STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335571	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockaway Care Center	353 Beach 48th Street Far Rockaway, NY 11691

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, record review, and interviews during an abbreviated survey (NY00360059), the facility did not ensure that a resident care plan was reviewed and revised by the interdisciplinary team. This was evident in one (1) out of ten (10) residents (Resident #2) sampled. Specifically, on 11/11/2024 Resident #2 alleged Certified Nursing Assistant #5 hit them on their head and pushed them to the ground on the evening of 11/10/2024. The facility investigated the allegation and concluded that the abuse allegation was inconclusive. Resident #2's care plan was not reviewed and revised to reflect the allegation of abuse and it's outcome. The findings include: The facility's Policy and Procedure titled Comprehensive Care Planning dated 03/10/2025, documented the facility utilizes an interdisciplinary team to provide an individualized comprehensive resident assessment and care planning process in order to maximize and maintain every resident's functional potential and quality of life. The care plan is revised when appropriate to reflect the resident's current needs based on evaluation and episodic changes to include medication changes, physician order changes, behavior/mood state changes, accidents and/or incidents. Resident #2 was admitted to the facility with diagnoses including Hypertension and Bipolar Disorder. Minimum Data Set (a resident assessment tool) dated 09/27/2024 documented Resident #2 had a Brief Interview of Mental Status score of 13 out of 15, indicating intact cognition. A Comprehensive Care Plan for Risk for Abuse dated 09/20/2024, documented interventions to observe for changes in customary routines and encourage resident to voice concerns to staff regarding their peers. The care plan was not updated to reflect the alleged abuse incident on 11/10/2024. Record review reveals there were no new interventions implemented since 09/21/2024. The facility's Accident/Incident Report dated 11/11/2024 at 10:30 AM documented Resident #2 reported to the Social Worker that they were hit on the head and pushed to the ground by Certified Nursing Assistant #5 on the evening of 11/10/2024. Resident #2 was assessed and there were no redness or injuries noted. The facility conducted their investigation and determined abuse was inconclusive. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/07/2025 at 1:32 PM, Director of Nursing stated the admitting nurse, and the Minimum Data Set Coordinator are responsible for initiating the care plans and the unit manager are responsible for updating the care plans. They stated the Minimum Data Set Coordinator, Supervisors and disciplinary team ensures that the care plans are updated. During an interview on 04/21/2025 at 2:58 PM, Registered Nurse Supervisor #6 stated the abuse care plan was not updated because it was an oversight. 10 NYCRR 415.11(c)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during an abbreviated survey, (NY00376954), the facility failed to ensure that the physician reviewed the resident's total program of care, including medications, at each visit. This was evident in one (1) out of ten (10) residents (Resident #1) sampled for quality of care. Specifically, Resident #1 who exhibited increased agitation with behavioral disturbances secondary to Huntington's Disease, verbalized suicidal ideation from [DATE] to [DATE]. Resident #1 was transferred to the hospital emergency department on [DATE], [DATE], and [DATE]. A Patient Visit Information (Hospital Discharge Summary) from the hospital emergency department dated [DATE], documented as recommended on [DATE], Abilify 20 milligram to be decreased to 10 milligram daily due to the risk of akathisia restlessness, and agitation. There was no documented evidence that a physician reviewed the hospital emergency room discharge summary and recommendation. There were no physician's interventions recommended after Resident #1 transfers to the emergency department on [DATE] and [DATE]. The Psychiatrist was not notified of the recommendation of [DATE] for Abilify to be decreased from 20 milligrams to 10 milligrams. Record review of the medical notes revealed no documented evidence Resident #1 was seen and evaluated by a Physician from [DATE] to [DATE]. On [DATE] at 2:58 AM, Resident #1 jumped from their room window and was found lying on facility grounds. Resident #1 was transferred to the emergency room where they expired. The findings are: The facility policy titled Medical Service Policy dated [DATE] documented the attending physicians shall oversee the comprehensive medical care of all assigned residents, ensure the delivery of timely, coordinated, and ethical care consistent with federal, state, and facility standards. The policy further documented that the physicians must maintain regulatory compliance with CMS F-tags F710 through F714, F841, F842, and F865. The facility policy titled Psychoactive Medications dated [DATE] documented in procedure (21) the Primary Physician will review the recommendations made by the Psychiatrist and incorporate these in the medical record. Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia (forgetfulness) and Huntington's Disease (brain disorder that causes nerve cells to break down). The Minimum Data Set, dated [DATE] documented Resident #1 had intact cognition. A Nursing Progress Note dated [DATE] at 5:27 AM by Registered Nurse Supervisor #2 documented Resident #1 was observed going from room to room agitated trying to open and break windows. Resident #1 was observed banging their head on to the windows and was a danger to themself. 911 was called and Resident #1 left the unit on a stretcher to the hospital at 5:20 AM. (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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note by Registered Nurse #1 dated [DATE] at 6:45 PM documented Resident #1 arrived from the emergency department at 4:00 PM. The Resident was sent to the hospital for evaluation due to suicidal ideation and behaviors. The resident was sent back with no changes in medication and no documentation if the Resident was a danger to self at this time. Resident stated they did not want to kill themself. The Resident stated they were frustrated and made remarks out of frustration. The Resident was immediately evaluated by Psychologist and placed on 1:1 monitoring. A Progress Note by Psychology Consultant dated [DATE] at 6:54 PM documented staff reported Resident #1 became agitated and was attempting to harm self. The resident was transferred to the acute care facility for evaluation and was later readmitted to the nursing home. Resident #1 admitted to self-injurious behaviors, but was unable to provide any insight as to their motivation or any events that may have triggered self-injurious behaviors. Resident #1 denied any intent to harm self at this time, and verbally contracted for safety (a legally binding agreement made without any written documentation). Staff reported increased withdrawal/avoidance behaviors. Resident declined psychological services at this time. A Prehospital Care Report Summary - Fire Department of New York dated [DATE] revealed when 911 arrived at the facility, Resident #1 was lying on the floor being restrained by Police Officers. The police stated staff reported Resident #1 was trying to jump out the window but was unable to open the window. A Physician Comprehensive Monthly note by Physician #1 (Resident #1's primary physician) dated [DATE] at 12:49 PM documented that they were following up on Resident #1's functional status. There were no complaints in the morning, Resident #1 denied pain secondary to abscess (gum). Chief complaint: functional impairment. There was no mention of Resident #1's emergency room visit or recommendation for monitoring for safety. A Psychiatrist noted dated [DATE] at 3:29 PM documented they evaluated Resident #1 and increased Abilify (antipsychotic used primarily to treat mood disorders and schizophrenia) to 30 milligrams. A Nursing Progress Note dated [DATE] at 2:53 AM by Registered Nurse Supervisor #2 documented Resident #1 was very agitated, destroying property and stating they will jump out of the window. Resident #1 was very combative and could not be redirected. The Resident was a danger to themself and others. 911 was called and the Resident was taken out of the facility at around 2:30 AM. A Physician's progress note dated [DATE] at 11:01 AM (for services provided on [DATE]), by Physician #2 documented Resident #1 was clinically stable and was seen by psychiatrist. Recommendation reviewed and agreed to continue Abilify for psychosis and chorea related to Huntington's disease. Increased Ability to 30 milligrams daily. Will monitor. Continue Celexa 20 milligrams daily to address poor impulse control which contributes to behavior problems. There was no mention of Resident #1 being transferred to the hospital emergency room on [DATE] at 2:30 AM, there was no mention of the emergency room discharge summary and recommendation to decrease Abilify. (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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note dated [DATE] at 1:45 PM by Registered Nurse Supervisor #1 documented Resident #1 was transferred to the hospital emergency department for the same behaviors displayed three days ago, physically aggressive behaviors with suicidal ideations. Resident returned calm and cooperative. No recommendations and no changes in medication. Documentation revealed Resident is not a danger to self or others at this time. A Patient Visit Information (Hospital Discharge Summary) dated [DATE] documented Resident #1 was observed in the emergency department overnight. Resident #1 was calm and cooperative, and they did not observe any aggressive behavior or suicidal behaviors in the emergency room. Resident #1 was not a danger to themself or others at this time and was psychiatric cleared for discharge. Resident #1 to continue all home medications and follow up with their primary provider at the facility. As recommended on [DATE], Ability 20 milligram to be decreased to 10 milligram daily due to the risk of akathisia restlessness, and agitation. There was no documented evidence that medical staff were aware of the hospital's recommendation of [DATE] to decrease Abilify from 20 milligrams to 10 milligrams. A review of the resident's Medication Administration Record revealed Resident #1 was receiving Abilify 20 milligrams daily and Celexa 20 milligrams daily by oral route from [DATE] through [DATE]. There was no documented evidence that Resident #1 was being monitored to determine the effectiveness of the medication. A Nursing Progress Note dated [DATE] at 8:28 PM by Registered Nurse Supervisor #3 documented at 7:35 PM, they responded to a call from the unit and observed Resident #1 pacing their room. The room was freezing, the window was on the floor with window screen torn. Resident #1 stated they opened their window to put a soda can outside to get cold. Resident #1 was laughing inappropriately with a gazed look. 1:1 monitoring was provided for safety. Medical Doctor was informed and 911 was called. Resident #1 left for psychiatric evaluation at 8:00 PM. Medical record review revealed no documented evidence Resident #1 was seen and evaluated by a Physician from [DATE] to [DATE]. A Nursing Progress Note by Licensed Practical Nurse #2 dated [DATE] at 7:17 AM documented Resident #1 returned from the hospital emergency room at 12:20 AM and was placed on 30 minutes rounds. At about 2:58 AM, Certified Nursing Assistant #1 (making rounds) went into Resident #1's room and observed the Resident at the window and the Resident immediately jumped from the window. Registered Nurse Supervisor #2 was notified. The Resident was lying on ground awake and in stable condition. 911 called and Police Officers and ambulance came and took over. A Prehospital Care Report Summary - Fire Department of New York dated [DATE] when emergency service arrived Resident #1 was lying supine on the sidewalk surrounded by Police Officers. Resident #1 jumped out of the open window on the fourth floor, approximately 40 feet fall. Resident #1 was transferred to the hospital. No visible injuries. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 3:54 PM, Physician #1 stated Resident #1 did not voice suicidal concerns to them. Physician #1 stated they were informed by a staff nurse each time Resident #1 was transferred to the hospital, however, they cannot recall who informed them or the time they were informed. Physician #1 stated they did not call the hospital to inquire about sending Resident #1 back to the facility after they verbalized suicidal ideations. They stated the hospital psychiatrist evaluated Resident #1 and documented Resident #1 was not at risk for suicide. They stated the facility staff maintained Resident #1 on close monitoring. They stated Resident #1 was not on 1:1 monitoring, but considering what had happened, having Resident #1 on 1:1 would have helped. During a telephone interview with Registered Nurse Supervisor #1 on [DATE] at 9:38 AM, Registered Nurse Supervisor #1 stated there were no recommendation on the emergency room Discharge summary dated [DATE]. They stated the form documented if the symptoms got worse the resident should return to the emergency room. Registered Nurse Supervisor #1 stated the emergency discharge form dated [DATE] documented that Resident #1 was not a danger to their self or others. They stated they did not see the recommendation documented to decrease Abilify to 10 milligrams. They stated every time Resident #1 returned from the hospital, they informed Physician #2. During a follow interview on [DATE] at 1:45 PM, Physician #1 stated they were informed by the nurse (can't recall the time or who informed them) that the hospital discharge summary recommended medication adjustment but cannot recall what the recommendation was. Physician #1 stated they were made aware of Resident #1 having erratic behavior and the goal was to have then evaluated by the Psychiatrist, so they can adjust their medication. They stated they cannot recall if Resident #1 was seen by the Psychiatrist in-house, but Resident #1's condition became concerning, so they were sent to the hospital for evaluation. They stated they do not recall if Resident #1 had labs done. During a telephone interview on [DATE] at 12:55 PM, Physician #2 stated they did not review the emergency room discharge summary of [DATE]. They stated they evaluated Resident #1 on [DATE] and reviewed the Psychologist consultation on [DATE]. They stated they did not receive any calls from the facility after [DATE] because they were on maternity leave. During a telephone interview on [DATE] at 11:38 AM, Psychiatrist #1 stated Resident #1 was evaluated every quarter and as needed. They stated Resident #1 had Huntington's disease which affected the resident behavior. Psychiatrist #1 stated Registered Nurse Supervisor #1 asked them to evaluate Resident #1 because the resident attempted to open a window and was sent to the emergency room. Psychiatrist #1 stated they recommended increasing Abilify to 30 milligrams on [DATE] after they evaluated the resident. They stated Resident #1 was taking Ability for Huntington's Disease. The Psychiatrist stated they were not aware of the emergency room recommendation dated [DATE] to decrease the Abilify to 10 milligrams. Psychiatrist #1 stated Abilify was approved for the diagnosis and was helpful in diminishing impulsivity and outbursts, therefore, they would not have deceased the Abilify to 10 milligrams. The Psychiatrist stated the Abilify did not contribute to the suicidal ideation. Psychiatrist #1 stated their role was to provide pharmacological management; they do not have a role to tell nursing staff to how manage resident's behavior. During a telephone interview on [DATE] at 2:45 PM, the Medical Director stated they were not aware of any recommendations made by the hospital for Resident #1 as they were not aware of the [DATE], [DATE], and [DATE] hospital emergency room transfers. The Medical Director added that the Administrator notified them that Resident #1 was transferred to the emergency room after the incident on [DATE]. (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 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.15 (b)(2)(iii)

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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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during an abbreviated survey (NY00376954), the facility failed to ensure that a resident who displayed or was diagnosed with mental disorder or psychosocial adjustment difficulty, received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. This was evident in 1 out of 10 residents (Resident #1) sampled for behavioral health. Specifically, from [DATE] through [DATE], Resident #1 who had a diagnosis of Huntington's Chorea Disease (a neurological disorder that causes nerve cells in the brain to break down and die, leading to uncontrolled movements, cognitive decline, and personality changes) exhibited and verbalized suicidal ideation with increased agitation and behavioral disturbances. On [DATE], [DATE], and [DATE], Resident #1 was observed by the facility's nursing staff attempting to open their room window and the windows in other resident rooms, successfully removing the bottom panel from their window on [DATE], while verbalizing they wanted to jump out of the window. The resident was transferred to the hospital emergency room via emergency transport after each incident for behavioral evaluation. Upon return from the hospital on [DATE] at 12:20 AM the resident was placed back in the same room and their care plan was not updated with new interventions to address the resident behavior and suicidal ideation. On [DATE] at 2:58 AM, Certified Nursing Assistant #1 observed the bottom window panel on the floor of the resident's room and Resident #1 was outside of the window, hanging from the window ledge. Resident #1 then let go and fell from the 4th floor window. This deficient practice resulted in Resident #1's death that was immediate jeopardy. The findings are: The facility Policy and Procedure titled Behavioral Health Management dated [DATE], documented the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The policy further documented the facility will utilize non-pharmacological interventions as appropriate as part of the person-centered plan of care. Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia and Huntington's Disease (brain disorder that causes nerve cells to break down). The Minimum Data Set, dated [DATE] documented Resident #1 had intact cognition. A Nursing Progress Note dated [DATE] at 5:27 AM by Registered Nurse Supervisor #2, documented Resident #1 was observed going from room to room agitated trying to open and break windows. Resident #1 was observed banging their head on the windows and was a danger to themself. Emergency services was called, and Resident #1 left the unit on a stretcher to the hospital at 5:20 AM. A Prehospital Care Report Summary - Fire Department of New York dated [DATE] revealed when Emergency Services arrived at the facility, Resident #1 was lying on the floor being restrained by Police Officers. The police stated that staff reported Resident #1 was trying to jump out the window but was unable to open the window. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nursing Progress Note by Registered Nurse #1 dated [DATE] at 6:45 PM, documented Resident #1 returned from the emergency department at 4:00 PM. The note further documented that the resident was sent to the hospital for evaluation due to suicidal ideation and behaviors. The resident was sent back with no changes in medication and no documentation indicating the Resident was not a danger to self at this time. Resident #1 stated they did not want to kill themself. The resident stated they were frustrated and made remarks out of frustration. Resident #1 was immediately evaluated by Psychologist #1 and placed on 1:1 monitoring. A Patient Visit Information Follow-up and Referral Instructions (from the emergency department) dated [DATE] documented that Resident #1 should return to the emergency department if symptoms or condition worsened. Recommended to follow up with primary physician. A Progress Note by Psychology Consultant #1 dated [DATE] at 6:54 PM, documented staff reported Resident #1 became agitated and was attempting to harm self. The resident was transferred to the hospital for evaluation and was later readmitted to the nursing home. Resident #1 admitted to self-injurious behaviors, but was unable to provide any insight as to their motivation or any events that may have triggered self-injurious behaviors. Resident #1 denied any intent to harm self at this time, and verbally contracted for safety. Staff reported increased withdrawal/avoidance behaviors. Resident declined psychological services at this time. A Physician Comprehensive Monthly note by Physician #1 (Resident #1's primary physician) dated [DATE] at 12:49 PM, documented that they were following up on Resident #1's functional status. There were no complaints in the morning, Resident #1 denied pain secondary to abscess (gum). Chief complaint: functional impairment. Physician #1 documented the resident's history prior to being admitted to the facility. The note did not mention Resident #1's emergency room visit on [DATE] and there was no recommendation for monitoring for safety. A Physician's progress note dated [DATE] at 5:41 PM by Physician #2, documented Resident #1 was seen and examined. Clinically stable. Resident #1 returned from the hospital due to suicidal attempt. The resident has no behavioral issues now, on Abilify and Celexa. Referred to psychologist and psychiatrist for further evaluation. No side effect of medication, continue current medication. A Psychiatry note/follow up dated [DATE] at 3:29 PM, documented Resident #1 started pulling down shades and trying to open windows. Resident #1 reported they were angry with their roommate because their roommate made a feculent odor. Psychiatrist #1 recommended to increase the Ability from 20 milligrams to 30 milligrams daily. Physician #2 progress notes dated [DATE] at 11:01 AM documented date of service [DATE], Resident #1 was clinically stable and was seen by psychiatrist. Recommendation reviewed and agreed to continue Abilify for psychosis and chorea related to Huntington's disease. Increased Ability to 30 milligrams daily. Will monitor. Continue Celexa 20 milligrams daily to address poor impulse control which contributes to behavior problems. Resident Medication Administration Record reviewed on [DATE], Abilify 20 milligrams daily was increased to 30 milligrams daily. (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 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing Progress Note dated [DATE] at 2:53 AM by Registered Nurse Supervisor #2 documented Resident #1 was very agitated, destroying property and stating they will jump out of the window. Resident #1 was very combative and could not be redirected. The Resident was a danger to themself and others. Emergency services was called, and the Resident was taken out of the facility with police officers at around 2:30 AM. A Prehospital Care Report Summary - Fire Department of New York dated [DATE] revealed when Emergency Services arrived at the facility, staff reported Resident #1 was aggressive and was trying to jump out of the window to kill themself. The resident was calm with crew but was in handcuffs with police prior to emergency service arrival. Resident #1 was transported to the hospital without incident. A Nursing Progress Note dated [DATE] at 1:45 PM by Registered Nurse Supervisor #1 documented Resident #1 was transferred to the hospital emergency department for the same behaviors displayed three days ago, physically aggressive behaviors with suicidal ideations. Resident returned calm and cooperative. No recommendations and no changes in medication. A Patient Visit Information (Hospital Discharge Summary) dated [DATE], documented Resident #1 was observed in the emergency department overnight. Resident #1 was calm and cooperative, and they did not observe any aggressive behavior or suicidal behaviors in the emergency room. Resident #1 was not a danger to themself or others at this time and was psychiatrically cleared for discharge. Resident #1 to continue all home medications and follow up with their primary provider at the facility. As recommended on [DATE], Ability 20 milligrams to be decreased to 10 milligrams daily due to the risk of akathisia, restlessness, and agitation. There is no documented evidence the facility reviewed the recommendation of [DATE] for Abilify to be decreased to 10 milligrams. Medical record reviewed from [DATE] to [DATE], revealed no documented evidence Resident #1 was seen and evaluated by a Physician. A Nursing Progress Note dated [DATE] at 8:28 PM by Registered Nurse Supervisor #3 documented at 7:35 PM, they responded to a call from the unit and observed Resident #1 pacing in their room. The room was freezing, the window was on the floor with the window screen torn. Resident #1 stated they opened their window to put a soda can outside to get cold. Resident #1 was laughing inappropriately with a gazed look. Physician #1 was informed, and emergency services was called. 1:1 monitoring was provided for safety until emergency services arrived. Resident #1 was transported for psychiatric evaluation at 8:00 PM. A Prehospital Care Report Summary - Fire Department of New York dated [DATE] revealed facility staff reported that Resident #1 pushed out the mesh screen of a window in their room. Staff stated Resident #1 was suicidal. Resident #1 reported they were not hearing any voices and does not want to hurt themself or others. (continued on next page)

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Accident/Incident Report dated [DATE] at 2:58 AM documented Certified Nursing Assistant #1 was doing their rounds and observed Resident #1 jumped from the window. The facility's investigation documented that at 7:35 PM on [DATE], the window panel was found on the floor in Resident #1's room with the mesh screen partially torn. Resident #1 stated they had opened the window to put their can of soda outside to get cold. Given Resident #1's behavior and history, staff deemed Resident #1 a danger to self and others and obtained an order to transfer them to the hospital for evaluation, and resident left the facility at 8:00 PM. The window panel was reinserted by Certified Nursing Assistant #3 and placement was confirmed by Housekeeper #1. Resident #1 returned to the facility at approximately 12:20 AM. Thirty-minute visual monitoring was ongoing. At 2:58 AM, Certified Nursing Assistant #1 opened Resident #1's room door for scheduled room checks and observed Resident #1's hands gripping the windowsill from outside the window. The facility concluded that the event was unforeseeable, an isolated act likely resulting from Resident #1's neuropsychiatric condition. There was no documented evidence the facility initiated or updated Resident #1's care plan to identify and develop interventions for the [DATE], [DATE], and [DATE] suicidal ideations. A Nursing Progress Note by Licensed Practical Nurse #2 dated [DATE] at 7:17 AM, documented Resident #1 returned from the hospital emergency room at 12:20 AM and was placed on 30 minutes rounds. At about 2:58 AM, Certified Nursing Assistant #1 (making rounds) went into Resident #1's room and observed the Resident at the window and the Resident immediately jumped from the window. Registered Nurse Supervisor #2 was notified. The Resident was lying on ground awake and in stable condition. Emergency services was called, and police officers and ambulance personnel came and took over. A Prehospital Care Report Summary - Fire Department of New York dated [DATE] when emergency service arrived Resident #1 was lying supine (on their back) on the sidewalk surrounded by Police Officers. Resident #1 jumped out of the open window on the fourth floor, approximately a 40- foot fall. Resident #1 was transferred to the hospital. No visible injuries. During an interview on [DATE] at 10:15 AM, the Director of Maintenance stated that they were not aware Resident #1 had removed their room window on [DATE]. They became aware of the issues on [DATE] after Resident #1 was transferred to the emergency room. During a telephone interview on [DATE] at 11:25 AM, Certified Nursing Assistant #1 stated they arrived at the facility and made rounds at approximately 11:00 PM on [DATE]. Resident #1 was already transferred to the hospital. They stated that they checked Resident #1's room and nothing was broken, the window was closed, but the mesh was not in the window panel. Certified Nursing Assistant #1 stated that Resident #1 returned to the facility between midnight -12:15 AM on [DATE]. Certified Nursing Assistant #1 stated they and Certified Nursing Assistant #2 took turns checking on Resident #1 every 30 minutes. They stated they went back to check on Resident #1 on [DATE] at 2:58 AM and Resident #1's room was cold; their body was outside the window and their hands were holding onto the windowsill. They stated Resident #1 then let go of the windowsill before they could reach them. They stated they observed the bottom window panel on the floor, but did not see the window mesh. They stated Resident #1 had closed their room door. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335571	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rockaway Care Center	353 Beach 48th Street Far Rockaway, NY 11691

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 12:36 PM, Licensed Practical Nurse #1 stated they worked on [DATE] on the 3:00 PM to 11:00 PM shift. They stated Resident #1 transferred from Unit 6 to Unit 4 on [DATE]. Licensed Practical Nurse #1 stated Resident #1 was not on the unit when they conducted rounds, but they received a report from the off-going nurse (Licensed Practical Nurse #7) who stated Resident #1 was in the dining room eating on the first floor at approximately 5:00 PM. Licensed Practical Nurse #7 also reported that Resident #1 verbalized suicidal ideation and was on close monitoring. Licensed Practical Nurse #1 stated Resident #1 returned to the unit between 5:00 PM and 6:00 PM (exact time unsure) Licensed Practical Nurse #1 stated they observed Resident #1 pacing back and forth in their room between 7:15 PM and 7:30 PM and requested a pillow. Licensed Practical Nurse #1 stated they instructed Certified Nursing Assistant #4 to give Resident #1 a pillow. Licensed Practical Nurse #1 stated Certified Nursing Assistant #4 called out from Resident #1's room and when they arrived in the room, they observed the bottom window on the floor and the mesh screen was torn. Licensed Practical Nurse #1 stated they instructed another staff (Certified Nursing Assistant #3) to stay with Resident #1 while they paged the Registered Nurse Supervisor #3 and Housekeeper #1. Licensed Practical Nurse #1 stated Resident #1 remained at the nursing station with them for close observation until the emergency service arrived and transferred Resident #1 to the emergency room. They stated Certified Nursing Assistant #3 put the window back in the frame. During an interview with the Director of Nursing on [DATE] at 1:32 PM, they stated that Resident #1 should have been placed on 1:1 monitoring. During a telephone interview on [DATE] at 1:47 PM, Housekeeper #1 stated they were called to Resident #1's unit and responded between 7:00 PM and 8:00 PM. Housekeeper #1 stated License Practical Nurse #1 informed them that Resident #1 took their room window out of the wall. Housekeeper #1 stated they then entered Resident #1's room and observed the window slightly out of the window frame and it was not aligned properly. Housekeeper #1 stated they pushed the window into the frame, but it was still loose. They stated Licensed Practical Nurse #1 informed them that the window was on the floor and Certified Nursing Assistant #3 put the window back into the frame. Housekeeper #1 stated they documented the window was out in the maintenance book. During a telephone interview on [DATE] at 2:38 PM, Registered Nurse Supervisor #2 stated Licensed Practical Nurse #2 informed them at approximately 3:00 AM on [DATE], that Resident #1 fell out of the window. They stated they went outside the building and saw Resident #1 lying on the ground. Registered Nurse Supervisor #2 stated they called 911 at 3:02 AM or 3:03 AM and the police arrived followed by Emergency Medical Staff. They stated they informed the administrative team at 3:15 AM on [DATE]. They stated prior to the incident, they evaluated Resident #1 upon their return from the hospital at approximately 12:03 AM - 12:05 AM on [DATE] and Resident #1 was calm prior to the incident and was being monitored visually every 30 minutes. During a telephone interview on [DATE] at 3:54 PM, Physician #1 stated Resident #1 did not voice suicidal concerns to them. Physician #1 stated they were informed by a staff nurse each time Resident #1 was transferred to the hospital, however, they cannot recall who informed them or the time they were informed. Physician #1 stated they did not call the hospital to inquire about sending Resident #1 back to the facility after they verbalized suicidal ideations. They stated the hospital psychiatrist evaluated Resident #1 and documented Resident #1 was not at risk for suicide. They stated the facility staff maintained Resident #1 on close monitoring. They stated Resident #1 was not on 1:1 monitoring, but considering what had happened, having Resident #1 on 1:1 would have helped. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335571	A. Building B. Wing	04/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview on [DATE] at 3:18 PM with both the Director of Nursing and the Administrator revealed they were not informed of Resident #1's transfer to the hospital on [DATE] and [DATE]. The Administrator and Director of Nursing stated when the resident returned from the hospital emergency room on [DATE] at 12:20 AM, Registered Nurse #2 did not implement the 1:1 monitoring; instead, they placed the resident on 30-minute monitoring. During a telephone interview on [DATE] at 11:38 AM, Psychiatrist #1 stated Resident #1 was evaluated every quarter and as needed. They stated Resident #1 had Huntington's disease which affected the resident behavior. Psychiatrist #1 stated Registered Nurse Supervisor #1 asked them to evaluate Resident #1 because the resident attempted to open a window and was sent to the emergency room. Psychiatrist #1 stated they recommended increasing Abilify to 30 milligrams on [DATE] after they evaluated the resident. They stated Resident #1 was taking Ability for Huntington's Disease. The Psychiatrist stated they were not aware of the emergency room recommendation dated [DATE] to decrease the Abilify to 10 milligrams. Psychiatrist #1 stated Abilify was approved for the diagnosis and was helpful in diminishing impulsivity and outbursts, therefore, they would not have deceased the Abilify to 10 milligrams. The Psychiatrist stated the Abilify did not contribute to the suicidal ideation. Psychiatrist #1 stated their role was to provide pharmacological management; they do not have a role to tell nursing staff to how manage resident's behavior. During a telephone interview on [DATE] at 12:55 PM, Physician #2 stated they did not review the emergency room discharge summary of [DATE]. They stated they evaluated Resident #1 on [DATE] and reviewed the Psychologist consultation on [DATE]. They stated they did not receive any calls from the facility after [DATE] because they were on maternity leave. During an interview on [DATE] at 1:08 PM, Certified Nursing Assistant #3 stated on [DATE] (unable to recall the time), Licensed Practical Nurse #1 asked them for assistance because Resident #1 wanted to go out of the window. They stated when they entered Resident #1's room they observed the window on the floor, and they put the window back in the frame and locked the window. Certified Nursing Assistant #3 stated they left the room after putting the window back into the frame, but Resident #1 and Licensed Practical Nurse #1 remained in the room. During a telephone interview on [DATE] at 2:45 PM, the Medical Director stated they were not aware of any recommendations made by the hospital for Resident #1 as they were not aware of the [DATE], [DATE], and [DATE] hospital emergency room transfers. The Medical Director added that the Administrator notified them that Resident #1 was transferred to the emergency room after the incident on [DATE]. During an interview with the Administrator on [DATE] at 3:18 PM, they stated they were not aware of the resident's multiple emergency transfers to the hospital. They were informed of the [DATE] incident when staff told them the window was damaged. They were told by Registered Nurse #3 at 8:34 PM (on [DATE]) that Resident #1 was returning from the hospital and would be placed on 1:1 supervision. 10 NYCRR 415.12(f)(1)