STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335266	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest Rehab & Residential H C Center, L L C	119 09 26th Avenue Flushing, NY 11354

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews conducted during an Abbreviated Survey (NY00347821, NY00348092 and NY00354868), the facility did not ensure that the alleged violations involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property were reported immediately, but not later that two (2) hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not involve serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency). Additionally, the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident in three (3) out of seven (7) residents (Resident #1, #2 and #4). Specifically, on 07/10/2024 at 11:00 AM, Resident #1 reported that Licensed Practical Nurse #1 punched them in their face and was observed with small cut in their upper lip. On 07/10/2024 at 3:04 PM, The facility reported the incident to New York State Department of Health and the facility did not report the results of the investigation within five (5) days to the New York State Department of Health. On 07/12/2024 at 12:30 AM, Resident #2 complained of lower back pain and stated that Licensed Practical Nurse #2 pulled their left arm backward while they were sleeping. On 07/12/2024 at 4:48 PM, the facility reported the incident to New York State Department of Health. The facility did not submit the follow up investigation summary within five (5) days to the New York State Department of Health. On 09/05/2024 at 5 AM, Resident #4 was assessed by the Registered Nurse (#1) after hitting their head on the bed and observed with an open wound to the left scalp and bleeding in the left eye. Resident #4 and was transferred to the hospital. On 9/12/2024, Resident #4 was re-admitted to the facility with a hospital discharge note documented Resident #4 had head injuries are had staples to the forehead. On 09/20/2025, the facility reported resident neglect occurred on 09/05/2025 to the Department of Health. The findings include: The Facility's Policy and Procedure titled Abuse, Neglect and Exploitation: Prevention and Reporting dated 07/2024, documented allegations of abuse or neglect; serious bodily injury due to neglect, exploitation, mistreatment or an injury of unknown source must be reported within two (2) hours. The Director of Nursing/designee will investigate injuries of unknown origin and report findings to the Administrator. The Administrator will determine if other reporting is required by law. All findings of investigations will be documented. An investigative report will be completed within five (5) days and summarize the findings and outcome as well as any corrective action(s). If abuse cannot be ruled out the New York State Department of Health will be notified. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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	335266	A. Building B. Wing	07/01/2025

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #1 was admitted to the facility with diagnoses including Schizophrenia, Anxiety Disorder and Hypertension. The Minimum Data Set (a resident assessment tool) dated 07/08/2024 documented Resident #1 cognition was intact. In the facility's Accident/Incident Report dated 07/10/2024 at 11:30 AM, documented Resident #1 reported that they were punched by the Licensed Practical Nurse #1 in their face. Resident #1 was observed with a small tear on upper lip. The facility concluded that there was no evidence to support that Resident #1 was punched in their face. There was no swelling or bruising on the face. The Licensed Practical Nurse #1 sustained a superficial skin break and bleeding in their finger. It was concluded that Resident #1-bit Licensed Practical Nurse #1 on their finger as they were attempting to administer the medication. Resident #1 sustained trauma in their lip when Licensed Practical Nurse #1 pulled away their finger from Resident #1. The facility reported the incident to New York State Department of Health on 07/10/2024 at 3:04 PM and did not report the results of the investigation within five (5) working day to the Department of Health. Resident #2 was admitted to the facility with diagnoses including Chronic Obstructive Pulmonary Disease, chronic pain and anxiety. The Minimum Data Set (a resident assessment tool) dated 06/22/2024 documented Resident #3 cognition was intact. In the facility's Accident/Incident Report dated 07/12/2024 at 9:30 AM, documented Resident #1 complained of lower back pain and reported that Licensed Practical Nurse #2 pulled their left arm backward while they were sleeping. The facility's summary of investigation dated 07/15/2024, documented that Resident #2 was angry when they were awakened at midnight for administration of medications by Licensed Practical Nurse #2. Resident #2 was assessed and there was no injury. The radiology results of lumbar spine, left forearm, left arm and left elbow were negative. The facility's investigations concluded no abuse occurred. The facility reported the incident to New York State Department of Health on 07/12/2024 at 4:48 PM. The facility did not report the results of their investigation within five (5) working days to New York State Department of Health. Resident # 4 was admitted to the facility with diagnoses including Alzheimer's Disease, seizure disorder and adult failure to thrive. The Minimum Data Set (a resident assessment tool) dated 08/01/2024, documented Resident #4 was severely cognitive impairment and is non-ambulatory. In the facility's Incident Report dated 09/5/2024 at 5 AM, completed by the Registered Nurse (#1) documented Resident #4 was seen with a left scalp three (3) centimeters x 0.1centimeters open area to the head. Resident unable to state what happened. Resident #4 was transferred to hospital as ordered by the physician/nurse practitioner. The facility's summary of the investigation documented that on 9/12/2024, Resident #4 was re-admitted to the facility. The hospital discharge notes documented Resident #4 had head injuries that required staples to close the wound. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/23/2025 at 9:00 AM, Director of Nursing stated they reported to New York State Department of Health of the allegations and stated they did not report timely. Director of Nursing stated they are aware that any allegations of abuse should be reported within two (2) hours. Director of Nursing further stated they failed to submit the follow up report within five (5) days to New York State Department of Health. During an interview on 06/23/2025 at 6/23/25 9:51 AM, the Administrator stated they were not aware that the incidents were not reported timely, and they were not aware the results of the investigations were reported within five (5) days to New York State Department of Health. During a follow up interview on 6/24/2025 the Administrator and Director of Nursing at 5:20 PM and 5:23 PM respectively, the Director of Nursing stated on 9/5/2024, Resident #4's injuries were assessed as superficial scratches but after Resident #4 returned to the facility on 9/12/2024 they realized the injury was worse as Resident #4 had staples according to the hospital's records. The Administrator stated when they were informed on 9/19/2025 the incident was reported to New York State Department of Health. 10 NYCRR 415.4 (b)(1)(ii)