

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER N Y S Veterans Home IN N Y C		STREET ADDRESS, CITY, STATE, ZIP CODE 178 50 Linden Blvd Jamaica, NY 11434	
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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on record review and interviews conducted during the Recertification and Abbreviated (NY00334937) survey from 5/9/2024 to 5/16/2024, the facility did not ensure services provided met professional standards. This was evident for 1 (Resident #24) of 38 total sampled residents. Specifically, Licensed Practical Nurse #5 did not inform the Registered Nurse and Medical Doctor when Resident #24 had a fall incident. The findings are: The facility's policy titled Standards of Nursing Practice and Nursing Care dated 1/22/2022 documented standards of care employed by the nurse includes implementing nursing actions and interventions that promote, maintain, and or restore physical and mental health, prevent illness, and effect rehabilitation and recovery and/or enhance quality of life. Resident #24 had diagnoses of cerebral infarction and atrial fibrillation. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #24 had severely impaired cognition. A Nursing Note dated 3/1/2024 documented Registered Nurse #3 received a report from Resident #24 and their roommate that Resident #24 fell on [DATE] at night while attempting to transfer to their wheelchair. The residents reported that a male staff member responded to the roommate's call bell and assisted Resident #24 back to bed. The facility Investigation Report dated 3/5/2024 documented Licensed Practical Nurse #5 and Certified Nursing Assistant #10 failed to follow facility policy and did not inform a nursing supervisor when Resident #24 sustained a fall, delaying the resident's care. There was no documented evidence Licensed Practical Nurse #5 informed the Registered Nurse supervisor and the Medical Doctor when Resident #24 sustained a fall on 2/29/2024, delaying evaluation and assessment necessary to determine Resident #24's condition. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 3:44 PM, Certified Nursing Assistant #10 was interviewed and stated Licensed Practical Nurse #5 called them to Resident #24's room on 2/29/2024 and Certified Nursing Assistant #10 observed Resident #24 sitting on the floor. Licensed Practical Nurse #5 instructed Certified Nursing Assistant #10 to assist with getting Resident #24 back into bed. Certified Nursing Assistant stated they did not know Licensed Practical Nurse #5 did not report the incident to the nursing supervisor. On 05/14/2024 at 10:18 AM, Registered Nurse #3 was interviewed and stated they were the nurse manager on 3/1/2024 when Resident #24 and their roommate reported that Resident #24 fell on the floor on 2/29/2024. Certified Nursing Assistant #10 and Licensed Practical Nurse #5 transferred Resident #24 back to bed without informing the Registered Nurse supervisor so that Resident #24 received the necessary assessment of their condition. Upon inquiry, Certified Nursing Assistant #10 admitted they assisted in transferring Resident #24 back to bed following their fall in 2/29/2024. Licensed Practical Nurse #5 initially denied that Resident #24 fell but eventually admitted they did not inform the Registered Nurse supervisor when the resident fell . On 05/15/2024 at 10:20 AM, the Director of Nursing was interviewed and stated staff were responsible for reporting resident falls to the Registered Nurse and Medical Doctor to ensure the resident receives an assessment. Licensed Practical Nurse #5 and Certified Nursing Assistant #10 did not follow the facility's policy and placed Resident #24 back into bed without informing a Registered Nurse. Licensed Practical Nurse #5 was placed on administrative leave and has not returned to work. 10 NYCRR 415.11(C)(3)(i)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876 Based on record review and interviews conducted during the Recertification and Abbreviated (NY00334937) survey from 5/9/2024 to 5/16/2024, the facility did not ensure a resident received quality of care. This was evident for 1 (Resident #24) of 38 total sampled residents. Specifically, Licensed Practical Nurse #5 did not inform the Registered Nurse when Resident #24 sustained a fall, delaying an assessment of the resident's condition and potential injuries. The findings are: The facility's policy titled Standards of Nursing Practice and Nursing Care dated 1/22/2022 documented standards of care employed by the nurse includes implementing nursing actions and interventions that promote, maintain, and or restore physical and mental health, prevent illness, and effect rehabilitation and recovery and/or enhance quality of life. Resident #24 had diagnoses of cerebral infarction and atrial fibrillation. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #24 had severely impaired cognition. A Nursing Note dated 3/1/2024 documented Registered Nurse #3 received a report from Resident #24 and their roommate that Resident #24 fell on [DATE] at night while attempting to transfer to their wheelchair. The residents reported that a male staff member responded to the roommate's call bell and assisted Resident #24 back to bed. The facility Investigation Report dated 3/5/2024 documented Licensed Practical Nurse #5 and Certified Nursing Assistant #10 failed to follow facility policy and did not inform a nursing supervisor when Resident #24 sustained a fall, delaying the resident's care. There was no documented evidence Licensed Practical Nurse #5 informed their Registered Nurse supervisor when Resident #24 sustained a fall on 2/29/2024, delaying evaluation and assessment necessary to determine Resident #24's condition and potential injuries. On 05/14/2024 at 3:44 PM, Certified Nursing Assistant #10 was interviewed and stated Licensed Practical Nurse #5 called them to Resident #24's room on 2/29/2024 and Certified Nursing Assistant #10 observed Resident #24 sitting on the floor. Licensed Practical Nurse #5 instructed Certified Nursing Assistant #10 to assist with getting Resident #24 back into bed. Certified Nursing Assistant stated they did not know Licensed Practical Nurse #5 did not report the incident to the nursing supervisor. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/2024 at 10:18 AM, Registered Nurse #3 was interviewed and stated they were the nurse manager on 3/1/2024 when Resident #24 and their roommate reported that Resident #24 fell on the floor on 2/29/2024. Certified Nursing Assistant #10 and Licensed Practical Nurse #5 transferred Resident #24 back to bed without informing the Registered Nurse supervisor so that Resident #24 received the necessary assessment of their condition. Upon inquiry, Certified Nursing Assistant #10 admitted they assisted in transferring Resident #24 back to bed following their fall in 2/29/2024. Licensed Practical Nurse #5 initially denied that Resident #24 fell but eventually admitted they did not inform the Registered Nurse supervisor when the resident fell . On 05/15/2024 at 10:20 AM, the Director of Nursing was interviewed and stated staff were responsible for reporting resident falls to the Registered Nurse and Medical Doctor to ensure the resident receives an assessment. Licensed Practical Nurse #5 and Certified Nursing Assistant #10 did not follow the facility's policy and placed Resident #24 back into bed without informing a Registered Nurse. Licensed Practical Nurse #5 was placed on administrative leave and has not returned to work. 10 NYCRR 415.12		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observation, record review and interviews conducted during the Recertification and Complaint Survey (NY00336934 & NY0032139) from 5/9/2024 through 5/16/2024, the facility did not ensure that the resident environment remains as free of accident hazards. This was evident for 2 (Resident #72 and #33) of 38 total sampled residents. Specifically, 1) Certified Nursing Assistant #5 transferred Resident #72 without assistance and the resident required 2 person assistance for transfer, and 2) Resident #33 was not adequately supervised to prevent them from being found outside the building unsupervised on 8/2/2023 and from being missing for over an hour on 3/5/2024. The findings are: The Facility's Policy and Procedure titled Wandering and Elopement: Risk Assessment and Interventions dated last reviewed 5/2024, documented it is the policy of the home to ensure that the resident environment remains free as free from accident hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents. The policy further documented it is the responsibility of the Home to supervise all residents to ensure their safety and know their whereabouts. The Facility's policy and Procedure titled Policy for Safe patient Handling last revised 12/2016 documented all lifting and transferring of residents shall be performed utilizing the approved lift/transfer devices and methods to prevent resident and employee injury. the lift transfer shall be performed as determined by lift/transfer assessment as documented on comprehensive care plan, resident profile and Certified Nursing Assistant Accountability Record. There must be two caregivers present when using the total mechanical lift. Resident #72 was initially admitted to the facility on [DATE]. The Quarterly Minimum Data Set MDS dated [DATE] documented the resident's cognitive level is severely impaired. The resident needs total dependence and two assist for bed mobility, toilet use and transfer. The resident's diagnoses include dementia, PVD, hyperlipidemia and medically complex condition. Fall assessment dated [DATE] documented the resident is high risk for falls. Fall care plan initiated on 9/22/23 documented the resident needs two persons assist for Hoyer lift transfer. Care plan for Activities for Daily Living initiated on 9/22/23 and last updated on 03/23/24 documented two persons assist is needed for Hoyer lift transfer to reclining chair. The intervention as documented in the CCP was that nursing staff were to ensure two persons in application of Hoyer pad and removal. A Total of two staff for safety. Approach staff in a calm manner. Resident is confused and can be agitated and physically aggressive. If a resident is agitated during care, leave resident, monitor closely and reapproach him when he is calm. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing note dated 3/23/24 at 01:50 PM stated that the assigned Certified Nursing Assistant reported that the resident fell from the reclining chair to the floor while Certified Nursing Assistant was attempting to remove the Hoyer lift pad underneath the resident. Skin assessment reveled blanchable redness and closed blister noted to right upper back. Certified Nursing Assistant # 5 stated on 3/23/24 at 10:50 AM, He transferred resident #72 by himself to the reclining chair. The resident was seating down in the chair, and I proceeded to take the Hoyer lift pad from under him. I pulled him towards me and was able to get most of the pad away from him. Unfortunately, I attempted to remove the pad under his buttocks, the resident slipped off the chair onto the pillow placed under him. The facility's Investigation revealed that the Assigned Certified Nursing Assistant transferred the resident alone using Hoyer lift without assistance, failed to request additional assistance from nursing staff on the unit to assist him to provide care for resident. The resident is dependent on staff and two persons assist for activities of daily living. The plan of care was not followed. To conclude, the CNA failed to follow facility's policy on safe patient handling and failure to follow plan of care. There is reason to believe that evidence of neglect has occurred in the case. The New York Police department was informed of the incident. The facility's in-service records revealed Certified Nursing Assistant #5 received training on safe patient handling on 12/15/23. On 05/14/24 at 03:37 PM, Certified Nursing Assistant #3 stated that Certified Nursing Assistant #5 did not ask for help. The resident needs two persons assist for Hoyer lift transfer. The Hoyer lift the pad should stay on the chair. It should not be removed unless it is causing discomfort for the resident. Certified Nursing Assistant #3 stated that two CNAs have to be with the resident from the beginning of transfer until the resident is safely positioned on the recliner chair. We need two Certified Nursing Assistant #3 to assist the resident for safety reasons. The plan of care call for two persons assists for Hoyer lift transfer. On 05/14/24 at 11:57 AM, Certified Nursing Assistant #5 stated that it is unknown to why the resident was transferred without assistance. Certified Nursing Assistant #5 stated that the resident is a long-term resident. Certified Nursing Assistant #5 stated that the protocol was not followed when the resident was transferred via Hoyer lift without help. Certified Nursing Assistant #5 stated that the resident was transferred safely to the reclining chair safely. When an attempt was made to remove the Hoyer lift pad under the resident buttocks, the resident slipped from the reclining chair to the floor. The charge nurse was informed of the resident being on the floor. Certified Nursing Assistant #5 further stated that the resident needs two people assist for Hoyer lift transfer from beginning to end of the transfer. Certified Nursing Assistant #5 further stated that the resident should have never been transferred without assistance from another nursing staff. Certified Nursing Assistant #5 stated that education on safe patient transfer was provided to all staff prior to the incident. Certified Nursing Assistant #5 apologized for the occurrence. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/24 03:43 PM, Registered Nurse #6 stated while passing out medications, Certified Nursing Assistant #5 reported the resident fell out of recliner chair when Certified Nursing Assistant #5 was attempting to remove the Hoyer lift pad under the resident. Registered Nurse #6 stated the resident was assessed along with RN # 4. Redness and closed blister we reobserved on right side of resident back. No discomfort noted. we transferred the resident to bed. The resident requires two persons assist for Hoyer lift transfer. Registered Nurse #6 further stated the assigned CNA was trained on safe transfers. The Certified Nursing Assistant did not follow the facility's protocol. The resident's care plan call for two persons assists. It is also reflected on the Activities of Daily living care plan and the Certified Nursing Assistant Accountability record. The CNA did not follow the plan of care for the resident. On 05/14/24 at 04:04 PM, Registered Nurse #4 stated that the RN Supervisor is responsible for supervising all nursing staff on the unit. Registered Nurse #4 stated that several rounds were made on the day of the incident. During rounds, Registered Nurse #4 overheard Certified Nursing Assistant #5 telling Registered Nurse #6 that the resident was on the floor. The resident was observed seating on the floor in front of the wheelchair. Certified Nursing Assistant #5 stated that he just finished transferring resident without help. When Certified Nursing Assistant # 5 attempted to remove the Hoyer lift pad under resident #72 and he slid off the chair. Registered Nurse # 4 further stated there were five other nursing staff on the unit to assist. The protocol is there should be two people from beginning of transfer to the end of transfer. Two staff members must always remain at patient side. Certified Nursing Assistant # 5 failed to follow the facility's policy for safe transfer. the resident sustained redness and a blister on his right back. Resident #72 had redness and blister from the friction. The resident had no other skin abnormalities prior to the incident. We concluded that the resident plan of care was not followed. Registered Nurse#4 also stated that the resident # 72 plan of care requires two persons assist for transfer. On 05/15/24 at 11:51 AM, the Director of Nursing Services stated that our policy is that all equipment used for transfer requires two persons assist. We always need two staff for transfer. The Director of Nursing Services stated when an aide must transfer a resident; the Aide has to get assistance from a second staff member for safety reasons. We do annual trainings on safe transfer. Certified Nursing Assistant # 5 was trained prior to the incident. We want the staff to remove the Hoyer lift pad after transfer with assistance because it may cause skin impairments. The staff still need another staff to remove the pad. It is always supposed to be two people. Everyone was trained on safety protocol. The Director of Nursing Services further stated that there were four other Certified nursing Assistants plus three nurses on the floor around that time. There is no good reason why Certified Nursing Assistant # 5 transfer the resident without help. 415.12 (h) (2) 41709 Resident #33 Accidents 2. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Policy and Procedure titled Wandering and Elopement: Risk Assessment and Interventions dated last reviewed 5/2024, documented it is the policy of the home to ensure that the resident environment remains free as free from accident hazards as is possible and that each resident receives adequate supervision and assistance to prevent accidents. The policy further documented it is the responsibility of the Home to supervise all residents to ensure their safety and know their whereabouts. Resident #33 was admitted to the facility on [DATE] with diagnoses including Post Traumatic Stress Disorder, Hypertension, Malignant Neoplasm of the Prostate, Wanderer, Diabetes, Non-Alzheimer's Dementia, and Insomnia. The Annual Minimum Data Set assessment tool dated 6/10/2023 and Quarterly Minimum Data Set assessment tool dated 2/3/2024 documented Resident #33 had severely impaired cognition. The resident required limited assistance of one person for bed mobility and transfers, supervision of eating and extensive assistance of one person from dressing, toilet use and personal hygiene. Both Minimum Data Set assessment tool documented the resident uses wheelchair for ambulation. The resident was observed on two occasions throughout this survey: On 05/09/24 at 12:51 PM, resident observed sitting in the dining area sitting in wheelchair eating in dining area. Resident able to wheelchair independently. 05/10/24 at 11:52 AM, Resident wheeling self-up and down the unit, wheeling towards the elevator pressing buttons, but not entering the elevator. Appropriately dressed in no distress. On 05/14/24 at 09:32 AM, and 05/16/24 at 11:04 AM, Resident not on the unit. Staff reporting resident fell and transfer to the hospital for evaluation and remains in the hospital. The resident annual elopement assessment dated [DATE] documented the resident was not at risk for elopement. Subsequent elopement assessments dated 8/2/2023 documented a score of 9 (8 or higher is considered high risk for elopement), and further documented the resident tends to wander thru out the building, requires wheelchair but can propel self, resident able to walk short distances, tends aimless seeking the social security office to collect resident check, has history taking the elevator to the basement. Fall risk assessment dated [DATE] documented score of 17 (score of 10 or higher considered high risk for falls) (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing progress notes dated 8/2/2024 documented Fall with injury, at 8:00 pm recreation personnel reported the resident is on the floor. Upon response resident observed outside the main front door on resident knees attempting to climb to the wheelchair with security guard and recreation staff standing by resident, ensuring resident will not fall again. Injuries to face observed upon approach, superficial abrasion above right eyebrow, right cheek and nose noted. According to recreation staff observed resident on the floor an as approach resident tried to get up and fell on face on the ground. Resident was agitated, refusing assistance, and attempting to stand and come out of the wheelchair while being assisted back to the unit. Body assessment done abrasion to right knee noted, skin injuries cleansed Bacitracin applied. Complain of knee pain Tylenol given. Neuro check done, no deviation. Doctor informed. Telephone order to transfer to emergency room for evaluation. Resident niece informed of Medical Doctor order to transfer to the hospital, resident left facility in stable condition, alert and responsive at 9:25 pm. Nursing progress notes dated 8/3/2023 at 3:31 pm documented approximately 10:00 am resident returned from [NAME] Hospital. Resident observed with abrasions/scabs' formation to right elbow, right cheek and nose and right knee abrasion. Resident received daily medications, administer by nurse. According to discharge notes: Computed Tomography scan of head, sinus maxilla facial bones without contrast, and x-ray of right and lateral head, medication administered Haldol and midazolam. Nurse Practioner informed. Resident placed on every 15 minutes monitoring and code alert placed to left ankle. A facility investigation dated 08/02/24 documented that on Wednesday August 2nd at 8:02 pm, staff heard a loud scream heard coming from the outside. On arrival outside observed the two-recreation staff (Activity staff #1 and #2) yelling about something. When arrived they saw resident #33 on the ground. The investigation further stated resident #33 was last seen by staff at 6:30 pm in the hallway, after given evening care. The investigation further documented the rounding monitoring was incorrect and the resident was not on the unit at 8:00pm. The investigation concluded the resident left by the main entrance and not any other entrance and was not redirected by the security guard. The report concluded the resident did not leave buy any other door because in the walk through the resident was unable to navigate through two doors, the door saddle and ramp. Residents sustain abrasion to face, elbow, and knees. Resident was transfer to the hospital with all negative results. The facility provided no documented evidence that the other exit out of the facility was monitored, and the alarm at the door was working on 8/2/2023. The facility provided monitoring logs dated 8/1/2023 and 8/3/2023 and stated unable to find any monitoring logs for 8/2/2023. There was no documented evidence that resident was monitored hourly before being found outside the facility. Physician order last recertified dated 3/1/2024 documented order for visual monitoring every 15 minutes Nursing progress notes dated 3/5/2024 documented received report resident was noted asleep in unoccupied bed on [NAME] unit overnight. Resident skin was assessed for abnormalities, no visible injuries noted. Resident had no recall due to cognitive impairment to what occurred and stated, I don't know what happened. Resident continues to wander on/off unit and redirected by staff as needed, on every 15 minutes monitoring. Resident niece was notified by writer. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Investigative summary dated 3/5/2024 documented resident was last seen by staff at 11:50 pm and reported missing by staff at 12:05 AM when assigned Certified Nursing Assistance was looking for resident to change. Resident was later found at 1:05 am sleeping on a closed unit. The investigation further documented the Certified Nursing Assistant did not document every 15 minutes monitoring as ordered and last documented at 11:30 am. Facility documented titled observation 15 min documented the resident was last seen at 11:30 am and was in room. There were no signatures on the documented from 11:45 PM to 7:15 AM. There was no documented evidence that resident #33 was adequately monitored hourly on 8/2/2023 and no documented evidence resident #33 was monitored every 15 minutes as ordered on 3/5/2024. On 05/14/24 at 10:12 AM, an interview was conducted with Nursing Supervisor Register Nurse #4. Nursing Supervisor Register Nurse #4 stated completed the investigation for the incident on 3/5/2024, when staff reported the resident was missing, and or not on the unit. Nursing Supervisor Register Nurse #4 stated the staff on unit reported the resident was reported missing at 12: 05 AM, and staff looked all over the building for the resident and eventually looked on the empty unit and the resident was found sleeping in an empty be in room [ROOM NUMBER] A. Nursing supervisor stated the resident who was on every 15 minutes monitoring was found at 1: 05 am. Nursing Supervisor Register Nurse #4 sated the resident wanders and is free to go on and off the unit, free to get on the elevators and go anywhere in the facility. Nursing Supervisor Register Nurse #4 stated the resident have a code alert attached to the resident wheelchair and if the resident goes to the basement security will get and alert, if the resident attempted to go through the doors on 1st floor the security will get an alert as well. Nursing Supervisor Register Nurse #4 has Post traumatic Stress Disorder, Impulse behaviors and cannot stay a constant place, always wants to go and get check about Social Security, and it staff attempts to restrain or stop the resident, the resident will get agitated, yells scream, attempt to roll over staff with the wheel chair, use profanity so staff have to back away, and allow the resident to go on the elevator and staff monitor. Nursing Supervisor Register Nurse #4 stated the resident is currently in the hospital secondary to two falls this weekend. Nursing Supervisor #4 stated when the resident was sleeping in another closed unit the Certified Nursing Assistant assigned did not do every 15 minutes monitoring as ordered. Nursing Supervisor Register Nurse #4 stated the last round was done at 11: 30 pm and the facility started looking for the resident at 12:05 AM. Nursing Supervisor Register Nurse #4 stated the Certified Nursing Assistant did not give an answer as to why the rounds were not completed during interview. Nursing Supervisor Register Nurse #4 stated was inserviced on elopement and stated knows the protocol for if a resident is missing and to communicate and inform all units right away so they can help locate the resident. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/14/24 at 02:55 PM, an interview was completed with Nursing Home Activity Assistant #1. Nursing Home Activity Assistant #1 stated was leaving the facility with colleague at 8:00 pm. Nursing Home Activity Assistant #1 stated saw an empty wheelchair was standing empty, and resident was on the ground right in front the building. Nursing Home Activity Assistant #1 immediately inform security and alert nursing. Nursing Home Activity Assistant #1 stated resident able to wheel self independently and when on the ground saw little blood on the resident face and stated told the resident to wait, called security and security came out and stay with the resident. Nursing Home Activity Assistant #1 stated the resident was on the ground and saw no one was around the area. Nursing Home Activity Assistant Nursing #1 stated nursing came and help the resident and check resident and was informed to write a statement and wrote the statement. Nursing Home Activity Assistant#1 stated the resident is known to staff and the resident can go on and off the unit independently, redirect as needed. Nursing Home Activity Assistant #1 stated was inserviced on elopement and missing resident. On 05/14/24 at 04:20 PM, a telephone interview was completed with Certified Nursing Assistant #4. Certified Nursing Assistant #4 stated was assigned to the resident on 3/5/2024. Certified Nursing Assistant #4 stated the night of 3/5/2024 the resident was on the unit at the time coming into the unit. Certified Nursing Assistant #4 stated took care of another resident and come back around to get the resident and resident was not there. Certified Nursing Assistant #4 started look around with coworkers to look for the resident. Certified Nursing Assistant #4 stated thought the resident was in the dining room but once was not there went to look on the other units. Certified Nursing Assistant #4 stated did go onto the empty and did see the wheelchair but did not see the resident in the wheelchair. Certified Nursing Assistant #4 stated was so used to seeing the resident in the wheelchair did not think to go into the room and investigate the bed to look for the resident. Certified Nursing Assistant #4 stated after looking for a while another coworker went and look on the same unit and found the resident sleeping in the bed with wheelchair at bedside. Certified Nursing Assistant #4 stated miss the resident and if would of gone into the room would of seen the resident sleeping in the bed. Certified Nursing Assistant #4 stated the resident was found after 1:00 am. Certified Nursing Assistant #4 stated the resident on 15 minutes watch and made a mistake of not documenting the 15 minutes watch on the resident, and stated this was just a mistake. Certified Nursing Assistant #4 stated was in-service on 15 minutes documentation, as well as for protocol regarding elopement. On 05/14/24 at 03:06 PM, an interview was completed with Nursing Home Activity Assistant #2. Nursing Home Activity Assistant #2 stated was going home a little after 8:00 pm on 8/2/2023 and saw a wheelchair upwards and there was no one in the chair. Nursing Home Activity Assistant #2 stated when look to the side of the wheelchair and saw the resident lying on the ground right outside the building. Nursing Home Activity Assistant #2 stated left colleague with the resident and alerted security and Nursing. Nursing Home Activity Assistant #2 stated security reported right away, and Nursing also came to assist the resident, and escorted the resident back to the unit. Nursing Home Activity Assistant #2 stated the resident is known throughout the facility because the resident goes up and down on the unit, in the lobby, basement. Nursing Home Activity Assistant #2 stated the resident was sent to the hospital. Nursing Home Activity Assistant #2 started was in-service on elopement and not aware of this resident ever trying to leave the facility before this incident. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER N Y S Veterans Home IN N Y C		STREET ADDRESS, CITY, STATE, ZIP CODE 178 50 Linden Blvd Jamaica, NY 11434	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/15/24 at 11:59 AM, an interview was completed with Register Nurse #5 on unit. Register Nurse #5 stated the resident have a diagnosis of Dementia with behaviors of wandering on and off the unit as well as other behaviors. Register Nurse #5 stated the resident have code alert in the wheelchair because the resident keeps cutting it off the Code alert. Register Nurse #5 stated the resident is allowed to go on and off unit, and the resident is not restricted form freedom. Register Nurse #5 stated the resident is allowed to go on and off the unit, and the Code alert works on the two exit doors on the first floor, as well as the basement area. Register Nurse #5 stated was aware when the resident fell outside in August 2023 and when resident was found sleeping on the bed in the closed unit. Register Nurse #5 stated the resident was on the closed unit before it was empty. Register Nurse #5 stated the staff supervise the resident and the resident is on every 15 minutes monitoring, and the closed unit now have an alarm , and if resident or staff entering the unit the alarm will sound. Register Nurse #5 stated resident remains on every 15 minutes monitoring. Register Nurse #5 stated that the resident goes on and off the unit independently by wheeling in the wheelchair, and all staff is aware of the resident and redirects the resident as needed. Register Nurse #5 stated if staff attempts to redirect the resident, the resident will roll the wheelchair over the staff feet, yell screams, exposes self. On 05/15/24 at 12:24 PM, an interview was conducted with The Director of Nursing Services. Director of Nursing Services stated the incident of 8/2/2023, according to report two recreation staff saw the resident outside the door and called the security and Nursing staff to assist. Director of Nursing Services stated the resident was in an unsupervised area and reporting is part of the elopement process. Director of Nursing Services stated the supervisor assessed the resident and after the investigation concluded the resident was able to wheel self-past security and get outside the building. Director of Nursing Services stated the resident did fall outside the front door and passed security, so it was an elopement. Director of Nursing Services stated the resident have a wandering behavior of going on and off the unit, visits all the offices here on the 1st floor, and ask everyone for Social Security checks. Director of Nursing Services stated all the staff is familiar with this resident, and the resident had never made any attempt to elope or leave the facility. Director of Nursing Services stated the second incident is when the resident was found on a closed unit unharmed. Director of Nursing Services stated the staff did not do the monitoring in both incident and staff was disciplined and inserviced. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335770	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER N Y S Veterans Home IN N Y C		STREET ADDRESS, CITY, STATE, ZIP CODE 178 50 Linden Blvd Jamaica, NY 11434	
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/16/24 at 08:53 AM, a Telephone interview was conducted with Security Guard #1 on duty at time of incident on 8/2/2023. Security Guard #1 stated is responsible for sitting on the front desk on the evening shift on 8/2/2023. Security Guard #1 stated while sitting at the desk at some point in the evening heard a faint noise of someone yelling and followed the noise coming from outside. Security Guard #1 stated went outside and saw two staff from recreation yelling telling the security guard to look. Security Guard #1 stated when turn around notice resident lying on the ground in front of the building next to a car that was packed outside the door. Security Guard #1 stated the resident wheelchair was in the regular position and the resident on the ground. Security Guard #1 stated it looked like the resident fell out of the chair. Security Guard #1 stated the resident was saying was hurt and in pain. Security Guard #1 stated there are two exits, the main entrance where and the second exit over by the volunteer office. Security Guard #1 stated multiple people exit at the main entrance door on 8/2/2023 and the resident #33 was not one of them. Security Guard #1 stated every door has an alarm box and if the resident exit at the side entrance, the alarm will sound at the security front desk. Security Guard #1 stated the side entrance alarm for the door was not working on 8/2/2023, and the resident is able to go through the door and no one will know. Security Guard #1 stated there was no camera. Security Guard #1 stated this is a resident who was known to the facility and is known to use feet to move the wheelchair, and it was possible for the resident to use the wheelchair and go down the ramp, and along the path and end up in front of the building. Security Guard #1 stated the security Guard is responsible for walking and checking all the doors. Security Guard #1 stated Security is responsible for checking exit doors and writes in a log when the door is checked. Security Guard #1 stated check door by ensuring the alarm box is on and this is done by pushing on the door and the alarm will go off. Security Guard #1 stated if the door is pushed there is a red dot on the alarm box. Security Guard #1 stated did a walk through the next day with Nursing and proved the door was not working at the time Security Guard #1 stated did not get an alarm alert on that evening of 8/2/2023. Security stated did demonstrate that the door was not working at the times. Security Guard #1 stated was asked questions and stated was inserviced and receive no disciplined for this. On 05/16/24 at 11:59 AM, an interview was conducted with the Administrator for the facility regarding incident on 8/2/2023. The administrator stated aware that two recreation staff was leaving for the evening, and they observed the resident outside on the walkway and resident was unable to state how get outside. The Administrator stated the next day did a return demonstration, as well as a walk through with the resident, and the resident was not able to get through the double doors, over the door saddle and down the ramp. The Administrator stated the second exit was alarmed and working during the walk through. The Administrator stated based on the return demonstration it was not possible for the resident to go through any door than the front door. The Administrator stated the front door is not alarmed, and staff, visitors go freely with no alarm. The Administrator stated most likely this resident went through the front door. The Administrator stated the Code alert or alarm system on the door was working on 8/2/2023, and when the walk through was done the door was working. The Administrator stated if the resident went through any other door than the front door, the alarm would have sounded. The Administrator stated the resident is allowed to go freely on and off unit and was not at risk at the time was found outside. The Administrator stated based on the investigation, the concluded was the only way the resident left the facility was the front door. The Administrator stated the doors are checked and not sure about the logs for monitoring on 8/2/2023 for the doors. 10 NYCRR 415.12(h)(1)(2)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on record reviews and interviews conducted during the recertification and complaint survey (NY00336988) from 05/09/2024 to 05/16/2024, the facility did not ensure that all residents were free of significant medication errors. Specifically, Resident #109 did not receive antianxiety medication in accordance with Physician's Orders. The findings are: The facility policy titled Medication Administration General Procedure dated 04/2022 documented medications are to be charted as soon as they are given. Resident #109 had diagnoses of schizoaffective disorder and anxiety. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident @109 was cognitively intact. The facility Investigation Report documented Resident #109 was ordered to receive Ativan, an antianxiety medication, at 10 PM on 3/24/2024. The blister pack count at the beginning and end of the evening shift (3PM to 11PM) was 9 pills of Ativan, indicating that the 10PM dose of Ativan was not administered. The facility investigation concluded that Licensed Practical Nurse # 2 failed to follow facility's policy on preventing medication errors. On 05/14/2024 at 03:50 PM, Licensed Practical Nurse #2 was interviewed and stated they signed the Medication Administration Record on 3/24/24 confirming they provided Resident #109 with Ativan which was an error. Resident #109 did not receive their prescribed Ativan on 3/24/24. On 05/15/24 at 11:51 AM, the Director of Nursing Services stated that nurses fill out the Medication Administration Record after medication has been administered. Resident #109 reported they did not receive their Ativan on 3/24/24. The facility investigation concluded Resident #109 did not receive their Ativan. All the nurses were re-trained on medication administration and policy for control substances. 10 NYCRR 415.12(m)(2)		