

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335155	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2023
NAME OF PROVIDER OR SUPPLIER  Windsor Park Rehab & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  212 40 Hillside Avenue Queens Village, NY 11427	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285</b></p> <p>Based on observation, interviews, and record review conducted during an abbreviated survey (NY00324912), the facility failed to protect resident's rights to be free from physical abuse. The facility did not ensure that each resident was free from physical abuse. This was evident for 1 out of 6 residents (Resident #4) sampled for Abuse. Specifically, the facility surveillance camera, dated 09/26/23, showed Resident #4 hit Certified Nursing Assistant (CNA) #4 as CNA #4 was escorting Resident #4 from the dining room to Resident #4's room. CNA #4 then pulled Resident #4's hair.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure dated 01/09/23, titled Abuse and Neglect states that it is the policy of the facility to assure residents are free from abuse and neglect, including involuntary seclusion. Residents will not be subjected to abuse by anyone, including, but not limited to facility staff, other residents, consultants, volunteers, family members, legal guardians, or outside members of the community.</p> <p>Resident #4 was admitted to the facility on [DATE] with diagnosis of Mild Intellectual Disabilities and Schizoaffective Disorder.</p> <p>The Minimum Data Set (MDS, a resident assessment tool) dated 09/08/23 documented that Resident #4 had moderately impaired cognition.</p> <p>A Psychosocial Well-being Care Plan dated 09/12/23, documented that Resident #4 has the potential to be victimized and the potential to abuse others. The interventions included providing early interventions, setting limits on inappropriate behaviors, and remove Resident #4 from area of aggressor.</p> <p>An Investigation Summary dated 09/26/23 documented that Registered Nurse Supervisor (RNS) #2 notified the Director of Nursing (DON) at approximately 11:07 PM (on 09/25/23) that Resident #4 was aggressive towards staff and scratched RNS #2. The medical doctor (MD) #1 was notified with instructions to monitor Resident #4's behavior and to transfer Resident #1 to the hospital if behavior continues. Resident #4 was assessed and had no recollection of the incident and outburst. The investigation also states that based on camera review; Resident #1 was aggressive, and CNA #4 used physical force to redirect Resident #4.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Surveillance Camera Recording dated 09/25/23 was reviewed on 10/04/23: the recording showed on 09/25/23 at 10:25PM, Resident #4 walked into the dining room with their rolling walking. At 10:27PM, Resident #4 began coloring in a book. At 10:32PM, CNA #3 and CNA #5 approached Resident #4 and was talking to Resident #4. At 10:33PM Resident #4 was shaking both their hands at CNA #3 and CNA #5. Resident #4 also threw their walker to the floor. At 10:34 PM, Licensed Practical Nurse (LPN) #2 arrived in the dining area along with CNA #3, #5, #6 and all four staff members were observed talking to Resident #4. At 10:35PM, CNA #4 approached Resident #4, tapped Resident #4 on their right shoulder and Resident #4 stood up and began walking out of the dining room with CNA #4. CNA #4 pulled Resident #4's chair back after Resident #4 stood up from their chair. At 10:35 to 10:36PM, CNA #4 was walking next to Resident #4 and LPN #2 walking behind them in the hallway. Resident #4 began hitting CNA #4. CNA #4 put both their hands up in the air pulled on Resident #4's hair then let go of Resident #4's hair. CNA #3 appeared in the hallway and assisted CNA #4 to escort Resident #4 back to their room. At 10:37:36 PM, RNS #2 approached LPN #2 in the hallway and was talking to LPN #2. At 10:38PM, RNS #2 and LPN #2 walked towards Resident #4's room.</p> <p>A Nursing Progress Note dated 09/25/23 at 10:24PM, by LPN #2 documented that Resident #4 was observed with non-compliance behavior, not staying in their room. Resident #4 was walking on the floor with their rolling walker and without assistance. Resident #4 became very aggressive, hitting themselves and staff.</p> <p>A Nursing Progress Note dated 09/26/23 at 12:29AM, by Registered Nurse (RN) #2, documented that at 10:40PM Resident #4 was observed to be agitated. Staff reported that Resident #4 was observed pacing in the hallway with their walker. Staff was not able to redirect Resident #4. Resident #4 became physically aggressive, towards staff. Resident #4 was observed banging their hands on the table and hit themselves in the face.</p> <p>During a telephone interview on 10/04/23 at 1:04PM, CNA #4 stated that at 10:40PM on 09/25/23, LPN #2 screamed at CNA #4 to get Resident #4 out of the dining room. CNA #4 said that they went to the dining room and observed that Resident #4 was agitated but they persisted on taking Resident #4 to their room because LPN #2 instructed them to do so. CNA #4 stated that while they were escorting Resident #4 to their room Resident #4 began hitting CNA #4. CNA #4 stated that they put their hands up in the air to block Resident #4 from hitting them and in the process their hand must have touched Resident #4's hair. CNA #4 stated that they did not pull Resident #4's hair. CNA #4 stated that LPN #2 was waking behind in the hallway.</p> <p>During an interview on 10/04/23 at 4:17PM, LPN #2 stated that Resident #4 went to the dining room and was coloring. LPN #2 stated that they informed CNA #4, who Resident #4 was familiar with and who was assigned to Resident #4, that Resident #4 was in the dining room. LPN #2 stated that CNA #4 approached Resident #4 in the dining room and encouraged Resident #4 to go back to their room. LPN #2 stated that Resident #4 willing got up and followed CNA #4 out of the dining room. LPN #2 stated that while CNA #4 was walking with Resident #4 in the hallway, they observed Resident #4 hit CNA #4. LPN #2 stated that they encouraged Resident #4 to stop hitting CNA #4 and informed CNA #4 to leave Resident #1. LPN #2 stated that CNA #4 did not walk away from Resident #4 because Resident #4's gait was unsteady. LPN #2 stated that CNA #3 came and assisted CNA #4 to escort Resident #4 to their room. LPN #2 stated that they were walking behind Resident #4 and CNA #4 and did not see when CNA #4 pulled on Resident #1's hair.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/04/23 at 5:21PM, RNS #2 stated that they arrived on the unit at approximately 10:35PM and LPN #2 notify them that Resident #4 was physically aggressive as CNA #4 attempted to escort Resident #4 to their room. RNS #2 stated that a body assessment was done on 09/25/23 and there was no redness, no bruising, no discoloration no injuries. RNS #2 stated that they called the Medical Doctor and received a telephone order to monitor Resident #4 for any further behavior and if the behavior escalate, Resident #4 should be sent to the hospital for further evaluation. RNS #2 stated that Resident #4 calmed down at 11:30PM and went back to the dining room to color in their book. RNS #2 stated that they became aware on 09/26/23, after reviewing the surveillance camera, that CNA #4 pulled on Resident #4's hair. RNS #2 said that there was no injury to Resident #4's scalp on 09/26/23.</p> <p>During an interview on 10/06/23 at 3:33PM, the DON stated that RNS #2 did not inform them of any altercation between Resident #4 and CNA #4. The DON stated that on 09/26/23 at 12:30PM during an Interdisciplinary Team (IDT) meeting a discussion led them to review the surveillance camera. The DON stated that the camera footage showed that CNA #4 pulled on Resident #4's hair. The DON stated that CNA #4 was called immediately and was removed from the schedule.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>43285</p> <p>Based on observation, interviews, and record review conducted during an abbreviated survey (NY00324912), the facility failed to ensure that a reasonable suspicion of a crime against a resident or an individual receiving care from the facility was reported to the local law enforcement. This was evident for 1 out of 6 residents (Resident #4) sampled. Specifically, the facility surveillance camera dated 09/26/2023 showed Resident #4 hit Certified Nursing Assistant (CNA) #4 as CNA #4 was escorting Resident #4 from the dining room to Resident #4's room. CNA #4 then pulled on Resident #4's hair. The facility did not report the alleged allegation of abuse within 2 hours on 09/25/23 to local law enforcement. The facility reported the abuse to local law enforcement on 10/04/23 while the Department of Health (DOH) surveyors were onsite investigating the allegation of abuse.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure title Reporting of Crime states that it is the policy of the facility to assure all alleged/suspected violations and all substantiated incident of abuse, or a crime has been committed will be promptly reported to appropriate state agencies and other entities or individuals as required by law and CMS expectations.</p> <p>An Investigation Summary dated 09/26/23 documented that RNS #2 notified the Director of Nursing (DON) at approximately 11:07 PM (on 09/25/23) that Resident #4 was aggressive towards staff and scratched RNS #2. The medical doctor (MD) #1 was notified with instructions to monitor Resident #4's behavior and to transfer Resident #4 to the hospital if behavior continues. Resident #4 was assessed and had no recollection of the incident and outburst. The investigation also states that based on camera review; it was evident that CNA #4 violated redirection of Resident #4 while the Resident was agitated. CNA #4 also used physical force on Resident #4.</p> <p>The Surveillance Camera Recording dated 09/25/23 was reviewed on 10/04/23: the recording showed on 09/25/23 at 10:25PM, Resident #4 walked into the dining room with their rolling walking. At 10:27PM, Resident #4 began coloring in a book. At 10:32PM, CNA #3 and CNA #5 approached Resident #4 and was talking to Resident #4. At 10:33PM Resident #4 was shaking both their hands at CNA #3 and CNA #5. Resident #1 also threw their walker to the floor. At 10:34 PM, Licensed Practical Nurse (LPN) #2 arrived in the dining area along with CNA #3, #5, #6, and all four staff members were observed talking to Resident #4. At 10:35PM, CNA #4 approached Resident #4, tapped Resident #4 on their right shoulder and Resident #4 stood up and began walking out of the dining room with CNA #4. CNA #4 pulled Resident #4's chair back after Resident #4 stood up from the chair. At 10:35 to 10:36PM, The camera footage showed CNA #4 was walking next to Resident #4 and LPN #2 walking behind them in the hallway. While they were walking in the hallway to Resident #4's room, Resident #4 began hitting CNA #4. CNA #4 put both their hands up in the air pulled on Resident #4's hair then let go of Resident #4's hair. CNA #3 appeared in the hallway and assisted CNA #4 to escort Resident #4 back to their room. At 10:37:36 PM, Registered Nurse Supervisor (RNS) #2 approached LPN #2 in the hallway and was talking to LPN #2. At 10:38PM RNS #2 and LPN #2 walked towards Resident #4's room.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/06/23 at 3:33PM, the DON stated that on 09/26/23 at 12:30PM during an Interdisciplinary Team (IDT) meeting a discussion led them to review the surveillance camera footage which CNA #4 pulled on Resident #4's hair. The DON stated Resident #1's family stated that they did not want the incident to be reported to local law enforcement. The DON stated that they did not call local law enforcement to honor Resident #4's family's request.</p> <p>During an interview on 10/6/23 at 3:51PM, the Administrator stated that the incident was reported to local law enforcement on 10/04/2023 at 7:00PM.</p> <p>10NYCRR 415.4(b)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>39659</p> <p>Based on observation, interviews, and record review conducted during an abbreviated survey (NY00321418), the facility did not ensure that a resident drug regimen was free from unnecessary medication. This was evident for one out of six residents (Resident #1) reviewed for antipsychotic medication. Specifically, Resident #1, who was not initially receiving an antipsychotic medication, was administered Haloperidol (an antipsychotic medication use used to treat certain mental/mood disorder such as schizophrenia, schizoaffective disorder) 2milligrams (mg) as a onetime dose on 08/02/23 for diagnosis of Anxiety. There was no documented evidence that non-pharmacological interventions were attempted prior to the administration of the anti-psychotic medication.</p> <p>The findings are:</p> <p>Review of the Antipsychotic Medication Use Policy, revision date of 12/2016, states that Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The attending physician and facility staff will identify acute psychiatric episodes and will differentiate them from enduring psychiatric conditions. Diagnosis of a specific condition for which antipsychotic medications are necessary to treat will be based on a comprehensive assessment of the resident. Diagnoses alone do not warrant the use of antipsychotic medication.</p> <p>Resident #1 was admitted to the facility with diagnosis including Pneumonia, Arthritis and Anxiety disorder. A Minimum Data Set (MDS, a resident assessment tool) was not done as Resident #1 had been just admitted to the facility.</p> <p>A Nursing Progress Note dated 08/02/2023 at 9:29PM, by Registered Nurse (RNS #1) documented That Resident #1 was observed to be anxious and was talking to themselves several times during the shift. Resident #1 was constantly yelling and talking to self. Resident #1 appeared alert and oriented times four. After a few hours, Resident #1 start yelling again. The Medical Doctor (MD) #1 was notified and ordered one dose of Haloperidol 2mg. Resident #1 will be seen by psychiatrist as well. Monitoring continues.</p> <p>A Physician Order Report dated 08/02/2023 - 09/08/2023 documented Haloperidol 2mg, orally STAT for diagnosis of Anxiety disorder due to known physiological condition.</p> <p>There was no documented evidence in Resident #1's medical record that non-pharmacological interventions were completed prior to the administration of the anti-psychotic medication.</p> <p>There was no documented evidence in Resident #2's medical record that Resident #2 was assessed or monitored for the effectiveness of the medication and potential adverse consequences.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/04/2023 at 3:04PM, Certified Nursing Assistant (CNA) #1, who assisted CNA #2 with caring for Resident #2 on 08/02/2023 on the evening shift stated that during care Resident #1 was not physically abusive and was not aggressive and they provided incontinent care without any issues. CNA #1 stated that they returned to Resident #2 a second time during the shift and Resident #1 was being picky (very specific with what Resident #1 wanted) and was switching topics and was not concentrating.</p> <p>During an interview on 10/04/2023 at 3:35PM, Licensed Practical Nurse (LPN) #2 stated that Resident #1 was upset and was demanding everything to be done the way Resident #1 wanted it. LPN #2 stated that Resident #1 yelled when the CNAs (CNA #1, CNA #2) tried to change Resident #2's incontinence brief. LPN #2 stated that Haloperidol one tablet 2mg was administered to Resident #1 by oral route as per the physician's order.</p> <p>During a subsequent telephone interview on 10/24/2023 at 4:08PM, LPN #2 stated that they do not recall attempting any non-pharmacological interventions prior to administering the Haloperidol medication. LPN #2 stated that they went to Resident #1 's room and informed the Resident #1 that he MD #1 ordered a onetime dose of Haloperidol 2mg and Resident #1 took the medication. LPN #2 stated that they monitored Resident #1 but could not recall documenting.</p> <p>During an interview on 10/04/2023 at 4:04PM, RNS #1 stated that they admitted Resident #1 to the unit on 08/02/2023 and that Resident #1 was alert and oriented times four. RNS #1 stated that Resident #1 was very emotional, very specific about all aspects of care, especially food preferences. RNS #1 stated that Resident #1 was not confused but had difficulty to focusing on topics when they were discussing preferences of care. RN #1 stated that Resident #1 was cooperative during admission and did not demonstrate any behavioral problems. RNS #1 stated that later in the shift Resident #1 had outbursts of yelling. RNS #1 stated that they went to Resident #1 's room and talked to Resident #1, but Resident #1 did not have any complaints. RN #1 stated that after RN #1 left Resident #1's room, Resident #1 started yelling and was disturbing other Residents. RN #1 stated that they called MD #1 and MD #1 ordered Haloperidol 2mg to be administered orally STAT.</p> <p>During a subsequent telephone interview on 10/24/2023 at 3:50PM, RNS #1 stated that Resident #1 was monitored after the medication was administered and that Resident #1 was observed relaxed and calmer. RNS #1 stated that they were not sure if they had documented in the medical record. RNS #1 stated that no one forced Resident #1 to take the medication and that Resident #1 was aware of what Resident #1 was taking.</p> <p>During a telephonic interview on 10/04/2023 at 4:43, MD #1 stated Resident #1 was a newly admitted Resident and was not yet evaluated. MD #1 stated that they were notified about Resident #1 's erratic aggressive behavior of yelling and disturbing the piece of other residents. MD #1 stated that prescribing an antipsychotic medication for Anxiety induced psychosis cause by chronic opioid intake. MD #1 stated that a non-pharmacological intervention like trying to talk, trying to calm down Resident #1, and calling the family were not effective. MD #1 stated that the Haloperidol 2mg was ordered 08/02/2023 as a STAT order oral medication. MD #1 stated that they did not document in Resident #1's medical record.</p> <p>During an interview on 10/04/2023 at 5:12PM, the Director of Nursing (DON) stated that they met Resident #1 the next day after admission on 8/03/2023. DON stated that there should have been more documentation on the reason for the STAT order of Haldol.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated that the nurse documented that Resident #1 was yelling as the indicator for the STAT order, but yelling is not an acceptable indicator for the use of Haldol.</p> <p>10 NYCRR 415.12(1)(2)(i)</p>		