STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335808	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hempstead Park Nursing Home	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 Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review during the abbreviated survey, the facility failed to ensure resident rights to be free from abuse for two (Resident #11 and Resident #12) of three residents reviewed for Abuse. Specifically, Staff observed Resident #12 having a physical altercation with Resident #11. Resident #12 was on top of Resident #11 with both hands placed around Resident #11's neck. Resident #12 stated they were attempting to retrieve a belt they alleged Resident #11 had taken. Assessment of Resident #11 revealed bleeding from their nose, mouth, and the right second toe.Incident # 2693929The findings include:The facility's Abuse Prevention Policy, dated 09/19/2022 and revised on 05/10/2025, documented that it is the facility's policy 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. Abuse will be monitored for negative psychosocial outcomes related to crime, allegation, or incident. Residents will be provided with needed interventions to mitigate the potential for developing negative psychosocial outcomes. Resident #12 was admitted with diagnoses of a traumatic brain injury, 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 Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated Resident #12 had intact cognition. The Minimum Data Set assessment documented that Resident #12 did not exhibit any behaviors, and it was very important for Resident #12 to take care of their personal belongings.A Comprehensive Care Plan titled Risk for Abuse initiated on 10/23/2025, documented Resident #12 will be free from abuse, with interventions that included to address concerns as they arise.A Comprehensive Care Plan titled Mood State Psychosocial Well-Being, dated 10/23/22025, documented interventions including monitoring for negative psychosocial outcomes related to untoward events, monitoring for non-verbal signs of distress such as restlessness, decreased appetite, agitation and or isolation after an untoward event.A Comprehensive Care Plan titled Behaviors, Altercation dated 07/09/2025 last revised on 8/27/2025 included interventions to set and enforce clear limits, assess and address for contributing sensory deficits, analyze the time of day, place, circumstance, triggers and what de-escalated the behavior and document.A review of the electronic medical record from April 2025-December 2025 indicated the resident had a history of physical altercation with a resident on 04/25/2025 and a verbal altercation with another resident on 07/09/2025.A Physician's progress note dated 12/16/2025, documented Resident #12 was seen after peer-to-peer altercation where Resident #12 was the aggressor. Resident #12 presented as angry, defensive, and argumentative. Resident #12 reported only having an argument with Resident #11 and was defensive when asked to provide details. Resident #12 denied choking behavior and blamed incident on staff, the roommate, and the Psychologist.Resident #11 was admitted with diagnoses that included chronic obstructive pulmonary (continued on next page)

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: The nursing home is disputing this citation.	disease (progressive lung disease that causes breathing difficulty), benign prostatic hyperplasia (enlarged prostate that can slow or block the flow of urine), and type 2 diabetes mellitus (where the body cannot use insulin properly). The quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score was not completed and that Resident #11 was rarely or never understood. The Minimum Data Set assessment documented Resident #11 was not short tempered, or easily annoyed, Resident #11 did not have a behavior of wandering.A Comprehensive Care Plan titled Risk for Abuse related to vulnerability due to deficits in medical/physical conditions, dated 06/07/2025, documented the resident demonstrates behaviors that can disturb others. Interventions included encouraging resident to voice concerns to staff regarding their peers.A Comprehensive Care Plan titled Behaviors related to Dementia, dated 06/07/2025 documented Resident #11 had a tendency to take food off the food truck. Interventions included approaching the resident in a calm manner and addressing the resident's concerns as they arise.An Abuse Risk assessment dated [DATE] documented Resident #11 had a history of mental illness and history of dementia. It documented Resident #11 did not have a history of taking other residents' belongings, displaying threating or intimidating behaviors, or being physically aggressive toward peers.A review of the Accident/Incident Report dated 12/15/2025 documented Resident #12 and Resident #11 were in their shared bedroom and #12 was observed sitting on the floor with their hands around the neck of Resident #11, Resident #12 stated Resident #11 took his belt. Resident #11 had bleeding from their nose, mouth right second toe and pinky finger. Resident #12 sustained no injuries. Both residents transferred to two area hospitals. The root cause analysis documented Resident #12 had a psyche diagnosis and complained about any roommate they had and presented with impulsive behaviors toward Resident #11, stating Resident #11 took their belt. This incident constituted resident-resident abuse because the aggressor was alert and oriented. The conclusion documented resident to resident incident was the result of an impulsive aggression by an alert and oriented resident toward his roommate over his belt they assumed on Resident #11 possession. During an interview on 06/08/2026 at 11:08 AM, Resident #12 stated they had a roommate who left, that roommate took their belt, they took it back. They denied going to the hospital after taking the belt back. They stated the roommate they have now is fine, we get along. This Resident did not recall any problems with other residents in the facility and denied any aggressive behavior toward others.Resident #11 was not interviewable.During an interview on 6/10/2026 at 9:07 AM, Certified Nursing Assistant #3 stated they heard a resident yelling for help and called the nurse. Certified Nursing Assistant #3 stated they saw Resident #12 sitting on top of Resident #11 with their hands around Resident #11's neck. Resident #12 was angry and said Resident #11 took their belt, and they wanted the belt back.During an interview on 06/10/2026 at 11:25 AM, Certified Nursing Assistant #2 stated they were regularly assigned to both Resident #11 and Resident #12. They did not witness the altercation between Resident #11 and Resident #12 on 12/15/2025 as they were in the dining room at the time of the incident. Resident #11 and Resident #12 did not have a history of altercation prior to 12/15/2025. During an interview on 6/10/2026 at 11:32 AM, Licensed Practical Nurse #3 stated on 12/15/2025 they were near Resident #11 and Resident #12's room when they heard a commotion. They went into the room and saw Resident #12 sitting on top of Resident #11 with their hands on Resident #11's neck. Resident #12 said Resident #11 took their belt and they wanted it back. Both residents were sent out to hospital, they could not recall if either resident had any injuries. Licensed Practical Nurse #3 stated that Resident #12 and Resident #11 did not have any altercation with each other prior to 12/15/2025.During an interview on 06/10/2026 at 12:28 PM, Registered Nurse Supervisor #1 stated when they responded to the residents' room Licensed Practical Nurse #3 had already separated the two residents. Resident #11 was observed bleeding from the right foot 2nd toe, right fifth finger, nose, and tongue. Resident #11 was sent to the hospital. Resident #12 did not have visible injuries; however, they were sent to the hospital for a psychiatric evaluation. Resident #12 alleged that Resident #11 took their belt, and they wanted the belt back. After the incident Resident (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#11 was moved to another unit to keep them safe. During an interview on 06/11/2026 at 10:48 AM, the Minimum Data Set Coordinator, who was the Director of Nursing Services on 12/15/2025, stated they completed the investigation related to an altercation that took place on 12/15/2025 between Resident #11 and Resident #12 and concluded that resident to resident abuse occurred as Resident #12 was alert and oriented and willfully hit Resident #11 with an intent to take their belt back from Resident #11.10 New York Code Rules and Regulations 415.4(b)(1)(i)