STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335606	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen of Peace Residence	110-30 221st Street Queens Village, NY 11429

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on record review and staff interviews conducted during the Recertification survey, the facility did not ensure a performance review of every nurse's aide was conducted at least once every 12 months and that regular in-service education was provided based on the outcome of these reviews. This was evident for all Certified Nursing Assistants reviewed for nurse aides' training requirements.The findings are:The facility did not provide a policy and procedure regarding certified nursing aides yearly performance reviewsOn 09/26/2025, Certified Nursing Assistants records were reviewed, and there was no documented evidence a performance review was conducted for any of the Certified Nursing Assistants.On 09/26/2025 at 4:42 PM, the Director of Nursing was interviewed and stated the facility does not have a policy and procedure for Certified Nursing Assistants performance review and subsequent regular in-service based on the performance review.On 09/29/2025 at 2:11 PM, the Administrator was interviewed and stated since the In-service Coordinator passed away, it was hard to find someone to replace them. The Administrator also stated the performance review and required in-service for Certified Nursing Assistants was not done. The Administrator further stated they are aware the performance review must be done first and then training provided for the Certified Nursing Assistants, however this was not done. 10 NYCRR 415.26(d)(8)(i)

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interviews conducted during the Recertification survey, the facility did not ensure that training requirements were met. This was evident for all certified nurse's aides. Specifically, there was no documented evidence certified nurse aides received no less than 12 hours per year of in-service training.The findings are:The facility did not provide a policy and procedure on nurse's aide training.On 09/26/2025 certified nurse's aides records were reviewed. There were no inservice records or lesson plans provided that certified nurse's aides received 12 hours in-service education in the past year. On 9/26/2025 at 4:42 PM, the Director of Nursing was interviewed and stated they have provided episodic in-service when problems occurred since they started working in the facility in December 2024. The Director of Nursing also stated the In-service Coordinator passed away suddenly in December 2024 and the position had not yet been filled. The Director of Nursing further stated they provided in-service on the Health Insurance Portability and Accountability Act, Quality Assurance, infection prevention, antibiotic stewardship, workplace violence, harassment, corporate compliance and fire safety only.On 9/29/2025 at 2:11 PM, the Administrator was interviewed and stated it has been hard to find someone to replace the in-service coordinator. The Administrator also stated they have had in-service with all staff but the required mandatory in-service trainings for certified nurse aides were not done.10 NYCRR 415.26(d)8(vi)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the Recertification survey, the facility did not ensure residents were provided the proper treatment and assistive devices to maintain vision abilities. This was evident for 1 (Resident #16) of 1 resident reviewed for Communication-Sensory, out of a sample of 16 residents. Specifically, there was no documented evidence a follow up Ophthalmology consult was done for Resident #16 who had high intraocular pressure. The findings are:The facility did not have a policy related to following up on residents' medical consults.Resident #16 had diagnosis of Bilateral Ocular Hypertension, Dry Eye Syndrome of Bilateral Lacrimal Glands, and Hypertension.The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #16 had intact cognition, impaired vision, and used corrective lenses.On 09/24/2025 at 10:21 AM, Resident #16 was interviewed and stated they have not seen an eye doctor since the COVID-19 pandemic, and they cannot see well with their eyeglasses.The Comprehensive Care Plan related to Vision dated 07/27/2017 and last reviewed 08/02/2025 documented increased bilateral intraocular pressure (rule out Glaucoma). The goals included Resident #16 will verbalize ability to see adequately thru next review. Interventions included instruct Resident #16 to notify staff if having difficulty seeing, monitor for further signs of poor vision, and provide eye appointments as per physician orders.An Ophthalmology consult dated 08/28/2024 documented intraocular pressure too high. Begin Timolol eye drops both eyes every morning. Recommendations to return in 2 months for intraocular check.A nursing progress note written by the Assistant Director of Nursing dated 08/28/2024 documented Resident #16 returned from an outside eye doctor appointment. Consult documented intraocular pressure high, follow up in 2 months for intraocular pressure check. Physician will review eye doctor's consult tomorrow morning on 08/29/2024.A physician's progress note dated 08/29/2024 documented status post ophthalmology. To begin Timolol eye drops and follow up with Ophthalmology.The Physician's Orders with active order date of 11/05/2024 documented Ophthalmology consult and as needed follow up.The Physician's Order dated 12/29/2024 with active orders date of 11/05/2024 documented Timoptic Ophthalmic Solution 0.5 % (Timolol Maleate Ophthalmic) Instill 1 drop in both eyes one time a day for lower intraocular pressure. Hold for apical pulse under 55.There was no documented evidence that a follow up Ophthalmology consult was done.On 09/29/2025 at 11:13 AM, the Assistant Director of Nursing was interviewed and stated Resident #16 has not been back to the Ophthalmologist since their last consult on 08/24/2024. The Assistant Director of Nursing also stated it was an oversight Resident #16 did not return for a follow up visit.On 09/30/2025 at 12:36 PM, the Director of Nursing was interviewed and stated when the physician orders a consult the Assistant Director of Nursing starts the process by filling out the heading on a consult form then gives this form to the Medical Secretary. The Medical Secretary calls the doctor's office and makes the appointment, and arrangements are made for transportation to the appointment. The Director of Nursing also stated they are unable to explain why Resident #16 did not have their follow up Ophthalmology consult as they were not working in the facility at that time.10 NYCRR 415.12

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, interviews, and record review conducted during the Recertification survey, the facility did not ensure that the results of the most recent health survey were posted in a place readily accessible to residents, visitors, or legal representatives of residents. Specifically, upon review of the survey binders on the 1st and 2nd floor, the facility did not have the health survey results for the Recertification Survey conducted from 06/13/2023 to 06/20/2023 included in the survey binder. The findings are:The facility did not have a policy related to posting the most recent health survey results.During multiple observations during the survey, the survey binders were observed by the reception area and in the 2nd floor library. The binders contained Recertification Life Safety survey results for 11/22/2021 and 6/20/2023, and Recertification Health Survey results for 11/22/2021 only.On 09/25/2025 at 10:00 AM, twelve (12) members of the Resident Council were interviewed and stated they had not personally observed or read the survey results in the facility. Resident #23 stated there is a notice on the main floor which is posted in a glass case by the gift shop on where to locate survey results.On 09/29/2025 at 3:29 PM, the Recreation Director was interviewed and stated they were not aware the 2023 health survey results were not in the binders. The Recreation Director also stated the Social Worker, or the Administrator is responsible for posting the survey results. On 09/29/2025 at 3:56 PM, the Social Worker was interviewed and stated the Administrator is responsible for putting survey results in the binder.On 9/30/25 at 2:19 PM, the Administrator was interviewed and stated they were not aware the 06/13/2023 to 06/20/2023 survey results were not in the binders. The Administrator further stated it was an oversight that the results were not posted within the facility.10 NYCRR 415.3(d)(1)(vi)