STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and interviews, the facility failed to ensure sufficient nursing staff were available to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility reported short staffing on weekends confirmed by a review of the Daily Staffing and the Payroll Based Journal Staffing Data Report Quarter 1 2026 (October 1-December 31). The findings include: The facility policy titled Staffing reviewed 11/2025 stated that the facility will provide adequate staffing to meet needed care and services of our resident/patient population, promote resident quality care and safety by ensuring adequate and competent staffing levels are based on the Facility Assessment. The policy also stated that on a regular basis, a minimum of annually and upon changes in the facility population and care needs, the facility will evaluate the overall number of staff needed to ensure sufficient qualified staff are available to meet each resident needs. On 04/22/2026 at 10:52 AM, ten (10) residents (Residents #4, #7, #20, #83, #84, #205, #214, #254, #308, #322) attended the Resident Council meeting and all stated that they felt staffing was a concern in the facility. Resident #214 stated that low staffing levels were a huge problem, resulting in residents waiting up to 40 minutes to receive help after ringing their call bell, and that staffing levels were worse on weekends. Resident #4, who is the Resident Council President, stated that call bell response times were long on Unit 8. Resident #254 stated that low staffing on the weekends results in meal trays not being delivered to residents in a timely manner and food being served cold. The Payroll Based Journal Staffing Data Report Quarter 1 2026 (October 1-December 31) documented that excessively low weekend staffing was triggered. The Facility Assessment last updated 12/09/2025 documented facility capacity of 320 residents, staffing everyday including weekend staff are distributed as follows: Day shift by units:Unit 1: 1 Registered Nurse, 1 Licensed Practical Nurse and 5 Certified Nursing AssistantsUnit 2: 0 Registered Nurse, 2 Licensed Practical Nurses and 4 Certified Nursing AssistantsUnit 3: 1 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 4: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 5: 1 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 6: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 7: 1 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 8: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsTotal = 4 Registered Nurses, 10 Licensed Practical Nurses, and 33 Certified (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	NursingAssistants. Evening Shift: Unit 1: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 2: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 3: 1 Registered Nurse, 2 Licensed Practical Nurses and 4 Certified Nursing AssistantsUnit 4: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 5: 1 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 6: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 7: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsUnit 8: 0 Registered Nurse, 1 Licensed Practical Nurse and 4 Certified Nursing AssistantsTotal= 2 Registered Nurses, 9 Licensed Practical Nurses, and 32 Certified Nursing Assistants. Night Shift:Unit 1: 0 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 2: 0 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 3: 1 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 4: 0 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 5: 1 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 6: 0 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 7: 0 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsUnit 8: 0 Registered Nurse, 1 Licensed Practical Nurse and 3 Certified Nursing AssistantsTotal=2 Registered Nurses, 8 Licensed Practical Nurses, and 24 Certified Nursing Assistants Review of the actual weekend facility staffing schedule from 10/04/2025 to 12/28/2025 revealed the following but was not limited to: On 10/04/2025 on the 7:00 AM to 3:00 PM shift, there was a shortage of 7 CertifiedNursing Assistants over units 1, 2, 3, 4, 5, 7, and 8. On 10/04/2025 on the 3:00 PM to 11:00 PM shift, there was a shortage of 5 Certified Nursing Assistant across units 2, 3, 5, 7, and 8. On 10/04/2025 on the 11:00 PM to 7:00 AM shift, there was a shortage of 6 Certified Nursing Assistants across units 2, 3, 5, 6, and 7. Total staff shortage in a 24-hour period was 18 Certified Nursing Assistants with no replacement of staff. On 10/05/2025 on the 7:00 AM to 3:00 PM shift, there was a shortage of 5 Certified Nursing Assistants across units 1, 2, 3, 7, and 8. On 10/05/2025 on the 3:00 PM to 11:00 PM shift, there was a shortage of 7 Certified Nursing Assistants across units 2, 3, 4, 5, 6, 7, and 8. On 10/05/2025 on the 11:00 PM to 7:00 AM shift, there was a shortage of 1 Licensed Practical Nurse for Unit 1, and a shortage of 7 Certified Nursing Assistants across units 2, 3, 4, 5, 6, 7, and 8. Total staff shortage in a 24-hour period was 1 Licensed Practical Nurse and 19 Certified Nursing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assistants with no replacement of staff. On 11/01/2025 on the 7:00 AM to 3:00 PM shift, there was a shortage of 3 Certified Nursing Assistant across units 1, 2, and 5. On 11/01/2025 on the 11:00 PM to 7:00 AM shift, there was a shortage of 2 Licensed Practical for units 7 and 8 and a shortage of 5 Certified Nursing Assistants across units 3, 4, 6, 7, and 8. Total staff shortage in a 24-hour period was 2 Licensed Practical Nurses, and 8 Certified Nursing Assistants with no replacement of staff. On 11/02/2025 on the 7:00 AM to 3:00 PM shift, there was a shortage of 5 Certified Nursing Assistants across units 2, 3, 5, 7, and 8. On 11/02/2025 on the 3:00 PM to 11:00 PM shift, there was a shortage of 6 CertifiedNursing Assistant across units 2, 4, 5, 6, 7, and 8. On 11/02/2025 on the 11:00 PM to 7:00 AM shift, there was a shortage of 7 Certified Nursing Assistant across units 2, 3, 4, 5, 6, 7, and 8. Total staff shortage in a 24-hour period was 18 Certified Nursing Assistants with noreplacement of staff. On 12/13/2025 on the 7:00 AM to 3:00 PM shift, there was a shortage of 2 Licensed Practical Nurses for Units 2 and 3, and a shortage of 3 Certified Nursing Assistants across units 3, 4, and 5. On 12/13/2025 on the 3:00 PM to 11:00 PM shift, there was a shortage of 6 Certified Nursing Assistant across units 2, 3, 4, 5, 7, and 8. On 12/13/2025 on the 11:00 PM to 7:00 AM shift, there was a shortage of 5 Certified Nursing Assistants across units 1, 4, 5, 6, and 8. Total staff shortage in a 24-hour period was 2 Licensed Practical Nurses and 14 Certified Nursing Assistants with no replacement of staff. On 12/14/2025, on the 7:00 AM to 3:00 PM shift, there was a shortage of 8 Certified Nursing Assistants across units 1, 2, 3, 4, 5, 6, 7, and 8. On 12/14/2025 on the 3:00 PM to 11:00 PM shift, there was a shortage of 8 Certified Nursing Assistants across units 1, 2, 3, 4, 5, 6, 7, and 8. On 12/14/2025 on the 11:00 PM to 7:00 AM shift, there was a shortage of 7 Certified Nursing Assistants across units 2, 3, 4, 5, 6, 7, and 8. Total staff shortage in a 24-hour period 23 Certified NursingAssistants with no replacement of staff. Review of the actual weekend facility staffing schedule from 10/04/2025 to 12/28/2025 revealed that the facility had an ongoing pattern of shortage of staff for both Licensed Practical Nurses and Certified Nursing Assistants. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 04/21/2026 at 11:00 AM, Resident #79 stated, their unit has only one Certified Nurse Assistant on almost all weekends especially on the night shift since probably October to December of last year and bells were unanswered. Resident #79 also stated on the weekend of October 4th and 5th, 2025 there were only 2 Certified Nursing assistants instead of 3 Certified Nursing assistants assigned to the unit. During an interview on 04/23/2026 at 10:00 AM, Certified Nurse Assistant #3 who was assigned to work on the night shift stated that staffing is poor and is inadequate on the night shift and on weekends. During an interview on 04/23/2026 at 11:00 AM, the Staffing Coordinator was interviewed and stated it is very hard to get a replacement for staff that calls in sick. The Staffing Coordinator also stated when they have called everyone, and nobody else can come in to work, the unit will only have staff that is present, and the nurse must help. During an interview conducted on 04/23/2026 at 01:40 PM, Resident #38's Representative stated they are not aware of what nursing staffing is for the building. Resident #38's Representative also stated when they needed to get an issue addressed with their family member, there was only one (1) nurse and one (1) supervisor in the building. Resident #38's Representative further stated that staffing is low all the time, especially on the weekends when they visit Resident #38 on the unit. On 04/24/2026 at 10:58 AM, an interview was conducted with Certified Nurse Assistant #4 who stated when there is not enough staff, residents care is delayed, they chart when they can, and all due showers may not be done, especially on weekends as all shifts are short staffed. Certified Nurse Assistant #4 also stated on the weekend some floors have 2 Certified Nurse Assistants and sometimes 1 Certified Nurse Assistant on all shifts, so staff do their best, and do what they can. Certified Nurse Assistant #4 further stated that sometimes they will escort residents to activities or go into the day room to interact with residents, but they have to feed residents and monitor the day room, which takes up the majority of the day. Certified Nurse Assistant #4 stated they have not been the facility is hiring. On 04/24/2026 at 12:14 PM, an interview was conducted with Licensed Practical Nurse #3 who stated that there is usually one (1) Registered Nurse in the building during the day on weekends. Licensed Practical Nurse #3 also stated very rarely they have four (4 Certified Nursing assistants. Licensed Practical Nurse #3 further stated they pitch in to help aides when they can with food trays, give showers, and feed residents. Licensed Practical Nurse #3 stated they have been asked to pick up an extra shift but cannot and they work every other weekend; when staffing is short instead of taking break, they complete documentation. Licensed Practical Nurse #3 stated they were informed the facility hired a lot of agency staff, but they see new staff for one to two days and then they are not seen anymore. On 04/24/2026 at 01:11 PM, an interview was conducted with Registered Nurse Supervisor #3 who stated that they were aware of the low staffing, and staff are told to make sure they care for the residents. Registered Nurse Supervisor #3 also stated the nurses get involved at mealtimes, and the nurses have raised the issue that they need other disciplines to assist. Registered Nurse Supervisor #3 further stated they have tried to get coverage, especially on weekends, but no one was available. Registered Nurse Supervisor #3 confirmed that last year from October to December the facility staffing was really short, and they were told that the administration is hiring but those new hires will work for one or two days and after orientation and they will be gone to another facility. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 04/24/2026 at 02:24 PM, the Staffing Coordinator stated that staff are given their monthly schedules ahead of time, and based on their availability, they are added to the daily schedule for the month. The Staffing Coordinator also stated the weekends are more challenging, and always short mostly because Certified Nurse Assistants call in sick, they are unable to replace them, and it is hard to get other Certified Nurse Assistants to come to work on the weekends. The Staffing Coordinator further stated on the weekends the supervisor covers one or more floors, in addition to being the supervisor for the entire facility. On 04/24/2026 at 03:30 PM, the Director of Nursing was interviewed and stated they are aware of low weekend staffing, especially from October to December 2025, and they have actively hired Licensed Practical Nurses and Certified Nurse assistants but unfortunately, they do not stay and hiring has to start again. The Director of Nursing also stated they do not know the reasons why staff do not stay, as the pay is competitive and yet the facility ends up short especially on weekends. The Director of Nursing further stated they only deal with one staffing agency at present and moving forward they will contact additional staffing agencies to assist them with the staffing shortages. On 04/24/2026 at 4:00 PM, the Administrator was interviewed and stated they follow the par level in staffing the nursing department particularly Licensed Practical Nurses and Certified Nurse Assistants, and if there are call outs, the supervisors tried to call for replacements. The Administrator also stated they are aware that appropriate staffing following the facility Assessment is important to deliver quality care to all residents and continuous hiring must be done to ensure low weekend staffing will be prevented in the future. During a follow-up interview on 04/28/2026 at 02:03 PM, the Administrator stated they reviewed the weekend staffing from October to December 2025 and do not know why they reported excessively low weekend staffing that period. The Administrator also stated they reviewed the facility assessment and found that the facility met the par level, however they will further review with the management team of the facility. 10 New York Codes, Rules, and Regulations 415.13(a)(1)(i-iii)

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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. Based on observation, record review, and interviews, the facility failed to ensure that necessary housekeeping and maintenance services were provided to maintain a safe, clean, comfortable and homelike environment for residents. This was evident for two (2) of eight (8) resident units (Unit 1 and Unit 2) observed for the Environment Task. Specifically, blood pressure stands were observed with the base layered with dirt dust and debris, wheelchairs, Geri chairs and wheelchair seat cushions were observed to be heavily soiled, layered with an accumulation of dirt, dust and debris, air conditioners were observed with black substances and an accumulation of dirt and debris within the grates, and an air conditioner did not have an outside cover. The findings include:The facility policy titled Cleaning and Disinfection of Equipment stated all wheelchairs and mobility devices are maintained in a clean sanitary and safe condition. The policy also stated proper cleaning and disinfection reduce the risk of cross contamination, infection transmission, and environmental hazards while promoting resident safety, comfort and dignity. The policy further stated resident care equipment includes but is not limited to wheelchairs, Geri chairs, blood pressure machines.During observations of Unit 1 and Unit 2 in the facility from 04/21/2026 at 10:52 AM to 04/28/2026 at 10:21 AM, the following were observed:Unit 1a). Two (2) blood pressure stands with an accumulation of layered dirt, dust and debris at the base.b). On the Geri-Chair for Resident #331 the front corners were wrapped in white loose hanging tape that was black colored. The seat cushion was encrusted with dried food particles, white stains, and streaks. The bilateral arm rests were covered with faded pale-yellow foam padding. The foam padding was marked with diffuse, dark black spots.Unit 2a). The wheelchair for Resident #104 was heavily encrusted with an accumulation of dried food particles, debris, and dirt. The seat cushion and arm padding were stained with dried brownish substances and accumulated dirt and debris.b). The wheelchair for Resident #203 was layered with dirt and debris.c). The wheelchair for Resident #254 had multiple white splatter stains noted to the outer back side. d). The wheelchair seat cushion for Resident #89 was encrusted with an accumulation of dried food particles, debris, and brownish streaks. The metal parts were noted with an accumulation of layered dust and dirt. e). Three (3) of three (3) dining room air conditioners were noted with an accumulation of black substance layered inside the grates. An accumulation of dirt and debris layered the bottom front section of the air conditioner. f). One (1) of three (3) dining room air conditioners were noted without an outer cover.During an interview on 04/28/2026 at 10:37 AM, Registered Nurse Supervisor #1 stated nursing staff are supposed to check resident equipment, specifically the residents' wheelchairs and Geri Chairs for cleanliness before transferring a resident onto the chair. Registered Nurse Supervisor #1 also stated there is a process in which information is relayed to our housekeeping department or maintenance department. Registered Nurse Supervisor #1 further stated an electronic request for repairs can be submitted to the rehabilitation department for any repairs or replacement needed.During an interview on 04/28/2026 at 10:48 AM, the Director of Rehabilitation stated their department has a technician specifically to ensure the repairs or replacement of wheelchairs. The Director of Rehabilitation also stated that if during therapy sessions a staff identifies that a wheelchair needs to be cleaned or that the seat padding needs to be cleaned, they notify the housekeeping department.During an interview on 04/28/2026 at 11:04 AM, the Director of Supportive/Environmental Services stated cleanliness is important to reduce the risk or spread of infection and prevention of disease. The Director of Supportive/Environmental Services also stated that daily rounds to ensure staff complete their assignments, and to ensure the safety of our residents' staff and visitors are performed. The Director of Supportive/Environmental Services further stated they have daily morning and daily afternoon huddles with their staff to informed of any changes or notices and provided assignments, and that the afternoon huddles include reminders to staff for replenishing soap dispensers, paper towels, and toilet paper for resident and staff (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bathrooms. The Director of Supportive/Environmental Services stated that during the overnight shift a porter is responsible for removing the wheelchairs to the basement for power washing and drying and disinfecting the seat cushions. The Director of Supportive/Environmental Services also stated they maintain a monthly wheelchair cleaning schedule for each unit and provides a copy of the wheelchair schedule to the Director of Nursing who informs the nurse department staff about leaving soiled chairs outside the room. The Director of Supportive/Environmental Services further stated the air conditioners are to be covered in clear plastic during the cold weather months, which is removed during the warm weather months, at which time the grates and filters are cleaned. The Director of Supportive/Environmental Services stated the cleaning of the blood pressure stands is the responsibility of my department.During an interview on 04/28/2026 at 11:53 AM, the Director of Nursing stated that a copy of the wheelchair schedule is provided to them and is also provided to the units' nurses by the Director of Supportive/Environmental Services. The Director of Nursing also stated nurses should be notifying the housekeeping department when resident equipment needs cleaning or repairs, and they can submit a ticket via the electronic system for repairs needed. The Director of Nursing stated that their understanding was that the wheelchair schedule was being given directly to the unit nurses by the Director of Supportive Services and not given to them for distribution to the nurse.During an interview on 04/28/2026 at 12:01 PM, the Administrator stated that the safety and cleanliness of the facility is important in maintaining the dignity of all residents. The prevention of infection control is important for all residents, visitors and staff. The Administrator also stated they do rounds at different hours of the day, including early morning rounds. I speak to staff in support of them. I speak with residents and listen to what they have to say. The Administrator further stated if they come across any environmental issues, they address them right away. The Administrator stated wheelchairs are cleaned according to the monthly wheelchair cleaning schedule; a copy of the wheelchair schedule is provided to the Director of Nursing who then distributes and communicates with the nursing supervisors who inform the unit nurses to have the wheelchairs placed outside room doors in preparation for cleaning.10 New York Codes, Rules, and Regulations 415.5(h)(2)