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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335446 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 04/01/2025 |
| NAME OF PROVIDER OR SUPPLIER Cypress Garden Center for Nursing and Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 139 66 35th Avenue 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.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38306</p> <p>Based on observation, record review, and interviews during the abbreviated survey (NY00375573), the facility failed to ensure a resident was protected from abuse of any kind by anyone. This was evident for one (1) out of five (5) residents (Resident #1). Specifically, on 3/19/2025 Licensed Practical Nurse (#1) pulled Resident #1 on to and off the elevator. This was witnessed by Certified Nursing Assistants # 1, #2, Security Guard #1, and Registered Nurse Supervisor #1.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled, Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident's Property, dated 03/20/2025, documented the purpose of the policy is to ensure a resident was protected from abuse of any kind by anyone. The policy stated abuse does not have to be intentional and can still be considered abuse if the potential for harm is present. The policy defines willful as acting deliberately, not that the individual must have intended to inflict injury or harm.</p> <p>The facility's Summary of Investigation dated 03/21/2025, documented that on 03/19/2025, at approximately 10:16 PM, Resident #1 was in the hallway of the first-floor lobby with the assigned Certified Nursing Assistant #1, Registered Nurse Supervisor #1 and Certified Nursing Assistant #2 who were encouraging Resident #1 to return to their floor. Licensed Practical Nurse #1, the Charge nurse on Resident #1's floor was returning from their break, and they took Resident #1's hand as Resident #1 became combative, Licensed Practical Nurse #1 pulled Resident #1 towards and into the elevator while Resident #1 remained combative.</p> <p>Resident #1 was admitted to the facility with a diagnosis of Hemiplegia post Cerebral Infarction, Anxiety Disorder and Depression.</p> <p>The Minimum Data Set (an assessment tool) dated 03/13/2025, documented Resident #1 as severely cognitively impaired.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 335446 |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>The facility's Video Surveillance Camera footage was viewed 03/31/2025 at 12:08 PM, showed the first-floor lobby of the facility on 03/19/2025. There was no audio and time on video starts at 9:13 PM, the actual time was 10:13 PM. Certified Nursing Assistants # 1, # 2, Security Guard #1, and Registered Nurse Supervisor #1 were in the lobby trying to redirect Resident #1 verbally, no touching was observed. At 9:16 PM video time (actual / real time was 10:16 PM), Licensed Practical Nurse #1 entered the lobby area, spoke to the staff that was already present, then suddenly grabs at Resident #1 who becomes combative. Licensed Practical Nurse #1 was seen pulling Resident #1 into the elevator, Resident #1 tumbled and was observed seated on the elevator floor. Certified Nursing Assistants # 1, #2 are also in the elevator. The elevator door opened on the Resident #1's floor and Licensed Practical Nurse #1 was seen helping Resident #1 up from the elevator floor and pulled Resident #1 along the floor and out of the elevator. The elevator door closes and the video ends.</p> <p>Care Plans for Risk for Abuse initiated on 09/16/2022 due to physical limitation and disorientation were reviewed and included interventions.</p> <p>Behavior Care plan updated 10/11/2024, documented increasing aggressiveness. Interventions included room changes and increase in anxiety medication in addition to non-pharmacological interventions.</p> <p>Physician Order dated 02/26/2025-03/21/2025, documented monitoring for altered mental status and informing the physician. As of 03/20/2025 wander-guard (wander assistive device) was ordered and visual monitoring every 30 minutes for three days.</p> <p>Statement of Occurrence dated 03/19/2025, documented Licensed Practical Nurse #1 was the nurse on duty on 03/19/2025. Licensed Practical Nurse #1 stated they observed Resident #1 on the first floor being aggressive and they took Resident #1's arm and escorted Resident #1 to the elevator. While in the elevator Resident #1 continued punching and kicking. On the unit Resident #1 was given some juice.</p> <p>During a telephone interview on 04/01/2025 at 10:56 AM, Registered Nurse Supervisor #1 stated they were one of two nurse supervisors on the evening shift on 03/19/2025. One of the Certified Nursing Assistant called them to the lobby asking for help with Resident #1. A family or a translator was not called while they were in the lobby as Resident #1 understood gestures and some English. They used gestures and a popsicle to encourage Resident #1 to cooperate. Resident #1 was just standing there, and they decided they would just wait. Licensed Practical Nurse #1 came from the outside and approached Resident #1 and held Resident #1 by the arm as Resident #1 became combative. Licensed Practical Nurse #1 started to pull Resident #1 towards the elevator, and they (Nurse Supervisor #1) were in shock, it was so fast. Licensed Practical Nurse #1 pulled Resident #1 into the elevator and closed the door. The Nurse Supervisor #2 was informed what happened and went to assess Resident #1. The Administrator was informed. The family was called, and the adult child translated. Resident #1 denied that anything happened, and that they had no pain, The family and Resident #1 refused transfer to the emergency room. Licensed Practical Nurse #1 was escorted out of the building by the security guard after writing a statement and the Registered Nurse Supervisor #1 are also suspended.</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During a telephone interview on 04/01/2025 at 11: 58 AM, Certified Nursing Assistant # 1 stated they are still out on suspension. Certified Nursing Assistant #1 stated they knew Resident #1 from another unit and was assigned to Resident #1 on 03/19/2025 during the evening shift. Resident #1 was restless and was trying to go downstairs several times and at one point left the floor. Certified Nursing Assistant (#2) assisted them searching for the resident. The resident was found in the lobby, and we were offering food for cooperation to go upstairs. Certified Nursing Assistant (#1) called the Nurse Supervisor (#1) requesting assistance. Certified Nursing Assistant (#1) stated if we touched the resident, we knew the resident would have become combative. Also stated all staff had in services they tell us to talk calmly, not to touch them when agitated. When the Licensed Practical Nurse #1 arrived, the resident was told to go back upstairs. The nurse was trying to touch the resident, and the resident was pushing back. The nurse tried to hold the resident's arm, and the resident was being combative. The nurse held the resident and pulled the resident into the elevator. When in the elevator the resident fell on the floor. On [NAME] resident's floor the nurse was holding the resident's arm, and the resident was still fighting. The nurse pulled the resident by the arm out of the elevator along the floor.</p> <p>During Surveyor interview with Resident #1 via Mandarin speaking translator on 03/31/2025 at 11:45 AM, Resident #1 stated no one hurting them and did not recall the incident.</p> <p>During an interview on 04/01/2025 at 5:10 PM, the Administrator stated Registered Nurse Supervisor #1 informed them at about 10:21 PM on 03/19/2025, Licensed Practical Nurse #1 dragged Resident #1 into the elevator as seen on the footage. They directed the Registered Nurse Supervisor #1 to have Resident #1 assessed and remove Licensed Practical Nurse #1 immediately. The Administrator stated the Registered Nurse Supervisor #1 did not intervene and stated it was due to the shock factor. Licensed Practical Nurse #1 wrote a statement and left the facility escorted by security. The Administrator stated they called the Nurse Supervisor #2 and the Director of Nursing to ensure that everything requested was done. The police were called and responded realized Resident #1 had no capacity they asked to see the footage on 03/20/2025. The officers reviewed the footage on 03/20/2025 and spoke with their sergeant. They also requested the family contact information. Immediate interventions were started as stated in the corrective actions below.</p> <p>10 NYCRR 415.11(c)(3)(i)</p> <p>Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance with this specific regulatory requirement on 03/23/2025, prior to and during the time of this survey.</p> <p>A Plan of Correction was not required for this citation.</p> <p>The facility took corrective actions and was found to be in substantial compliance prior to the surveyor's onsite visit on 3/31/2025.</p> <ol style="list-style-type: none"> 1. The facility immediately assessed Resident #1. There were no visible injuries. 2. Licensed Practical Nurse #1 was removed immediately from the facility and reported to New York State Office of Professions (Nursing). The Registered Nurse Supervisor #1 and Certified Nursing Assistants #1 and #2 were suspended until the investigation was completed. <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>3. The New York City Police Department local precinct 109 was informed on 03/19/2025. The Video footage viewed by the police officers on 3/20/2025.</p> <p>4. The facility's Policy titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation was reviewed and no revision was needed.</p> <p>5. The Facility provided in-services on Abuse/Neglect/Mistreatment, Abuse Prevention/ Prohibition and Management of Residents with Behavioral Issues started on the night shift on 03/19/2025.</p> <p>6. An Ad hoc Quality Assurance Performance Improvement meeting with all department heads was held on 03/20/2025 and the video footage was shown.</p> <p>7. On 03/20/2025, the in- service of all staff on abuse was initiated, any one out on vacation were called and given a brief version of the lesson plan.</p> <p>8. 180 Nursing staff (100%) staff were in-serviced to date.</p> <p>9. Abuse Drill was conducted on 03/23/2025, during the 7AM-3PM shift and will be ongoing. Currently on second round of drills. Since the drill Certified Nursing Assistant have been prompted to question how to handle some behavioral issues. Staff unit discussions are being encouraged.</p> <p>10. The facility staff completed questionnaires on abuse after in-services and drills.</p> <p>11. QAPI meetings are held quarterly, the next meeting is scheduled for the second week of April.</p> <p>12. During interview on 04/01/2025, Licensed Practical Nurses and Certified Nursing Assistants stated understand</p> | | |