STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335804	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Queens for Rehabilitation & Nrsing	36 17 Parsons Boulevard Flushing, NY 11354

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907 Based on record review and interviews conducted during a Recertification and Complaint survey (NY00347992) from 11/13/2024 to 11/20/2024 the facility did not ensure a resident's designated representative was notified of changes in condition. This was evident for 1 (Resident #177) of 1 residents reviewed for Notification of Change out of 38 sampled residents. Specifically, a Nurse's Progress Note dated 07/05/2024 documented that Resident #177 was noted with a bruise on their nose and the charge nurse and supervisor were informed, however family was not informed about the bruise until 3 days later on 07/08/2024. The findings are: The facility policy titled Notification of Changes for Residents revised 03/04/2024 documented that the facility shall promptly notify the resident and/or designated representative and physician of changes in the resident's condition in order to obtain orders for appropriate treatment and monitoring, promote resident's right to make choices about treatment and care preferences and to keep resident and designated representative informed. Resident #177 was admitted to the facility with diagnoses including Hypertension, Anxiety Disorder, and Diabetes Mellitus. On 11/15/2024 at 1:12 PM, Resident #177's Representative was interviewed and stated that they were not informed of the bruise to Resident #177's nose until days after it occurred. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #177 had moderately impaired cognition. A Nurse's Progress Note dated 07/05/2024 documented Resident #177 was noted with bruising to their nose and the Charge nurse and supervisor were informed immediately. A Medical Doctor's Note dated 07/05/2024 documented Resident #177 was seen for follow up for ecchymosis on their nose. Resident #177 denied any recent fall but was unable to say how the bruise occurred. X-ray ordered. No other concerns from the staff. Medications were reviewed and deemed appropriate. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note dated 07/08/2024 documented Resident #177 denied pain and skin was intact with superficial redness. The Physician Assistant was notified on the findings for verbal order of a facial bone x-ray. Resident #177's family were updated. There was no documented evidence that Resident #177's representative was notified on 07/05/2024 when the bruise on nose was first observed. During an interview on 11/19/20224 at 12:29 PM, Registered Nurse Supervisor #2 stated that the redness on Resident #177's nose was observed on 07/05/2024 and they called the family and notified them but did not document this in Resident #177's chart. Registered Nurse Supervisor #2 also stated that on 07/08/2024 they spoke to Resident #177's family to follow up and update them on the facility's investigation for the redness to the resident's nose. During an interview on 11/19/2024 at 11:47 AM, the Assistant Director of Nursing stated they did not report the discoloration to the family and that the nurse who discovered the discoloration reported to the family the same day. The Assistant Director of Nursing also stated that they met with the family after they conducted their investigation to update them on the conclusion. 10 NYCRR 415.3(f)(2)(ii)(a)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 18881 Based on observations and interviews conducted during the Recertification Survey from 11/13/2024 to 11/20/2024, the facility did not ensure that the Nurse Staffing Information was posted appropriately. Specifically, there has been no posting in the appropriate required form of the daily nurse staffing information and was not posted in a prominent area which was readily accessible to residents and visitors. The finding is: The facility policy and procedure titled Posted Nurse Staffing Information dated 10/10/2021 with a review date of 01/15/2024 documented that the facility will ensure that the Nursing Staffing Information is posted daily at the beginning of each shift in a prominent place where it is accessible to residents and visitors. During observations conducted on 11/13/2024, the State Surveyor was unable to locate the posting of the daily nurse staffing levels for each shift or any signage instructing residents or visitors where it was located. On 11/14/2024, a posting was observed on wall next to the side of the elevator, however, the form did not include the current daily census and the actual hours worked by each category of staff. The facility was also unable to provide copies of previous staffing postings. On 11/18/2024 at 3:45 PM, the Staffing Coordinator was interviewed and stated that they post the daily staff schedule on the bulletin board near the Nursing office and only began posting the daily staffing on 11/14/2024 and included the number of Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistant and posted it near the elevator. The Staffing Coordinator also stated that they were not aware that the notice was to be posted where it is visible for visitors, families, and residents. On 11/19/2024 at 10:27 AM, the Director of Nursing was interviewed and stated that prior to 11/14/2024, the staffing schedule was posted on the bulletin board near the Nursing office, and they had not been posting the nursing staffing posting as required. The Director of Nursing further stated that the staffing schedule had been placed near the Nursing office and was not in an area readily accessible to residents or visitors. 10 NYCRR 415.13