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| 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 10/03/2024 |
| 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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>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.</p> <p>44472</p> <p>Based on observation, record review, and interview conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure the residents' right to a safe, clean, comfortable, and homelike environment was maintained. This was evident in 1 (West Side) of 2 units observed. Specifically, 1.) A resident's wheelchair has been observed with torn cushion on the left arm rest, 2.) The Hoyer lift was rusty with dark yellow and blackish stains on the metal frame, 3.) The wooden door frame on the whirlpool room had chipped paint, and 4.) The elevator was observed with layers of mismatched black colored paint.</p> <p>The findings are:</p> <p>The facility's policy titled Maintenance Service with a revision date of 01/2024 stated that it is the policy of the facility to provide maintenance services to all areas of the building, grounds, and equipment. The functions of maintenance personnel include maintaining the building in good repair and establish priorities in providing repair service.</p> <p>The following were observed during multiple observations conducted from 09/26/2024 to 10/03/2024 on the [NAME] Side unit:</p> <ol style="list-style-type: none"> 1.) Resident #54's wheelchair was observed with a torn cushion on the left arm rest. 2.) The Hoyer lift being used on the [NAME] Side unit was observed with rust and had a large area of dark yellow and blackish stain on the metal frame. 3.) The wooden door frame in the whirlpool room was observed with chipped paint. 4.) The elevator door was observed with layers of mismatched paint. <p>A review of the [NAME] Side unit Maintenance Workbook from 01/2024 through 09/2024 revealed no documentation of the concerns noted during the State Surveyor's observation.</p> <p>During an interview on 10/01/2024 at 10:41 AM, Resident #54 stated that the cushion on their wheelchair arm rest has been torn since they were admitted . They stated that the staff replaced their wheelchair yesterday and gave them another one that has no rip.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: 335155 | Facility ID: 335155 If continuation sheet Page 1 of 5 |

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| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>During an interview on 10/03/2024 at 12:05 AM, the Director of Rehabilitation stated they were responsible for inspecting and repairing the wheelchairs and might have missed the torn arm rest on Resident #54's wheelchair.</p> <p>During an interview on 10/02/2024 at 10:43 AM, the Director of Maintenance stated they were responsible for maintaining the walls and other equipment including the Hoyer lift. The Director stated they make their rounds every morning and missed some areas that need to be repainted.</p> <p>10 NYCRR 415.5(h)(2)</p> | | |

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| <p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p> | <p>Post nurse staffing information every day.</p> <p>44472</p> <p>Based on observation, record review, and interview conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure that the nurse staffing information was posted in a prominent place readily accessible to residents and visitors. Specifically, there was no available posting of daily nurse staffing information.</p> <p>The findings are:</p> <p>The facility policy titled Staffing with a reviewed date of 01/2024 stated that the facility provides sufficient number of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. Direct care staffing information per day is submitted to the Centers for Medicaid and Medicare Services payroll based journal system on the schedule specified but no less than once a quarter. The policy did not contain information on posting of the daily nurse staffing information.</p> <p>During multiple observations conducted on 09/26/2024 and 09/30/2024, the State Surveyor was unable to locate the postings of the daily nurse staffing data for each shift or any signage instructing residents or visitors where it was located.</p> <p>During an interview on 09/27/2024 at 02:10 PM, the Staffing Coordinator stated they only post the names of the staff and their assigned units. The Staffing Coordinator stated they do not post the actual hours worked by the nursing staff or the resident census.</p> <p>During an interview on 09/30/2024 at 01:30 PM, the Director of Nursing stated that they were not aware of the regulation that the nurse staffing information must be posted daily.</p> <p>During an interview on 10/01/2024 at 10:45 AM, the Administrator stated it was the Staffing Coordinator's responsibility to post the nurse staffing information.</p> <p>10 NYCRR 415.13</p> |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide and implement an infection prevention and control program.</p> <p>44864</p> <p>Based on observations, record review, and interviews conducted during the Recertification Survey from 09/26/2024 to 10/03/2024, the facility did not ensure infection control practices and procedures were maintained. This was evident in 3 (Resident #159,#35, and #22) of 18 total sampled residents. Specifically, Licensed Practical Nurse #1 was observed using the same blood pressure cuff for Residents #159 and #22 without cleaning and disinfecting the blood pressure cuff in between each resident use. Licensed Practical Nurse #1 also failed to clean and disinfect the blood pressure machine after each usage.</p> <p>The findings are:</p> <p>The facility's policy titled Cleaning and Disinfection of Non -Critical Resident Care Equipment with a revision date of 01/2024 documented that shared equipment including transport equipment, will be cleaned, and disinfected after use by each patient/resident and as needed.</p> <p>On 10/01/2024 at 09:45AM, Licensed Practical Nurse #1 was observed going into Resident #159's room, removed the blue blood pressure cuff from the blood pressure machine and took Resident's # 159 blood pressure. Licensed Practical Nurse #1 did not sanitize the blood pressure cuff prior to placing the cuff on Resident #159's arm. Licensed Practical Nurse #1 then rolled the blood pressure machine out of the room, into the hallway, then logged the blood pressure results. Licensed Practical Nurse #1 without sanitizing the blood pressure cuff, then proceeded to take the blood pressure machine into Resident #22's room. Licensed Practical Nurse #1 washed their hands and applied the same blue blood pressure cuff on Resident's #22's left arm without sanitizing the blood pressure cuff or machine prior to use. Licensed Practical Nurse #1 then washed their hands, rolled the blood pressure machine in the hallway, and continued to prepare the medications to be administered for Resident #22. Licensed Practical Nurse did not sanitize the blood pressure cuff nor the blood pressure machine.</p> <p>After administering Resident #22's medications, Licensed Practical Nurse #1 washed their hands and without sanitizing the blood pressure machine or the blood pressure cuff, took the blood pressure machine into Resident #35's room . Licensed Practical Nurse #1 then took Resident #35's blood pressure using a red cuff. Licensed Practical Nurse#1 administered Resident's #35's medication, washed their hands, and rolled the blood pressure machine next to the medication cart. Licensed Practical Nurse #1 did not cleaning or sanitize the blood pressure machine and the blood pressure cuff after use.</p> <p>On 10/01/2024 at 10:22 AM, immediately following Resident #35's medication administration, Licensed Practical Nurse#1 was interviewed and stated that they had cleaned the blood pressure machine prior to the start of their daily medication administration, and that they are aware that they are to clean the blood pressure machine and blood pressure cuffs between residents' usage. They stated they forgot to clean the blood pressure machine and cuffs between each residents.</p> <p>On 10/01/2024 at 11:07 AM, the Director of Nursing was interviewed and stated that the licensed nurses were given in-service on cleaning the blood pressure cuffs and the blood pressure machine between residents' usage. The Director of Nursing stated that the Licensed Practical Nurse #1 should have cleaned the blood pressure machine between each residents' usage.</p> <p>(continued on next page)</p> | | |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>10 NYCRR 415.19 (a)(1-3)</p> |