

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Holliswood Center for Rehabilitation and Healthcar		STREET ADDRESS, CITY, STATE, ZIP CODE 195 44 Woodhull Avenue Hollis, NY 11423	
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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure that a resident was able to exercise their autonomy regarding choices that are important to their life. This is evident in one out of seven residents sampled. Specifically, on 02/15/2026 at 5:00 PM, Resident #1 who was alert and oriented times three, attempted to leave the dining room and Certified Nursing Assistant #1 stood in front of their wheelchair and placed both their hands on the armrests of the wheelchair preventing Resident #1 from leaving the dining room. The findings are: The facility's Policy titled Resident Rights dated 05/28/2024 states that healthcare personnel shall treat all residents with kindness, respect and dignity. Also documented resident's right to self-determination; exercise his or her rights as a resident of the facility and as a resident or citizen of the United States; be supported by the facility in exercising his or her rights. Resident #1 was admitted to the facility with diagnoses including Anxiety, Cerebral Infraction (stroke) with Hemiparesis (weakness on one side of the body, affecting the face, arm, and leg) and Hemiplegia (a medical condition causing total or partial paralysis on one side of the body, typically affecting the face, arm, and leg, and resulting from brain or spinal cord damage). The Minimum Data Set (a resident assessment tool) dated 02/04/2026 documented Resident #1 had intact cognitions. A Comprehensive Care Plan Resident is able to make leisure Preferences known dated 07/29/2025, interests include watching television, reading, and listening to music. A summary of investigation dated 02/20/2026 documented on 02/15/2026 at 5:00 PM Resident #1's family reported to Registered Nurse Supervisor #1 that Resident #1 stated they were hit on the right chest and right knee by Certified Nursing Assistant #1. Resident #1 was assessed with no discoloration, no redness, swelling or injuries. Certified Nursing Assistant #1 stated they were monitoring the dining room when Resident #1 approached the exit door to leave the dining room. Resident #1 was instructed to stay in the dining room because they were at risk of falling and were being monitored. Resident #1 refused to go back to the dining room and Certified Nursing Assistant #1 reported that they positioned themselves in front of Resident #1 wheelchair, placed their hands on the wheelchair armrests and explained to Resident #1 why they should be in the dining room and that was when Resident #1 struck them in their chest and kicked them. Certified Nursing Assistant #1 stated they touched Resident #1 on their right knee during the interaction to get Resident #1's attention. Certified Nursing Assistant #1 was suspended pending outcome of the investigation. The facility conclusion documented there is no evidence of abuse, neglect, or mistreatment. A Nursing Progress Note by Registered Nurse #3 dated 02/15/2026 at 11:35 PM, documented Resident #1's family reported that a staff member hit Resident #1 on their right chest and their right knee. Body assessment revealed no redness and no bruises. 911 called and four Police Officers responded to the facility. Resident #1 was transferred to hospital for chest pain. A late entry progress note by Registered Nurse #2 dated 02/17/2026 at 5:37 documented writer and social worker (continued on next page)		

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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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	met with Resident #1 and Resident #1 reported that they asked the staff to put them back in their bed because they were sitting long in the chair and it hurts my hips and legs. They said they would put them back in bed, but a tall lady said no. One lady grabbed them and pushed them back in their chair very hard. Resident #1 was asked if they hit the staff member and Resident #1 stated I cannot hardly lift their arms how can they hit the staff. Resident #1 declined room change offer. Resident #1 call bell within reach, bed in lowest position. Resident #1 was asked if there are anything else they can do to make them comfortable and Resident #1 said no.A Physician's Progress Note dated 02/18/2026 documented that Resident #1 was seen and examined with no acute changes reported and no acute distress. Stable clinically at baseline.A Psychiatric Progress Note dated 02/21/2026 at 7:04 AM documented Resident #1 alleged that while in dining room they were getting uncomfortable sitting in their wheelchair, they were raising up to change their position, and a staff pushed them back in their wheelchair. Resident #1 did not present traumatized by the incident although Resident #1 reported some residual chest/muscular pain.During an interview on 07/09/2026 at 3:30 PM, Resident #1 stated they have no complaints and that they do not recall the incident.During an interview on 07/29/2026 at 1:35 PM, Certified Nursing Assistant #1 stated on 02/15/2026 (unsure of time) they were assigned to monitor the dining room. Certified Nursing Assistant #1 stated they were instructed to ensure residents do not fall. Certified Nursing Assistant #1 stated Resident #1 who has had a recent fall was in the dining room for monitoring. Certified Nursing Assistant #1 stated while they were sitting at the dining room entrance Resident #1 wheeled their wheelchair towards them, stating they needed to go. Certified Nursing Assistant #1 stated they asked from another Certified Nursing Assistant (unsure of name) if Resident #1 had to go somewhere and was told no. Certified Nursing Assistant #1 stated they redirected Resident #1 to go back to where they were sitting but Resident #1 refused and continued wheeling themselves towards them. Certified Nursing Assistant #1 stated they positioned themselves in front of Resident #1's wheelchair and placed both hands on the armrests of the wheelchair while explaining to Resident #1 why they should remain in the dining room. Certified Nursing Assistant #1 stated while they were in front of the wheelchair, hands on the armrests pushing the chair back in the dining room, Resident #1 hit and kicked them in the chest area. Certified Nursing Assistant #1 stated that the residents have a right to move about freely, however, they were just focusing on keeping Resident #1 from falling. Certified Nursing Assistant #1 stated they were just trying to keep Resident #1 in the dining room until their family came.During an interview on 07/29/2026 at 2:00 PM, Assistant Director of Nursing stated that all staff members received prior in-service on resident rights. Assistant Director of Nursing #1 stated while they were conducting the investigation they interviewed Certified Nursing Assistant #1 who explained to them that they were not blocking Resident #1, they were trying to keep Resident #1 engaged in the dining room until their family came because Resident #1 had recently fallen into their room. Assistant Director of Nursing stated that the facility is Resident #1's home and staff members are aware the residents have the right to move about freely. Assistant Director of Nursing stated Certified Nursing Assistant #1 was not preventing Resident #1 from moving about freely.10 New York Codes, Rules and Regulations 415.5(a)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure that residents are free from physical abuse. This was evident for one of seven residents (Resident #1) sampled for abuse. Specifically, on 04/08/2026, Resident #7 reported to Registered Nurse Supervisor #7 that because they refused to take their medications, Licensed Practical Nurse #7 pushed them in their chest causing them to fall on the floor on 04/08/2026 at approximately 5:15 AM. Resident #7 was assessed by Registered Nurse Supervisor #7 with no visible injuries. The findings are: Resident #7 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease, speech disturbances and dysphagia (difficulty swallowing. The Minimum Data Set (an assessment tool) dated 03/18/2026 documented Resident #7 had intact cognition. A care plan, titled at Risk for Misappropriation, Neglect, Abuse and/or Exploitation dated 03/28/2026. Interventions included provide support and ensure that resident is free from abuse. Assess resident for signs/symptoms of abuse or neglect and report to appropriate resources. A Nursing Progress Note by Registered Nurse #7 dated 04/08/2026 documented that Resident #7 reported they were hit in the chest by Licensed Practical Nurse #7 during morning medication administration. No bruising or injuries noted. Nurse Practitioner #7 and Resident #7's family notified. A Medical Progress Note by Nurse Practitioner #7 dated 04/08/2026 documented during their examination of Resident #7, the resident reported that Licensed Practical Nurse #7 hit them in the chest during medication administration. No bruising, swelling or visible injury noted. Psychology and psychiatrist referral. The facility's investigation dated 04/13/2026 documented Resident #7 reported that Licensed Practical Nurse #7 pushed them in the chest because they refused to take their medications. Resident #7 was assessed and there were no visible injuries. Resident #7 was visibly upset while they were reporting (the incident). Licensed Practical Nurse #7 denied the allegation. The facility investigated the allegation and concluded there was some form of contact between Resident #7 and Licensed Practical Nurse #7. The facility concluded there was no evidence of abuse, neglect, exploitation or mistreatment. A progress note, by Psychiatrist #7 dated 04/18/2026 documented that they examined Resident #7 due to allegation of being hit in the chest by a staff. They asked Resident #7 about the incident, but Resident #7 waved their hands indicating it was over. No need for psychotropic medication. Supportive counseling is recommended. During an interview on 07/10/2026 at 10:00 AM, Resident #7 communicated in writing and hand gestures due to history of laryngectomy (removal of larynx). They wrote/gestured that they told Licensed Practical Nurse #7 to leave their room and Licensed Practical Nurse #7 pushed them in their chest and they fell on the floor. Resident #7 wrote they were fine and comfortable with the staff on the unit. The interview ended by Resident #7. During an interview with Licensed Practical Nurse #7 on 07/20/2026 at 3:30 PM, they stated they were terminated from the facility by the Director of Nursing for having an altercation with a staff prior to Resident #7's allegation. Licensed Practical Nurse #7 stated they have been a nurse for 14 years and had worked at the facility for two years. Licensed Practical Nurse #7 stated it was their first time being assigned on Resident #7's unit (on 04/08/2026 on the night shift) and that they went to Resident #7's room to administer their medications on 04/08/2026 at around 5:30 AM. Licensed Practical Nurse #7 stated when they entered Resident #7's room, the resident was sitting on their bed and communicated to them angrily, using hand gestures, to leave the room. Licensed Practical Nurse #7 stated they were holding a medication cup and a cup with water in their hands and while they were (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	walking out of Resident #7's room, they were not aware Resident #7 was walking closely behind them and when they turned around their left shoulder accidentally touched Resident #7's chest. Licensed Practical Nurse #7 stated that when their shoulder touched Resident #7's chest, the resident stumbled but did not fall. Licensed Practical Nurse #7 stated that they met with the Director of Nursing for counselling and was terminated from the facility for unrelated performance issues. Licensed Practical Nurse #7 stated they did not punch or push Resident #7. A review of a statement written by Licensed Practical Nurse #7 to the facility on [DATE] at 5:00 AM documented that they entered Resident #7's room to administer medication; Resident #7 stood up and used both hands to push them out of their room. They stopped short and turned to ask Resident #7 if they wanted the medication, Resident #7's chest bumped into their back and Resident #7 took a few steps backward. A review of Licensed Practical interview on 07/20/2026 and their written statement to the facility provided contradictory tales of the incident. During an interview with Registered Nurse Supervisor #7 on 07/20/2026 at 2:10 PM. They stated they are no longer working at the facility. Registered Nurse Supervisor #7 stated on 04/08/2026 (unsure of time), but it was early morning while they were in the nursing office on the first floor, Resident #7 came to see them and wrote a note stating that Licensed Practical Nurse #7 pushed them in the chest and that they fell on the floor and got up by themselves. Registered Nurse Supervisor #7 stated they accompanied Resident #7 to their room and performed a head-to- toe assessment that revealed no visible injuries. Registered Nurse Supervisor #7 stated that Resident #7 was visibly upset. Registered Nurse Supervisor #7 stated that Licensed Practical Nurse #7 reported they went into Resident #7's room to give medication and Resident #7 pushed them to leave the room. They stated that they turned around and Resident #7's chest accidentally touched their back. Registered Nurse Supervisor #7 stated that Licensed Practical Nurse #7 was dismissed from duty. Registered Nurse Supervisor #7 stated they called the Director of Nursing and notified Resident 7's physician and emergency contact. Registered Nurse Supervisor #7 stated Law enforcement was notified, and Police Officers came and interviewed Resident #7 and Licensed Practical Nurse #7 but did not file a report. During an interview with Nurse Practitioner #7 on 07/20/2026 at 3:00PM. They stated that on 04/08/2026 Registered Nurse Supervisor #7 notified them about the allegation and the need to assess Resident #7. Nurse Practitioner #7 stated they visited Resident #7 in their room and they reported that Licensed Practical Nurse #7 pushed them in their chest. They stated that Resident #7 denied pain and refused to continue the interview. Nurse Practitioner #7 stated they ordered laboratory testing for complete blood count, metabolic panel and urine analysis/culture and sensitivity. They stated that laboratory values were normal and psychology/psychiatric consults were ordered. During an interview on 07/10/2026 at 4:00 PM, the Director of Nursing stated on 04/08/2026 (unsure of time) Registered nurse supervisor #7 notified them of an incident that occurred between Resident #7 and Licensed Practical Nurse #7 on the 11:00 PM-7:00 AM shift. They stated that Resident #7 angrily reported an allegation of abuse to Nursing Supervisor #7. The Director of Nursing stated that they interviewed Resident #7 and Licensed Practical Nurse #7 and Resident #7 reported that Licensed Practical Nurse #7 pushed them in the chest when they refused to take their medication. Licensed Practical Nurse #7 reported that they went to Resident #7's room to administer their medication and Resident #7, who was sitting on their bed, suddenly got up and signaled for them to leave the room. Licensed Practical Nurse #7 said they had medication and a cup of water in their hands and as they walked towards the door they turned back and encountered Resident #7 close behind them resulting in Licensed Practical Nurse #7 accidentally connecting with Resident #7's chest. The Director of Nursing stated a head-to-toe assessment was done and Resident #7 did not sustain any visible injuries. The Director of Nursing (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated they met with Licensed Practical Nurse #7 for suspension counseling and during the meeting, they were not receptive of the counseling and was terminated. During a follow-up interview on 07/29/2026 at 2:45 PM, the Director of Nursing stated they determined that Resident #7's chest connecting with Licensed Practical Nurse #7's body was accidental and there was no evidence of abuse. Additionally, Resident #7 was inconsistent reporting a fall during the incident.10 New York Codes, Rules and Regulations 415.4(b)(1)(i)		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during a Survey (2804872), the facility failed to provide adequate supervision to a resident to prevent an accident. This was evident in one out of two residents (Resident #2) sampled for accidents. Specifically, Resident #2 was left unsupervised in the shower room by Certified Nursing Assistant #2 on 03/15/2026 at 4:20 AM. Resident #2 sustained a raised area on the right side of their forehead with active bleeding. Pain medication was administered, and the resident was transferred to the hospital on [DATE] at 5:40 Am and returned to the facility same day at 12:05 PM. The findings are: The facility Policy and Procedure for Accident and Incident Reporting dated 06/01/2024 documented it is the policy of the facility to monitor and evaluate all occurrences of accidents or incidents or adverse events occurring on the facility's premises which is not consistent with the routine operation of the facility or care of a particular resident. These occurrences must be evaluated and investigated. An incident is any occurrence not consistent with the routine operation of the center, normal care of the residents a happening involving visitors, malfunctioning equipment, or observation of a condition which might be a safety hazard. The occurrence may be a fall, skin tear, bruise, new pressure ulcer and may involve abuse, neglect, and mistreatment or an injury of unknown origin. The incident may be a theft of misappropriation of resident property. The facility Policy and Procedure for Abuse Reported dated 07/18/2025 documented the facility prohibits the mistreatment, neglect and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Resident #2 was admitted to the facility with diagnoses including Bipolar Disorder, Dementia and Major Depressive Disorder. The Minimum Data Set, a resident assessment tool, dated 03/12/2026 documented Resident #2 cognition was severely impaired. Resident #2 required partial/moderate assistance with shower/bath self. (Helper does less than half the effort. Helper lifts, holds, or supports trunks or limbs, but provides less than half the effort. A Fall Care Plan dated 02/11/2026 documented Resident #2 was at risk for falls. The interventions documented to anticipate and meet resident needs, check for toileting needs and provide toileting/incontinence care as needed. A Care Plan for Activities of Daily Living dated 02/11/2026 documented shower/tub transfer partial assistance times one staff (Helper completes less than half of the activity. Helper uses own strength to lift or hold the resident's body, arms, or legs. The resident completes more than half of the activity using own physical strength. A Minimum Data Set Kardex Report (a document for Certified Nursing Assistants) dated 05/06/2024 documented Resident #2 required physical help in part of bathing activity with one-person physical assistance. Resident #2's shower days are Wednesday and Saturday. There were no documented instructions for staff not to leave Resident #2 in the shower/bathroom by themselves. A Nursing progress note dated 03/15/2026 at 4:30 PM by Registered Nurse Supervisor #2 documented at around 4:20 AM Resident #2 was noted with bump to their right forehead. On assessment, swelling noted to right side of forehead measuring 4.0 x 5.5 centimeter and small skin opening to forehead 0.5 x 0.5 centimeter with scant amount of sanguineous drainage. Nurse Practitioner (1) was notified and ordered Resident #2 to be transferred to hospital for Computer Tomography scan (a noninvasive medical imaging procedure). A (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Telehealth progress note by Nurse Practitioner #1 documented that Registered Nurse Supervisor #2 asked them to assessed Resident #2 who had a raised area to their forehead. It is documented that the raised area measured 4.0x5.5 centimeters with a small opening and scant bleeding. A Physician's order dated 03/06/2026 Acetaminophen tablet 325 milligrams, give 2 tablets by mouth every 6 hours as needed for pain. Physician's order dated 03/15/2026 Bacitracin external ointment 500 unit/Gram apply to right forehead laceration topically two times a day for wound care times 10 daysA Medication Administration Record dated 03/01/2026 - 03/31/2026 revealed Resident #2 received pain medication on 03/15/2026 as per physician's order.A Treatment Administration Record dated 03/15/2026 documented Bacitracin external ointment, apply to right forehead laceration topically two times a day for wound care for 10 days.An Investigation Summary dated 03/20/2026 documented Certified Nursing Assistant #2 reported that they brought Resident #2 to the bathroom/shower suite in a shower chair (at 4:20 AM) after observing that the resident had a bowel movement. Certified Nursing Assistant #2 reported that they locked the shower chair and left Resident #2 in the shower room by themselves to get soap for the soap dispenser. Before they, left Resident #2 in the shower room by themselves they instructed Resident #2 to stay seated. When they returned to the shower room, they observed Resident #2 standing in front of the shower chair and a bump was observed on their forehead. Registered Nurse Supervisor #2 came and assessed Resident #2 with hematoma to the right forehead and mild bleeding. The opening measured 4.0 x 5.5 x 0.5 x 0.5 centimeters. Resident #2 denied pain and was transferred to the hospital for computer tomograph scan. The results were negative, and the residents returned to the facility with no new recommendations. The facility investigated the accident and conceded that abuse, neglect or mistreatment was not identified. Root Cause Analysis concluded it was incomplete preparation of bathing supplies before initiating shower transfer. Facility educated nursing staff and housekeeping to ensure soap is always in the shower roomDuring an interview on 07/09/2026 at 1:07 PM, Certified Nursing Assistant #2 stated on 03/15/2026 they worked on the 11:00 PM to 7:00 AM shift and were assigned to Resident #2. Certified Nursing Assistant #2 stated Resident #2 was awake and had a large bowel movement (unsure of time) so they took Resident #2 to the shower/bathroom to give them a shower. Certified Nursing Assistant #2 stated when they were about to give Resident #2 the shower, they observed that there was no soap in the dispenser. Certified Nursing Assistant #2 stated before they left the shower room, they locked Resident #2's shower chair and instructed Resident #2 not to get up. Certified Nursing Assistant #2 stated they went to the nursing station to get a new soap and when they returned to the shower room, they observed Resident #2 standing up with their hands resting on the shower room wall that divides the shower room and toilet. Certified Nursing Assistant #2 stated that Resident #2 had a raised area to the right-side to their head with blood and that Resident #2 must have hit their head on the wall dividing the shower room and toilet area. Certified Nursing Assistant #2 stated they notified Licensed Practical Nurse #2 who notified Registered Nurse Supervisor #2. Certified Nursing Assistant #2 stated they should not have left Resident #2 unsupervised in the shower room.During an interview on 07/09/2026 at 1:30 PM, Licensed Practical Nurse #2 stated on 03/15/2026 they worked on the 11:00 PM to 7:00 AM shift. Licensed Practical Nurse #2 stated they were closed by the nursing station preparing the morning medications and that certified nursing assistant #2 did not ask them for assistance. Licensed Practical Nurse #2 stated they never saw when Certified Nursing Assistant #2 took Resident #2 to the shower at 4:20AM.During an interview on 07/09/2026 at 2:00 PM, Registered Nurse Supervisor #2 stated on 03/15/2026 that a certified nursing assistant (unsure of name) informed them that certified nursing assistant #2 need them to come to the shower room. Registered Nurse Supervisor #2 stated that when they entered the shower/bathroom they observed Resident #2 (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting in the shower chair with a raised area to their right forehead. Registered Nurse Supervisor #2 stated Resident #2 reported that they hit their head on the wall. Registered Nurse Supervisor #2 stated that they conducted a body assessment and Resident #2 was observed with a raised area with a small opening and small amount of blood; no other injuries observed. Registered Nurse Supervisor #2 stated they notified Nurse Practitioner #1 who ordered Resident #2 to be transferred to the hospital for computer tomography scan. Registered Nurse Supervisor #2 stated Resident #2 was transferred to the hospital (03/15/2026 and returned to the facility later in the day 12.05 PM. Registered Nurse Supervisor #2 stated Certified Nursing Assistant #2 was in-service and aware that Resident #2 should not be left in the bathroom unsupervised. During an interview on 07/10/2026 at 10:25 AM, Nurse Practitioner #1 stated they were informed by Registered Nurse Supervisor #2 that at approximately 4:20 AM they were informed that Resident #2 was sitting in a shower chair in the shower/bathroom and had a bump on their forehead. Nurse Practitioner #2 stated Resident #2 was assessed with swelling at the right side of their forehead measured 4.0 x 4.5 x 0.5 x 0.5 centimeter opening with scan amount of blood. Nurse Practitioner #1 stated Resident #2 was sent to emergency room for further evaluation. During an interview on 07/14/2026 at 3:42 PM, the Director of Nursing stated they were made aware by Registered Nurse Supervisor #2 on 03/15/2026 (unsure of time) that Resident #2 bumped their forehead on the wall in the bathroom. The Director of Nursing stated all staff including Certified Nursing Assistant #2 were in-serviced on preparing their supplies prior to performing their tasks. The Director of Nursing stated they conducted a Root Cause Analysis, and it was identified that Certified Nursing Assistant #2 left Resident 2 unsupervised alone in the shower room. The Director of Nursing stated they identified the issues and put corrective measures in place. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement prior to surveyors' s onsite visit on 07/09/2026. A Plan of Correction is not required for this citation. 10 New York Code, Rules and Regulations 415.12(h)(1) The facility took immediate corrective actions and was found to be in substantial compliance on 03/25/2026. On 03/15/2026, Resident #2 was assessed for injury by Registered Nurse Supervisor #2, provider and family notified. 03/15/2026, Resident #2 was transferred to the emergency room for further evaluation. On 03/15/2026, Hospital Computer Tomography scan of the Head documented findings with no acute hemorrhage. No evidence of acute infarct. No hydrocephalus. No extra-axial collection or subdural hemorrhage. On 03/15/2026, Staff disciplinary action for Certified Nursing Assistant #2 reviewed. On 03/18/2026, an Ad Hoc Quality Assurance Performance Improvement meeting with signing sheet reviewed. On 03/18/2026, Policies and Procedures on Abuse Prevention, Activities of Daily Living Care and Accident/Incident Safety and Supervisor reviewed with no changes. 03/20/2026, in-service for housekeeping staff to ensure all shower rooms are stocked, reducing the likelihood of staff missing supplies mid-care. 03/16/2026 - 04/13/2026 Housekeeping audit for shower room check soap and shampoos. 03/18/2026 Root Cause Analysis - Resident was left unattended in the bathroom shower suite and resident sustained a bump to the head. Root Causes: Lack of soap supply in shower room. On 03/25/2026 in-service on resident high risk for falls and/or with cognitive impairment are not to be left unsupervised in the bathroom. On 03/25/2026, Facility-wide (all staff members) in-service on abuse, mistreatment and neglect. On 03/25/2026 Registered Nurse Supervisors 92 percents, Licensed Practical Nurses 91 percents and Certified Nursing Assistants 90.1 percents were in-service on abuse, mistreatment and neglect, accident/incident and shower room supply stock.		