

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335808	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2025
NAME OF PROVIDER OR SUPPLIER Hempstead Park Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 800 Front Street Hempstead, NY 11550	

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey and Abbreviated Survey (Complaint #697429) initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure resident rights to be free from abuse. This was identified for two (Resident #83 and Resident #98) of three residents reviewed for Abuse. Specifically, on 04/25/2025, Resident #83, with intact cognition, was using a common bathroom. Resident #98, with severely impaired cognition, attempted to enter the same bathroom, and Resident #83 told Resident #98 to get out. Resident #98 made a fist and swung at Resident #83. Resident #83, in turn, punched Resident #98 in the right eye; Resident #98 was sent to the emergency room for evaluation for complained of pain and redness in the right eye. The finding is: The facility's Abuse Prevention Policy, dated 9/19/2022 and revised on 2/3/2025, documented to provide a safe resident environment that protects residents from abuse, including verbal, mental, sexual, or physical abuse. This includes staff-to-resident abuse of any type, resident-to-resident abuse of any type, and visitor-to-resident abuse of any type. Physical abuse is inappropriate physical contact resulting in injury or likely to harm a resident. Physical abuse includes, but is not limited to, hitting, slapping, punching, biting, and kicking. The policy defined willful as the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Resident #83 was admitted to the facility with diagnoses of Diabetes, Epilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures), and Metabolic Encephalopathy (a brain disorder caused by a chemical imbalance). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #83 had intact cognition. The Minimum Data Set documented that Resident #83 did not exhibit any behaviors. A Comprehensive Care Plan titled Risk for Abuse, dated 04/24/2023 and updated on 04/24/2025, with interventions including observing changes in customary routines, keeping the resident away from other peers whenever possible, and staff to observe during rounds and care. Resident #98 was admitted to the facility with diagnoses of Diabetes, Alzheimer's, and Hypertension. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of seven (7), which indicated Resident #98 had severe cognitive impairment. The Quarterly Minimum Data Set assessment documented that Resident #98 did not exhibit any behaviors. A review of the Abuse Risk assessment dated [DATE] revealed that Resident #98 had behavior factors of being verbally disruptive, repetitive calling out, and had a history of being aggressive to peers. A Comprehensive Care Plan titled Behaviors, as evidenced by an altercation dated 04/25/2025, documented interventions including administering medications as ordered, observing for changes in behaviors, and redirecting the resident to an alternative environment. The Resident-to-Resident Altercation Report dated 04/25/2025 documented that Resident # 83 was in the common bathroom, by the Activity Room, when Resident #98 went in [the same bathroom] to wash their hands. Resident #83 told Resident #98 to get out, but Resident #98 insisted on coming in. Resident #98 then swung their fist, tapping Resident #83's right side of the chin. Resident #83 then punched Resident #98's right eye. The Recreation Aide (#1) immediately intervened and separated both residents. The investigation summary concluded there was no evidence of abuse, neglect, or mistreatment. The incident was unpredictable. Resident #98's insights and judgment were poor. The facility will continue to offer resident #98 diversional activities and redirection. The Accident and Incident report dated 04/25/2025 for Resident #83 documented a statement from Resident #83 indicating stated the resident was using the bathroom, and Resident #98 opened the bathroom door. Resident #83 stated they told Resident #98 to leave, but Resident #98 refused. Resident #83 stated they hit Resident #98. The Accident and Incident report dated 04/25/2025 for Resident #98 documented a statement from Resident #98 indicating the resident went to the bathroom, but Resident #83 was inside, and they (Resident #98) told Resident #83 to leave. Resident #98 stated that Resident #83 punched them (Resident #98) in the face. During an interview on 07/29/2025 at 10:30 AM, Resident #83 stated they remembered the altercation with Resident #98. Resident #83 stated they were using the bathroom first and needed privacy, and Resident #98 did not acknowledge their request to wait until they were finished using the bathroom. Resident #83 stated they punched Resident #98 to stop them (Resident #98) from coming into the bathroom. During an interview on 07/31/2025 at 8:47 AM, the Recreation Aide #1 stated that they went into the bathroom when a resident reported to them that something was going on in the bathroom. Resident #83 and Resident #98 were already separated. The</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 07/28/2025 and completed on 08/05/2025, the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified on one (1) (Unit 4 South) of six (6) units reviewed for the Sufficient Nursing Staffing Task. Specifically, the Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Two 2025 (January 1st-March 31st) indicated that the facility had a one (1)-star staffing rating. Additionally, there were multiple occasions when the facility had insufficient Licensed Practical Nurses assigned to Unit 4 South, as specified on the Facility Assessment. The finding is: The Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Two 2025 (January 1st-March 31st) documented the facility triggered for the Metric of One Star Staffing Rating. The Facility assessment dated [DATE], last reviewed and/or updated on 06/2025, documented that the facility had a 251-bed capacity with an average daily census of 225. The Administrator provided an updated Facility Assessment on 08/01/2025, which indicated Unit 4 South had a 41-bed capacity and required two Licensed Practical Nurses during the 7:00 AM-3:00 PM shift. A review of the Facility Unit Census logs from 01/05/2025 to 01/11/2025; 02/09/2025 to 02/15/2025; 03/16/2025 to 03/22/2025, and 07/28/2025 to 08/04/2025 revealed resident census on Unit 4 South was between 37 and 41 residents. A review of the 7:00 AM-3:00 PM shift schedule for Unit 4 South from 01/05/2025 to 01/11/2025 indicated the following:- On 01/06/2025, 01/07/2025, 01/08/2025, 01/09/2025, and 01/10/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 38 residents. A review of the 7:00 AM-3:00 PM shift schedule for Unit 4 South from 02/09/2025 to 02/15/2025 indicated the following:- On 02/10/2025 and 02/11/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 40 residents.- On 02/12/2025, 02/13/2025, and 02/14/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 41 residents. A review of the 7:00 AM-3:00 PM shift schedule on Unit 4 South from 03/16/2025 to 03/22/2025 indicated the following:- On 03/17/2025 and 03/19/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 37 residents.- On 03/16/2025, 03/20/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 38 residents.- On 03/21/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 38 residents. A review of the 7:00 AM-3:00 PM shift schedule on Unit 4 South from 07/28/2025 to 08/4/2025 indicated the following:- On 07/28/2025 and 07/30/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 39 residents.- On 08/01/2025, there was one (1) Licensed Practical Nurse assigned to Unit 4 South with a census of 40 residents. Resident #133 was admitted with diagnoses of Type 2 Diabetes Mellitus, Hypertension, and Major Depressive Disorder. The Annual Minimum Data Set assessment dated [DATE] documented that Resident #133 had a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition. During an interview on 07/28/2025 at 10:35 AM, Resident #133 stated that they had not received their morning medications today. During the Medication Administration task observation with Licensed Practical Nurse #8 on 07/28/2025 from 11:07 AM to 11:30 AM, Licensed Practical Nurse #8 administered Resident #133's 10:00 AM medications at 11:30 AM, which was 30 minutes beyond the facility's required time frame. During an interview immediately after the observation on 07/28/2025, Licensed Practical Nurse #8 stated they were the regularly assigned charge nurse on Unit 4 South. Licensed Practical Nurse #8 stated there were usually two Licensed Practical Nurses assigned to each of the 4th-floor units (4 South and 4 North). Licensed Practical Nurse #8 stated that both the assigned Licensed Practical Nurses were responsible for administering medications. Licensed Practical Nurse #8 stated today (07/28/2025) they were alone on the unit, and the second Licensed Practical Nurse (#2), who usually worked on Unit 4 South, was assigned to work alone on Unit 4 North. Licensed Practical Nurse #8 stated they were passing medications and providing treatments by themselves and therefore were not able to administer Resident #133's morning medications on time. During an interview on 07/28/2025 at 11:40 AM, Licensed Practical Nurse #2 stated that they regularly worked with Licensed Practical Nurse #8 on Unit 4 South and were reassigned to Unit 4 North today (07/28/2025) due to a call-out. Licensed Practical Nurse #2 stated there should be two Licensed Practical Nurses assigned to each unit (4 South and 4 North) During an interview on 07/29/2025 at 12:22</p>		

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<p>F 0838</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the Recertification Survey initiated on 07/28/2025 and completed on 08/5/2025, the facility did not ensure the Facility Assessment considered specific staffing needs for each resident unit for each shift, such as day, evening, and night. This was identified during the Sufficient Nursing Staffing Task. Specifically, the Facility Assessment, last reviewed in June 2025, did not indicate staffing needs for Certified Nursing Aides, Monday to Friday, for each unit and each shift. Additionally, the Facility Assessment did not specify the staffing needs for Licensed Practical Nurses for each unit for the 3:00 PM-11:00 PM shift and the 11:00 PM-7:00 AM shift during the weekdays. The finding is: The facility's policy, titled Facility Assessment, last reviewed/revised on 8/1/2024, documented the facility will conduct and document a facility-wide assessment to determine the resources necessary to care for residents competently during day-to-day operations and emergency services. The Facility Assessment will identify the facility's resident population, including the number of residents, residents' capacity, and the care required by the residents. The Facility Assessment will provide a staffing template for both weekday and weekend/holiday staffing [need] for each shift. A review of the Facility assessment dated [DATE], revealed the Facility Assessment did not indicate weekdays (Monday to Friday) staffing needs for Certified Nursing Aides for each unit and each shift (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM). Additionally, the Facility Assessment did not specify the staffing needs for Licensed Practical Nurses for each unit for the 3:00 PM-11:00 PM shift and the 11:00 PM-7:00 AM shift during the weekdays. During an interview on 08/1/2025 at 08:45 AM, the Administrator stated they and the Director of Nursing Services were involved in developing and reviewing the Facility Assessment. The Administrator stated the Director of Nursing Services was responsible for completing the nursing staffing portion of the Facility Assessment. The Administrator stated they were responsible for reviewing and ensuring the Facility Assessment was completed accurately. The Administrator stated they were not aware that the Facility Assessment did not include the number of nursing staff required for each unit, each shift, for the weekdays (Monday to Friday). The Administrator stated that the Facility Assessment should have clearly indicated specific nursing staffing needs by resident units for each shift, and it was an oversight. The Administrator stated that the Director of Nursing Services, who was responsible for the nursing staffing portion of the Facility Assessment, was no longer employed at the facility. 10 NYCRR 415.26</p>		