STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335349	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cliffside Rehab & Residential Health Care Center	119 - 19 Graham Court Flushing, NY 11354

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/16/2025 to 07/23/2025, the facility failed to ensure that residents were free from physical restraints for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. This was evident for 5 (Residents #29, 142, #206, #125, and #3) of 8 residents reviewed for physical restraints out of 35 total sampled residents. Specifically, 1.) Residents #29, 142, #206, #125, and #3 were observed on multiple occasions in bed with both upper and lower half side rails raised on both sides. All 5 residents had impaired cognition; were either dependent on staff or required substantial / maximal assistance for bed mobility; and were unable to easily and voluntarily release the side rails. 2.) Resident #142 was observed on a wheelchair with a lap tray that prevents the resident from rising and cannot be removed easily and voluntarily. There was no documented evidence that alternatives were attempted prior to implementing side rails and lap tray use. Additionally, there was no documented evidence of informed consent or that education regarding the risks and benefits of side rail and lap tray use was given to the family. The findings include: The facility's policy titled Physical & Chemical Restraints with a last reviewed date of 05/2025 documented that the facility supports the philosophy that residents/persons served will remain free from any physical and chemical restraints unless residents/person served has medical symptoms that warrant the use of restraints for health and safety measures. The policy documented all residents served requiring a physical restraint shall be assessed by the interdisciplinary team to assess the need for restraints and the least restrictive device to be used. A physician's order must be obtained for any restraint use and must include appropriate medical symptoms that warrants it use, for example active seizure disorder, Huntington's Chorea. All in-house residents who have restraint orders will be assessed quarterly, or more frequently, if necessary, by the interdisciplinary team to determine the need or continued need for restraint or for restraint reduction. The facility's policy included side rails that keep the residents from voluntarily getting out of bed as a type of restraint. The policy further documented that full side rails are considered to be physical restraint. 1. Resident#29 was admitted to the facility with diagnoses that included Non-Alzheimer's Dementia, Anxiety, Depression and Bipolar Disorder. The quarterly Minimum Data Set assessment dated [DATE] documented that resident had severely impaired cognition, no behaviors, had impairment on both sides of upper and lower extremities, and was dependent on staff for bed mobility, chair transfer, no toilet use, and always incontinent of urine and bowel. The assessment documented that bed rail was not in use. During observation on 07/18/2025 at 9:57 AM at 10:02 AM, Resident #29 was in bed with upper and lower half side rails raised on both sides. At 10:02 AM, the resident was provided care by the Certified (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing Assistant; the resident was unable to follow instructions, unable to turn, and unable to hold onto the side rails. On 07/21/2025 at 12:25 PM and on 07/22/2025 at 9:08 AM, Resident #29 was observed in bed with upper and lower half side rails raised on both sides. A Full Side Rail Assessment form documented the date of initial assessment was 11/01/2024. The assessment documented that side rail use will limit Resident #29's ability to exit the bed and documented unable to define bed boundaries as the medical symptom for side rail use. The form documented that the family was informed of side rail use but did not indicate whether consent was given by the family member. There was no documented evidence that education regarding the risks and benefits of side rail use was given to the family. The side rail quarterly review documented that reviews were completed by the interdisciplinary team on 02/05/2025 and 05/13/2025. There were no documented attempts to reduce the use of side rails. The review documented positioning legs off bed and continue use of full side rails. A physician's orders dated 07/10/2025 documented bed mobility using full side rail, elevated with bumper guard due to unawareness of bed boundaries, family requested full side rail secondary to history of patient getting out of bed. A comprehensive care plan for restraints was initiated on 11/01/2024, related to poor bed boundaries. The care plan documented to initiate full side rails. The goal include Resident #29 will be safe in the least restrictive device daily. The facility interventions included to monitor and evaluate continued need to use physical restraints per protocol and to discuss with team. A comprehensive care plan for falls was initiated on 11/01/2024. The goal included Resident #29 will have no future falls or sustain any injury. The facility interventions include to keep both upper side rails up when resident is in bed. A comprehensive care plan for total self-care deficit related to hemiparesis / hemiplegia/ and contractures was initiated on 11/26/2024. The facility interventions include applying 2 half bed side rails as enabler to assist in bed mobility and turning and positioning. A nurse's note dated 04/17/2025 documented Resident #29 was met in bed, responsive to tactile stimuli, unable to make needs known, bilateral handrails raised for repositioning. A nurse's note dated 07/12/2025 documented Resident #29 was alert with some confusion and forgetfulness, reoriented, and redirected when needed, both full side rails up due to unawareness of bed boundaries. The Certified Nursing Aide Accountability Record had no instructions on side rail use. A review of Resident #29's medical record revealed no documented evidence that alternatives were attempted prior to implementing side rails. On 07/22/2025 at 10:53 AM, Certified Nursing Assistant #7 was interviewed and stated that Resident #29 needs complete assistance with activities of daily living and can be resistant with care. Certified Nursing Assistant#7 stated Resident #29 is provided side rails, however resident is not able to take it down or use it. They stated that Resident #29's family requested the side rails. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/22/2025 at 10:22 AM, Registered Nurse #5, who was the Unit Supervisor, was interviewed and stated that Resident #29's family requested the side rails prior to the resident coming to the unit. The supervisor stated Resident #29 had been in the unit since April 2025 and they had no discussion with the resident's family about the use of side rails. They stated they provided the side rails for the resident because the resident can be restless in bed. Registered Nurse #5 stated there was no instructions in the Certified Nursing Aide Accountability Record regarding the use of side rails. On 07/22/2025 at 2:34 PM, Nurse Practitioner #3 was interviewed and stated Resident #29 had an order for the use of full side rails since November 2024. Nurse Practitioner #3 stated they are planning to talk with the family about reducing the side rail use because the resident had less agitation in the last month. 2. Resident #142 was admitted to the facility with diagnoses that included Encephalopathy, Anxiety Disorder, and Hypertension. The Minimum Data Set assessment dated [DATE] documented that Resident #142 was severely cognitively impaired, had no behavior, had impairment on both sides of lower extremities, and required dependent assistance of staff with transfers and dependent to substantial/maximal assistance with bed mobility. The assessment documented that bed rails were used daily and a chair that prevents rising was used daily. During observation on 07/16/2025 at 10:36 AM, Resident #142 was sleeping in bed with upper and lower half side rails raised on both sides. On 07/21/2025 at 10:39 AM, Resident #142 was observed awake and alert, lying in their bed, with padded upper and lower half side rails raised on both sides. The resident was unable to release the side rails independently. On 07/21/2025 at 11:00 AM, Resident #142 was observed on a wheelchair with a lap tray secured with Velcro straps that the resident cannot easily remove and prevents the resident from rising. The Restraint Assessment Record Form documented the date of initial assessment was 10/15/2022 documented that wheelchair with lap tray and full side rails were ordered. It documented that alternative measures attempted was redirection. The medical symptom for restraint use was unsteady gait and unaware of functional limitations. The form documented the family was informed of side rail use but did not indicate whether consent was given by the family member. There was no documented evidence that education regarding the risks and benefits of side rail and lap tray use was given to the family. The most recent restraint quarterly review was completed on 07/03/2025; there was no documented attempts to reduce the use of side rails and lap tray. The review documented poor bed boundaries and positioning body off bed. A Half Side Rail Assessment Form with undated initial assessment documented that the side rail limits the resident's ability to exit the bed and that the side rail was for enhancing bed mobility. The form documented to initiate half side rails. A review of the physician's orders documented bed mobility, using full side rails elevated with bumper guard due to unawareness of bed boundaries. Both, full side rail up; therapeutic device mobility on/off unit in high back reclining wheelchair with full lap tray. Reason not defined. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A comprehensive care plan for restraints was initiated on 01/19/2023. The care plan documented that Resident #142 required the use of full siderails, full lap tray, and bed alarm due to inability to define bed boundaries. The care plan goal was that Resident #142 will be safe in the least restrictive device. The facility interventions included incontinent care, monitor skin condition, monitor for signs and symptoms of changes in cognition, behavior, and activities of daily living, restraint reduction evaluation per protocol. Bed mobility using full side rails evaluated with bumper guard due to unawareness of bed boundaries, both full siderails up for ambulation. A comprehensive care plan for total self-care deficit was initiated on 10/04/2022 and was last reviewed on 07/16/2025. The care plan documented that Resident #142 had the inability to provide for own activities of daily living needs that includes bed mobility and transfer via Hoyer lifter that requires 2 person assist. A nurse's progress notes dated 07/17/2025 documented Resident #142 had periods of confusion and forgetfulness. The resident attempted to climb out of bed between two siderails as usual several times. Full siderails up and bilateral floor mats to prevent fall. Resident was unable to recognize bed boundaries. Continues to position legs outside the bed. Out of bed using high-back reclining wheelchair with full lap tray as Resident #142 attempts to get out of the wheelchair even though Resident #142 required maximum assistance from two staff members. The weekly psychiatric consult note dated 07/20/2025 documented Resident #142 was confused and forgetful at times. Resident #142 tried to remove their lap buddy. Four side rails with bumper guard always up while in bed as ordered. Resident removes bumper guard and tries to come off from bed between the two side rails. Dangles their legs between side rails. A review of Resident #29's medical record revealed no documented evidence that alternatives were attempted prior to implementing side rails and lap tray. On 07/21/2025 at 12:15 PM, Certified Nurse Assistant #5 was interviewed and stated Resident #142 has side rails because the resident was very agitated and wants to come out of bed. They stated when in bed, Resident #142 crosses their legs on the side rails. They stated they remove the side rails when Resident #142 is out of bed. Certified Nurse Assistant #5 stated Resident #142 uses the lap tray because the resident moves a lot and tends to get up. On 07/17/2025 at 11:52 AM, Registered Nurse #4, who was the nursing supervisor, was interviewed and stated they are not aware of any assessments conducted for the use of side rails and lap tray. They stated if they feel that a resident needs side rails, they only call the doctor, and the doctor gives the order. Registered Nurse #4 stated Resident #142 also uses a lap tray so that the resident does not fall when they are out of bed. Registered Nurse #4 also stated that Resident #142 had side rails because the resident had no bed boundaries; the resident keeps putting their feet outside of the bed. They stated the lap tray is used for the resident because the resident is very confused and keeps trying to stand up from the wheelchair. On 07/22/2025 at 11:00 AM, Nurse Practitioner #2 was interviewed and stated Resident #142 had cognitive impairment and uses bed rails for safety, to make sure the resident does not fall. The Nurse Practitioner stated if a resident needs side rails, the nursing staff will call the doctor and gets the order. The Nurse Practitioner stated they are not sure how Resident #142 was assessed for the side rails and not sure how the side rail use was being monitored. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident #206 was admitted to the facility with diagnoses that included Dementia with agitation, Depression, and Insomnia. The Minimum Data Set assessment dated [DATE] documented that Resident #206 was severely cognitively impaired, had impairment on both sides of upper and lower extremities; and was dependent on staff for all activities of daily living. The assessment documented that the resident used bed rails daily. On 07/16/2025 at 12:39 PM, Resident #206 was observed with upper and lower half side rails raised on both sides. Resident #206 was unable to release the siderails independently. On 07/17/2025 at 12:29 PM, Resident #206 was observed awake, lying in bed with upper and lower half side rails raised on both sides. Resident #206 was unable to unsecure the bed rails independently. On 07/21/2025 at 10:44 AM, Resident #206 was observed awake and alert, lying in bed with upper and lower half side rails raised on both sides. A Full Siderail Assessment Form documented the date of initial assessment was 03/20/2025. The assessment documented that the interdisciplinary team recommended the initiation of full side rail use, the medical symptom for side rail use was unable to define bed boundaries. The form documented the family was informed of side rail use but did not indicate whether consent was given by the family member. There was no documented evidence that education regarding the risks and benefits of side rail use was given to the family. The most recent restraint quarterly review was completed on 06/09/2025; there was no documented attempts to reduce the use of side rails. The review documented positioning body off bed, continue full side rail. A physician's order dated 03/20/2025 documented full side rails with bumper guard elevated due to unawareness of bed boundaries. A comprehensive care plan for restraints related to motor agitation and poor bed boundaries, initiate full side rails, was initiated on 03/08/2024. The facility interventions include to monitor and evaluate continued use of physical restraints and monitor for negative outcome. A care plan note dated 06/09/2025 by the Director of Nursing documented that resident continues with full side rails due to inability to regulate bed boundaries. A care plan for falls was initiated on 12/06/2023. The facility interventions include keeping both upper side rails up when resident is in bed. The nurse's progress notes dated 03/20/2025 and 07/17/2025 documented Resident #206 was unaware of bed boundaries, continues to position their legs off bed, to continue with full side rails with bumper guard. A review of Resident #206's medical record revealed no documented evidence that alternatives were attempted prior to implementing side rails. On 07/21/2025 at 12:22 PM, Licensed Practical Nurse #6 was interviewed and stated Resident #206 has side rails because they keep trying to jump out of bed and kicks very high. They stated the resident had fallen 3 times before and side rails were used for protection. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/21/2025 at 11:37 AM, Registered Nurse #4, who was the nursing supervisor, was interviewed and stated that Resident #206's full side rails were initiated on 03/08/2025 because of agitation and resident had behavior of putting their feet outside the bed. They stated there is no restraint assessment form that needs to be filled out prior to initiating the use of side rails. They stated if a resident needs side rails, they call the doctor, tell them what they observed, and ask the doctor for an order. They stated side rails are also recommended by the Rehabilitation Department. On 7/22/2025 at 10:31 AM, Medical Doctor #2 was interviewed and stated Resident #206 is severely cognitively impaired and is unaware of their own safety. They stated side rails are used to protect Resident #206 from falling. Medical Doctor #2 stated the medical reason for the resident use of side rail was that Resident #206 was not aware of their own bed boundaries. They stated that side rail assessment is completed by the nursing staff. The nurses will then call the doctor, and the doctor will put in the order. Medical Doctor #2 stated they are not sure how often the siderails are assessed. 4. Resident #125 was admitted to the facility with diagnoses that included Mood Disorder, Psychosis, and Adjustment Disorder. The Minimum Data Set assessment dated [DATE] documented that Resident #125 was severely cognitively impaired, had impairment on both sides of lower extremity, and required substantial / maximal assistance in rolling left and right; and sit to lying. The assessment documented that bed rails are used daily. During observations on 07/16/2025 at 10:36 AM, 07/17/2025 at 10:05 AM, and on 07/18/2025 at 9:30 AM, Resident #125 was observed in bed with upper and lower half side rails raised on both sides. The resident was unable to release the side rails independently. A Full Siderail Assessment Form documented the date of initial assessment was 04/06/2023. The assessment documented that side rail use limit the resident's ability to exit the bed, the medical symptom for side rail use was unable to define bed boundaries and motor agitation. The form documented that the care plan team recommended full side rail use. The form documented the family was informed of side rail use but did not indicate whether consent was given by the family member. There was no documented evidence that education regarding the risks and benefits of side rail use was given to the family. The most recent restraint quarterly review was completed on 07/03/2025. There was no documented attempts to reduce the use of side rails. The review documented positioning body off bed, continue full side rail. A physician's order dated 04/06/2023 and was last renewed on 07/04/2025 documented bed mobility both full side rails up due to unawareness of bed boundaries. A comprehensive care plan for restraints was initiated on 04/06/2023 and was last reviewed on 05/25/2025. The care plan documented use of 2 full side rails. The facility intervention included to apply and release restraint as per physician's order and to monitor and evaluate continued need to use physical restraint. The care plan evaluation notes completed by the Director of Nursing dated 04/02/2025 documented Resident #125 continued to position legs and body off bed, continue full side rails. A comprehensive care plan for falls was initiated on 03/19/2021 and was last reviewed on 05/25/2025. The facility interventions include keeping both side rails up when in bed. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A nurse's progress notes dated 06/03/2025 documented Resident #125 was in bed with both full side rails up due to unawareness of bed boundaries. A review of Resident #206's medical record revealed no documented evidence that alternatives were attempted prior to implementing side rails. On 07/18/2025 at 9:43 AM, Certified Nursing Assistant #6 was interviewed and stated Resident #125 has side rails and that they do not know how long the resident has it. They stated the resident shakes the side rails, wanted to have it taken off, and would scream to get out of bed. On 07/18/2025 at 9:48 AM, Licensed Practical Nurse #5 was interviewed and stated that Resident #125 has side rails because the resident is unpredictable and was falling frequently and would try to climb out of bed. They stated the resident had no falls since they applied the side rails. On 07/17/2025 at 10:00 AM, Registered Nurse Supervisor #5 was interviewed and stated Resident #125 uses side rails because the resident thinks they can still walk and would get out of bed without assistance and had history of frequent falls. They stated side rail use is for the resident's safety, it keeps Resident #125 from falling out of bed. On 7/22/2025 at 10:31 AM, Medical Doctor #2 was interviewed and stated Resident #125 is severely cognitively impaired and is unaware of their own safety. 5. Resident #3 was admitted to the facility with diagnoses that included Dementia, Diabetes Mellitus, and Hypertension. The Minimum Data Set assessment dated [DATE] documented that Resident #3 had moderately impaired cognition, had no behaviors, and had impairment on both sides of upper and lower extremities. The resident required substantial / maximal assistance with rolling left and right and sitting to lying position. The assessment documented bed rails was used daily. During observations on 07/16/2025 at 11:29 AM, 07/17/2025 at 11:18 AM, and on 07/21/2025 at 10:335 AM, Resident #3 was observed in bed with upper and lower half side rails raised on both sides. The resident was unable to release the side rails independently. A Full Siderail Assessment Form documented the date of initial assessment was 06/04/2025. The assessment documented that side rail use limit the resident's ability to exit the bed, the medical symptom for side rail use was unable to define bed boundaries. The form documented that the care plan team recommended full side rail use. The form documented the family was informed of side rail use but did not indicate whether consent was given by the family member. There was no documented evidence that education regarding the risks and benefits of side rail use was given to the family. A physician's order dated 06/09/2025 documented bed mobility using full side rails with bumper guard elevated due to unawareness of bed boundaries. A comprehensive care plan for restraints was initiated on 05/02/2025 as related to motor agitation / poor bed boundaries, initiate full side rails. The facility interventions included bed mobility using full side rails and apply and release physical restraint per physician's order. The 06/04/2025 care plan progress notes documented Resident #3 has been keeping their legs off bed and is unable to define bed boundaries. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A comprehensive care plan for falls related to impaired mobility history of falls was initiated on 01/21/2025. The facility interventions included keeping both side rails up when resident is in bed. On 07/21/2025 at 11:49 AM, Certified Nursing Assistant #4 was interviewed and stated that Resident #3 is not mentally good, cannot stand and cannot walk, and slides off bed. They stated the resident has side rails to keep the resident from getting out of bed. Certified Nursing Assistant #4 stated Resident #3 does not know how to put the side rails down. On 07/21/2025 at 12:45 PM, Licensed Practical Nurse #4 was interviewed and stated Resident 33 had double side rails because the resident fell a couple of times before. On 07/21/2025 at 10:50 AM, Registered Nurse #4, who was the nursing supervisor, was interviewed and stated Resident #3 had side rails because the resident tries to get out of bed and puts their legs over the bed. 07/23/2025 10:21 AM, Medical Doctor #2 was interviewed and stated that Resident #3 has history of agitation and tries to get out of bed. They stated the side rails are for the resident's safety. Medical Doctor #2 stated they were not sure what interventions were used prior to the implementation of side rails, they stated that is nursing. They stated, the residents are assessed by the nurse for side rail use, the nurse then calls the doctor for the order. On 07/22/2025 at 11:00 AM, the Medical Director was interviewed and stated side rails are used for resident safety. On 07/18/2025 at 1:33 PM, the Director for Rehabilitative Therapy was interviewed and stated that side rail referral comes from nursing. They stated side rails are used by residents to enable them to move and reposition in bed, and the residents must be able to hold and grab the side rails. The Director stated that the nursing department determines and recommends the use of side rails, and that Rehabilitation Department is not involved in the assessment of side rails and restraints. They stated nursing department determines and recommends the use of side rails. They stated that the side rail form is filled out by nurses and kept by the Director of Nursing. They stated that nurses do the reassessment for side rail use and not Rehabilitation Department. On 07/18/2025 at 1:21 PM, the Maintenance Director was interviewed and stated Maintenance Department install the side rails after the nurses got the doctor's order for side rail use. The Director stated that side rails are not removable, and it cannot be removed by the residents, but it can go up and down. They stated that side rails cannot be operated by the residents and residents have to call for staff assistance to lower them. On 07/23/2025 at 3:19 PM, the Director of Nursing was interviewed and stated that residents with poor cognition, who places their legs and body off the bed, and who are not aware of bed boundaries are identified for side rail use. They stated they initiate full side rails to provide boundary for residents who does not know where the bed ends. They stated that side rails are also used for motor and physical agitation. They stated that residents had not fallen when the side rails are in use and that they do not see an issue with the use of side rails. 10 NYCRR 415.4(a) (2-7)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/16/2025 to 07/23/2025, the facility failed to ensure that residents admitted with a limited Range of Motion and/or mobility, are provided services and/or treatment to increase range of motion/mobility and/or to prevent further decrease in range of motion/mobility, including the provision of equipment for limited mobility. This was evident for 2 (Residents # 20 and #85) of 4 residents reviewed for Position Mobility/Limited Range of Motion, out of 35 total sampled residents. Specifically, Residents #20 and #85, who had contractures, were observed without hand rolls as ordered by the physician to improve the residents' contractures. The findings include:The facility's Policy titled Care of Resident with Adaptive Devices dated 02/17/2009 and was last updated on 05/2025 documented that the purpose of the policy was to prevent reduction of Range of Motion (contracture). The type of adaptive devices includes hand rolls. The policy documented that Physical/Occupational Therapy Department will assess and recommend appropriate devices; will in-service nursing staff on application of device; the Certified Nursing Assistant will apply and remove device as instructed on accountability record; charge nurse will revise accountability record of devices as needed; and charge nurse will also monitor for discomfort and irritation and report problem to rehabilitation nurse, supervisor and therapist.1. Resident #20 had diagnoses that included Hypertension, Respiratory Failure, Amyotrophic Lateral Sclerosis.The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #20 had severe impairment in cognition and was totally dependent on staff for all activities of daily living. The assessment also documented Resident #20 had pressure reducing device for chair and for bed. A Comprehensive Care Plan for contractures, position/mobility was initiated on 02/10/2023 and was last updated on 06/23/2025. The care plan documented that Resident #20 had contractures to both hands and both feet. The facility interventions: to inspect skin condition around contracture site daily, monitor for sign of pain during range of motion/therapy, provide adaptive devices as per orders, and provide routine hygiene to contracture site every shift.The occupational therapy evaluation plan and treatment dated 11/01/2024 documented Resident #20 presented with stiffness on both hands. The rehabilitation communication / order form dated 11/13/2024 documented to apply bilateral hand rolls at all times. A physician's order dated 06/25/2025 documented Therapeutic devices apply both hand rolls at all times, remove for skin checks, hygiene care, and range of motionThe Certified Nursing Assistant Accountability Record from 07/01/2025 to 07/22/2025 had no consistent documentation that the hand roll was being provided to Resident #20 as per order.On 07/16/2025 at 11:02 AM, Resident #20 was observed in bed, noted with contractures on both hands. The resident was noted without a hand roll on the right hand. Further observations were made between 8:00 am and 1:00 pm on 07/17/2025, 07/18/2025 and 07/21/2025. Resident #20 was observed without a hand roll on the right hand. On 07/22/2025 at 8:14 AM, Resident #20's family member was at the bed side and was interviewed. Resident's family stated that whenever they come to visit, Resident #20 has only one roll applied. They stated resident was supposed to have the device on both hands but was not sure why only one was being applied. The family member stated they had not asked the staff why only one device is applied.On 07/22/2025 at 9:12 AM, Certified Nursing Assistant #1 was interviewed and stated they have been taking care of Resident #20 for the past 3 weeks. They stated they perform range of motion for Resident #20 and that the resident must have hand rolls on both hands. They stated they have been seeing and applying only one hand roll on the resident since having the resident in their assignment. On 07/22/2025 at 9:40 AM, Licensed Practical Nurse #1 was interviewed and stated they had not noticed that only one hand roll was being applied for Resident #20. 2. Resident #85 was admitted to the facility with diagnoses that included Anemia, Respiratory Failure, Amyotrophic Lateral (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335349	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cliffside Rehab & Residential Health Care Center	119 - 19 Graham Court Flushing, NY 11354

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sclerosis.The quarterly Minimum Data Set assessment dated [DATE] documented Resident #85 had severe impairment in cognition and was totally dependent to staff for all activities of daily living. The Comprehensive Care Plan for impaired physical Mobility was initiated on 12/10/2024 and was last updated on 07/16/2025. The facility interventions included providing assistive device as ordered, to provide range of motion, Physical/Therapy/Occupational Therapy evaluation as needed, bed mobility using both half rails up due to poor trunk control side rails bumper guard. The occupational therapy evaluation and plan of treatment dated 07/15/2025 documented resident exhibited new onset of decreased functional mobility, decreased range of motion and strength. The resident and caregiver roles included applying hand roll on both hands to prevent contracture. A physician's order dated 07/16/2025 documented: Therapeutic Devices Apply bilateral rolls at all times, remove for skin checks, hygiene care, and range of motion. On 07/16/2025 at 10:07 AM, during the initial pool process, Resident #85 was observed in bed, noted with contractures on both hand with no device applied to relief pressure on the contracted hands/fingers.Resident #85 was further observed daily between 8:30 am and 1:00 pm on 07/17/2025, 07/18/2025 and 07/21/2025 with no hand roll applied to both hands.On 07/22/2025 at 8:40 AM, Certified Nursing Assistant #2 was interviewed and stated Resident #85 is on their assignment and that the resident was supposed to have hand rolls in place. They stated they has not seen any hand roll to apply and notified the nursing supervisor, but they were only given a gauze to apply that does not stay in resident's hands. On 07/22/2025 at 9:49 AM, Licensed Practical Nurse #2 was interviewed and stated they were assigned to Resident #85 this morning and was not aware that resident had no hand rolls applied. On 07/22/2025 at 10:00 AM, Registered Nurse Supervisor #1 was interviewed and stated they make rounds when staff are giving care to the residents but did not realize that hand rolls were not applied for the residents as stated in their plan of care. On 07/22/2025 at 11:05 AM, the Rehabilitation Director was interviewed and stated that residents are screened upon admission to see if they need any adaptive devices. They stated referrals are received from nursing, and orders are written for the adaptive device. They stated they bring the hand rolls to try it on the resident to see how it is tolerated; they conduct in-service to the staff before the rolls are issued. They stated they may also train the family members how to put the device on the resident. The Director further stated that they would not know if a resident had no device to use unless the nursing staff notifies them. The Rehabilitation Director stated that instructions for residents' devices are in the Certified Nursing Assistant Accountability Record, and that nursing should make sure that the devices are applied on residents as per their plan of care. On 07/22/2025 at 12:11 PM, the Director of Nursing was interviewed and stated it is the responsibility of the Certified Nursing Assistants to ensure that residents are provided with their devices as per order and the nurses and the supervisor on the unit should be monitoring them to ensure that the Certified Nursing Assistants are doing their jobs. The Director of Nursing was not able to explain why devices are not being provided to residents as per order and as per their plan of care. The Director of Nursing further stated they are mad with the staff for allowing the surveyors to cite them for this kind of deficiencies.10 NYCRR 415.12 (e)(2)

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	335349	A. Building B. Wing	07/23/2025

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, record review, and interviews during the Recertification Survey conducted from 07/16/2025 to 07/23/2025, the facility failed to ensure residents are provided comfortable and homelike environment. This was evident for 1 (Unit1) of 3 resident units observed. Specifically, Resident #93's room appeared cluttered and disorderly, with lack of storage for resident's items. The findings include but are not limited to: Resident #93 was admitted to the facility with diagnoses of End Stage Renal Disease. The Quarterly Minimum Data Set, dated [DATE] documented Resident #93 had intact cognition, had no behaviors, and had impairment on both upper extremities. The assessment documented that resident required set up for eating, bed mobility, supervision for transfer and toilet use; and was always continent of bowel and bladder. During multiple observations on 07/18/2025 and 07/22/2025, Resident #93's was observed with cases of water, boxes, and other miscellaneous items placed on the floor next to the resident's beside. On 07/22/2025 at 3:26 PM, Resident #93 stated their daughter sends them goods and other items. A Comprehensive Care Plan for noncompliance manifested by noncompliance with medication administration and hoarding goods at bedside was initiated for Resident #93 on 07/10/2025. The facility interventions include to accept Resident #93's right to refuse and show respect for resident's decisions.There was no documented evidence that discussions were made to resolve Resident #93's hoarding of articles and storing their items on the floor inside resident's room. On 07/22/2025 at 3:16 PM, the Social Worker Director was interviewed and stated they had not spoken with Resident #93 about the resident's hoarding, and they do not know of any actual conversations made between the resident and the Administrator on how to store their items. On 07/22/2025 at 3:32 PM, the Director of Nursing was interviewed and stated they purchased bins for Resident #93 but was not aware if those bins were used. The Director of Nursing stated Resident #93 has lots of items in their room but is not always receptive to it being addressed. On 07/22/2025 at 3:26 PM, the Administrator was interviewed and stated they spoke with Resident #93 about the accumulation of items in their room and that they continue to monitor for rodents. They stated they have not suggested to elevate the items and to not place them on the floor. The Administrator stated they will place some of Resident #93's items in the storage if the resident allows it. 10 NYCRR 415.29

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, record review, and interviews conducted during the Recertification Survey from 07/16/2025 to 07/23/2025, the facility failed to ensure the nursing staff information posting was accurate and complete. This was evident during the Nursing Staffing Task. Specifically, the daily nurse staffing information posting was missing the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift. The findings include:The facility policy titled Assignment of Nursing Care with the effective date of 08/2001 and a revised date of 05/2025 documented that the staffing schedule is posted outside the nursing office for each shift: 07:30 AM-3:30 PM; 3:30 PM - 11:30 PM; and 11:30 PM - 07:30 AM. The schedule documents the units and staff: Registered Nurse Supervisors, Licensed Practical Nurses, and Certified Nurse Assistant. The policy also stated that the nursing daily staffing summary is posted. Observations and review of the Daily Nursing Staffing Information sheets posted by the nursing supervisors in the front lobby from 07/16/2025 through 07/23/2025 did not document the resident census and the total number and number of actual hours worked by Registered Nurse, Licensed Practical Nurse, and Certified Nurse Aide. On 07/23/2025 at 9:32 AM, the Assistant Director of Nursing was interviewed and stated the day shift supervisors posts the evening schedule, and the evening shift supervisor posts the night shift schedule, while the night shift supervisor posts the morning shift schedule. The Assistant Director of Nursing also stated they never document the census and the actual breakdown of hours worked by the nursing staff on the posting and was never cited for it. They stated no surveyors from the previous surveys told them that they were doing it wrong. On 07/23/2025 at 3:19 PM, The Director of Nursing was interviewed and stated they have been working at the facility for more than 10 years and 3 surveys had since passed and was never told that the nurse posting was not in compliance.10 NYCRR 415.13