STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335531	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Rehab & Extended Care Center	182 15 Hillside Avenue Jamaica Est, 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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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** 39365 Based on observation, record review, and interviews conducted during an Abbreviated and Partial Extended Survey (NY00354577), the facility failed to protect the residents' right to be free from physical abuse. This was evident for one out of six residents reviewed (Resident #1) for abuse. Specifically, on 09/16/2024 at 7:20 PM, Licensed Practical Nurse #1 did not intervene or remove Certified Nursing Assistant #1 from providing care to Resident #1 or any other residents assigned to Certified Nursing Assistant #1 when on 1) 09/16/2024 at around 7:20 PM, Licensed Practical Nurse #1 witnessed Certified Nursing Assistant #1 physically force Resident #1 to sit in a chair in the hallway; 2) between 8:15 PM - 8:30 PM Licensed Practical Nurse #1 and Certified Nursing Assistant #2 both witnessed Certified Nursing Assistant #1 grab and push Resident #1 to sit in a wheelchair and then wheel Resident #1 into their room; and 3) shortly after 8:30 PM, Licensed Practical Nurse #1 heard noises coming from Resident #1's room, entered the room and observed Certified Nursing Assistant #1 hitting Resident #1 multiple times on their right thigh with a closed fist. Licensed Practical Nurse #1 approached Resident #1 briefly and then exited the room closing the door behind them. This resulted in actual harm to Resident #1 with the potential for serious injury, serious harm, serious impairment, or death to all residents on the unit, which was Immediate Jeopardy and Substandard Quality of Care. The findings are: The facility's Policy and Procedure entitled Abuse Prevention, with revision date 11/07/2022, documented that residents will be protected from Abuse, Neglect, Mistreatment, Exploitation, or Misappropriation of resident property in accordance with State and Federal Regulations. Resident #1 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis (Inflammation of one or more joints), Osteoporosis (a condition when bone strength weakens and is susceptible to fracture), and Metabolic Encephalopathy (change in how your brain functions due to an underlying condition). The Minimum Data Set (an assessment tool), dated 08/13/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored 10 out of 15, indicating moderately impaired cognition. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Behavior/Victimization Care Plan dated 02/06/2024 documented interventions that included separate resident from others as needed, calm approach, talk to resident in soothing manner and orient resident to environment. The Accident/Incident Occurrence Report dated 09/16/2024 documented time of the occurrence as 8:15 PM. Licensed Practical Nurse #1 reported they witnessed, in the hallway, Certified Nursing Assistant #1 forcefully pull and guide Resident #1 by their right arm to sit in the wheelchair despite Resident #1 not wanting to sit down. Certified Nursing Assistant #1 made Resident #1 sit in the wheelchair and wheeled them to their room. Licensed Practical Nurse #1 continued to hear noises from Resident #1's room and went into the room. Licensed Practical Nurse #1 observed Resident #1 being resistive and not wanting to stay in bed. Resident #1 was agitated. Certified Nursing Assistant #1 tried to change Resident #1's pull-up while Resident #1 was being resistive and kicking. Licensed Practical Nurse #1 observed Certified Nursing Assistant #1 hit Resident #1 on the thigh. Licensed Practical Nurse #1 called the Registered Nurse Supervisor #1 immediately. Tylenol and Ice Compress were given for pain. The facility concluded the alleged abuse probably occurred, as evidenced by the report of Licensed Practical Nurse #1, who corroborated with Resident #1. A Police Incident Information Slip dated 09/25/2024 documented occurrence date 09/16/2024. Crime: Assault 2. The facility's surveillance video recording system was reviewed by the Surveyor, only captured the portion of the unit near the nursing station. It did not capture the entrance to Resident #1's room. A Nursing Incident Note dated 09/17/2024 at 1:37AM, written by Registered Nurse Supervisor #1, documented that License Practical Nurse #1 reported an incident that occurred around 8:15 PM - 8:30 PM. Registered Nurse Supervisor #1 met Resident #1 in the hallway crying, stating that a big, black lady beat them on their right shoulder and right upper thigh - right hip. Resident #1 also stated they were in so much pain. On assessment, bruising and redness were observed on Resident #1's right arm, with some skin scratch, bleeding, a slight bluish discoloration on the right hip area that was tender to the touch, and an ecchymosis (bruise) at Resident #1's left temple. Licensed Practical Nurse #1 reported they witnessed Certified Nursing Assistant #1 beating Resident #1. Certified Nursing Assistant #1 grabbed Resident #1 and forcefully dragged Resident #1 into a wheelchair. Resident #1 was resisting, but Certified Nursing Assistant #1 still brought Resident #1 to their room, where Certified Nursing Assistant #1 beat Resident #1. Tylenol was given for pain, and a cold compress was applied to the bruises. A Medical Note dated 09/17/2024 at 6:14 PM, written by the Nurse Practitioner #1, documented Resident #1 was seen and noted with small areas of ecchymosis on the left side of their forehead, a small area of ecchymosis on the middle of their right upper arm and forearm, ecchymosis of their right hand, and fading yellowish discoloration on the side of their right thigh. Resident #1 complained of pain to the right shoulder with Range of Motion (movement). Observation on the 5th Unit was conducted on 09/25/2024 between 10:30 AM and 11:30 AM. Resident #1 was observed in the hallway sitting on a regular chair. Resident #1 was observed with yellow and dark discolorations on their right hand, right forearm, and upper forearm. There was a healing scratch on Resident #1's right upper arm. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Psychologist's note dated 09/27/2024 at 5:12 PM documented Resident #1 reported they were dragged in a chair and was taken to their room by a staff member. Resident #1 reported the staff member kept hitting their arm and hips. Psychotherapy was recommended to reduce emotional symptoms. During an interview on 09/25/2024 at 10:30 AM, Resident #1 stated Certified Nursing Assistant #1 hit them on their right arm and tried to break their right arm. Resident #1 reported their arm still hurts when they raise their arm up. During an interview on 09/25/2024 at 11:10 AM, Resident #2, who had intact cognition, stated on 09/16/2024 (in the evening) they were in the hallway close to Resident #1. Resident #2 stated they observed Certified Nursing Assistant #1 grab Resident #1 by their shoulders and forcefully push Resident #1 to sit in the wheelchair. Then, Certified Nursing Assistant #1 wheeled Resident #1 to their room while Resident #1 was resisting and kicking. During a phone interview on 09/25/2024 at 12:40 PM, Certified Nursing Assistant #1 stated they were assigned to Resident #1 on 09/16/2024 on the 3:00 PM to 11:00 PM shift. Certified Nursing Assistant #1 stated they observed Resident #1 entering another resident's room at around 8:00 PM and they tried to redirect Resident #1 to their room. Certified Nursing Assistant #1 stated Resident #1 was irritated and mad and tried to hit them and did not want to go to their room. Certified Nursing Assistant #1 stated Resident #1 threw the walker on the floor and lost their balance. Certified Nursing Assistant #1 stated they prevented Resident #1 from falling by holding on to Resident #1's right arm while grabbing a wheelchair. Certified Nursing Assistant #1 stated they held Resident #1 at their waist, with their hands, from behind and made Resident #1 sit in the wheelchair. Certified Nursing Assistant #1 stated a Licensed Practical Nurse #1 spoke with Resident #1 and Resident #1 calmed down a bit. Certified Nursing Assistant #1 stated they took Resident #1 to their room and Resident #1 sat on the bed and then laid down. Certified Nursing Assistant #1 stated they pulled off Resident #1's pull-ups while Resident #1 was being resistive and did not want to be touched. Certified Nursing Assistant #1 stated they did not hit Resident #1 at any point. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/25/2024 at 1:10 PM, Licensed Practical Nurse #1 stated at around 7:20 PM, they observed Certified Nursing Assistant #1 grab Resident #1's right upper arm and roughly put Resident #1 in a regular chair in the hallway while Resident #1 was resisting. Licensed Practical Nurse #1 stated they felt it was abuse and they did not intervene, but gave Certified Nursing Assistant #1 a look, and Certified Nursing Assistant #1 went to care for other residents. Licensed Practical Nurse #1 stated at around 8:15 PM - 8:30 PM, they observed Certified Nursing Assistant #1 suddenly grab Resident #1's upper right arm, then Certified Nursing Assistant #1 reached over to a wheelchair and tried to forcefully get Resident #1 into the wheelchair. Licensed Practical Nurse #1 stated Resident #1 was still holding onto their rolling walker and did not want to sit in the wheelchair. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 forcefully repositioned Resident #1 in the wheelchair and wheeled Resident #1 to their room. Licensed Practical Nurse #1 stated they did not intervene because they were in shock. Licensed Practical Nurse #1 stated they returned to their medication cart that was by Resident #1's room and heard noise and a tapping (twice) body sound coming from Resident #1's room. Licensed Practical Nurse #1 stated they went into Resident #1's room and observed Resident #1 sitting on their bed while Certified Nursing Assistant #1 was holding both hands of Resident #1 and was pushing Resident #1 to lie down. Licensed Practical Nurse #1 stated Resident #1 continued to resist lying down. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #1 to stop, but Certified Nursing Assistant #1 continued pushing Resident #1 to lie down. Licensed Practical Nurse #1 stated they stood in Resident #1's room trying to calm Resident #1, but Resident #1 was not listening. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 ripped the pull-ups off Resident #1 and hit Resident #1 with closed fist twice on their right upper thigh. Licensed Practical Nurse #1 stated they replaced Resident #1's pull-ups and left the room. Licensed Practical Nurse #1 stated they left Certified Nursing Assistant #1 in the room with Resident #1 and closed the door. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 exited the room in 30 seconds to 1 minute. Licensed Practical Nurse #1 stated after 5 minutes not knowing what to do, they reported the incident to Registered Nurse Supervisor #1. During an interview on 09/25/2024 at 2:40 PM, Certified Nursing Assistant #2 stated after supper time (they didn't recall the exact time), they were by the nursing station and observed Certified Nursing Assistant #1 roughly force Resident #1 to sit in a wheelchair in the hallway while Resident #1 was resisting. Certified Nursing Assistant #2 stated Licensed Practical Nurse #1 was with Resident #1 and Certified Nursing Assistant #1. During an interview on 09/25/24 at 5:02 PM, Registered Nurse Supervisor #1 stated they were notified by License Practical Nurse #1 at approximately 9:00 PM that between 8:15 PM and 8:30 PM, Licensed Practical Nurse #1 stated they observed Certified Nursing Assistant #1 beating Resident #1. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 also reported they stopped Certified Nursing Assistant #1 and assisted in providing care to Resident #1. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported they were afraid, confused, hesitant, and did not know what to do. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 also reported shortly after 7:20 PM they saw Certified Nursing Assistant #1 forcefully drag Resident #1 out of the wrong room and Resident #1 was fighting back with Certified Nursing Assistant #1. Registered Nurse Supervisor #1 stated they assessed Resident #1 and notified the Medical Doctor and notified the Director of Nursing at 9:30 PM. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 should have reported the first encounter. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/26/2024 at 10:51 PM, the Director of Nursing stated they were notified about an abuse incident between 9:30 PM and 10:00 PM by Registered Nurse Supervisor #1. The Director of Nursing stated they directed Registered Nurse Supervisor #1 to call the police and send Certified Nursing Assistant #1 home. The Director of Nursing stated they did not conduct a body assessment on the confused residents that were assigned to Certified Nursing Assistant #1's assignment. The Director of Nursing stated Certified Nursing Assistant #1 stated they did not hit Resident #1, but they made Resident #1 go to their room while Resident #1 was being resistive. The Director of Nursing stated Licensed Practical Nurse #1 did not intervene. The Director of Nursing stated Licensed Practical Nurse #1 should have separated Certified Nursing Assistant #1 when they first observed rough handling in the hallway. The Director of Nursing also stated Certified Nursing Assistant #2 could have stepped in and taken over for Certified Nursing Assistant #1. The Director of Nursing stated they have concluded it was possible abuse happened based on Licensed Practical Nurse #1's interview. The Director of Nursing stated the charge nurses on the unit and supervisors are responsible for monitoring the units to ensure the residents are free from abuse. During an interview on 09/26/2024 at 12:36 PM, the Administrator stated they were notified about the allegation of abuse at 11:46 PM by The Director of Nursing. The Administrator stated the police were called at 10:06 PM and responded, but they are not aware if an arrest was made. The Administrator stated police officers returned to the facility on [DATE] and notified them the incident was an Assault in the second degree. The Administrator stated it is a serious charge. The Administrator stated they were part of the investigation and concluded that abuse occurred. During an interview on 09/27/2024 at 4:50 PM, Attending Physician #1 stated Registered Nurse Supervisor #1 called them on 09/16/2024 at around 11:00 PM and reported Certified Nursing Assistant #1 hit Resident #1 and gave them a report of their assessment findings. Attending Physician #1 stated Resident #1 was complaining, moaning, and crying from pain in their right shoulder, which was scored as moderate to severe pain (5-6 out of 10). Attending Physician #1 stated a STAT (immediate) x-ray was ordered to rule out fracture, Tylenol for pain, and an Ice Pack. During an interview on 09/26/2024 at 1:54 PM, the Medical Director stated they were notified two days after Resident #1 was hit by Certified Nursing Assistant #1. The Medical Doctor stated they reviewed Resident #1's medical chart and discussed the incident with covering Attending Physician #1 and Nurse Practitioner #1, who evaluated Resident #1, and, in their professional opinion, Resident #1 sustained a minor injury that was managed successfully with Tylenol and Ice Pack. The Medical Director further stated there was no reason to transfer Resident #1 to the hospital. _____ On 09/26/2024 at 06:25 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified. On 09/26/2024 at 10:48 PM, the facility presented a removal plan which listed the immediate action the facility would take to prevent serious harm from occurring or recurring. The removal plan was accepted. Based on observation, interview, and record review, as of 09/30/2024 at 3:15 PM, the removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility: (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Certified Nursing Assistant #1 was removed from the unit, relieved of duty on 09/16/2024 at 10:00 PM, and was terminated on 09/20/2024. 911 Police were called on 09/16/2024 at 10:06 PM. On 09/17/2024, a Quality Assurance Performance Improvement meeting was held. The abuse incident and actions to be taken were discussed. 0n 09/26/2024, all 12 residents on Certified Nursing Assistant #1's assignment were assessed for bruising by a Registered Nurse #1. There were no negative findings. Licensed Practical Nurse #1 was counseled on abuse prevention and reporting immediately. Licensed Practical Nurse #1 was suspended on 09/26/2024 post counseling. Certified Nursing Assistant #2 was counseled on abuse prevention and reporting immediately and was suspended on 09/26/2024. A Psychiatrist evaluated Resident #1 on 09/27/2024 and documented Resident #1 did not sustain any psychosocial harm. A Psychologist evaluated Resident #1 on 09/27/2024 at 5:12 PM, and recommendations were made for individual Psychotherapy to reduce emotional symptoms. The facility revised its policy on abuse prevention on 09/26/2024 to include a Registered Nurse/supervisor complete a full body assessment of the resident to determine injuries. The facility will monitor trends and/or patterns of occurrence via the Quality Assurance Committee to identify any potential incidents of abuse. The facility conducted all house in-service (classroom and via phone) from 09/26/2024 to 09/30/2024 on Abuse for F600 and F610 with 98% active staff in-serviced. Staff members who are furloughed will be in-serviced before returning to their shift. Interviews were done with several staff members: nurses, Certified Nursing Assistants, housekeeping/environmental staff, security staff, recreation staff, physical/occupational therapist, social workers, dietary staff, and administrative staff, and all were knowledgeable on the abuse prevention protocol, what do if they observe abuse, when to report, and who they should report to. 10 NYCRR 415.4(b)(1)(i)

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review, and interview during an Abbreviated and Partial Extended Survey (NY00354577), the facility failed to remove Certified Nursing Assistant #1 from resident care after witnessed abuse. This was evident for one out of six residents reviewed (Resident #1) for abuse. Specifically, 1) On 09/16/2024 at around 7:20 PM, Licensed Practical Nurse #1 witnessed Certified Nursing Assistant #1 physically force Resident #1 to sit in a chair in the hallway; 2) between 8:15 PM - 8:30 PM Licensed Practical Nurse #1 and Certified Nursing Assistant #2 both witnessed Certified Nursing Assistant #1 grab and push Resident #1 to sit in a wheelchair and then wheel Resident #1 into their room; and 3) shortly afterwards Licensed Practical Nurse #1 heard noises coming from Resident #1's room, entered the room and observed Certified Nursing Assistant #1 hitting Resident #1 multiple times on their right thigh with a closed fist. Licensed Practical Nurse #1 did not intervene or remove Certified Nursing Assistant #1 from providing care to Resident #1 or to any other residents assigned to Certified Nursing Assistant #1. This resulted in actual harm to Resident #1 and the potential for serious injury, serious harm, serious impairment, or death to all residents on the unit, which was Immediate Jeopardy and Substandard Quality of Care. The findings are: The facility's Policy and Procedure entitled Abuse Prevention, with revision date 11/07/2022 states the facility will protect all residents during any abuse investigation by removing staff from direct care and/or removing them from schedule pending conclusion. The facility will provide counseling and support for residents as needed. Resident #1 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis (Inflammation of one or more joints), Osteoporosis (a condition when bone strength weakens and is susceptible to fracture), and Metabolic Encephalopathy (change in how your brain functions due to an underlying condition). The Minimum Data Set (an assessment tool), dated 08/13/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored 10 out of 15, indicating moderately impaired cognition. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing Incident Note dated 09/17/2024 at 1:37 AM, written by Registered Nurse Supervisor #1, documented that License Practical Nurse #1 reported an incident that occurred around 8:15 PM - 8:30 PM. Registered Nurse Supervisor #1 met Resident #1 in the hallway crying, stating a big, black lady beat them on their right shoulder and right upper thigh - right hip. Resident #1 also stated (bruise they were in so much pain. On assessment, bruising and redness were observed on Resident #1's right arm, with some skin scratch, bleeding, a slight bluish discoloration on the right hip area that was tender to the touch, and an ecchymosis (bruise with discolored skin) at Resident #1's left temple. Licensed Practical Nurse #1 reported that they witnessed Certified Nursing Assistant #1 beating Resident #1. Certified Nursing Assistant #1 grabbed Resident #1 and forcefully dragged Resident #1 into a wheelchair. Resident #1 was resisting, but Certified Nursing Assistant #1 still brought Resident #1 to their room, where Certified Nursing Assistant #1 beat Resident #1. Tylenol was given for pain, and a cold compress was applied to the bruises. The Employee timecard (KRONS) dated 09/16/2024 showed Certified Nursing Assistant #1 clocked out at 10:00 PM. A Police Incident Information Slip dated 09/25/2024 documented occurrence date 09/16/2024. Crime: Assault 2. During an interview on 09/25/2024 at 10:30 AM, Resident #1 stated Certified Nursing Nurse #1 hit them on their right arm and tried to break their right arm. Resident #1 reported their arm still hurts when they raise their arm up. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/25/2024 at 01:10 PM, Licensed Practical Nurse #1 stated at around 7:20 PM, they observed Certified Nursing Assistant #1 grab Resident #1's right upper arm and roughly put Resident #1 in a regular chair in the hallway while Resident #1 was resisting. Licensed Practical Nurse #1 stated they felt it was abuse and they did not intervene, but gave Certified Nursing Assistant #1 a look, and Certified Nursing Assistant #1 went to care for other residents. Licensed Practical Nurse #1 stated at around 8:15 PM - 8:30 PM, they observed Certified Nursing Assistant #1 suddenly grab Resident #1's upper right arm, then Certified Nursing Assistant #1 reached over to a wheelchair and tried to forcefully get Resident #1 into the wheelchair. Licensed Practical Nurse #1 stated Resident #1 was still holding onto their rolling walker and did not want to sit in the wheelchair. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 forcefully repositioned Resident #1 in the wheelchair and wheeled Resident #1 to their room. Licensed Practical Nurse #1 stated they did not intervene because they were in shock. Licensed Practical Nurse #1 stated they returned to their medication cart that was by Resident #1's room and heard noise and a tapping (twice) sounds coming from Resident #1's room. Licensed Practical Nurse #1 stated they went into Resident #1's room and observed Resident #1 sitting on their bed while Certified Nursing Assistant #1 was holding both hands of Resident #1 and was pushing Resident #1 to lie down. Licensed Practical Nurse #1 stated Resident #1 continued to resist lying down. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #1 to stop, but Certified Nursing Assistant #1 continued pushing Resident #1 to lie down. Licensed Practical Nurse #1 stated they stood in Resident #1's room trying to calm Resident #1, but Resident #1 was not listening. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 ripped the pull-ups off Resident #1 and hit Resident #1 with a closed fist twice on their right upper thigh. Licensed Practical Nurse #1 stated they adjusted Resident #1's pull-ups and left the room. Licensed Practical Nurse #1 stated they left Certified Nursing Assistant #1 in the room with Resident #1 and closed the door. Licensed Practical Nurse #1 stated Certified Nursing Assistant #1 exited the room in 30 seconds to 1 minute. Licensed Practical Nurse #1 stated after 5 minutes not knowing what to do, they reported the incident to Registered Nurse Supervisor #1. During an interview on 09/25/2024 at 5:02 PM, Registered Nurse Supervisor #1 stated they were notified by Licensed Practical Nurse #1 at approximately 9:00 pm that between 8:15 PM and 8:30 PM, Licensed Practical Nurse #1 observed Certified Nursing Assistant #1 beating Resident #1. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 also reported they stopped Certified Nursing Assistant #1 and assisted in providing care to Resident #1. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 reported they were afraid, confused, hesitant, and did not know what to do. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 also reported that earlier (7:20 PM) they saw Certified Nursing Assistant #1 forcefully drag Resident #1 out of the wrong room and Resident #1 was fighting back with Certified Nursing Assistant #1. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 should have reported the first encounter. During an interview on 9/26/2024 at 10:51 PM, the Director of Nursing stated they were notified about an abuse incident between 9:30 PM and 10:00 PM by Registered Nurse Supervisor #1. The Director of Nursing stated they directed Registered Nurse Supervisor #1 to call the police and send Certified Nursing Assistant #1 home. The Director of Nursing stated Licensed Practical Nurse #1 did not intervene. The Director of Nursing stated Licensed Practical Nurse #1 should have separated Certified Nursing Assistant #1 when they first observed rough handling in the hallway. The Director of Nursing also stated Certified Nursing Assistant #2 could have stepped in and taken over for Certified Nursing Assistant #1. The Director of Nursing stated the charge nurses on the unit and supervisors are responsible for monitoring the units to ensure the residents are free from abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335531	A. Building B. Wing	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Manor Rehab & Extended Care Center	182 15 Hillside Avenue Jamaica Est, NY 11432

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	_____ On 09/26/2024 at 06:25 PM, Immediate Jeopardy was identified and declared. The facility's Administrator and the Director of Nursing were notified. On 09/26/2024 at 10:48 PM, the facility presented a removal plan which listed the immediate action the facility would take to prevent serious harm from occurring or recurring. The removal plan was accepted. Based on observation, interview, and record review, as of 09/30/2024 at 3:15 PM, the removal plan was implemented, and Immediate Jeopardy was lifted based on the following corrective actions taken by the facility: Certified Nursing Assistant #1 was removed from the unit, relieved of duty on 09/16/2024 at 10:00 PM, and was terminated on 09/20/2024. 911 Police were called on 09/16/2024 at 10:06 PM. On 09/17/2024, a Quality Assurance Performance Improvement meeting was held. The abuse incident and actions to be taken were discussed. 0n 09/26/2024, all 12 residents on Certified Nursing Assistant #1's assignment were assessed for bruising by a Registered Nurse #1. There were no negative findings. Licensed Practical Nurse #1 was counseled on abuse prevention and reporting immediately. Licensed Practical Nurse #1 was suspended on 09/26/2024 post counseling. Certified Nursing Assistant #2 was counseled on abuse prevention and reporting immediately and was suspended on 09/26/2024. A Psychiatrist evaluated Resident #1 on 09/27/2024 and documented Resident #1 did not sustain any psychosocial harm. A Psychologist evaluated Resident #1 on 09/27/2024 at 5:12 PM, and recommendations were made for individual Psychotherapy to reduce emotional symptoms. The facility revised its policy on abuse prevention on 09/26/2024 to include a Registered Nurse/supervisor complete a full body assessment of the resident to determine injuries. The facility will monitor trends and/or patterns of occurrence via the Quality Assurance Committee to identify any potential incidents of abuse. The facility conducted all house in-service (classroom and via phone) from 09/26/2024 to 09/30/2024 on Abuse for F600 and F610 with 98% active staff in-serviced. Staff members who are furloughed will be in-serviced before returning to their shift. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interviews were done with several staff members: nurses, Certified Nursing Assistants, housekeeping/environmental staff, security staff, recreation staff, physical/occupational therapist, social workers, dietary staff, and administrative staff, and all were knowledgeable on the abuse prevention protocol, what do if they observe abuse, when to report, and who they should report to. 10 NYCRR 415.4 (b)(3)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39365 Based on observation, record review, and interview during an Abbreviated and Partial Extended Survey (NY00354577), the facility's administration failed to ensure that the facility was operated in a manner that use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evident in one out of six residents sampled (Resident #1). Specifically, on 09/16/2024, the facility did not intervene or remove Certified Nursing Assistant #1 from the unit resulting in further abuse to Resident #1. Administration failed to ensure in-service lesson plans provided guidance to facility staff on how to protect residents from suspected or witnessed abuse. The findings are: The facility's Policy and Procedure entitled, Abuse Prevention, with revision date 11/07/2022, documented residents will be protected from Abuse, Neglect, Mistreatment, Exploitation, or Misappropriation of resident property in accordance with State and Federal Regulations. The facility's in-service Lesson Plan on tips (14) for managing aggressive behavior did not include what staff should do or how staff should respond when resident abuse was witnessed. Resident #1 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis (Inflammation of one or more joints), Osteoporosis (a condition when bone strength weakens and is susceptible to fracture), and Metabolic Encephalopathy (change in how your brain works due to an underlying condition). The Minimum Data Set (assessment tool), dated 08/13/2024, documented that Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) and scored 10 out of 15, indicating moderately impaired cognition. A review of the Accident/Incident Occurrence Report dated 09/16/2024, documented time of occurrence 8:15 PM. Licensed Practical Nurse #1 reported that they witnessed in the hallway Certified Nursing Assistant #1 forcefully pull and guide Resident #1 by their right arm to sit in the wheelchair despite Resident #1 not wanting to sit down. Certified Nursing Assistant #1 made Resident #1 to sit in the wheelchair and wheeled them to their room. Licensed Practical Nurse #1 continued to hear noises from Resident #1's room and went into the room. Licensed Practical Nurse #1 observed that Resident #1 continued to resist Certified Nursing Assistant #1, did not want to stay into the bed, and was agitated. Certified Nursing Assistant #1 tried to change Resident #1's pull-up while Resident #1 resisted and kicked. Then, Licensed Practical Nurse #1 observed the Certified Nursing assistant hit Resident #1 on the thigh. Licensed Practical Nurse #1 called the Registered Nursing Supervisor #1. During interviews conducted from 09/25/2025 to 09/26/2024, multiple staff including Licensed Practical Nurse #1, stated that they did not know that they had to separate the victim from the abuser. (continued on next page)

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/26/2024 at 10:51 AM, The Director of Nursing stated Licensed Practical Nurse #1 should have separated Certified Nursing Assistant #1 when they first observed rough handling in the hallway. The Director of Nursing stated all staff received in-service on abuse prevention before the incident. The Director of Nursing stated that the charge nurses on the unit and supervisors are responsible for monitoring residents to prevent abuse. During an interview on 09/26/2024 at 12:13 PM,, the In-service Coordinator #1, stated the lesson plan did not include how facility staff would protect residents from suspected or witnessed abuse. The In-service Coordinator stated they'll do another in-service to address abuse and what staff should do when they suspect or witness residents' abuse. During an interview on 09/26/24 at 12:36 PM, the Administrator stated that all staff received mandatory in-service training regarding abuse prevention prior to the incident. The Administrator stated that nurses on the units, supervisors, and heads of departments are responsible for monitoring residents for abuse. The Administrator stated that Licensed Practical Nurse #1 acted appropriately in reporting abuse, but they should not have left Certified Nurse Assistant #1 in the room with Resident #1. The Administrator also stated that it was poor judgment from Licensed Practical Nurse #1 not to remove Certified Nursing Assistant #1 from Resident #1 in the hallway, which would have prevented abuse in Resident #1's room. 10NYCRR 415.26