STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335434	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Neck Care Center	260 19 Nassau Boulevard Little Neck, NY 11362

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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. Based on observation, record review, and interviews conducted during survey, the facility failed to ensure residents' safety after an allegation of abuse was made and the facility failed to complete a thorough investigation of the alleged violation. This was evident for one of five residents (Resident #1) reviewed and sampled for risk of abuse. Specifically, on 05/02/2026 between 5:30 AM to 5:45 AM, Certified Nursing Assistant #1 reported to Licensed Practical Nurse #1 that in the presence of Certified Nursing Assistant #2, Resident #1 assaulted them during care. Licensed Practical Nurse #1 went to Resident #1's room and Resident #1 told Licensed Practical Nurse #1 they were beaten up. Licensed Practical Nurse #1 stated during an interview that Certified Nursing Assistant #2 reported that Resident #1 assaulted Certified Nursing Assistant #1 and in retaliation, Certified Nursing Assistant #1 hit Resident #1 and threw a trash can toward the resident. Licensed Practical Nurse #1 left the unit to report the incident to Registered Nurse Supervisor #1. However, Licensed Practical Nurse #1 left Certified Nursing Assistant #1 and Certified Nursing Assistant #2 in the room with Resident #1 unsupervised. Registered Nurse Supervisor #1 was informed of the abuse allegations and failed to initiate and complete a thorough investigation of the alleged abuse violation, including assessing the resident. This resulted in the potential for serious harm to Resident #1 and other residents on the unit that was determined to be Immediate Jeopardy. The findings are:The facility's policy and procedure titled, Abuse Prevention and Reporting dated 07/01/2006, last reviewed on 03/2026, documented, In accordance with the Patient Abuse Reporting Law (Public Health Law Section 2803-d), this facility will maintain a system in place to protect residents from abuse in order to protect the health and safety of our residents It is our policy to ensure that residents are free of verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, mistreatment , neglect and misappropriation of property. The policy documented that the facility would conduct an immediate investigation of all reports of suspected abuse or exploitation. An accident or incident report must be completed on the shift in which the accident or incident occurred. A copy of the report is provided to the risk manager within 24 hours of the incident for review and analysis. The need for further investigation will be determined on a case-by-case basis. Residents involved are placed on the 24-hour report for at least three days. The reports are reviewed daily to ensure that the investigation is in progress, and the care plans are updated and interventions implemented.Resident #1 was admitted to the facility with diagnoses of coronary artery disease (poor blood flow to the heart), peripheral vascular disease (slow blood flow to the legs), and non-Alzheimer's dementia cognitive communication deficit (problems with thinking and speaking).The Minimum Data Set (a resident assessment tool) dated 02/22/2026, documented Resident #1 was severely cognitive impaired. Resident #1 needed moderate to total assistance for activities of daily living (dressing, eating, toileting, and showering). Record review of the nurses' note dated 05/02/2026 by Licensed Practical Nurse #1 documented Resident #1 was alert and responsive and was very combative, resistive to care, and physically abusive. There were no complaints about pain or discomfort. The facility investigation consisted of statements written on 05/02/2026 by License Practical Nurse #1, Certified Nursing Assistant #1, and Certified Nursing Assistant #2. There was no documented evidence that a thorough investigation was conducted. There was no evidence that interviews of staff were (continued on next page)

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

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conducted to verify the written statements. There was no evidence that measures were taken to protect Resident #1 on 05/02/2026 after the allegation was reported to Licensed Practical Nurse #1 or Registered Nurse Supervisor #1.The facility's video surveillance footage was viewed on 05/13/2026 from 11:00 AM to 11:30 AM with the Administrator. The footage was reviewed from 5:33 AM to 7:00 AM on 05/02/2026. At 5:38 AM, Certified Nursing Assistant #2 was seen entering Resident #1's room speaking with Certified Nursing Assistant #1 as they both entered Resident #1's room together. At 5:40 AM, Certified Nursing Assistant #1 and Certified Nursing Assistant #2 left Resident #1's room. At 5:48 AM, Licensed Practical Nurse #1 entered Resident #1's room. At 5:50 AM, Licensed Practical Nurse #1 left Resident #1's room. The footage did not show Registered Nurse Supervisor #1 entering Resident #1's room. A record review of the nurse's note dated 05/04/2026 by Licensed Practical Nurse #2 documented, Resident #1 was observed with slight redness and swelling of the face. A record review of the nurse's note dated 05/05/2026 by the Assistant Director of Nursing, documented Resident #1 complained of pain to the right facial area. They documented mild swelling to the right upper lip with no surrounding redness or discoloration seen. It was documented that the Nurse Practitioner #1 was informed. During a telephone interview on 05/13/2026 at 9:34 AM, Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 informed them Resident #1 made a general statement that they were beaten up and that Resident #1 scratched Certified Nursing Assistant #1. Registered Nurse Supervisor #1 denied being informed by Licensed Practical Nurse #1 that Certified Nursing Assistant #2 reported to them Certified Nursing Assistant #1 slapped Resident #1 in retaliation for being hit or that they threw a trash can at Resident #1.During a telephone interview on 05/13/2026 at 10:38 AM, Licensed Practical Nurse #1stated on 05/02/2026 at approximately 5:45 AM, Certified Nursing Assistant #1 reported that Resident #1 assaulted them during care. Licensed Practical Nurse #1 further stated that when they went to check on the resident, Resident #1 stated that they were beaten up and asked if they were also going to beat them up. Licensed Practical Nurse #1 stated that they did not observe any injuries on Resident #1. Licensed Practical Nurse #1 stated that Certified Nursing Assistant # 2 who was also in the room, reported that Resident #1 hit Certified Nursing Assistant #1 and Certified Nursing Assistant #1 slapped Resident #1 and threw a trash can at Resident #1 in retaliation. Licensed Practical Nurse #1 stated they informed Registered Nurse Supervisor #1 who did not go to Resident #1's room to assess Resident #1. They did not remove Certified Nursing Assistant # 1 from the unit or stop them from providing direct care to other residents. They stated Registered Nurse Supervisor #1 said Resident #1 was abusive to staff and is confused. Licensed Practical Nurse #1 stated that no one from administration inquired about the incident and the two certified nursing assistants remained on the staffing schedule. Licensed Practical Nurse #1 further stated they wrote an incident report and nothing was done. Licensed Practical Nurse #1 stated three days later, on 05/05/2026, they wrote a letter to the Director of Nursing about the incident that occurred on 05/02/2026 the letter was hand delivered to the Director of Nursing three days later and after no investigation was done, Licensed Practical Nurse #1 then called the New York State Department of Health. During a telephone interview on 05/14/2026 at 10:15 AM, Certified Nursing Assistant #1 stated Certified Nursing Assistant #2 asked for help to provide care to Resident #1 because Resident #1 was, verbally and physically aggressive. Certified Nursing Assistant # 1 was standing at the head of the bed and Certified Nursing Assistant #2 was at the foot of the bed, adjusting the bed down to give care and to change the adult brief. At this time, Resident # 1 suddenly scratched them on their face. They stated that they left the room to give Resident #1 time to calm down. They showed Licensed Practical Nurse #1 that their face was bleeding and told them that Resident #1 hit them. Registered Nurse Supervisor # 1 was on the unit and cleaned their face. Certified Nursing Assistant #1stated they did not slap Resident #1 or throw a trash can at Resident #1. They stated that they left the room, Licensed Practical Nurse #1 did not direct them to leave the room. During a telephone interview on 05/14/2026 at 12:30 PM, Certified Nursing Assistant #2 stated Resident #1 scratched the face of Certified Nursing Assistant #1. They both left the room to allow (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident # 1 to calm down. They both went back to care for Resident #1 who was cooperative and calmer. They did not see Certified Nursing Assistant #1 slap or throw a trash can at Resident #1. They did not report anything to License Practical Nurse #1, nor did they see anything.During an interview on 05/14/2026 at 1:25 PM, Nurse Practitioner #1 stated they were asked to see Resident #1 with swelling and redness to the lip on 05/07/2026, and the diagnosis was cellulitis (a spreading skin infection) and they started Resident #1 on antibiotics. They were not made aware of any allegations of assault against Resident #1. During an interview on 05/13/2026, with the Director of Nursing and Assistant Director of Nursing, they stated that they were not aware of the alleged abuse incident despite receiving a letter and an incident report from Licensed Practical Nurse #1 (the Charge Nurse on duty 05/02/2026) during the incident. They stated they did not investigate, report to law enforcement or report to the Department of Health. During an interview on 05/13/2026 at 8: 45 AM, the Administrator stated this is the first time they were hearing about the allegation of abuse of Resident #1.During a telephone interview on 05/18/2026 at 3:21 PM, the Medical Director stated after they were informed about the allegation with Resident #1, they spoke to all the medical providers, including the Nurse Practitioner, to be vigilant in examination of residents for any signs and marks that may be indicative of abuse. 10 New York Codes, Rules, and Regulations 415.4 (b)(3)Immediate Jeopardy was identified, and the Administrator was notified on 05/15/2026 and provided with the Immediate Jeopardy Template on 05/15/2026 at 12:26 PM. On 05/15/2026, an acceptable corrective action plan for the removal of the Immediate Jeopardy with a target completion date of 05/18/2026 was received from the facility. On 05/18/2026, the corrective action plan for the removal of the Immediate Jeopardy was verified. The following was implemented:The facility identified all residents at risk for abuse and residents with behaviors that put these residents at risk for abuse. The facility identified 10 residents with behavioral issues. During an interview on 05/17/2026 at 1:00 PM, the Director of Nursing stated there are ten residents identified with behaviors that are at risk of abuse. Director of Nursing stated five of these residents will need and were assigned two persons assistance and the other five residents require one person assist for activities of daily living. Education and In-services were provided to all staff; 100 % compliance was verified. The following documents were submitted, reviewed and accepted: The in-service lesson plan, the in-service attendance record, a list of residents with behavior, and F610 Audit Tool. The facility's policy and procedure titled Abuse, Identification and Reporting were reviewed and no changes were made.