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	03/31/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19546 Based on record review and interviews during the Recertification and Abbreviated Survey (NY00342691) conducted from 03/24/2025 to 03/31/2025, the facility did not ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation is made to the New York State Department of Health. This was evident in 1 (Resident #230) of 3 residents reviewed for Abuse. Specifically, Resident #230 had an unwitnessed incident on 05/17/2024 at approximately 4:00 AM, when the resident was observed sitting on the floor gym mat on the left side of their bed. Hospital x-ray report showed right pelvic fracture. Resident #230 was unable to explain the occurrence. This incident was not reported to the New York State Department of Health. The findings are: The facility policy titled Abuse Prevention with a revised date of 09/26/2024 documented the facility will report any incident and/or violation where abuse, neglect, or mistreatment is suspected to the New York State Department of Health according to all federal and state regulations. Resident #230 had diagnoses of Unspecified Dementia, Mood Affective Disorder, and Chronic Kidney Disease. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #230 had severe cognitive impairment. A nurse progress note dated 05/17/2024 at 12:59 PM by Registered Nurse #1 documented late entry note, on 05/17/2024 at 4:00 AM, Registered Nurse #1 was called by the charge nurse to assess Resident #230 who was sitting on a gym mat next to their bed. Body check revealed no injuries were noted. A nurse progress note dated 05/17/2024 at 10:33 AM documented Resident #230 complained of pain to the right hip. The resident was noted with mild swelling and bluish discoloration on the right hip. The physician was notified and ordered hospital transfer. Resident #230 left the facility at 8:45 AM. (continued on next page)

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Investigation Statement form dated 05/17/2024 completed by Licensed Practical Nurse #2 documented on 05/17/2024 at 4:00 AM, Resident #230 was observed in their room, sitting in a gym mat on the left side of their bed. The form documented Resident #230 had dementia, confused, and forgetful. There was no documented resident statement of occurrence. A review of the employee written statements revealed no one had witnessed the incident. During an interview with Certified Nurse Aide #3 on 03/27/2025 at 10:04 AM, they stated they were on duty on 05/17/2024 from 11:00 PM to 7:00 AM. They stated they found Resident #230 sitting on the floor gym mat, and they called for help and the nurse came. During an interview on 03/27/2025 at 9:46 AM, Registered Nurse #1, who was the Nursing Supervisor, stated they were on duty on 05/17/2025 from 11:00 AM to 7:30 AM. They stated they cannot recall when they received a call in the early morning about Resident #230 being found on the floor sitting on the gym mat. Registered Nurse #1 stated they assessed Resident #230, and the resident seemed alright. Registered Nurse #1 stated they did not consider the incident as a fall because Resident #230 was sitting on the gym mat. During an interview on 03/28/2025 at 7:55 AM, the Director of Nursing stated this incident was not reported to the New York State Department of Health because Resident #230 was observed on the gym mat and that was the basis of Resident #230's injury. They stated there was no unknown factor and that they concluded in their investigation that abuse was not determined. The Director of Nursing stated , because the fall was unwitnessed, the incident should have been reported to the New York State Department of Health. 10 NYCRR 415.4(b)(2)