STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335472	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Queens Rehab & Nursing Center	69 95 Queens Midtown Expressway Maspeth, NY 11378

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Recertification Survey from 07/28/2025 to 08/04/2025, the facility did not ensure each resident was treated with respect and dignity. This was evident for 1 (Resident #38) of 1 resident reviewed for Dignity out of 37 total sampled residents. Specifically, the Infection Control Preventionist was observed using profane language when speaking to Resident #38.The findings are: The facility's policy titled Quality of Life - Dignity last reviewed 01/2025 stated that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall speak respectfully to residents and staff shall treat cognitively impaired residents with dignity and sensitively, including addressing the underlying motives or root causes for behaviors. Resident #38 had diagnoses including Non-Alzheimer's Dementia, Anxiety Disorder, and Major Depressive Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #38 had moderate cognitive impairment, exhibited physical and verbal behavioral symptoms, rejected care daily, and exhibited wandering behaviors daily. On 07/28/2025 at 10:47 AM, Resident #38 was observed removing personal protective equipment from a bin in the hallway. The Infection Control Preventionist was observed using profane language while telling Resident #38 to stop touching things. The Infection Control Preventionist was then observed using profane language while telling Housekeeper #1 to clean urine on the other side of the unit.The Comprehensive Care Plan titled At Risk to Be a Victim of Abuse, Neglect, and/or Mistreatment last updated 06/08/2025 documented a goal of Resident #38 would not be abused or victimized by others. Interventions included calmly redirecting Resident #38 away from areas of potential harm.The Comprehensive Care Plan titled Behavioral Symptoms last reviewed 11/26/2024 documented a goal of Resident #38 would be free of conditions that may contribute to behaviors. Interventions included approaching Resident #38 calmly and using a calm and friendly tone, and careful gestures. On 07/28/2025 at 11:39 AM, Housekeeper #1 was interviewed and stated after a resident urinated in the hallway, Resident #38 had attempted to wipe it up with personal protective equipment and this made the Infection Control Preventionist upset. Housekeeper #1 also stated they felt like the way the Infection Control Preventionist spoke to Resident #38 was not right, and staff should not speak to residents like that. On 07/28/2025 at 12:40 PM, the Infection Control Preventionist was interviewed and stated they had become upset after a resident with a history of disruptive behaviors urinated in the hallway. The Infection Control Preventionist further stated Resident #38 had removed personal protective equipment from a bin near the urine, which the facility disposed of, but then continued to remove personal protective equipment from another bin on the other side of the unit. The Infection Control Preventionist stated they told Resident #38 to stop removing the items, but they were unusually stressed and should not have cursed at the resident. On 07/31/2025 at 12:20 PM, Registered Nurse #4 was interviewed and stated Resident #38 had severe dementia, was confused, and had behaviors including taking other residents' belongings. Registered Nurse #4 stated Resident #38 could be easily redirected when given time to calm down. On 08/04/2025 at 11:17 AM, Certified Nursing Assistant #3 was interviewed and stated Resident #38 had (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors including being verbally aggressive and becoming agitated, but Resident #38 could be easily redirected by speaking to them nicely. On 08/04/2025 at 12:16 PM, the Director of Nursing was interviewed and stated they supervised the Infection Control Preventionist, and all staff, including the Infection Control Preventionist, were in-serviced annually and as needed on abuse, dignity, and providing respectful care. The Director of Nursing stated as soon as they became aware of the Infection Control Preventionist using profane language directed at Resident #38, they re-educated the Infection Control Preventionist and suspended them while they investigated the incident. On 08/04/2025 at 12:23 PM, the Administrator was interviewed and stated they had been made aware of the incident involving the Infection Control Preventionist speaking inappropriately to Resident #38. The Administrator stated they believed the Infection Control Preventionist had been stressed at the time, but that was not an excuse for their behavior. The Administrator further stated the Infection Control Preventionist should never speak to a resident like that and should have calmly redirected Resident #38. 10 NYCRR 415.5(a)

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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 conducted during the Recertification survey, the facility did not ensure a safe, clean, comfortable, and homelike environment was provided to the residents, and maintenance services necessary to maintain a sanitary, orderly and comfortable interior were provided to the residents. This was evident on 1 (Unit 5) of 5 units. Specifically, on Rooms 501, 505, 507, 509, and 517, and the general residents' bathroom were observed with air conditioners with dirty and rusty grill covers, mismatched chipped paint in the residents' room, hole in the wall and unclean discolored bathroom heater. The findings are: The facility's policy titled Homelike Environment effective 1/2017 last reviewed date 1/2025 states it is the policy of Central Queens Rehabilitation and Nursing Center to provide a safe, clean, comfortable and homelike environment to all residents. During multiple observations from 07/28/2025 at 10:00 AM to 08/04/2025 at 11:00 AM the following was observed: 1. On 07/28/2025 at 10:00 AM, in room [ROOM NUMBER] observed the air conditioner cover grill was dirty and rusted in multiple areas. 2. On 07/28/2025 at 10:30 AM, in room [ROOM NUMBER] observed a hole in the wall, approximately 3 inches by 3 inches, and cement debris was falling out from the hole.3. On 07/29/2025 at 11:00 AM, in room [ROOM NUMBER] observed the windowsills had peeling paint, and the air conditioner grill cover was rusty.4. On 08/04/2025 at 10:45 AM. in room [ROOM NUMBER] observed the floor had dry soap remnants, the floor stained with whitish dry sediments, and the air conditioner grill cover was rusty. 5. On 08/04/2025 at 11:00 AM room [ROOM NUMBER] observed the bathroom heater cover rusty and soiled with a brownish discoloration on the whole cover.6. In the resident's General Bathroom, the ceiling and a cubicle had mis matched, unfinished paint. On 08/04/2025 at 11:00 AM, the resident who resided in room [ROOM NUMBER] was interviewed and stated the bathroom heater cover has been dirty since they came to this room and it does not look good, and they wish someone would clean and paint it. On 08/04/2025 at 11:25AM, the Maintenance log book for the 5th floor was reviewed and revealed no entries regarding the observations in rooms 501, 505, 507, 509, 517 and the general residents' bathroom. On 08/04/2025 at 11:24 AM, the Director of Maintenance was interviewed and stated the issues identified on the fifth floor including the dirty, rusty air conditioner grill covers, hole in the wall, mismatched paint, dirty floors were missed during their rounds and should have been corrected, repaired and or cleaned. The Director of Maintenance also stated they do not know why the staff had not done the repair yet. The Director of Maintenance further stated the maintenance workers were supposed to do the repair and as the Director of Maintenance they were responsible for inspecting their work and making rounds on the unit. On 08/04/2025 at 1:57 PM, the Administrator was interviewed and stated areas of concern observed in the fifth floor were brought to their attention today and acknowledged the findings. The Administrator also stated the Maintenance and Housekeeping staff missed those areas and resident's immediate environment must be cleaned at all times since this is their home. Administrator further stated they make daily rounds in the morning to ensure areas needed repairs are done to make their environment homelike. 10 NYCRR 415.5(h)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview conducted during the Recertification and Complaint survey from 07/28/2025 to 08/04/2025, the facility did not ensure that a Comprehensive Care Plan for each resident was developed and implemented consistent with the resident rights that includes measurable objectives and time frames to meet a resident's medical, nursing and mental psychosocial needs that are identified in the comprehensive assessment. This was evident for 1 (Resident #82) of 1 resident reviewed for Hospice and End of Life out of 37 sampled residents. Specifically, there was no care plan created that addressed comfort care for Resident #82. The findings are: The facility policy and procedure titled Comprehensive Care Planning with a review date of 01/2025 stated it is the facility policy to implement a Comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The Interdisciplinary team will initiate upon admission and update the care plan quarterly and as needed. Resident #82 was admitted to the facility with diagnoses that included Squamous Cell Skin cancer, Heart Failure, and Respiratory Failure. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #82 was severely cognitively impaired and required dependent assistance of staff with most activities of daily living, including dressing, transfer and bed mobility. On 07/31/2025 from 12:15 PM to 12:32 PM, Resident #82 was observed in bed, awake with spouse at bedside. Resident #82 appeared weak, with poor appetite, taking only sips of a supplement with encouragement from their spouse. The Physician's order dated 06/12/2025 and renewed on 07/13/2025 documented an order for Comfort care, with advance directive of Do Not Resuscitate, Do Not Intubate, no tube feeding, no hemodialysis, and no weight taking. There was no documented evidence a care plan regarding comfort care had been created for Resident #82. On 08/04/2025 at 11:09 AM, Registered Nurse Supervisor #5 was interviewed and stated they are covering for the Unit Manager. Registered Nurse Supervisor #5 also stated the care plans for Hospice, Palliative and Comfort care is done by the Social Worker. On 08/04/2025 at 12:18 PM, the Director of Social Work was interviewed and stated they are responsible for creating care plans for Hospice, Palliative and Comfort Care, and Advance Directives. After reviewing the chart, the Director of Social Work stated there is a care plan for Advance Directives, but no care plan for comfort care was formulated. 10 NYCRR 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews conducted during the Recertification survey from 07/28/2025 to 08/04/2025, the facility did not ensure that each resident's Comprehensive Care Plans were reviewed and revised. This was evident for 1 resident reviewed for Dignity out of 37 sampled residents. Specifically, there was no documented evidence that the Comprehensive Care Plans for Mood State, Cognitive Loss/Dementia, Wandering/Elopement, Behavioral Symptoms (Verbally Abusive Behavior), and Behavioral Symptoms were reviewed and revised for Resident #38 after their last quarterly Minimum Data Set assessment was completed.The findings include:The facility policy and procedure titled Comprehensive Care Planning last reviewed 01/2025 stated that it is the facility's policy to implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs. The interdisciplinary team will review and update the care plan quarterly (in conjunction with the Minimum Data Set schedule) and as needed. Quarterly reviews of care plans are completed prior to the scheduled Comprehensive Care Plan meeting.Resident #38 had diagnoses including Non-Alzheimer's Dementia, Anxiety Disorder, and Major Depressive Disorder.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #38 had moderate cognitive impairment, exhibited physical and verbal behavioral symptoms, rejected care daily, and exhibited wandering behaviors daily.The Mood State Comprehensive Care Plan, effective 02/12/2023, documented Resident #38 was at risk for impaired mood state, psychosocial wellbeing, and behavioral disturbances, as evidenced by their diagnoses of Dementia, Major Depressive Disorder, and Altered Mental Status. The Mood State Comprehensive Care Plan was last reviewed on 02/20/2025 and there was no documented evidence the care plan was reviewed following Resident #38's Quarterly Minimum Data Set assessment on 05/23/2025. The Cognitive Loss/Dementia Comprehensive Care Plan, effective 02/19/2023, documented Resident #38 had impaired cognitive function/dementia or impaired thought processes related to their diagnosis of Dementia. The Cognitive Loss/Dementia Comprehensive Care Plan documented it was last reviewed on 02/22/2025, and there was no documented evidence the care plan was reviewed following Resident #38's Quarterly Minimum Data Set assessment on 05/23/2025. The Wandering/Elopement Comprehensive Care Plan, effective 03/04/2023, documented Resident #38 wandered with no rational purpose, seemingly oblivious to needs or safety. The Wandering/Elopement Comprehensive Care Plan documented it was last reviewed on 03/09/2025, and there was no documented evidence the care plan was reviewed following Resident #38's Quarterly Minimum Data Set assessment on 05/23/2025.The Behavioral Symptoms (Verbally Abusive Behavior) Comprehensive Care Plan, effective 06/19/2023, documented Resident #38 had the potential to demonstrate verbally abusive behaviors related to their diagnoses of Dementia, Major Depressive Disorder, and Altered Mental Status. The Behavioral Symptoms (Verbally Abusive Behavior) Comprehensive Care Plan documented it was last reviewed on 11/26/2024, and there was no documented evidence it was reviewed following Resident #38's Quarterly Minimum Data Set assessments 02/22/2025 and on 05/23/2025. The Behavioral Symptoms Comprehensive Care Plan, effective 04/23/2023, documented Resident #38 exhibited behavioral problems including episodes of wandering, threatening behavior, and resisting care. The Behavioral Symptoms Comprehensive Care Plan documented it was last reviewed on 11/26/2024, and there was no documented evidence it was reviewed following Resident #38's Quarterly Minimum Data Set assessments 02/22/2025 and on 05/23/2025. On 08/04/2025 at 10:59 AM, Registered Nurse #4 was interviewed and stated care plans are updated on a quarterly basis after the quarterly Minimum Data Set assessment is completed. Registered Nurse #4 further stated the Social Services department was responsible for updating the Mood and Cognitive Loss care plans, and the nurse manager was responsible for updating other care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plans, including care plans related to Behaviors and Wandering/Elopement. Registered Nurse #4 was unable to provide an explanation for why Resident #38's care plans related to behavioral symptoms, wandering, and cognitive loss were not updated. On 08/04/2025 at 12:16 PM, the Director of Nursing was interviewed and stated Comprehensive Care Plans are updated on a quarterly basis by the relevant department. The Director of Nursing also stated there is an alert that is sent out through the electronic medical record when a review is due to alert staff to review it. The Director of Nursing was unable to provide an explanation for why the care plans were not updated for Resident #38. On 08/04/2025 at 12:50 PM, the Director of Social Services was interviewed and stated they were responsible for reviewing all Social Services Comprehensive Care Plans, which included care plans for Advanced Directives, Discharge, Cognitive Loss/Dementia, Psychosocial Wellbeing, Trauma Informed Care, Mood, and Victimization. The Director of Social Services also stated these reviews are done quarterly, and the electronic medical record alerts them when a review is due. The Director of Social Services further stated they did not realize that the Cognitive Loss/Dementia and Mood Care Plans had not been reviewed because they did not receive an alert related to it. NYCRR 415.11(c)(2)(i-iii)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1 Based on observation, record review and staff interviews conducted during the Recertification survey, the facility did not ensure that services provided or arranged by the facility as outlined by the Comprehensive Care Plan meet professional standards of quality including current evidence-based practice. This was evident for 1 (Resident #14) of 5 residents reviewed for Unnecessary Meds, Chemical Restraints/Psychotropic Meds, and Med Regimen Review out of 37 sampled residents. Specifically, Licensed Nurses did not inform the Physician or the Physician Assistant when a resident with diagnosis of Diabetes Mellitus had elevated blood glucose readings, of inconsistent blood glucose monitoring as per Physician's order of four times a day and of Resident's refusal of treatment as ordered by the Physician.The finding is: The Licensed Practical Nurse job description states charting and documentation includes transcribing physician's orders to resident charts, Kardex, medication cards, treatment or care plans, as required and chart nurses notes in an informative and descriptive manner that reflects the care provided to the resident as well as the resident's response to the care, prepare and administer medications as ordered by the Physician, and notify the Nurse Supervisor or Unit Manager for any discrepancies noted on your shift. Resident #14 had diagnoses which included Diabetes Mellitus, Hypertension, Morbidly Obesity, and Status Post Cardiac Arrest. The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #14 was cognitively intact and was dependent on staff for most Activities of Daily Living and required set up assistance only for eating. The Physician's order dated 06/19/2025 with a renewal date of 07/05/2025 documented Admelog Insulin 8 units three times a day, Jardiance 10 milligram daily, Insulin Glargine 28 units at bedtime, and monitor blood glucose before each meals and at bedtime .Call Physician if lesser than 80 and greater than 400 milligram per dilution. The Comprehensive Care Plan on Diabetes Mellitus dated 05/09/2025 with revision date of 06/22/2025 documented a goal of resident will be free from signs and symptoms of hyper/hypoglycemia, will maintain glucose levels within the prescribed parameters. Interventions included administer medications as per physician's order, monitor effect and adverse effect and report to physician, educate resident and family with diabetes as a chronic disease and compliance is essential to prevent further complications, implement diet as prescribed, provide skin, foot care and refer to physician for consultations as needed. The blood glucose readings dated 07/01/2025 to 07/30/2025 documented elevated results with the lowest reading at 309 milligram per dilution (mg/dl) on 07/15/2025 at 11:49 am and the highest reading was 499 mg/dl at 1:53 PM on 07/02/2025. On the following dates the blood glucose readings were higher than 400 mg/dL:07/02/2025 AM-485 mg/dL07/02/2025 PM -499 mg/dL07/04/2025 AM-495 mg/dL07/04/2025 PM-495 mg/dL07/17/2025 PM-401 mg/dL07/19/2025 PM-402mg/dL There was no documented evidence that the Nursing Supervisor, Physician or Physician's Assistant were notified of blood glucose levels over 400mg/dL as per Physician's order. Further review of the Blood Glucose readings from 07/12/2025 to 07/21/2025 revealed blood glucose was not monitored as per Physician's order on the following dates and times:07/12/2025-dinner and bedtime 07/13/2025-breakfast, lunch and bedtime07/14/2025-breakfast and bedtime07/15/2025-bedtime07/17/2025-dinner07/18/2025-breakfast and bedtime07/19/2025-breakfast and bedtime 07/20/2025 breakfast and bedtime 07/21/2025-bedtime The Nurses Progress notes dated 07/01/2025 to 07/28/2025 revealed no documented evidence the Nursing Supervisor, Attending Physician or Physician Assistant were notified of blood glucose not taken and there was no documentation of resident refusal. On 08/01/2025 at 2:20 PM, Nursing Supervisor #4 was interviewed and stated no staff reported Resident #14's did have elevated blood glucose readings. Nursing Supervisor #4 also stated that they would not know about the elevated levels if the nurse did not inform them. On 08/01/2025 at 4:37 PM, the Director of Nursing was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed and stated all staff are educated on the blood glucose elevated readings and when to call the Physician. The Director of Nursing also stated it is the responsibility and is expected the Unit Nursing Supervisor is following up on the care residents receive on the unit, including elevated blood glucoses levels. 10 NYCRR 415.11(c) (3)(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during the Recertification survey, the facility did not ensure that each resident received treatment and care in accordance with goals for care and professional standards of practice. This was evident for 1 (Resident #6) of 4 residents reviewed for Limited Range of Motion out of 38 sampled residents. Specifically, Resident #6, who had a history of limited neck flexion, and a Physician's order for cervical brace to be worn at all times except for skin check, hygiene, and exercise was observed on several occasions without them.The findings are:The facility's policy titled Assistive Device and Equipment Policy last reviewed on 1/20/25 stated it is the responsibility of the facility to ensure residents are provided with a safe environment. The policy also stated all recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the resident care plan, and direct care staff are trained and demonstrated competency on the use of devices and equipment prior to assisting or supervising residents.Resident #6 was admitted to the facility with diagnoses that included Non-Alzheimer's Dementia, Peripheral Vascular Disease, and Coronary Artery Disease.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #6 had moderately impaired cognition. The Minimum Data Set assessment also documented Resident #6 required dependent assistance of staff for personal and oral hygiene, toileting and transfer, and had no falls since the prior assessment.Occupational Therapy note dated 05/27/2025 documented Resident was seen after readmission and provided with cervical collar due to lateral flexion of neck. Nursing made aware. Will continue to follow.The Physician order dated 05/27/2025 documented cervical brace to be worn at all times except for skin check, hygiene, and exercise.The Comprehensive Care Plan for Mobility Devices effective 05/28/2025 documented that Resident #6 had a history of limited neck flexion, and cervical brace to be worn at all times except for skin check, hygiene, and exercise.On 07/28/25, 07/29/25 and 7/30/25 between the hours of 10:00 AM and 1:20 PM, Resident #6 was observed in bed, and there was no cervical brace observed placed on their neck. A cervical brace was observed in Resident #6's closet.The Resident Certified Nursing Assistant Documentation History dated from 07/28/2025 to 08/04/2025 documented Resident #6 had splint and braces were being used. On 07/30/2025 at 10:13 AM, an interview was conducted with Certified Nursing Assistant #1 who stated they were not aware Resident #6 had cervical brace to be worn to their neck. Certified Nursing Assistant #1 also stated they were not informed about the cervical neck brace, and they were not sure if the cervical neck brace included on their daily work plan.On 07/30/2025 at 10:33 AM, an interview was conducted with Registered Nurse #1, a unit supervisor, who stated they used to see the neck brace a while back when Resident #6 was first admitted to the unit in May 2025, but Resident #6 had not had it since then. Registered Nurse #1 also stated they believe the Interdisciplinary team were discussing the revaluation of the neck and the need for the continuation of the neck brace. Registered Nurse #1 concluded they were not aware Resident #6 was currently using the cervical neck brace.On 07/30/2025 at 10:42 AM, an interview was conducted with the Licensed Practical Nurse #1 who stated they had not seen Resident #6 with a neck brace since Resident #6 was transferred from the 2nd floor to the 6th floor.On 07/30/2025 at 10:42 AM an interview was conducted with the Licensed Practical Nurse #1 who stated that they have not seen the resident with neck brace since the resident came back from 2nd floor to the 6th floor. On 08/01/2025 at 11:50 AM, an interview was conducted with the Assistant Director of Nursing who stated Resident #6 had a Physician's order for a cervical neck brace for comfort of the neck and to prevent any deterioration because Resident #6 had limited mobility and impairment to their neck. The Assistant Director of Nursing also stated that the order was still active, and the resident's plan of care had not been changed. The Assistant Director of Nursing further stated that the Nursing Supervisors are responsible to ensure that the Certified Nursing Assistants are doing their work according to the resident's plan of care. On 08/01/2025 at (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12:11 PM, an interview was conducted with the Director of Nursing who stated the cervical neck brace order was still active, and the Certified Nursing Assistants are responsible for the application of it. The Director of Nursing also stated they spoke with the assigned Certified Nursing Assistants about it, and they are currently in servicing the staff on need to apply residents' devices, not only the neck brace but all other devices necessary to improve the quality of life of residents.On 08/01/2025 at 02:20 PM, an interview was conducted with the Director of Rehab who stated once a device is determined to be used on a resident, they would get a Physician's order, and they would also train the nursing staff on the proper application of device. The Director of Rehab also stated Resident #6 was seen after readmission and provided with a cervical collar due to lateral flexion of neck, and they ensured staff did a return demonstration of the proper application of the cervical collar. 10 NYCRR 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335472	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Queens Rehab & Nursing Center	69 95 Queens Midtown Expressway Maspeth, NY 11378

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during the Recertification survey, the facility did not ensure that the Physician reviewed the resident's total program of care at each visit. This was evident for 1 (Resident #14) of 5 resident reviewed for Unnecessary Meds, Chemical Restraints/Psychotropic Meds, and Med Regimen Review out of 37 sampled residents. Specifically, there was no documented evidence the Physician addressed Resident #14's consistently high blood sugars and non-compliance with diabetic management. The findings include: The facility policy and procedure titled Diabetes Protocol with a review date of 1/2025 stated all residents will have their diabetes managed according to Physician recommendations and resident/resident representative preferences. The Physician will follow up on any acute episodes associated with significant sustained change in blood glucose levels or significant deterioration of previous glucose control and document resident status at subsequent visits until the acute situation is resolved. Resident #14 had diagnoses which included Diabetes Mellitus, Hypertension, Morbidly Obesity, and Status Post Cardiac Arrest. The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #14 was cognitively intact and was dependent on staff for most Activities of Daily Living and required set up assistance only for eating. The Physician's order dated 06/19/2025 with a renewal date of 07/05/2025 documented Admelog Insulin 8 units three times a day, Jardiance 10 milligram daily, Insulin Glargine 28 units at bedtime, and monitor blood glucose before each meals and at bedtime. Call Physician if lesser than 80 and greater than 400 milligram per dilution. The Comprehensive Care Plan on Diabetes Mellitus dated 05/09/2025 with revision date of 06/22/2025 documented a goal of resident will be free from signs and symptoms of hyper/hypoglycemia, will maintain glucose levels within the prescribed parameters. Interventions included administer medications as per physician's order, monitor effect and adverse effect and report to physician, educate resident and family with diabetes as a chronic disease and compliance is essential to prevent further complications, implement diet as prescribed, provide skin, foot care and refer to physician for consultations as needed. The facility Clinical Monitoring Detail Report dated 07/01/2025 to 07/30/2025 documented elevated blood glucose readings results with the lowest reading at 309 milligram per dilution (mg/dl) on 07/15/2025 at 11:49 am and the highest reading was 499 mg/dl at 1:53 PM on 07/02/2025. On the following dates the blood glucose readings were higher than 400 mg/dL: 07/02/2025 AM-485 mg/dL07/02/2025 PM -499 mg/dL07/04/2025 AM-495 mg/dL07/04/2025 PM-495 mg/dL07/17/2025 PM-401 mg/dL07/19/2025 PM-402mg/dL The facility Clinical Monitoring Detail Report also documented the following elevated blood sugar levels: 07/12/2025 breakfast-384mg/dL lunch-396 mg/dL07/13/2025 dinner -396 mg/dL07/14/2025 lunch-301 mg/dL dinner-346 mg/dL07/15/2025 breakfast-312 mg/dL lunch-309 mg/dL dinner-341 mg/dL07/17/2025 breakfast-383 mg/dL lunch-401 mg/dL bedtime-328 mg/dL07/18/2025 lunch-397 mg/dL dinner-345 mg/dL07/19/2025 lunch-390 mg/dL dinner-342 mg/dL 07/20/2025 lunch-390 mg/dL dinner-400 mg/dL 07/21/2025 breakfast-400 mg/dL lunch-389 mg/dL dinner-342 mg/dL The Physician's Assistant Progress note dated 06/27/2025 documented last labs seen and appreciated from May 2025 with elevated Hemoglobin A1C of 11.5 % with glucose result of 400 mg/dL. Plan of care: Continue Admelog 8 units three times a day, Jardiance 10 mg daily and Lantus 28 units at Bedtime. Hold if blood glucose is 200 mg/dL. Lab results dated 07/12/2025 documented Hemoglobin A1C (HgbA1C) result of 12.8 % which was increased from result of 11% in May 2025. Glycated Hemoglobin or Hgb A1C is a blood test that provides a long-term average of a person's blood sugar levels which reflects how much glucose has attached to hemoglobin in red blood cells over the past 2-3 months which is crucial in the diagnosis of Diabetes Mellitus. The Physician Assistant Progress note dated 07/21/2025 documented monthly assessment, last labs were seen and appreciated. The plan for Diabetes Mellitus 2 was continue Ozempic, Jardiance, Admelog 8 units, and (continued on next page)

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	335472	A. Building B. Wing	08/04/2025

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lantus 28 units daily. Monitor for Hyper/Hypoglycemia, trend HgbA1C and fingerstick. The Physician Assistant Progress note dated 07/26/2025 documented follow-up on poorly controlled Diabetes. Finger sticks are in the 300 range, this visit at 312 mg/dL sometimes higher, medication regime remains the same, hold parameters if below 200, which is seldom ever below 200. The resident is morbidly obese and is contributing to poorly controlled Diabetes with food choices that they get from the vending machine and from outside delivery. Plan of care: Hemoglobin A1C previously 11.5 now 12.8. Continue Admelog 8 units three times a day, Jardiance 10 milligram daily, Lantus 28 units bedtime. On 07/31/2025 at 12:14 PM, Physician Assistant #1 was interviewed and stated Resident #14 is noncompliant and will drink two bottles of soda. Physician Assistant #1 also stated that the medication was not adjusted because of the last holiday in July, and it should have been addressed at that time. On 07/31/2025 at 12:18 PM, Attending Physician #1 interviewed via telephone and stated Resident #14 is noncompliant and will order food from outside. Attending Physician #1 also stated they met with Resident #14 and Resident #14 refused to attend appointments with the Endocrinologist when they were at another facility prior to admission here. Attending Physician #1 further stated that they do not want Resident #14's blood sugars to go too low. Attending Physician #1 stated they would review Resident #14's and adjust medication if needed. On 08/01/2025 at 2:21 PM, the Medical Director was interviewed via telephone and stated they reviewed Resident #14's record and with elevated blood glucose such as this the medications should have been adjusted. The Medical Director also stated they would speak with Resident #14's Attending Physician about this matter. The Medical Director further stated this issue had not come to their attention. 10 NYCRR 415.15(b)(2)(iii)