STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335294	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Long Island Care Center Inc	144-61 38th Ave 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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 43285 Based on observation, record review, and interviews during an abbreviated survey (NY00308373), the facility failed to protect a resident from physical abuse by a nursing home staff. This was evident in one out of two residents (Resident #1) sampled for abuse. Specifically, on 01/09/23 at approximately 9:44 pm the facility's surveillance video recording showed Licensed Practical Nurse #1 hit Resident #1 on the left side of their face with a bottle (plastic). The facility's Accident and Incident Report dated 01/09/23 at 9:45 pm documented Resident #1 called the police and was transferred to the hospital. The findings are: The facility's Policy and Procedure titled Resident Abuse, Mistreatment, Exploitation, Misappropriation of Property, Corporal Punishment, Involuntary Seclusion, Neglect, and Injury of Unknown Source, dated 02/2022 states it is the policy of the facility to assure all residents and families that the facility has taken steps within its control to prevent abuse, neglect, and mistreatment, exploitation of the residents and the misappropriation of their property. Resident #1 was admitted to the facility with diagnoses of Anxiety, Borderline Personality, and End Stage Renal Disease. The Minimum Data Set (an assessment tool), dated 12/15/2022, documented Resident #1 had a Brief Interview for Mental Status (used to determine attention, orientation, and ability to recall information) score of 13 associated with intact cognition. Resident #1 required extensive assist of one person for locomotion on and off the unit using a wheelchair. A Care Plan on Risk for Victimization dated 11/20/2022 documented interventions to redirect Resident #1 from physical and verbal aggression towards staff members and Social Worker to monitor and intervene as necessary. A Care plan for Behavior dated 09/19/2022 documented interventions to monitor behavior and to educate Resident #1 on coping skills. The care plan was updated to reflect on the incident of 01/09/2023. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's surveillance video camera recording dated 01/09/2023 at 9:41 pm showed at 9:41 pm Licensed Practical Nurse #1 and one Certified Nursing Assistant were sitting down at the nursing station working. At 9:41 pm two other Certified Nursing Assistants approached the nursing station and was talking to Licensed Practical Nurse #1. At 9:42 pm the three Certified Nursing Assistants left the nursing station. At 9:43 pm Licensed Practical Nursing #1 was sitting alone at the nursing station when Resident #1 approached Licensed Practical Nurse #1, in their wheelchair, and said something to Licensed Practical Nurse #1 then Resident #1 wheeled themself away from the nursing station and out of camera view. At 9:44 pm Resident #1 wheeled themself into the area of the nursing station where Licensed Practical Nurse #1 was sitting. Licensed Practical Nurse #1 quickly stood up from their chair while holding a bottle (identified as a cranberry juice bottle with small amount of juice in bottle) in their right hand and a sanitizer container in their left hand. Licensed Practical Nurse #1 launched forward, raised their right hand, and hit Resident #1 on the left side of their face. Staff members approached and intervened by separating Licensed Practical and Resident #1. At 9:44:31 after Resident #1 was separated from Licensed Practical Nurse # 1, Resident #1 raised their hand and threw something in Licensed Practical Nurse #1's direction. At 9:44 pm Registered Nurse Supervisor #1 arrived on the unit and was talking with Licensed Practical Nurse #1 and Resident #1. At 9:47:38 pm Registered Nurse Supervisor #1 walked out of camera view and reappeared in camera view at 9:47:54 pm. At 9:46:40 pm Resident #1 wheeled themself out from the nursing station and was observed in front of the nursing station in the hallway using their cell phone. At 9:50:31 pm the surveillance camera recording ended while Registered Nurse Supervisor #1 was talking to Licensed Practical Nurse #1 on the unit at the nursing station. The Resident Accident and Incident Report dated 01/09/23 at 9:45 pm documented that Resident #1 was observed with increased aggressiveness, yelling, and cursing at staff member. Resident #1 verbalized Licensed Practical Nurse #1 threw a bottle of cranberry juice and jar of sanitizing wipes hitting them in their left eye. Resident #1 complained of pain. No redness, swelling or tenderness noted. No visible injury. 911 was called and responded at 10:10 pm. Resident #1 requested to be transferred to the hospital. Resident #1 left the unit for the hospital at 10:35 pm. Facility investigated the abuse incident and documented that after they reviewed the unit camera, they have concluded there is evidence to believe physical abuse had occurred. A Behavior Progress Note, written by Registered Nurse Supervisor #1, dated 01/10/2023 at 1:35 am documented at approximately 9:50 pm on 01/09/2023 writer was called to the unit by Licensed Practical Nurse # 1 who reported that Resident #1 was yelling and cursing on the unit. Upon entering on the unit, they observed Resident #1 sitting in their wheelchair by the nursing station cursing and yelling at Licensed Practical Nurse #1. Resident #1 reported Licensed Practical Nurse #1 threw a cranberry juice bottle and a jar of sanitizing wipes hitting them in their left eye. On assessment no redness, swelling or tenderness to the area. Resident #1 requested to transferred to the hospital. Resident #1 left the unit at 10:35 pm for the hospital. Resident #1 was admitted to the hospital with undisclosed diagnosis. A Nursing Progress Note dated 01/27/2023 at 7:12 pm documented Resident #1 was readmitted to the facility with diagnosis of Assault by unspecified means. A full body assessment was done, and no injury observed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/04/2024 at 5:06 pm Registered Nursing Supervisor #1 stated when they arrived on the unit, they observed Resident #1 sitting in their wheelchair in between the nursing station and the hallway. Registered Nursing Supervisor #1 stated Resident #1 was cursing and yelling at Licensed Practical Nurse #1. Registered Nursing Supervisor #1 stated that Resident #1 reported that Licensed Practical Nurse #1 hit them pointing to their left eye. Registered Nursing Supervisor #1 stated Licensed Practical Nurse #1 was still standing at the nursing station and reported Resident #1 was coming at them and they picked up the cranberry juice and the hand sanitizer to prevent Resident #1 from picking them up. Registered Nursing Supervisor #1 stated Licensed Practical Nurse #1 reported that they did not hit Resident #1. Registered Nursing Supervisor #1 stated that they assessed Resident #1 and Resident #1 did not have any visible injury. Registered Nursing Supervisor #1 stated that Resident #1 complained of pain to their left eye and reported they wanted to go to the hospital. Registered Nurse Supervisor #1 stated 911 was called and arrived on the unit at 10:10 pm. Registered Nursing Supervisor #1 stated Resident #1 and Licensed Practical Nurse #1 were interviewed by the Police Officers. Registered Nursing Supervisor #1 stated Resident #1 immediately left for the hospital. Registered Nursing Supervisor #1 stated they did not call the Medical Doctor when Resident #1 was yelling at Licensed Practical Nurse #1. Registered Nursing Supervisor #1 stated they took Resident #1 off the unit to the nursing supervisor's office until the police arrived. Registered Nursing Supervisor #1 stated that after the police came to the facility, they took Resident #1 back to the unit where they were interviewed by the police. Registered Nursing Supervisor #1 stated Licensed Practical Nurse #1 left the facility after the police interviewed them. Registered Nursing Supervisor #1 stated they separated Licensed Practical Nurse #1 and Resident #1, but they were not aware that they were supposed to immediately remove Licensed Practical Nurse #1 from the unit. During an interview on 04/04/2024 at 6:34 pm, Licensed Practical Nurse #1 stated they were behind the nursing station when Resident #1 requested to have someone assisted them in packing out their personal belongings. Licensed Practical Nurse #1 stated that they instructed Certified Nursing Assistant #1 to assist Resident #1. Licensed Practical Nurse #1 stated that Resident #1 started to curse at Certified Nursing Assistant #1 stating that they needed everything to be packed out. Licensed Practical Nurse #1 went on to say that Resident #1 approached them at the nursing station and requested to speak with Registered Nursing Supervisor #1 and left the unit. Licensed Practical Nurse #1 went on to say that Resident #1 returned to the unit and approached inside of the nursing station and picked up the keys that were on the desk. Licensed Practical Nurse #1 stated that they sustained a laceration to their hand while they were taking the keys from Resident # 1. Licensed Practical Nurse #1 stated they picked up a cranberry and sanitizer bottle off the desk to prevent Resident #1 from throwing the bottles at them. Licensed Practical Nurse #1 stated that they did not hit Resident #1. During an interview on 05/02/2024 at 11:50 am, the Director of Nursing stated they were not the Director of Nursing at the time of the incident. During an interview on 05/02/2024 at 12:15 pm, the Administrator stated they are new to the facility and does not know Licensed Practical Nurse #1 or Resident #1. 10 NYCRR 415.4(b)(1)(i)