STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335791	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queens Boulevard Extended Care Facility	61 11 Queens Boulevard Woodside, NY 11377

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 39136 Based on record review and staff interview conducted during the Recertification Survey from 06/13/2024 to 06/21/2024, the facility did not ensure that a resident was assessed using the quarterly review instrument specified by the State and approved by the Centers for Medicare and Medicaid Services not less frequently than once every 3 months. This was evident for 1 (Resident #107) of 2 residents reviewed for Resident Assessment out of 38 total sampled residents. Specifically, Resident #107's quarterly assessment was not completed. The findings are: The Centers for Medicare and Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 October 2023 documented that the Federal requirement mandates facilities to encode and electronically transmit Minimum Data Set 3.0 data. The Manual also stated that Assessment Completion refers to the date that all information needed has been collected and recorded for a particular assessment type and staff have signed and dated that the assessment is complete. The undated facility policy titled Minimum Data Set 3.0 documented the Minimum Data Set assessments and reviews are maintained electronically by the facility's Electronic Medical Record software company. The policy documented that the Minimum Data Set Coordinator shall determine the type of assessment needed and the assessment reference date, completion date, and comprehensive care plan meeting date following the Centers for Medicare and Medicaid Services guidelines. The schedule will be given to all disciplines to start and complete in a timely manner. The Minimum Data Set Coordinator will sign for completion and ready for transmission following the Federal and State regulations. Resident #107's Minimum Data Set Admission Assessment was completed on 12/22/2023 and submitted on 01/09/2024. There was no documented evidence of quarterly assessment completed after 12/22/2023. On 06/18/2024 at 9:48 AM, the Director of Minimum Data Set was interviewed and stated they were responsible for ensuring all Minimum Data Sets were completed and submitted on time. They stated that they completed and submitted Resident #107's Admission and 5-day scheduled assessment on 01/09/2024. They stated that they created a Discharge Assessment for Resident #107 because they had a planned discharge in February 2024, but the discharge did not happen. The Director of Minimum Data Set stated they deleted the discharge assessment and did not realize that the system in their electronic medical record had stopped generating the subsequent assessments. They stated that they completed Resident #107's quarterly assessment on 06/17/2024. (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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/21/2024 at 1:25 PM, the Director of Nursing was interviewed and stated they were not aware that Resident #107's quarterly assessment had not been completed and submitted. On 06/21/2024 at 4:22 PM, the Administrator was interviewed and stated that Resident #107 was supposed to be discharged from the facility. They created a Discharge Assessment, but the Resident did not leave, and the Minimum Data Set assessment schedule sequence was altered. The Administrator stated that the quarterly assessment was not completed because of a computer glitch. 10 NYCRR 415.11(a)(4)

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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 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** 39136 Based on observation, record review, and interviews conducted during the Recertification Survey from 06/13/2024 to 06/21/2024, the facility did not ensure that services provided or arranged by the facility met professional standards of quality. This was evident for 2 (Resident #85 and #20) of 38 total sampled residents. Specifically, 1.) Resident #85 was observed with oxygen via nasal cannula with no physician's order. 2.) Resident #20 had physician's order to notify the physician when Resident's finger stick blood sugar (method of drawing drops of blood from the finger for testing the blood glucose level) result is less than 70 milligrams per deciliter or more than 400 milligrams per deciliter. The licensed nurse failed to notify the physician when Resident #20's finger stick blood sugar was higher than 400 milligrams per deciliter on 7 occasions from 06/09/2024 through 06/18/2024. In addition, Resident #20 was administered 7 units of Novolin R insulin (a short acting insulin that lowers blood sugar) on 5 occasions, when Resident #20's finger stick blood sugar results were above 400 milligrams per deciliter, without a physician's order. The findings are: 1.) The facility's policy titled Oxygen Therapy - Oxygen Tanks dated 02/2022 documented that oxygen therapy must be ordered by a physician. However, in an emergency, a Registered Nurse may start oxygen therapy without a physician's order and then obtain the order. Resident #85 was admitted to the facility with diagnoses of Renal Insufficiency and Pneumonia. The Minimum Data Set assessment dated [DATE] documented Resident #85's had intact cognition. On 06/14/2024 at 9:56 AM, Resident #85 was observed in bed with oxygen via nasal cannula at 2 liters per minute. On 06/18/2024 at 9:43 AM, Resident #85 was observed in a wheelchair inside their room with oxygen via nasal cannula at 2 liters per minute. An oxygen tank was noted attached to the wheelchair. On 06/20/2024 at 12:12 PM, Resident #85 was observed in bed with oxygen via nasal cannula at 2 liters per minute. A review of Resident #85's physician's orders from 06/11/2024 to 06/18/2024 showed no orders for oxygen therapy. A review of the nurses' and medical progress notes from 06/01/2024 through 06/20/2024 showed no documentation of oxygen use. During an interview on 06/18/2024 at 2:50 PM, Resident #85 stated they had been using oxygen for about a week and they even take it to dialysis and physical therapy. During an interview on 06/20/2024 at 2:32 PM, Certified Nursing Assistant #1 stated that Resident #85 started using oxygen about a week ago. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/20/2024 at 2:40 PM, Licensed Practical Nurse #1 stated that Resident #85 was being administered oxygen, but they had not seen the physician's order for it. During an interview on 06/20/2024 at 2:56 PM, Registered Nurse #1, who was the nursing supervisor, stated that Resident #85 was being administered oxygen as needed at 2 liters per minute depending on the oxygen saturation (the measure of how much oxygen is traveling through a person's body in their red blood cells). They stated they do not know why Resident #85 had no physician's order for oxygen use. During an interview on 06/20/2024 at 3:34 PM, Registered Nurse #2 stated that Resident #85 sometimes had difficulty breathing and that oxygen was being administered when the Resident's oxygen saturation was low. They stated that Resident #85 was administered oxygen on and off after dialysis. Registered Nurse #2 stated that the order to administer oxygen must be obtained from the physician. During an interview on 06/20/2024 at 3:04 PM, Attending Physician #1 stated Resident #85 had been transferred to their service 3 days ago. They stated licensed nurses may administer oxygen to the resident but have to obtain a physician's order. During an interview on 06/21/2024 at 1:16 PM, the Director of Nursing stated that a nurse can administer oxygen and then call the doctor to get an order. The nurse who initiated the oxygen should have called the doctor for an order, and oxygen administration must be documented. 44842 2.) The facility's policy titled Change in a Resident's Condition or Status with a reviewed date of 01/2011 documented the Nurse Supervisor / Charge Nurse will notify the resident's attending physician or on-call physician when there has been a change in resident's physical condition. Resident #20 had diagnoses of Schizophrenia, Bipolar Disorder, and Diabetes Mellitus. The Minimum Data Set assessment dated [DATE] documented that Resident #20 was severely cognitively impaired. A Comprehensive Care Plan for Diabetes was initiated on 02/20/2023. The facility interventions include to observe for signs and symptoms of hypoglycemia (a condition when the blood sugar level was lower than normal) and hyperglycemia (a condition when the blood sugar was higher than normal), finger stick as ordered, and to refer to physician accordingly. A physician's order dated 06/19/2024 documented Basaglar KwikPen 100 units per milliliter (3 milliliters) subcutaneous, inject 5 units subcutaneously once daily at bedtime. Monitor blood sugar and notify the physician if finger stick blood sugar result is less than 70 milligrams per deciliter or more than 400 milligrams per deciliter. A physician's order dated 06/19/2024 documented Novolin R Regular 100 units per milliliter injection solution, inject subcutaneously every day at 11:00 AM and 5:00 PM when finger stick blood sugar reading are as follows: Between 0 and 180 no insulin, between 181 and 260 give 3 units, between 261 and 340 give 5 units, between 341 and 400 give 7 units. Above 400 or below 70, call the physician. The electronic Medication Administration Record for 06/2024 documented the following finger stick blood sugar results: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/06/2024 at 9:00 PM, 406 milligrams per deciliter. On 06/09/2024 at 5:00 PM, HI (high reading on a glucometer, blood glucose level is very high exceeding the maximum range that the device can measure). On 06/15/2024 at 5:00 PM, HI. On 06/16/2024 at 5:00 PM, HI. On 06/17/2024 at 5:00 PM, HI. On 06/17/2024 at 9:00 PM, 425 milligrams per deciliter. On 06/18/2024 at 5:00 PM, 427 milligrams per deciliter. A further review of Resident #20's electronic Medication Administration Record showed that 7 units of Novolin R were administered to Resident #20 at 5:00 PM when Resident #20's finger stick blood sugar results were above 400 milligrams per deciliter on 06/09/2024, 06/15/2024, 06/16/2024, 06/17/2024, and 06/18/2024 without a physician's order. A review of the nurses' and medical progress notes from 06/06/2024 through 06/19/2024 showed no documentation that the physician was notified when Resident #20's finger stick blood sugar results were above 400 milligrams per deciliter. During an interview on 06/20/2024 at 3:33 PM, Licensed Practical Nurse #2, who was the evening shift nurse on duty on 06/06/2024, 06/09/2024, and 06/15/2024 through 06/18/2024, stated they did not notify the physician when Resident #20's blood sugar was above 400 because Resident #20 was a known sensitive diabetic. They stated that they administered the insulin without notifying the physician of the blood sugar results exceeding 400 because Resident #20 had a history of life threatening hypoglycemia and that Resident's blood sugar will drop if they were given additional insulin coverage. During an interview on 06/21/2024 at 5:39 PM, Attending Physician #1 was interviewed and stated that even though Resident #20 had history of life threatening hypoglycemia, the licensed nurse should have notified them of finger stick blood sugar result above 400 so an infection can be ruled out. During an interview on 06/21/2024 at 10:36 AM, the Director of Nursing stated that the standard of practice dictates that Licensed Practical Nurse #2 should have followed the physician's order to notify the physician when Resident #20's blood sugar was above 400 milligrams per deciliter. 10 NYCRR 415.11(c)(3)(i)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, interview, and record review conducted during the Recertification Survey from 06/13/2024 to 06/21/2024, the facility did not ensure that food was served at an appetizing temperature during meal service. This was evident for 2 (5th and 6th floor) of 2 units observed during dining observation. Specifically, food served during lunch meal service were not maintained at palatable and appetizing temperatures. The findings are: The facility's policy titled Communal Dining with a revision date of 04/10/2024 documented the purpose of the policy was to enhance the quality of life through the provision of nourishing, palatable, attractive meals that meet the residents' daily nutritional needs in a communal dining experience. The policy documented that the dietary department would bring meals to the floors via food trucks as quickly as possible to maintain temperatures, where nursing staff will be ready to receive and distribute meals. Temperatures for hot meals must be maintained at 140 degree Fahrenheit or above. Temperature for cold meals must be maintained at 35 degrees or below. The Meal Service Schedule documented that lunch meal service for 5th floor starts at 12:15 PM and 6th floor starts at 12:30 PM. 1.) Resident #38 was admitted to the facility with diagnoses of Hyperlipidemia, Hypertension and Heart Failure. The Minimum Data Set assessment dated [DATE] documented that Resident had intact cognition and required supervision for eating. During an interview on 06/13/2024 at 12:56 PM, Resident #38 stated meals were served lukewarm most of the time and not hot enough. 2.) Resident #124 was admitted to the facility with diagnoses of Anxiety Disorder, Mood Disorder, Major Depressive Disorder. The Minimum Data Set assessment dated [DATE] documented that Resident had severely impaired cognition and required set-up or clean-up assistance with eating. During an interview on 06/14/2024 at 11:05 AM, Resident #124 stated that meals were always lukewarm and sometimes cold. Resident #124 stated they often like their food to be hotter. 3.) Resident #227 was admitted to the facility with diagnoses of Hypertension, End Stage Renal Disease, and Hyperlipidemia. The Minimum Data Set assessment dated [DATE] documented that Resident had intact cognition and required set-up or clean-up assistance with eating. During an interview on 06/13/2024 at 11:23 AM, Resident #227 stated they always ask staff to heat up their food in the microwave. On 06/18/2024 at 12:15 PM, the meal carts arrived, and distribution of meal trays continued until 1:01 PM on 5th floor. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/18/2024 at 12:30 PM, the meal carts arrived, and distribution of meal tray continued until 1:08 PM on the 6th floor. On 06/18/2024 at 1:01 PM, the food temperature on the test trays on the 5th floor were checked and revealed the following: chicken cacciatore at 124.8 degrees Fahrenheit, rice at 118.9 degrees Fahrenheit, broccoli at 119.3 degrees Fahrenheit, juice at 63.5 degrees Fahrenheit, milk at 63 degrees Fahrenheit, chopped chicken at 133.5 degrees Fahrenheit, chopped rice at 128 degrees Fahrenheit, chopped broccoli at 129.1 degrees Fahrenheit, and vegetable soup at 122.3 degrees Fahrenheit. On 06/18/2024 at 1:08 PM, the food temperature on the test trays on the 6th floor were checked and revealed the following: chicken cacciatore at 134.2 degrees Fahrenheit, broccoli at 123.5 degrees Fahrenheit, milk at 59.6 degrees Fahrenheit, rice at 127.9 degrees Fahrenheit, vegetable soup at 123.8 degrees Fahrenheit, chopped broccoli at 126.5 degrees Fahrenheit, and chopped chicken 126.7 degrees Fahrenheit. On 06/21/2024 at 10:07 AM, Certified Nurse Aide #4 was interviewed and stated there were a few residents on the 6th floor who request their meal to be heated up in the microwave daily because they want their food hot. On 06/21/2024 at 11:12 AM, the Food Service Director was interviewed and stated the food temperature was not hot enough when temperature checks were done on 06/18/2024. They stated that hot food should be higher than 140 degrees Fahrenheit and a little higher for the soups, and that meals should not be heated in the microwave daily to make it hot. They stated that the meal delivery on the 5th and 6th floor took longer than expected and that they will review their meal service process to correct the temperature issues. 10 NYCRR 415.14(d)(1)(2)