STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335737	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Lawrence Care Center, L L C	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 6Number of residents cited: 1Based on record review and staff interviews conducted during a Recertification and Complaint (759838) survey, the facility did not ensure that each resident is free from abuse, neglect, and corporal punishment of any type by anyone. This was evident for 1 (Resident #13) out 6 residents reviewed for Abuse. Specifically, Resident #13 was bit on their right arm by Certified Nursing Assistant #2 while being assisted with Activities of Daily Living on 03/23/2025. The findings include: The facility's policy and procedure titled Resident Abuse, Neglect, & Exploitation with effective date 3/2013 and last review date 1/2025 stated the facility is to ensure all residents are free from abuse, neglect, misappropriate of resident property, and exploitation. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. The policy also stated the responsible person for Abuse Prohibition is the Director of Nursing. The policy further stated all prospective employees will be screened prior to employment to rule out any history of abuse, neglect or mistreatment or resident. All employees would be trained on abuse prevention policy. All incidents will be investigated. The facility will report all incident or violations where abuse, neglect, mistreatment of misappropriation of property suspected to New York State Department of Health according to protocol.Resident #13 had diagnoses including Hemiplegia, Vascular dementia, and Aphasia. The Annual Minimum Data Set assessment dated [DATE] documented Resident #13 had severely impaired cognition, had no behavior symptoms, no rejection of care and was dependent on staff for Activities of Daily Living. The Nursing note dated 3/23/2025 documented that Resident #13 stated they had been bitten by Certified Nursing Assistant #2. The Nursing note also documented Certified Nursing Assistant #2 admitted biting Resident #13 with a towel placed over Resident #13's right arm. The Nursing note further documented redness, and a bite mark was observed on Resident #13's right arm.The Employee Statement by Certified Nursing Assistant #2 documented they placed a towel over Resident #13's right arm and bit Resident #13's right arm through the towel.The Facility Investigation Report dated 3/28/2025 documented there was reasonable cause to believe that abuse, neglect, or mistreatment occurred. The facility investigation report documented Resident #13 reported Certified Nursing Assistant #2 bit them. Certified Nursing Assistant #1 who was assigned to Resident #13 stated they asked Certified Nursing Assistant #2 for assistance as Resident #13 required 2-person assistance. Certified Nursing Assistant #1 witnessed a conversation between Resident #13 and Certified Nursing Assistant #2, in which Certified Nursing Assistant #2 told Resident #13 that if you bite me, I will bite you back. Certified Nursing Assistant #1 stated Resident #13 had tendencies to attempt to bite staff and could be resistive and combative during care at times. The facility investigation report documented Certified Nursing Assistant #1 observed Certified Nursing Assistant #2 place a towel on Resident #13's right arm as part of care. Certified Nursing Assistant #1 removed the towel after care and noticed redness and impressions on Resident #13's right arm. Certified Nursing Assistant #1 immediately reported the finding to the nurse on the unit. Certified Nursing Assistant #1 stated they did not witness Certified Nursing Assistant #2 biting Resident #13. The facility investigation report documented Certified Nursing Assistant #2 stated Resident #13 bit their right arm and that why they bit Resident #13 back. It also documented Certified Nursing Assistant #2 stated the placed their mouth over a towel on Resident #13's right arm and bit Resident #13. Licensed Practical Nurse #1 checked on Resident #13 and noticed redness on Resident #13's right arm after receiving report from Certified Nursing Assistant #1. Registered Nurse #1 assessed Resident #13 and interviewed all parties involved. The facility investigation report documented Certified Nursing Assistant #2 acknowledged biting Resident #13. It also documented 911 was called and police officers came and then left without arresting anyone. It further documented Certified Nursing Assistant #2 was suspended pending the outcome of the investigation.The Criminal History Record Check Termination Notice (Form 105) documented Certified Nursing Assistant #2 was terminated from the Criminal History Record Check Program on 3/25/2025. On 07/30/2025 at 10:05 AM, Certified Nursing Assistant #2 was interviewed and stated Resident #13 tried to bite them during care and they told Resident #13 that they would bite back if Resident #13 did so. Certified Nursing Assistant #2 admitted they placed a piece of towel on Resident #13's right arm and put their mouth on the towel. Certified Nursing Assistant #2 stated they just played with Resident #13 and did not bite Resident #13. On 07/30/2025 at 9:29 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #13 had intact skin and no redness

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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	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** Number of residents sampled: 4Number of residents cited: 2 Based on record review and interview conducted during the Recertification and Complaint Survey (759831), the facility did not ensure all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegations were made, to the State Survey Agency. This was evident for 2 (Resident #51 & Resident #104) of 4 resident reviewed for Abuse out of 34 total sampled residents. Specifically, the facility's incident report documented that on 11/11/2024 at 10:00 AM, Resident #51 hit Resident #104 with the leg rest of Resident #51's wheelchair, accusing them of stealing underwear. The Administrator was first made aware of the incident on 11/11/2024 at 10:45 AM, and the facility did not report the abuse allegation to the New York State Department of Health until 11/11/2025 at 02:52 PM.The findings are:The facility's policy titled Resident Abuse, Neglect, & Exploitation, effective 03/13, last reviewed 01/2025 stated the Administration/Director of Nursing is responsible to report immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in seriously bodily injury, to the Administrator of the facility and to other officials in accordance with State law through established procedure.Resident #51 was admitted to the facility with diagnoses that include Non-Alzheimer's Dementia, Anxiety Disorder, and Schizophrenia.The Annual Minimum Data Set assessment dated [DATE] documented Resident #51 had severely impaired cognition, and had no behavioral symptoms directed towards others.Resident #104 was admitted to the facility with diagnoses that include End Stage Renal Disease and Depression.The Annual Minimum Data Set assessment dated [DATE] documented Resident #51 had short and long-term memory impairment and had no behavioral symptoms directed towards others.A Nurse's note dated 11/11/24 documented the New York City Police Department was notified of the altercation, 2 officers reported to facility from precinct and Resident #51 to be transferred to the hospital for psychiatric evaluation and departed the facility at 3:35 PM.The facility's report titled Occurrence Report, dated 11/11/24 at 10:00 AM, documented Resident #51 accused Resident #104 of stealing underwear. Resident #51 used the leg rest of the wheelchair to hit Resident #104 on their leg. Both residents were evaluated and denied any injuries. An emergency code was called, and the residents were separated. Both residents were evaluated and there were no visible injuries. Resident #51 was transferred to the hospital for evaluation. The Nursing Home Facility Incident Report documented that the incident occurred on Monday, 11/11/2024 at 10:00 AM, the Administrator was first made aware of the incident on Monday, 11/11/2024 at 10:45 AM, and the Director of Nursing reported the altercation to the New York State Department of Health on Monday 11/11/2024 at 14:52.On 08/04/2025 at 4:09 PM, the Administrator was interviewed and stated that they were made aware when the resident-to-resident interaction occurred. The Administrator also stated that the Director of Nursing that reported the altercation no longer works with the facility, but that they do not recall if the regulations state that all resident-to-resident interactions are to be reported within 2 hours. 10 NYCRR 415.4(b)(2)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification and Complaint (759832) survey conducted from 7/28/2025 to 8/02/2025, the facility did not ensure that they permitted each resident to remain in the facility, and did not transfer or discharge the resident from the facility unless the transfer or discharge was necessary for the resident's welfare and the resident's needs cannot be met in the facility. This was evident for 1 (Resident #151) out of 5 reviewed for Choices out of a sample of 34 residents. Specifically, Resident #151 was not permitted to return to the facility after they went out on pass and returned late and was instead transferred to the hospital. In addition, the facility failed to provide any documentation regarding Against Medical Advice status or a discharge notice provided to the resident prior to hospital transfer. The findings included:The facility policy Out on Pass with Responsible Party/Leave of Absence reviewed 7/10/2024 documented to enable residents to safely enjoy and spend quality time outside the confines of the facility, [NAME] Center to grant temporary leave form the facility (Out on Pass/Leave of Absence). This temporary leave is granted upon request by either resident or family/responsible party after assessment by the Interdisciplinary Team. A resident leaving the facility other than going for scheduled or approved medical purposes is considered as Out on Pass/Leave of Absence. Out on Pass maybe in the form of a day pass (before midnight) or overnight pass (after midnight). Residents who go Out on Pass with Responsible Party must return prior to midnight. Failure to return by midnight will be considered a voluntary Against Medical Advice and be discharged from our facility. If resident wishes to be readmitted resident must go to the Hospital and obtain a Patient Review Instrument for admission. The interdisciplinary team may also specify the number of hours a resident may go Out On Pass with Responsible Party based on their specific medical status, care needs, diet order and medication/treatment regimen. The facility policy and procedure Discharge Planning dated 01/2025 stated the facility will transfer or discharge resident only when such transfer or discharge is made in recognition of the resident's right to receive considerate and respectful care, to receive necessary care and services, and to participate in the development of the comprehensive care plan and in recognition of the residents rights of other resident in the facility. The policy also stated the facility will transfer or discharge a resident only when the interdisciplinary team, in consultation with the resident or the resident designated representative determines that: transfer or discharge necessary for the residents welfare and the residents needs cannot be met after reasonable attempts at accommodation in the facility. Resident # 151 was admitted to the facility with diagnoses that included Anxiety disorder, Osteoarthritis of knee, and Pain. The Quarterly Minimum Data Set assessment dated [DATE] and 07/09/2025 documented Resident #151 had intact cognition, required supervision or touching assistance with eating and participated in assessment and goal setting.The Annual Minimum Data Set assessment dated [DATE] documented in Section F Preferences for Customary Routines and Activities that it was very important to do their favorite activities and things with groups of people. The Physicians order initiated on 6/3/2022, last renewed on 7/16/2025 documented Resident #151 can go out on pass with a responsible party. The Nursing Progress notes dated 11/1/2024 documented at 10:17 PM, Resident went out of pass during 3 PM -11 PM shift for daughter's wedding. Resident did not return as of 10:15 PM, 3 PM-11 PM shift endorse to 11 PM-7 PM shift to follow up on return, The Nursing progress note dated 11/1/2024 at 11:56 PM, documented at 11:49 PM, Resident did not return from out on pass, call placed to emergency contact #4 that picked resident up message left with reminder that resident must be back in the facility prior to 12 AM. The Nursing progress note dated 11/2/2024 at 12:09 AM, documented 11:56 PM another call placed to emergency contact #4 was unanswered. Reminder message left that resident must be back prior to 12 AM for acceptance back to the facility. Attempt made to call emergency contact #1 was unsuccessful, Social Worker informed. The Nursing progress note written by Registered Nurse #5 on 11/2/2024 at 1:09 AM documented at 12:35AM call received from front desk the resident arrives outside the facility and wants to speak with writer. Resident noted sitting in wheelchair in entry area alone without responsible party. When asked for responsible party that he returned with the resident stated she is gone, she is incapacitated car noted reversing form driveway. Resident #151 was reeducated that Out On Pass protocol is that return must be done prior to 12 AM and if not, is considered as a voluntary Against Medical Advice so the responsible returning party would need to resume responsibility. Resident #151 was notably upset, the former Director of Nursing and Director Social Worker were notified. The Director of Social Work stated that resident has to return with party, or if left alone