

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335737	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2025
NAME OF PROVIDER OR SUPPLIER West Lawrence Care Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 1410 Seagirt Blvd 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)
<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>48907</p> <p>Based on observation, record review, and interviews during an abbreviated survey, (NY00325381), the facility did not ensure the resident's right to be treated with respect and dignity including the right to be free from physical or chemical restraints imposed for the purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. This was evident for one (1) out of three (3) residents sampled (Resident #1). Specifically, on 10/04/2023, Registered Nurse Supervisor #1 documented received a call from License Practical Nurse #1 at approximately 8:20 AM. License Practical Nurse #1 and Certified Nursing Assistant #1 stated Resident #1's left arm was tied to the siderail of the bed with a sock. Registered Nurse Supervisor #1 interviewed Resident #1 and Resident #1 stated they were tied up all night and was experiencing pain. There were no signs of bruised or injuries and an x-ray was ordered.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Resident Abuse, Neglect and Exploitation revised 04/2023, documented the facility ensures all residents are free from abuse, neglect, misappropriation of resident property and exploitation. This also includes the right to be free from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>The facility's Policy and Procedure titled, Physical Restraints revised 10/2024, documented the facility recognizes and respects the right of their residents to be free from physical and chemical restraints unless its use is medically indicated and permitted under applicable laws, guidelines, and standards.</p> <p>Resident #1 was admitted to the facility with diagnoses including Hypertension (high blood pressure), Hyperlipidemia (a condition characterized by abnormally high levels of fats in the blood), Age related muscle weakness with severe contractures to digits on the left hand.</p> <p>The Minimum Data Set (an assessment tool), dated 09/13/2023, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderately impaired cognition.</p> <p>(continued on next page)</p>

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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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's investigation dated 10/16/2023, documented on 10/04/2023 at approximately 8:15 AM, Certified Nursing Assistant #1 observed Resident #1's left arm tied with a sock to the siderail of the bed. They removed the sock immediately and reported it to License Practical Nurse # 1. Resident #1 was interviewed by the Social Worker #1, and they reported their arm was tied with a sock to the side rail all night. The facility's investigation revealed Certified Nursing Assistant #3 was assigned to Resident #1 on the 11:00 PM -7:00 AM shift, and the surveillance video showed they did not provide any activity of daily living care to Resident #1. On 10/04/2023 at approximately 12:00 PM, Certified Nursing Assistant #4 reported to the Director of Nursing that Certified Nursing Assistant #2 called the facility at approximately 9:00 AM requesting that Certified Nursing Assistant #4 untie Resident #1's hand from the siderail. The Facility's investigation concluded restraints were used.</p> <p>The x-ray results dated 10/04/2023 documented no obvious fracture or dislocation.</p> <p>Employee Statement of Occurrence (no date specified) by Certified Nursing Assistant #3 documented at 11:00 PM, when monitoring residents, (no date was provided) Resident #1. Was okay. Certified Nursing Assistant #3 did not notice anything unusual. Resident #1 appeared to be clean and dry and did not need to be changed.</p> <p>Employee Statement of Occurrence dated 10/04/2023, by Registered Nurse Supervisor #1 documented they received a call from License Practical Nurse #1 at approximately 8:20 AM, License Practical Nurse #1 and Certified Nursing Assistant #1 stated that they observed Resident #1's left arm tied to the bed rail with a sock. Registered Nurse Supervisor #1 interviewed Resident #1 and Resident #1 stated they were tied up all night and was experiencing pain. Physical assessment done and no bruises were noted, and an x-ray was ordered.</p> <p>Untitled statement dated 10/04/2023 by Certified Nursing Assistant #2 documented they did not restrain Resident #1 on 10/03/2023.</p> <p>Untitled statement dated 10/05/2023, by Receptionist documented on 10/04/2023 at approximately 8:45 AM, Certified Nursing Assistant #2 called the facility asking to speak to Certified Nursing Assistant #4. Statement further documented Certified Nursing Assistant #2's tone sound urgent.</p> <p>Employee Statement of Occurrence dated 10/12/2023, by Certified Nursing Assistant #1 documented on 10/04/2023 at 8:30 AM, Certified Nursing Assistant #1 observed Resident #1 soaked with urine and their left hand was tied to the siderail of the bed.</p> <p>During an interview on 12/31/2024 at 11:17 am, Resident #1 stated the staff does not disrespect them and that they have never tied their wrist.</p> <p>Several attempts made to interview Certified Nursing Assistant #1 but was unsuccessful, letter sent on 01/13/25.</p> <p>Several attempts made to interview Certified Nursing Assistant #3 but was unsuccessful, letter sent on 01/13/25.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 01/13/2025 at 1:31 PM, License Practical Nurse #1 stated Certified Nursing Assistant #1 reported to them on 10/04/2023 (can't recall the time) that Resident #1's left arm was observed tied to the bedrail with a sock. Certified Nursing Assistant #1 had removed the sock, and they did not observe any bruises to Resident #1's skin. License Practical Nurse #1 stated they reported it to their supervisor immediately.</p> <p>During a telephone interview on 01/13/2025 at 1:50 PM, Certified Nursing Assistant #4 stated they were sitting at the nurse's station when they answered a call on the facility's phone. Certified Nursing Assistant #4 stated it was approximately 9:00 AM and Certified Nursing Assistant #2 asked them if they can check on Resident #1. Certified Nursing Assistant #4 stated Certified Nursing Assistant #2 stated they tied Resident #1's hand. Certified Nursing Assistant #4 stated they did not witness Resident #1's hand tied, and they reported to their supervisor what Certified Nursing Assistant #2 told them.</p> <p>During a telephone interview on 01/21/2025 at 10:45 AM, Certified Nursing Assistant #2 stated they were assigned to Resident #1 on the 3:00 PM-11:00 PM shift 10/03/2023. They denied restraining Resident #1. Certified Nursing Assistant #2 stated they went back to Resident #1's room at 10:00 PM to check to see if Resident #1's incontinent brief was dry. They stated they pulled the sheet and Resident #1's incontinent brief was dry, and they did not observe anything on Resident #1. They stated they did not call or speak to anyone at the facility on 10/04/2023.</p> <p>During a telephone interview on 01/28/2025 at 11:36 AM, Social Worker stated Registered Nurse Supervisor #1 informed them on 10/04/2023 (can't recall the time) that Resident #1's wrist was tied with a sock to the bedrail. Social Worker stated they met with Resident #1 (on the same day, can't recall the time) and Resident #1 stated their hand was tied to the siderail with a sock all night and they were experiencing pain. Social Worker also stated Resident #1 stated they weren't changed all night.</p> <p>During a telephone interview on 01/28/2025 at 11:50 AM, Director of Nursing stated they concluded Certified Nursing Assistant #2 restrained Resident #1 because Certified Nursing Assistant #2 was the last known staff that cared for Resident #1. Certified Nursing Assistant #3 was assigned to Resident #1 on the 11:00 PM-7:00 AM shift and admitted to not providing care to Resident #1. Director of Nursing stated Certified Nursing Assistant #2 called the facility on 10/04/2023 and spoke to Certified Nursing Assistant #4. They reviewed the surveillance video and observed Certified Nursing Assistant #4 rushing to Resident #1's room after speaking on the phone.</p> <p>During a telephone interview on 01/28/2025 at 2:44 PM, the Administrator stated they were away and received a call from the facility informing them of the incident in October 2023 (can't recall date or time). They stated Certified Nursing Assistant #2 was removed from the schedule immediately and was later terminated.</p> <p>10 NYCRR 415.4(a) (2-7)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>48907</p> <p>Based on observation, record review, and interviews during an abbreviated survey (NY00325381), the facility did not ensure that a resident who is unable to carry out activities of daily living received the necessary services to maintain good personal hygiene. This was evident for one (1) out of three (3) residents sampled (Resident #1) Specifically, on 10/03/2023 during the 11:00 PM-7:00 AM shift, Certified Nursing Assistant #3 stated they did not provide personal care to Resident #1 because they forgot and falsely documented care was provided. The surveillance video was reviewed and confirmed that Certified Nursing Assistant #3 did not provide any activity of daily living care to Resident #1. On 10/04/2023 at 8:30 AM, Resident #1 was observed saturated with urine. Certified Nursing Assistant #3 was terminated.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Resident Abuse, Neglect and Exploitation revised 04/2023, documented the facility ensures all residents are free from abuse, neglect, misappropriation of resident property and exploitation.</p> <p>The facility's Policy and Procedure titled Activities of Daily Living Protocol revised 01/2023, documented the facility will implement measures to assess the resident's ability to perform activity of daily living and based on the assessment, implement treatment and services for resident's needs to maintain, improve and prevent decline.</p> <p>Resident #1 was admitted to the facility with diagnoses including Hypertension (high blood pressure), Hyperlipidemia (a condition characterized by abnormally high levels of fats in the blood), and Age related muscle weakness.</p> <p>The Minimum Data Set (an assessment tool), dated 09/13/2023, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderately impaired cognition.</p> <p>The Comprehensive Care Plan titled: Activity of Daily Living Tasks dated 08/07/2023, documented interventions to provide incontinent care.</p> <p>Resident Nursing Instructions dated 07/19/2022, documented Resident #1 was incontinent of bowel and bladder, and they required dependent assistance by staff for incontinent care every shift.</p> <p>The facility's investigation dated 10/16/2023, documented at approximately 8:15 AM on 10/04/2023, Certified Nursing Assistant #1 observed Resident #1 saturated with urine when they went to provide personal care. Initially, Certified Nursing Assistant #3 provided the facility with a statement documenting that they did resident monitoring and Resident #1 did not require changing. The Director of Nursing interviewed Certified Nursing Assistant #3 who was assigned to Resident #1 during the 11:00 PM-7:00 AM shift, and they stated they did not render care to Resident #1 because they forgot. The surveillance video was reviewed and confirmed that Certified Nursing Assistant #3 did not provide any activity of daily living care to Resident #1. Certified Nursing Assistant #3 was terminated on 10/04/2023, for confirmed patient neglect and mistreatment as well as falsification of documentation.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employee Statement of Occurrence (no date specified) by Certified Nursing Assistant #3, documented Certified Nursing Assistant #3 did resident monitoring at 11:00 PM (no date provided) and checked on Resident #1. Resident #1 stated they were okay. Certified Nursing Assistant #3 did not notice anything unusual. Resident #1 appeared to be clean and dry, and they did not need to be changed.</p> <p>Employee Statement of Occurrence dated 10/12/2023 by Certified Nursing Assistant #1 documented on 10/04/2023 at 8:30 am, Certified Nursing Assistant #1 observed Resident #1 soaked with urine.</p> <p>During an interview on 12/31/2024 at 11:17 am, Resident #1 stated the staff does not disrespect them.</p> <p>Several attempts made to interview Certified Nursing Assistant #1 but was unsuccessful, letter was sent on 01/13/2025.</p> <p>Several attempts made to interview Certified Nursing Assistant #3 but was unsuccessful, letter was sent on 01/13/2025.</p> <p>During a telephone interview on 01/28/2025 at 11:36 AM, Social Worker stated Resident #1 reported to them that they weren't changed all night.</p> <p>During a telephone interview on 01/28/2025 at 11:50 AM, Director of Nursing stated Certified Nursing Assistant #3 was assigned to Resident #1 on the 11:00 PM-7:00 AM shift and admitted to not providing care to Resident #1.</p> <p>During a telephone interview on 01/28/2025 at 2:44 PM, the Administrator stated they were away and received a call from the facility informing them of the incident in October 2023 (can't recall date or time).</p> <p>10 NYCRR 415.12(a)(3).</p>		