STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335472	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Queens Rehab & Nursing Center	69 95 Queens Midtown Expressway Maspeth, NY 11378

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907 Based on observation, record review and interviews during an abbreviated survey (NY00339419 and NY00342391), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, and mistreatment, are reported immediately, but not later than 2 hours after the allegation is made to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities). This was evident in three (3) out of five (5) residents sampled (Residents #1, Resident #2 and Resident #3). Specifically, on 04/11/2024 at 12:50 PM, Registered Nurse #1 documented while monitoring residents at the start of their shift 7:00 AM to 3:00 PM, Resident #1 complained of pain in their private area and stated they think someone might have touched their private area because it hurts. Resident #1 was transferred to the hospital for further evaluation. The facility reported the incident to the New York State Department of Health on 04/16/2024 at 4:17 PM. On 05/15/2024 at 5:45 PM, Resident #2 was sitting in the dining room when Resident #3 suddenly hit Resident #2 on their head with a soda can. Resident #2 was transferred to the hospital for further evaluation. The facility reported the incident to the New York State Department of Health on 05/16/2024 at 3:01 PM. The findings are: The facility's Policy and Procedure titled Abuse, Mistreatment, Neglect, Misappropriation of Resident 's Property, revised 01/2025. Number 6: Reporting and Response (pg.17) documented it is the facility's policy to report abuse allegations per Federal and State Law. The policy documented the facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Resident #1 was admitted to the facility with diagnoses including coronary artery disease and bipolar disorder (a chronic mental health condition characterized by extreme shifts in mood). The Minimum Data Set (an assessment tool), dated 03/22/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 14 associated with intact cognition. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Incident/Accident Report dated 04/10/2024, documented Resident #1 reported their private area was hurting because they think the nurse on the 11:00 PM-7:00 AM shift touched their private area. The facility's investigation dated 04/16/2024, concluded there was no credible evidence to suggest that abuse occurred. Resident #1 has history of confabulation and manipulation. Resident #1 initially denied seeing someone enter their room and touching them. The 11:00 PM- 7:00 AM shift reported that Resident #1 was observed sleeping throughout the shift. Resident #1 was transferred to the hospital and was evaluated for alleged sexual abuse and treated prophylactic. Resident #1 is no longer residing at the facility, several attempts made to interview Resident #1 was unsuccessful. During a telephone interview on 02/11/2025 at 1:15 PM, Assistant Director of Nursing stated any allegation of abuse should be reported within two hours to the New York State Department of Health. They stated they did not report the incident because Resident #1 denied the allegation when they were re-interviewed. Assistant Director of Nursing stated they reported the incident to the New York State Department of Health five days later because they wanted to complete their investigation and have concrete details before reporting the allegation. During a telephone interview on 02/12/2025 at 9:05 AM, the Administrator stated on 04/11/2024 at 9:30 AM, during morning meeting, Resident #1's concern was discussed, and an investigation was started, and Resident #1 was transferred to the hospital for further evaluation. Administrator stated abuse allegation are supposed to be reported to the New York State Department of Health within 2 (two) hours, however, this incident was not reported because Resident #1 recanted their statement, and the facility staff wanted to have concrete details before reporting the incident to the New York State Department of Health. Resident #2 was admitted to the facility with diagnosis including coronary artery disease (heart damage), and Schizophrenia (inability to think, feel, and behave clearly). The Minimum Data Set, dated dated [DATE], documented Resident #2 had a Brief Interview of Mental Status score of 14 associated with intact cognition. Resident #3 was admitted to the facility with diagnosis including Diabetes Mellitus and Alzheimer's Disease. The Minimum Data Set, dated dated [DATE], documented Resident #3 had a Brief Interview of Mental Status score of 7 associated with severely impaired cognition. An Incident/Accident Report dated 05/15/2024 at 5:45 PM, documented Resident #3 approached Resident #2 in the dining room hit Resident #2's head with a soda can. Staff were present in the dining room and were unable to prevent the occurrence. The facility's investigation dated 05/20/2024, concluded the altercation was unavoidable and unpredictable. Staff responded appropriately and separated the residents. Resident #2 and Resident #3 were transferred to the hospital for further evaluation. Resident #2 no longer resides at the facility. Resident #3 no longer resides at the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 02/11/2025 at 2:25 PM, Director of Nursing stated after an incident was discussed with the team, the Assistant Director of Nursing is responsible for reporting the incident to the New York State Department of Health. The Director of Nursing stated any allegation of abuse is supposed to be reported within 2 (two) hours. The Director of Nursing stated the Resident-to-Resident incident was reported on 05/16/24 because Resident #3 was confused and did not have capacity, and they did not assume this incident fell under the category to report within two hours. During a telephone interview on 02/12/2025 at 9:14 AM, the Administrator stated they were informed by the Director of Nursing that Resident #3 hit Resident #2 on their head with a soda can (cannot recall the time or date they were informed). Resident #2 refused assessment, 911 was called and Resident #2 transferred to the hospital. The Administrator stated the incident was reported to the New York State Department of Health the following day because there were no serious bodily injury and Resident #2 refused assessment. 10 NYCRR 415.4(b)