering medications is necessary to ensure the stomach is not full which can cause bloating, vomiting and discomfort, and if too much fluid is administered, it can cause the resident discomfort. On 12/08/2025 at 8:28 AM, Registered Nurse Supervisor #2 was interviewed and stated frequent rounds are conducted every day on every floor, after reports are obtained from prior shifts to ensure that continuity of care and services and needed follow ups are done. Registered Nurse Supervisor #2 also stated medications given to residents who have a gastric tube are to be crushed and administered separately, and checking for stomach contents is important to ensure placement stomach filling amount. Registered Nurse Supervisor #2 further stated the facility policy is to flush the gastric tube with 30 cubic centimeters of water after checking for patency. If there is 100 cubic centimeters of stomach content of more, then the feeds and medications are to be held, and the medical doctor is to be notified. Registered Nurse Supervisor #2 stated we dilute each medication with ten cubic centimeters of water for dilution of each medication, and flush with thirty cubic centimeters of water once all medication has been given. Registered Nurse Supervisor #2 also stated the nurse did not follow standards of practice and this could have had consequences for Resident #79. 10 NYCRR 415.12(g)(1-7)

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	335146	A. Building B. Wing	12/08/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Based on observation and staff interviews, the facility failed to ensure infection control prevention practices and procedures were maintained to provide a safe and sanitary environment, and to help prevent the development and transmission of communicable diseases and infections. This was evident during the Infection Control Task. Specifically, Resident #3 was observed with an open right shoulder wound and was not maintained on Enhanced Barrier Precautions. The findings are:The facility policy titled ?Enhanced Barrier Precautions' dated 05/18/2019 and last revised 06/10/2025 documented Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of community acquired multidrug resistant organisms colonization's/infections in patient care areas. The policy also documented Enhanced Barrier Precautions may be indicated for resident with wounds or indwelling medical devices regardless of multidrug resistant organism status. Wounds generally include chronic wounds, not shorter lasting wounds such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include but are not limited to pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and venous stasis ulcers. Resident #3 was admitted with diagnoses that included Cirrhosis, unspecified fracture of left patella and unspecified fracture of upper end of right humerus and was status post repair fracture of the shoulder. The admission Minimum Data Set, dated [DATE] documented Resident #3 had a major surgical procedure during the prior inpatient hospital stay and had a surgical wound with surgical wound care in place.Order details dated 10/23/2025 documented surgical site: cleanse right shoulder wound and peri-wound with wound cleanser, pat dry, apply skin-prep to peri-wound, apply Medi-honey to wound bed, cover with silver alginate twice daily and as needed. The Wound Care note dated 10/21/2025 documented right shoulder, 100% primary closed surgical wound with previous 19 sutures removed at clinic measured at 13.0 centimeters x 1.5 centimeters x 0.6 centimeters, 30% slough (dead tissue in a wound that can slow healing and may be yellow, tan or white in color) and 70% epithelial (healed cells that cover a wound) tissue. Dehiscence (a complication of surgery where a closed wound reopens) noted in the middle of surgical wound, 1.5 x 1.5 x 0.6 centimeters, 100% yellow slough and serous moderate exudate (fluid that leaks from a wound during the healing process). Start surgical site: cleanse right shoulder wound and peri-wound with wound cleanser, pat dry, apply skin prep to peri-wound, apply Medi-honey to wound bed then cover with silver alginate and dry protective dressing twice daily and as needed. Wound care note dated 12/04/2025 documented right shoulder 100% primary closed surgical wound with previous 19 sutures removed at clinic measured at 13.0 centimeters x 1.0 centimeters x 0.6 centimeters, 10% granulation tissue (new healed tissue on a wound), 90% epithelial tissue. Dehiscence noted in the middle of surgical wound measuring 1.0 centimeters x 1.0 centimeters x 0.0 centimeters, 100% pink granulation tissue and serous-sanguineus moderate exudate.Resident #3's name was not included on the Enhanced Barrier Precautions list last updated on 12/08/2025.On multiple observations between 12/01/2025 and 12/08/2025, there was no Enhanced Barrier Precautions signage noted in front Resident #3's room. On 12/04/2025 at 10:48 AM, the Wound Care Specialist was interviewed and stated Resident #3 has a history of methicillin-resistant staphylococcus aureus which is currently not active. Resident #3 initially presented with a closed right wound and a left open knee which eventually healed. On 10/14/2025, right shoulder sutures were removed and as of 10/21/2025, Resident #3 started having dehiscence from the right shoulder. The right shoulder wound is currently open but improving currently. From the right shoulder, there is moderate serosanguinous drainage. Wound care was performed this morning and Resident #3 was noted with small to moderate serosanguinous with orders to continue with alginate. The Wound Care Specialist also stated Resident #3 is not on the list for Enhanced Barrier Precautions at this time, and Enhanced Barrier Precautions are indicated for people who have a foley, (continued on next page)

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	335146	A. Building B. Wing	12/08/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peripherally inserted central catheter, perma-catheter, pressure wounds at a stage 3 or 4 and those with a huge surgical site or incision. In Residents #3's case, since the right shoulder wound is improving and the open part is less than 1 centimeter in length, Resident #3 does not need to be on Enhanced Barrier Precautions. On 12/04/2025 at 11:30 AM, the Infection Control Preventionist was interviewed and stated they have been working at the facility for 2 years. The Infection Control Preventionist also stated Enhanced Barrier Precautions are indicated for residents who have catheters with peripherally inserted central catheters, midline, foley catheter, major wounds and for those with current infections. The Infection Control Preventionist further stated Resident #3 is on vancomycin for prophylactic measures as they had a history of methicillin-resistant staphylococcus aureus which was resolved on 10/21/2025, and if a resident has major wound and if it warrants risk for infection, then the resident will be on Enhanced Barrier Precautions. The Infection Control Preventionist stated Resident #3 is currently not on Enhanced Barrier Precautions and they are not sure if they should be on it.On 12/04/2025 at 12:10 PM, the Medical Director was interviewed and stated that if a resident has a wound that is open, it may warrant that the resident is placed on Enhanced Barrier Precautions. On 12/05/2025 at 3:02 PM, wound care observation was performed with the Wound Care Specialist. Resident #3 was noted with a small open wound to the right shoulder with pink granulation tissue noted and a small amount of serous drainage noted on soiled dressing. Enhanced Barrier Precautions were not utilized during the wound care observation and there was no signage for Enhanced Barrier Precautions in front of Resident #3's room. On 12/05/2025 at 1:23 PM, the Wound Care Doctor was interviewed and stated they last evaluated Resident #3 this past Tuesday and Resident #3 was noted with an open right shoulder wound. The Wound Care Doctor also stated usually if a resident has a pressure ulcer at a Stage 2 or higher they are put on Enhanced Barrier Precautions, and if a resident has an open wound, they may need to be on Enhanced Barrier Precautions. The Wound Care Doctor further stated that from their judgment if a resident has an open surgical wound, Enhanced Barrier Precautions may be needed to prevent any infection to the surgical site.On 12/08/2025 at 11:22 AM, Certified Nursing Assistant #5 was interviewed and stated Resident #3 was initially on precautions when they first came to the facility but not at this time. Certified Nursing Assistant #5 also stated Resident #3 currently has a wound to the shoulder which is open as the nursing staff frequently change the dressing. Certified Nursing Assistant #5 further stated that they do not wear a gown or anything when giving care as Resident #3 is not on any precautions at this time. On 12/08/2025 at 12:21 PM, the Acting Administrator was interviewed and stated they have been working as the Acting Administrator since 08/20/2025 and prior to that was an Assistant Director of Nursing from 2021. The Acting Administrator also stated Enhanced Barrier Precautions are indicated if a resident has an active infection, is on isolation or if the doctor decides the resident should be on Enhanced Barrier Precautions. The Acting Administrator further stated is determined by the Infection Control Preventionist and the doctor. The Acting Administrator stated they are not sure if a resident with an open surgical wound needs to be on Enhanced Barrier Precautions. 10 NYCRR 415.19 (b)(4)