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	12/10/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Number of residents sampled: 2Number of residents cited: 1 Based on observations, record reviews, and interviews conducted during the Recertification and abbreviated survey (460002), the facility did not ensure residents were free from physical or chemical restraints imposed for purposes of discipline or convenience and that were not required to treat the resident's medical symptoms. This was evident for one (1) of two (2) residents (Resident #9) reviewed for Physical Restraints out of 41 sampled residents. Specifically, Resident #9 was observed by facility staff in their bed restless and agitated while on a mechanical ventilator, with each hand inside a pillowcase wrapped with tape around their wrists. The findings are: The facility policy titled 'Restraints' dated 07/08/25 stated it is the policy of the facility to promote and maintain residents' highest practicable well-being in a restraint free environment and only utilize a physical restraint in a circumstance in which the resident has medical symptoms that may warrant the use of a restraint. The facility policy also stated the facility would assess and review the use of any physical restraint to ensure that the least restrictive device is utilized with ongoing assessment for the reduction or elimination of the restraint. The facility would then ensure interventions are in place to minimize or eliminate the medical symptom and/or underlying problems causing the medical symptom. The facility policy further stated the use of hand mittens without proper protocols will be considered a physical restraint. Resident #9 had diagnoses which included Acute Respiratory Failure, Cardiovascular Accident, Seizure disorder, Anxiety disorder, Ventilator and Gastrostomy Tube Dependent. The Quarterly Minimum Data Set (an assessment tool) dated 06/19/2025 documented Resident #9 had severely impaired cognition and required extensive assistance of one person for transfers and toilet use. The Minimum Data Set assessment further documented limb restraints were not used.On 09/26/2025 at 10:07 AM, Resident #9 was observed in bed, alert and awake. Resident #9 was interviewed and stated they were happy their health was improving. Resident #9 also stated they could not recall the incident of pillowcases on their hands however, they recalled bilateral gloves were used on their hands and removed a while ago because they got better. The Facility Reported Incident (#460002) dated 07/02/2025 documented at approximately 9:30 AM on 07/02/2025, Licensed Practical Nurse #6 observed Resident #9 in bed with each hand inside pillowcases and tape wrapped around the resident's wrists. Resident #9 was also observed restless and agitated while under the mechanical ventilator. Licensed Practical Nurse #6 immediately informed Registered Nurse #2 (Supervisor) about the incident and quickly assessed the resident who sustained no injury. Registered Nurse #2 then used scissors to cut the tape around the resident wrists and remove resident's hand from the pillowcases. The Facility Investigative Summary dated 07/09/2025 documented that upon investigation, it was determined Respiratory Therapist #1 who worked on 07/01/2025 from 7:00 PM to 7:00 AM shift applied hand restraints by putting Resident #9's hands inside the pillowcase wrapped with tape. The summary also stated Respiratory Therapist #1 stated Resident #9 decannulated themselves three times during the night shift and all their efforts to get the resident hand mittens was unsuccessful, so Respiratory Therapist #1 then place the resident hand in pillowcases and wrapped tape around the resident's wrist. The Investigative Summary concluded Respiratory Therapist #1 violated facility restraint protocol and the facility terminated Respiratory Therapist #1. Review of documents in the medical records dated 06/12/2025 to 07/01/2025 contained no evidence Resident #9 used a limb restraint, and there was no Physician's order for the use of a limb restraint. On 09/26/2025 at 10:35 AM, an interview was conducted with the assigned Certified Nursing Assistant #7 who stated they worked from 7AM to 3 PM on 07/02/25 which was their regular schedule. Certified Nursing Assistant #7 also stated Resident #9 was confused and agitated when they were first admitted to the facility and had attempted to pull out the tracheostomy out before, so they always make frequent observations of them. Certified Nursing Assistant #7 further stated they did not observe Resident #9 with pillowcases on their hands because they had not yet been to the Resident #9's room at the time of incident. On 09/30/2025 at 10:07 AM, an interview was conducted with Licensed Practical Nurse #6 who observed Resident #9 with pillowcases on their hands. Licensed Practical Nurse #6 stated they worked from 7:00 AM to 3:00 PM on 07/02/2025 as a medication nurse, and when they entered Resident #9's room, they observed the resident appeared restless, each hand was placed inside a pillowcase and wrapped with tape at the resident's wrist, and they immediately informed the supervisor. Licensed Practical Nurse #6 also stated Resident #9 was unable to communicate at that time due to being maintained on a ventilator but at times was able to make some body gestures to communicate. Licensed Practical Nurse #7 further stated Resident #9 was not admitted with hand mittens and had never

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews conducted during the Abbreviated (459971) and Recertification survey, the facility did not ensure a comprehensive person-centered care plan for each resident was developed and implemented, that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs. This was evident for one (1) of two (2) residents (Resident #223) reviewed for Hospitalization out of 41 sampled residents. Specifically, there was no comprehensive care plan developed for tracheostomy care for Resident #223.The findings are:The facility policy and procedure titled 'Comprehensive Care Planning', last reviewed 10/16/2023, stated each resident will have a comprehensive person-centered care plan developed that is in compliance with Federal and State regulations. The facility will establish an interdisciplinary team care planning process to ensure resident care and treatment is planned appropriately for the resident's needs and condition, impairment, disability or disease process in a timely, systematic and comprehensive manner. Based on a comprehensive interdisciplinary assessment, the interdisciplinary team will address individualized resident needs to include physical, psychosocial, cognitive, functional, activities, emotional, spiritual, cultural, and communication needs. Services and care are identified and planned to meet resident's care goals. interdisciplinary team members who will provide care or service are also identified. Individual care and treatment goals are identified. Resident #223 was admitted to the facility with active diagnoses that included Non-Traumatic Brain Injury and Respiratory Failure with Tracheostomy.The admission Minimum Data Set (an assessment tool) dated 11/23/2024, documented Resident #223 was severely cognitively impaired, had shortness of breath or trouble breathing when lying flat, and received respiratory treatments including oxygen administration and tracheal suctioning.A Physician Treatment Order dated 12/05/2024, documented Oxygen 21% to be administered by tracheal collar 24 hours a day.A Physician Treatment Order dated 12/13/2024, documented suction tracheal secretions every shift and as needed.A Physician Treatment Order dated 12/13/2024, documented perform tracheal care every shift and as needed.There was no documented evidence a comprehensive care plan was created to address the treatment plan, goals, and interventions specifically associated with the tracheostomy tube.On 10/01/2025 at 2:42 PM, an interview was conducted with Registered Nurse #2, the nursing supervisor for the ventilator unit who stated the tracheostomy care plan should be entered at admission for all residents who are admitted to the facility with a tracheostomy tube. Registered Nurse #2 also stated that at admission, the Registered Nurse or Minimum Data Set assessment nurse enters the care plans. Registered Nurse #2 further stated all clinical staff providing tracheostomy care and treatments should check the medical chart every day to ensure the care plan associated with the residents' diseases, care, and treatments are entered and updated as needed. Registered Nurse #2 stated if the tracheostomy care plan is not present in the medical record or not updated, the care plan has to be entered to guide the associated care and treatments and outline the goals of care for the resident. On 10/01/2025 at 2:19 PM, an interview was conducted with the Director of Nursing who stated Registered Nurses and the Minimum Data Set assessment nurse who start and or complete the admission process for the resident is to enter the care plans. The Director of Nursing also stated at admission all standard care plans are entered and within twenty-four (24) to forty-eight (48) hours additional care plans are entered related to the resident's specific disease processes and treatments that are required and performed. The Director of Nursing further stated Registered Nurse supervisors are to review the care plans and make sure they are entered and updated. The Director of Nursing stated Resident #223 should have had a tracheostomy care plan entered into the medical record that addressed the tracheostomy care, the associated treatments, and the goals of the care. 10 NYCRR 415.11(c)(1)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record reviews, and interviews conducted during the Recertification survey, the facility did not ensure that the services provided or arranged by the facility as outlined by the comprehensive care plan, met professional standards of quality. This was evident for one (1) of two (2) residents (Resident #9) reviewed for Physical Restraint out of 41 sampled residents. Specifically, there was no documented evidence bilateral hand mittens for Resident #9 were released every two-hours as per Physician's order. The findings are: The facility policy titled 'Restraints' dated 07/08/25 stated it is the policy of the facility to promote and maintain residents' highest practicable well-being in a restraint free environment and only utilize a physical restraint in a circumstance in which the resident has medical symptoms that may warrant the use of a restraint. The facility policy also stated staff would monitor and document the use of physical restraint on resident's medical records as indicated by the Interdisciplinary team. Resident #9 had diagnoses which included Acute Respiratory Failure, Cardiovascular Accident, Seizure disorder, Anxiety disorder, Ventilator and Gastrostomy Tube Dependent. The Quarterly Minimum Data Set (an assessment tool) dated 06/19/2025 documented Resident #9 had severely impaired cognition, and they required extensive assistance of one person for transfers and toilet use. The Minimum Data Set assessment further documented limb restraints were not used. On 09/26/2025 at 10:07 AM, Resident #9 was observed in bed, alert and awake. Resident #9 was interviewed and stated they were happy their health was improving. Resident #9 also stated they could not recall the incident of pillowcases on their hands however, they recalled bilateral gloves were used on their hands and removed a while ago because they got better. The Physician's order dated 07/22/2025 and discontinued on 09/10/2025 documented Bilateral Hand Mittens-Restraint type for pulling the trach out. Release every 2 hours for 10 minutes for Range of Motion and Skin Check. The Respiratory Note dated 07/27/2025 documented Resident #9 was ventilator dependent with prescribed settings, no sign of distress noted. Head of bed elevated, gastrostomy tube is intact and patent, aspiration precautions maintained. Bilateral mittens in place to prevent pulling at trach, release every 2 hours for 15 minutes. Plan of care on going. The Comprehensive Care plans for Physical Restraint, initiated on 07/10/2025, documented the resident will no longer required hand mittens due to improved behavior. Hand mittens were discontinued on 09/10/2025. The Registered Nurse note dated 09/10/2025 documented Resident #9 was reevaluated, no behavioral issues noted recently. Order was obtained from physician by a nursing supervisor to discontinue hand mittens and to continue 30-minute monitoring.Review of the medical record contained no documented evidence bilateral hand mittens for Resident #9 were released every 2 hours as per Physician's order. On 09/26/2025 at 10:35 AM, an interview was conducted with assigned Certified Nursing Assistant #7 who stated Resident #9's bilateral hand mittens were put in place as Resident #9 was agitated and restless. Certified Nursing Assistant #7 also stated they were not responsible for applying or monitoring the hand mittens, as they believe the nurses apply them. On 09/30/2025 at 10:07 AM, an interview was conducted with Licensed Practical Nurse #6 who stated hand mittens are generally monitored by the medication nurse and release of mittens is supposed to be documented on the Treatment Administration Record. Licensed Practical Nurse #6 could not explain why and how documentation of the application and removal hand mittens was not found on the Treatment Administration Record and stated maybe it had not been linked with the Treatment Administration Record so documentation could be done. On 09/30/2025 at 10:55 AM, an interview was conducted with Registered Nurse #2 who stated they do not give medication, however, supervise nursing staff. Registered Nurse #2 also stated hand mittens monitoring is documented on the Treatment Administration Record and signed for by medication nurse. Registered Nurse #2 further stated they reviewed Resident #9's record and could not find any documentation that the hand mittens were monitored. On 10/01/2025 at 03:43 PM, an interview was conducted with the Director of Nursing who stated they could not find documentation regarding monitoring of the hand mittens for Resident #9. The Director of Nursing also stated it is the responsibility of the nursing supervisor to ensure care plans, and all other relevant documentation is in place. The Director of Nursing further stated the Certified Nursing Assistant and medication nurses are supposed to monitor any physical restraint device, and this should be documented on both the Certified Nursing Assistant and Treatment records 10 NYCRR 415.11(c)(3)(i)