STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335426	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Franklin Center for Rehabilitation and Nursing	142 27 Franklin Avenue Flushing, NY 11355

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. Based on observation, record reviews, and interviews, conducted during a survey, the facility failed to ensure that a resident was free from physical abuse. This was evident for one (1) out of seven (7) residents (Resident #1) sampled for abuse. Specifically, on 05/01/2026, Licensed Practical Nurse #1 was giving Resident #1 pain medication. Resident #1 refused the medication by putting their hand over their mouth. Licensed Practical Nurse #1 removed Resident #1's hand and placed the medication in Resident #1's mouth. Resident #1 spit the medication out and Licensed Practical Nurse #1 picked up the medication and gave it to Resident #1. Certified Nursing Assistant #1 who was present stated Resident #1 was refusing their medication.The findings are:The facility's Policy titled Abuse, Neglect, Mistreatment and Exploitation Prohibition dated 03/16/2026, documented that the facility shall not use or permit verbal, mental, sexual or physical abuse, including corporal punishment and involuntary seclusion of residents/patients, or other mistreatment or neglect. This can be directly or through electronic means such as using photographs or recordings in any manner that would demean or humiliate a resident(s), including, distribution of images, personal information photographs and recordings through any media including print, text and online social media. This prohibition extends to abuse by anyone, including, but not limited to, other residents, staff, consultants, volunteers, staff of other agencies serving the residents, family members, legal guardians, friends, or other individuals. Incidents where the facility determines upon review there is a reasonable cause an abuse occurred must be reported to the New York State Department of Health. All allegations of abuse must be immediately reported to the Administrator and no later than 2 hours to other officials (including to the State Survey Agency) after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury. The alleged violations must be reported no later than 24 hours to the State Survey Agency if the events that caused the allegation to not involve abuse and do not result in serious bodily injury.Resident #1 was admitted to the facility with diagnoses of acquired absence of left leg below knee (removal of leg), major depressive disorder (mood changes) and falls.The quarterly Minimum Data Set (a resident assessment tool) dated 04/21/2026, documented Resident #1 had severe cognitive impairment. Resident #1 required partial/moderate assistance with personal care.A care plan titled Abuse Prevention, dated 11/18/2025, with interventions that included offer recreational activities as directed by choices made by the resident and the family.The facility's Occurrence Report Summary dated 05/07/2026, documented on 05/01/2026 at approximately 11:20 PM, Resident #1 was observed on the floor. Registered Nurse Supervisor #1 was notified. Body assessment revealed a small scratch mark to the lower lip with minimal bleeding. Tylenol was administered for pain, initially Resident #1 covered their mouth and Licensed Practical Nurse #1 gently removed Resident #1's hand from their mouth and gave the medication. Facility investigated the alleged incident and concluded that there is no indication of abuse or neglect.A Nursing progress note dated 05/02/2026 at 3:33 PM, by Licensed Practical Nurse #3 documented Resident #1 noted to be bleeding from the lip. Nurse Practitioner made aware. Site cleaned and bacitracin applied.A Physician's progress note dated 05/02/2026 at 1:11 PM, documented post fall, skin cut on the chin or lower lips. Per nursing report, they found resident on the floor mat last night. Observed little skin (continued on next page)

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	scratch to lower lips. Resident #1 had before probably after shaving, scratch clean with normal saline and apply bacitracin. On examination no visible injury or trauma noted.Daily Staffing Sheet dated 05/01/2026 shows Licensed Practical Nurse #1 and Certified Nursing Assistant #1 was working on the 11:00 PM - 7:00 AM shift. Licensed Practical Nurse #1 was allowed to continue working their schedule from 05/01/2026 through 05/04/2026.During an interview on 05/07/2026 at 10:19 AM, Certified Nursing Assistant #1 stated on 05/01/2026 at approximately 11:20 PM, Resident #1 was observed on the floor. Certified Nursing Assistant #1 stated they picked up Resident #1 and put them back in bed, then informed Licensed Practical Nurse #1.During an interview on 05/07/2026 at 11:42 AM, Licensed Practical Nurse #1 stated on 05/01/2026 Certified Nursing Assistant #1 reported to them that Resident #1 had pain. Licensed Practical Nurse #1 stated they attempted to give Resident #1 pain medication and Resident #1 covered their mouth refusing the medication. Licensed Practical Nurse #1 stated they removed Resident #1's hand from their mouth to give them their medication.During an interview on 05/07/2026 at 11:30 PM, Registered Nurse Supervisor #1 stated that on 05/01/2026 Licensed Practical Nurse #1 reported to them that Resident #1 was on the floor. Registered Nurse Supervisor #1 stated when they got to Resident #1's room, Resident #1 was already in bed. Registered Nurse Supervisor #1 stated they performed body assessment and observed a scratch on Resident #1's lower lip with minimal dry blood. Licensed Practical Nurse #1 informed them Resident #1 covered their mouth refusing the medication and they removed Resident #1's hand to give them their medication. Registered Nurse Supervisor #1 stated they did not see this as abuse, but Licensed Practical Nurse #1 encouraged Resident #1 to take the medication. Licensed Practical Nurse #1 remained on the unit and continued to work through their shift.During an interview on 05/07/2026 at 12:35 PM, Director of Nursing stated they did not think Licensed Practical Nurse #1 abused Resident #1. Licensed Practical Nurse #1 was encouraging Resident #1 to take their medication. The Director of Nursing stated they never suspended Licensed Practical Nurse #1, and they never called local law enforcement or reported it to the State Department of Health.During an interview on 05/07/2026 at 4:46 PM Licensed Practical Nurse #2 stated on 05/01/2026 they worked on the 3:00 PM - 11:00 PM shift and was still on the unit. Licensed Practical Nurse #2 stated approximately 11:25 PM Licensed Practical Nurse #1 asked them to assist in giving Resident #1 their medication. Licensed Practical Nurse #2 stated when they went into Resident #1's room they observed Resident #1 covering their mouth. Licensed Practical Nurse #2 stated they explained to Resident #1 about the medication. Licensed Practical Nurse #2 stated they observed blood on Resident #1's lower lip. Licensed Practical Nurse #2 stated during their shift they did not observe any scratch or blood on Resident #1's lower lip.During an interview on 05/11/2026 at 1:22 PM, the Administrator stated on 05/04/2026 they become aware that Resident #1 had a fall on 05/01/2026 on the 11:00 PM - 7:00 AM shift in their room without injury. The Administrator stated they were not aware of any alleged incident related to Licensed Practical Nurse #1 forcefully give Resident #1's pain medication. The Administrator stated the facility's policy when a suspicion of a crime with serious injury occurred it must be reported to local law enforcement and the New York State Department of Health within 2 hours; and if there is no injury within 24 hours. The Administrator stated after reviewing and getting additional information inorder to be in compliance with the regulation, the alleged allegation was reported to the New York Department of Health 05/11/2026. The Administrator stated the facility did not believe abuse occurred.10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure that allegations of abuse were investigated thoroughly and that residents were protected from further abuse during the investigation. This was evident for one (1) out of seven (7) residents (Resident #1) sampled for abuse. Specifically, on 05/01/2026 at approximately 11:25 PM, Licensed Practical Nurse #1 was giving Resident #1 pain medication. Resident #1 refused the medication by putting their hand over their mouth. Licensed Practical Nurse #1 removed Resident #1's hand and placed the medication in their mouth. Resident #1 spit the medication out and Licensed Practical Nurse #1 picked up the medication and gave it to Resident #1. The facility failed to thoroughly investigate the allegation of abuse and remove Licensed Practical Nurse #1 from direct care and access to residents after Certified Nursing Assistant #1 reported the allegations to Registered Nurse Supervisor #1. The findings include:The facility's Policy titled Abuse, Neglect, Mistreatment, and Exploitation Prohibition dated 03/16/2026, documented that the facility shall not use or permit verbal, mental, sexual or physical abuse, including corporal punishment and involuntary seclusion of residents/patients, or other mistreatment or neglect. It was also documented if an alleged violation has been identified and reported to the administrator/Designee, the facility must immediately report it and provide protection for the identified resident(s) prior to conducting the investigation of the alleged violation. At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation, and if the alleged violation is verified, take corrective action in accordance with State Regulatory Requirements.Resident #1 was admitted to the facility with diagnoses of Acquired absence of left leg below knee (removal of a leg), major depressive disorder, and falls.The quarterly Minimum Data Set (a resident assessment tool) dated 04/21/2026, documented Resident #1 had severe cognitive impaired cognition. Resident #1 required partial/moderate assistance with personal care.The faility's Occurrence Report Summary dated 05/07/2026, documented on 05/01/2026 at approximately 11:20 PM Resident #1 was observed on the floor. Registered Nurse Supervisor #1 was notified. Body assessment revealed a small scratch mark to the lower lip with minimal bleeding. Tylenol was administered for pain, initially Resident #1 covered their mouth and Licensed Practical Nurse #1 gently removed Resident #1's hand from their mouth and gave the medication. The facility initiated an investigation into the abuse allegation on 05/07/2026. Licensed Practical Nurse #1 was removed from schedule on 05/07/2026 pending completion of investigation. During an interview on 05/07/2026 at 12:35 PM, Director of Nursing stated they were not informed that Licensed Practical Nurse #1 removed Resident #1's hand from their mouth to give Resident #1 their medication at the time when this occurred. Director of Nursing stated Licensed Practical Nurse #1 should have walked away and re-approached Resident #1 to take the medication. During an interview on 05/11/2026 at 1:22 PM, the Administrator stated they were not informed of the alleged allegation on 05/01/2026 until the Department of Health arrived in the facility. The Administrator stated after reviewing additional information and to be in compliance with the regulation, the alleged allegation was reported to the New York Department of Health 05/11/2026. The Administrator stated the facility did not believe abuse occurred. 10 New York Codes, Rules, and Regulations 415.4(b)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure each resident receives adequate supervision and assistance devices to prevent accidents. This was evident for one (1) out of two (2) residents (Resident #1) sampled for fall. Specifically, Resident #1 who has acquired bilateral below knees amputation was observed on the floor in their room on 05/01/2026. Certified Nursing Assistant #1 went into the room picked up Resident #1 and placed them back into the bed before Resident #1 was assessed by Registered Nurse Supervisor #1. On assessment Resident #1 was observed with a small scratch on their lower lip.The findings are:The facility's Policy title Resident Occurrences, dated 03/07/2023, documented all resident occurrences must be reported and investigated. Plans of correction will be developed in an attempt to prevent re-occurrence and unsafe conditions. Unusual and/or serious events will be brought to the attention of administration, in addition to following the routine procedure. Root Cause Analyses will be conducted by an interdisciplinary quality improvement team for sentinel events or more severe adverse events.Resident #1 was admitted to the facility with diagnoses of acquired absence of left leg below knee (removal of a leg), major depressive disorder and falls.The quarterly Minimum Data Set (a resident assessment tool) dated 04/21/2026 documented Resident #1 had severely impaired cognition. Resident #1 required partial/moderate assistance with personal care.The facility's investigation report dated 04/28/2026 at 3:20 PM, documented Resident #1 on the floor mat in their room. Body assessment revealed no visible injury.A Fall/Injury Risk Evaluation dated 04/28/2026, documented Resident #1 score high risk for falls.T he facility's Occurrence Report Summary dated 05/07/2026, documented on 05/01/2026 at approximately 11:20 PM, Resident #1 was observed on the floor. Registered Nurse Supervisor #1 was notified. Body assessment revealed a small scratch mark to the lower lip with minimal bleeding. Tylenol was administered for pain, initially Resident #1 covered their mouth and Licensed Practical Nurse #1 gently removed Resident #1's hand from their mouth and gave the medication. Facility investigated the alleged incident and concluded that there is no indication of abuse or neglect.Nursing progress note dated 04/28/2026 at 4:19 PM by Registered Nurse Supervisor #2 documented at approximately 3:20 PM Resident #1 was observed on the floormat on floor in their room. On assessment Resident #1 had no visible injury. Resident #1 was transferred to the hospital for Computer Tomography Scan. Computer Tomography Scan dated 04/28/2026 showed no fractures.A Physician's progress note dated 05/02/2026 at 1:11 PM documented post fall, skin cut on the chin or lower lips. Per nursing report, found Resident #1 on the floor mat last night. Observed little skin scratch to lower lips. Resident #1 had before probably after shaving, scratch clean with normal saline and apply bacitracin. On examination no visible injury or trauma noted.A Nursing progress note dated 05/02/2026 at 3:33 PM by Licensed Practical Nurse #3 documented Resident #1 noted to be bleeding from the lip. Nurse Practitioner made aware, and anticoagulants placed on hold. Site cleaned and bacitracin applied.The Activity Monitoring Record dated 05/01/2026 documented Resident #1 was on 30 minutes monitoring.During an interview on 05/07/2026 at 10:19 AM, Certified Nursing Assistant #1 stated on 05/01/2026 at approximately 11:20 PM, Resident #1 was observed on the floor. Certified Nursing Assistant #1 stated they picked up Resident #1 and put them back in bed, then informed Licensed Practical Nurse #1.During an interview on 05/07/2026 at 11:30 PM, Registered Nurse Supervisor #1 stated that on 05/01/2026 Licensed Practical Nurse #1 reported to them that Resident #1 was on the floor. Registered Nurse Supervisor #1 stated when they got to Resident #1's room, Resident #1 was already in bed. Registered Nurse Supervisor #1 stated they performed body assessment and observed a scratch on Resident #1's lower lip with minimal dry blood.During an interview on 05/07/2026 at 12:35 PM, Director of Nursing stated Resident #1 was observed on the floor on 05/01/2026 at approximately 11:20PM. Director of Nursing stated Certified Nursing Assistant #1 picked up Resident #1 before Resident #1 was assessed by Registered Nurse (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Supervisor #1. Director of Nursing stated that when residents are found on the floor, residents must be assessed by a Registered Nurse Supervisor before placing them back into bed. 10 New York Codes, Rules, and Regulations 415.12(h)(2)