

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335387	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2025
NAME OF PROVIDER OR SUPPLIER Peninsula Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 50 15 Beach Channel Drive Far Rockaway, NY 11691	

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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</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 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interviews conducted during an abbreviated survey (2643598), the facility failed to ensure that all alleged violations are thoroughly investigated in response to allegations of abuse, neglect, exploitation, or mistreatment, and that the results of all investigations are reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency. This was evident for 1 of 14 residents (Residents #1) sampled. Specifically, Resident #1, who was severely cognitively impaired, at risk for aspiration/choking, required supervision with eating and had a history of wandering and taking other resident's food, was found unresponsive in the hallway on 08/16/2025 at 11:45 PM by Certified Nursing Assistant #1. Emergency Medical Service was called at midnight and responded at 12:04 AM on 08/17/2025. Resident #1 was pronounced deceased at 12:27 AM by the Emergency Medical Service team. The facility did not conduct a thorough investigation to ascertain how Resident #1, who was on puree diet, was found unresponsive with food in their mouth. The findings include: The facility policy titled Resident Accident Reporting and Investigation, effective date 11/2016, documents that all incidents involving a patient/resident shall be documented on the Accident Reporting and Investigation Form at the time of the incident. A summary of the circumstances surrounding such an episode, including statements from staff on duty and all witnesses at the time of occurrence, and any related treatment or investigation, is to be documented and submitted by the nursing supervisor/designee to the Director of Nursing no later than 24 hours following the occurrence. Resident #1 was admitted to the facility with diagnoses including Schizophrenia (mental health condition) and Gastroesophageal Reflux disease without esophagitis (inflammation and irritation of the esophagus). A review of the Minimum Data Set (a resident assessment tool) dated 08/13/2025 documented Resident #1's cognition was severely impaired, and they required supervision during meals. A review of a nursing note by Registered Nurse Supervisor #1 dated 08/17/2025 at 12:52 AM documented at approximately 11:45 PM they received a call from Registered Nurse #1 informing them Resident #1 was found unresponsive in their wheelchair in the hallway. Upon assessment, Resident #1 did not show signs of breathing. Resident #1 was placed back into their bed, oxygen via bag valve and cardiopulmonary resuscitation was initiated and 911 was called at 11:50 PM. 911 responded at 12:05 AM on 08/17/2025 and they proceeded with cardiopulmonary resuscitation. Resident #1 was pronounced dead at 12:27 AM by Emergency Medical Service. A review of the Fire Department New York Prehospital Care Report Summary dated 08/17/2025 at 5:00 AM, revealed a call was received from the facility at 00:00:12 (midnight) and they arrived at the facility at 00:04 (12:04 AM) and contacted Resident #1 on the unit at 00:12:04 (12:12 AM). A review of the 'Narrative History Text' documented Resident #1 was found lying in bed apneic (cessation of breathing) and without a pulse. Facility staff reported Resident #1 was found in cardiac arrest about 10 minutes prior to emergency medical service arrival and cardiopulmonary resuscitation was initiated. Upon examination (by emergency medical team), Resident #1's airway was filled with food, peanut butter and meat product lodged in their throat. Airway had to be cleared and suctioned prior to intubation. Pupils were fixed unreactive, lung sounds clear on auscultation, skin warm, dry, and negative pulse. After 20 minutes of quality cardiopulmonary resuscitation was given Telemetry (the process of automatically collecting and transmitting data from a remote or inaccessible location for monitoring and analysis) was contacted. As per Telemetry Resident #1 was pronounced at 00:27 (12:27 AM) and left on-scene with nursing staff and Police Department. A review of a signed (by Paramedic #1) Fire Department City of New York Employee Statement Form dated 08/17/2025 documented aspiration precaution ignored. Upon arrival, they found Resident #1 lying in a supine position (lying on one's back) in cardiac arrest. As per the nursing home staff Resident #1 was last known to be well at 11:40 PM. According to Fire Department and Basic Life Support team, Resident #1 had food lodged in their throat and airway. Resident #1 was on aspiration precaution. Resident #1 had large amount of food lodge in their airway. The resident was not supervised, and nursing home staff was not aware of Resident #1's situation. Staff did not know the resident had food in their airway. During a telephone interview on 10/28/2025 at 8:45 AM, Licensed Practical Nurse #1 stated Resident #1 was at risk for choking and was last seen at approximately 11:30 PM in their room. Licensed Practical Nurse #1 stated when Certified Nursing Assistant #1 informed them Resident #1 was unresponsive on the adjacent unit, they, Certified Nursing Assistant #2, and #3 went to the adjacent unit and wheeled Resident #1 to their room where they met Registered Nurse Supervisor #1 and they all transferred Resident #1 from the wheelchair into their bed and</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Based on observation, record review, and interviews conducted during an abbreviated survey (2643598), the facility failed to ensure that residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices. This was evident for one (1) of 14 residents (Residents #1) sampled. Specifically, Resident #1 was found unresponsive in the hallway on 08/16/2025 at 11:45 PM by Certified Nursing Assistant #1 and was not immediately assessed and cardiopulmonary resuscitation was not initiated at that time. Additionally, Emergency Medical Services was called 15 minutes after the resident was found and responded to the scene at 12:04 AM on 08/17/2025. Resident #1 was pronounced deceased at 12:27 AM by the Emergency Medical Service team. This resulted in actual harm that is not Immediate Jeopardy. The findings include: A policy titled Cardiopulmonary Resuscitation dated 04/18/2014 documented cardiopulmonary resuscitation to be initiated on all residents who do not have a physician's order for do not resuscitate. All licensed nurses will receive training and certification to perform basic life support, including cardiopulmonary resuscitation, Heimlich maneuver and rescue breathing. Response Procedure (#4) includes-upon arrival on scene, the first responder will immediately conduct the primary assessment, check for consciousness, begin chest compressions, if indicated, open the airway using the head tilt/chin lift technique, check breathing. If resident is in respiratory arrest, begin rescue breathing and follow cardiopulmonary procedure. A policy titled Dysphagia/Aspiration Precaution dated 01/2016, documented residents will be provided a safe and therapeutic dining environment. This will include the ongoing assessment of the resident ability to eat and swallow safely. Mealtime safety will be followed for all residents to foster a safe eating environment and to encourage safe eating behaviors. Residents identified as having significant risk factors for choking and/or aspiration will have a green charm placed on the resident's wristband and a care plan will be established to address this. Interventions may include but are not limited to diet modification, behavioral interventions, positioning, environmental modifications, adaptive devices and resident/family education. Guideline for licensed nurse and certified nurse aide include to observe for a green charm on the resident's wristband indicating swallowing difficulty/aspiration risk and may require a special diet and to eat in a supervised environment. Observe the residents closely and report even a small suspicion of swallowing difficulty promptly to licensed nurse/medical provider. Residents with known dysphagia should be supervised closely. Intervene if resident attempts to share food. A policy titled Behavior Management Strategies dated 08/05/2020 documented it is the policy of the facility to provide the best quality of life and quality of care to residents with behavioral health needs. A person-centered care plan will be developed and will include interventions and approaches that assist the resident in all aspects of activity of daily living, clinical care needs and behavioral health needs. Resident #1 was admitted to the facility with diagnoses including Schizophrenia (mental health condition) and Gastroesophageal Reflux disease without esophagitis (inflammation and irritation of the esophagus). A review of the Minimum Data Set (a resident assessment tool) dated 08/13/2025 documented Resident #1's cognition was severely impaired, and they required supervision during meals. A review of the Comprehensive Care Plan for Behavior Problem related to Schizoaffective (a mental health condition that combines symptoms of schizophrenia) updated 11/11/2024 documented Resident #1 went to their roommate's side of the room and ate the roommate's sandwich. Interventions included explain to resident the risk of non-adherence and risk of negative outcome/impact. The care plan notes on 06/02/2025 documented Resident #1 remained at risk for behavior problems related to schizophrenia and dementia. Redirected by staff and appropriate interventions implemented, needs were anticipated and met by staff. The plan of care continued. A review of a nursing note by Registered Nurse Supervisor #1 dated 08/17/2025 at 12:52 AM documented at approximately 11:45 PM, they received a call from Registered Nurse #1 informing them Resident #1 was found unresponsive in their wheelchair in the hallway. Upon assessment, Resident #1 did not show signs of breathing. Resident #1 was placed back into their bed, oxygen via bag valve and cardiopulmonary resuscitation was initiated and 911 was called at 11:50 PM. 911 responded at 12:05 AM on 08/17/2025 and they proceeded with cardiopulmonary resuscitation. Resident #1 was pronounced dead at 12:27 AM by Emergency Medical Service. A review of a facility Cardiopulmonary Emergency Worksheet dated 08/17/2025 documented timeline of facility's staff response to Resident #1 being found unresponsive in the hallway on the adjacent unit. Code Blue was announced at 11:45 PM, Registered Nurse Supervisor #1 assessed Resident #1 at 11:50 PM. 911 was notified at 11:50 PM. Automated External Defibrillators was</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Based on observation, record review, and interviews conducted during an abbreviated survey (2643598), the facility failed to provide an environment that is free from accident hazards and to ensure that a resident received adequate supervision to prevent accidents. This was evident for one (1) of 14 residents sampled (Resident #1). Specifically, Resident #1, who was severely cognitively impaired, at risk for aspiration/choking, required supervision with eating and had a history of wandering and taking other resident's food, was found unresponsive in the hallway on 08/16/2025 at 11:45 PM by Certified Nursing Assistant #1. Emergency Medical Service was called at 00:00:12 (12 seconds after midnight) and they arrived at the facility at 00:04 AM (12:04 AM) on 08/17/2025. Resident #1 was pronounced deceased at 12:27 AM by the Emergency Medical Service team. This resulted in actual harm and death of Resident #1 that was Immediate Jeopardy with the potential for serious harm serious injury to 40 residents who were identified at risk for aspiration precaution. The findings include: A policy titled 'Dysphagia/Aspiration Precaution dated 01/2016, documented residents will be provided a safe and therapeutic dining environment. This will include the ongoing assessment of the resident ability to eat and swallow safely. Mealtime safety will be followed for all residents to foster a safe eating environment and to encourage safe eating behaviors. Residents identified as having significant risk factors for choking and/or aspiration will have a green charm placed on the resident's wristband and a care plan will be established to address this. Interventions may include but are not limited to diet modification, behavioral interventions, positioning, environmental modifications, adaptive devices and resident/family education. Guideline for licensed nurse and certified nurse aide include to observe for a green charm on the resident's wristband indicating swallowing difficulty/aspiration risk and may require a special diet and to eat in a supervised environment. Observe the residents closely and report even a small suspicion of swallowing difficulty promptly to licensed nurse/medical provider. Residents with known dysphagia should be supervised closely. Intervene if resident attempts to share food. Resident #1 was admitted to the facility with diagnoses including Schizophrenia (mental health condition) and Gastroesophageal Reflux disease without esophagitis (inflammation and irritation of the esophagus). A review of the Minimum Data Set (a resident assessment tool) dated 08/13/2025 documented Resident #1's cognition was severely impaired, and they required supervision during meals. 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A review of a Rehabilitation Intervention note dated 06/25/2025 by Speech Therapist #1 documented Resident #1 was evaluated for swallowing function because the resident took another resident's food. The resident was assessed for a potential diet upgrade. Resident #1 was given trials of puree, mechanical soft solid, regular solid, nectar thick liquids and thin liquids. Oral phase marked prolonged mastication of regular solids with moderate oral residue requiring cues to swallow/liquid wash to clear oral residue. Resident #1 observed with impulsive rate of intake. Resident #1 also observed with functional mastication of chopped solids, however, continues to require liquid wash to clear mild oral residue. Resident #1 presented with delayed coughing for thin liquids trials and no overt signs and symptoms of aspiration/penetration for nectar thick liquids. Speech therapist recommended allowance of soft sandwiches and bananas to improve variety of food choices. Resident #1 had a history of wandering and taking other resident's food and was on hourly monitoring. A review of the Documentation Survey Report revealed Resident #1 was last seen at 10:00 PM on 08/16/2025 in the hallway. A review of a nursing note by Registered Nurse Supervisor #1 dated 08/17/2025 at 12:52 AM documented at approximately 11:45 PM, they received a call from Registered Nurse #1 informing them that Resident #1 was found unresponsive in their wheelchair in the hallway. Upon assessment, Resident #1 did not show signs of breathing. Resident #1 was placed back into their bed, oxygen via bag valve and cardiopulmonary resuscitation was initiated and 911 was called at 11:50 PM 911</p>		