STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335503	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holliswood Ctr for Rehabilitation and Healthcare	195 44 Woodhull Avenue Hollis, NY 11423

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19546 Based on observations, interviews, and record review conducted during the recertification survey from on 04/17/2024 to 04/24/2024, the facility did not ensure the resident's right to a safe, clean, comfortable, and homelike environment. This was evident for 1 (Unit 4) of 5 resident units. Specifically, Unit 4 was observed with 1.) furniture heavily worn and in disrepair. 2.) torn and/or stained window curtains. 3.) stained privacy curtains. 4.) broken and chipped ceiling plaster. Torn room wallpaper. 5.) frame of room light fixture in disrepair. 6.) holes in walls/bathroom door. 7.) heavily stained and dirty toilet bowel. 8.) heavily stained, rusty, and dirty room commode. 9.) wheelchair with torn right-side armrest and layered dirt to the metal parts and wheel spokes. 10.) thick, orange-colored streaks of rust stains in the shower room stall. The ceiling tile surround the light fixture with rust stains. 11.) nurse front desk area layered with dirt/dust. 12.) loose rusty worn faucet handles. The findings are: On 04/17/2024 at 10:37 AM, the following observations were made on Unit 4: a.) room [ROOM NUMBER] had cracked/peeling ceiling plaster above the sink, light fixture above the sink in disrepair, torn and stained window curtains, toilet bowl stained with black grime, a rusty and dirty bathroom commode in disrepair, a wheelchair with torn armrest leather on the right side, and loose rusty faucet handles at the sink. b.) room [ROOM NUMBER] had a heavily worn dresser with inner corking exposed at the corners, stained privacy curtains and stained window curtains, holes in the wall near and above the closet, torn wallpaper above the headboard, slanted headboard in disrepairs, tape used to hold the footboard of the bed together. c.) 1 Hoyer lift in the hallway that was heavily worn on the metal frame, rusty, and layered with dirt and debris. d.) room [ROOM NUMBER] had ripped and stained window curtains, hole in the wall near the bathroom doorknob, and stained privacy curtains. e.) room [ROOM NUMBER] had loose and rusty faucet handles at the sink and stained privacy curtains. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f.) room [ROOM NUMBER] had stained, dusty, torn window curtains and clothing hampers embedded with dirt. g.) The Shower Room across room [ROOM NUMBER] with rust stains beneath the grab bars and rust stains on the ceiling tiles in the shower stall, around the sink, and by the light fixtures. h.) The Dining Room had moldings with worn, tattered decorations and in disrepair with inner metal exposed, wobbly tables, walls and ceilings with multiple holes from tack marks and staples, a table with a rusty metal frame and inner corking exposed, a chair with the vinyl seat cover torn and wooden frame heavily worn, rusty wall vent, and the kitchenette area with a broken drawer handle. i.) The Nursing Station floor was covered with dirt, dust, and grime and a bundle of wires under the desk was covered in dirt and dust. On 04/24/2024 at 10:53 AM, Housekeeper # 1 was interviewed and stated they were assigned to Unit 4 and their daily routine was to clean the resident rooms, bathrooms, and dining room. Housekeeper #1 called the [NAME] when window curtains and privacy curtains needed to be replaced. Any issues with repairs were reported to the Maintenance Department. All staff were responsible for reporting concerns regarding cleanliness and repair of resident equipment. On 04/24/2024 at 12:00 PM, the Director of Housekeeping was interviewed and stated they made environmental rounds daily throughout the entire facility to ensure that staff were performing their job responsibilities and to check for cleanliness and safety concerns. The Director of Housekeeping stated they also checked for dirt, debris, and stains. Maintenance Department issues were referred using an electronic ticket system. Housekeeping staff made the Director of Housekeeping aware of emergent issues by calling them directly. Resident equipment was washed and cleaned according to a devised schedule. 10 NYCRR 415.5(h)(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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864 Based on record review and interviews conducted during the Recertification and Abbreviated (NY00331574) survey from 4/17/2024 to 4/24/2024, the facility did not ensure that a resident received quality of care. This was evident for 1 (Resident #266) of 38 total sampled residents. Specifically, Resident #266 did not receive assessment by a qualified Registered Nurse following an injury of unknown origin and a fall. The findings are: The facility's policy titled Injuries of Unknown Etiology dated 11/2023 documented the Licensed Nurse on duty must report incidents and injuries to the on-duty Supervisor. Resident # 266 had diagnoses of Parkinson's disease and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #266 was moderately cognitively impaired and had 2 or more falls since their prior assessment. A Nursing Evaluation dated 4/14/2024 at 12:00 AM documented Licensed Practical Nurse #6 was called to the unit by the charge nurse. Resident #266 had swelling and discoloration to their left-hand 4th and 5th fingers of unknown origin. Licensed Practical Nurse #6 assessed Resident #266 and informed the Nurse Practitioner. A Nursing Evaluation Note dated 1/14/2024 at 4:10 AM documented Licensed Practical Nurse #6 was called to the unit by the charge nurse due to Resident #266 was found lying on the floor in the doorway of their room. Licensed Practical Nurse #6 assessed Resident #266, had them transferred to the wheelchair, and informed the Nurse Practitioner. The New York State Office Professions Registrations for Licensed Practical Nurse #6 documented they were registered until 6/2026. There was no documented evidence Resident #266 received quality of care and was adequately assessed by a Registered Nurse following an injury of unknown origin and fall on 1/14/2024. On 04/22/2024 at 04:33 PM, Licensed Practical Nurse #4 was interviewed and stated they were the charge nurse on Resident #266's unit when the resident had an injury of unknown origin and fall on 1/14/2024. Licensed Practical Nurse #4 called and reported the incidents to the Supervisor for that shift, Licensed Practical Nurse #6. On 04/23/2024 at 07:27 AM and 03:29 PM, Licensed Practical Nurse #6 was interviewed and stated they were the Supervisor in the building on 1/14/2024 when Resident #266 had discoloration to their left hand and a fall. Licensed Practical Nurse #6 assessed the resident, contacted the Nurse Practitioner, initiated an incident report, and ordered an x-ray. Licensed Practical Nurse #6 stated they failed the Registered Nurse licensing exam and was not approved for a permit to practice as a Registered Nurse in New York State. Licensed Practical Nurse #6 stated they were designated as a Supervisor and practicing the capacity of Registered Nurse on 1/14/2024 when Resident #266 had their incidents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/2024 at 12:10 PM, the Director of Nursing was interviewed and stated the nurse on the unit was responsible for assessing residents when incidents occur. Licensed Practical Nurse #6 was the Registered Nurse Supervisor for the building on 1/14/2024 on the 11PM to 7AM shift. The Director of Nursing stated they believed the Licensed Practical Nurse #6 could practice in the capacity as a Registered Nurse because they held degree in Associate's in Nursing meeting the education requirements of a Registered Nurse. The Director of Nursing did not know whether Licensed Practical Nurse #6 had a permit to practice as a Registered Nurse in New York State. 10 NYCRR 415.12

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review, and interviews conducted during the recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure a resident received adequate supervision to prevent accident hazards. This was evident for 1 (Resident #104) of 38 total sampled residents. Specifically, Resident #104's comprehensive care plan related to falls was not reviewed and revised to include supervision to prevent further accidents. The findings are: The facility's policy titled Falls Management and Prevention dated 1/2024 documented assessment and prevention of falls included staff reviewing and revising the interdisciplinary care plan after a fall event. Goals and interventions will be implemented based on the resident's individual needs. Resident #104 had diagnoses of schizophrenia and acute kidney failure. The Minimum Date Set 3.0 assessment dated [DATE] documented Resident #104 had moderately impaired cognition and 2 falls with no injury since the last assessment. The Comprehensive Care Plan created 6/16/2021 and last revised 1/5/2024 documented Resident #104 was at risk for falls due to psychoactive drug use, tremors, history of falls, and unsafe attempts to sefl-trasnfer. Interventions included provide urinal at resident bedside, toileting every 2 hours and as needed, bed in the lowest position, non-skid socks, floor mats, and resident education on safety. The Nursing Note dated 1/20/2024 documented at 7:45 PM, Resident #104 was observed laying supine on floor in the hallway bathroom close to nursing station. Occupational and physical therapy evaluation were initiated as interventions to decrease risk for falls. The Nursing Note dated 1/21/2024 documented at 8:30 AM, Resident #104 was noted sitting on the floor of the room in front of the bathroom with wheelchair unlocked. Non-skid socks were initiated to decrease risk for falls. There was no documented evidence Resident #104 was evaluated for and provided with supervision and interventions to prevent further fall occurrences. There was no documented evidence Resident #104's care plan related to falls was reviewed and revised after 1/5/2024. To address falls on 1/20/2024 and 1/21/2024. On 4/23/2024 at 11:46 AM, Registered Nurse #3 was interviewed and stated the Registered Nurse on duty was responsible for ensuring the resident's incident report and fall care plan were updated after a resident's fall. Registered Nurse #3 did not know whether interventions were reviewed and revised upon Resident #104's falls on 1/20/2024 and 1/21/2024. The care plan related to falls was not updated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/2024 at 12:08 PM, the Director of Nursing was interviewed and stated comprehensive care plans were reviewed and revised after each fall. Preventative interventions were initiated by nursing and implemented immediately to ensure the resident does not have any more falls. In addition, the interdisciplinary team reviewed interventions for their effectiveness and revised the care plan accordingly. The Director of Nursing was not able to explain why Resident #104's fall care plan was not reviewed or revised following falls on 1/20/2024 and 1/21/2024. 10 NYCRR 415.12(h)(2)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864 Based on record review and interviews conducted during the Recertification and Abbreviated (NY00331574) survey from 4/17/2024 to 4/24/2024, the facility did not ensure licensed nurses had the competencies and skills necessary to care for a resident's needs. This was evident for 1 (Resident #266) of 38 total sampled residents. Specifically, Resident #266 did not receive assessment by a qualified Registered Nurse following an injury of unknown origin and a fall. The findings are: The facility's policy titled Injuries of Unknown Etiology dated 11/2023 documented the Licensed Nurse on duty must report incidents and injuries to the on-duty Supervisor. Resident # 266 had diagnoses of Parkinson's disease and dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #266 was moderately cognitively impaired and had 2 or more falls since their prior assessment. A Nursing Evaluation dated 4/14/2024 at 12:00 AM documented Licensed Practical Nurse #6 was called to the unit by the charge nurse. Resident #266 had swelling and discoloration to their left-hand 4th and 5th fingers of unknown origin. Licensed Practical Nurse #6 assessed Resident #266 and informed the Nurse Practitioner. A Nursing Evaluation Note dated 1/14/2024 at 4:10 AM documented Licensed Practical Nurse #6 was called to the unit by the charge nurse due to Resident #266 was found lying on the floor in the doorway of their room. Licensed Practical Nurse #6 assessed Resident #266, had them transferred to the wheelchair, and informed the Nurse Practitioner. The New York State Office Professions Registrations for Licensed Practical Nurse #6 documented they were registered until 6/2026. There was no documented evidence Resident #266 received an assessment from a qualified and competent Registered Nurse following an injury of unknown origin and fall on 1/14/2024. On 04/22/2024 at 04:33 PM, Licensed Practical Nurse #4 was interviewed and stated they were the charge nurse on Resident #266's unit when the resident had an injury of unknown origin and fall on 1/14/2024. Licensed Practical Nurse #4 called and reported the incidents to the Supervisor for that shift, Licensed Practical Nurse #6. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/2024 at 07:27 AM and 03:29 PM, Licensed Practical Nurse #6 was interviewed and stated they were the Supervisor in the building on 1/14/2024 when Resident #266 had discoloration to their left hand and a fall. Licensed Practical Nurse #6 assessed the resident, contacted the Nurse Practitioner, initiated an incident report, and ordered an x-ray. Licensed Practical Nurse #6 stated they failed the Registered Nurse licensing exam and was not approved for a permit to practice as a Registered Nurse in New York State. Licensed Practical Nurse #6 stated they were designated as a Supervisor and practicing the capacity of Registered Nurse on 1/14/2024 when Resident #266 had their incidents. On 04/23/2024 at 12:10 PM, the Director of Nursing was interviewed and stated the nurse on the unit was responsible for assessing residents when incidents occur. Licensed Practical Nurse #6 was the Registered Nurse Supervisor for the building on 1/14/2024 on the 11PM to 7AM shift. The Director of Nursing stated they believed the Licensed Practical Nurse #6 could practice in the capacity as a Registered Nurse because they held degree in Associate's in Nursing meeting the education requirements of a Registered Nurse. The Director of Nursing did not know whether Licensed Practical Nurse #6 had a permit to practice as a Registered Nurse in New York State. 10 NYCRR 415.13(a-b)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37787 44864 Based on observation, record review, and interviews conducted during the Recertification survey from 04/17/2024 to 04/24/2024, the facility did not ensure that infection control prevention practices and procedures were maintained. This was evident for 2 (Resident #276 and #127) of 38 total sampled residents. Specifically, 1) Enhanced Barrier Precautions were not maintained during Foley catheter care for Resident #276, and 2) Enhanced Barrier Precautions were not maintained for gastrostomy tube medication administrations for Resident #127. The findings are: The facility policy titled Clinical Operations dated 5/18/2023 documented Enhanced Barrier Precautions are applicable for residents with infection or colonization of a multidrug-resistant organisms and indwelling medical devices (central line, urinary catheter, feeding tube, tracheostomy/ventilator). 1) Resident #276 had a diagnosis of obstructive uropathy and non-Alzheimer's dementia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #276 was severely cognitively impaired and had an indwelling catheter. On 04/19/2024 at 09:56 AM, Licensed Practical Nurse #7 was observed entering Resident #276's room to provide Foley catheter care. Licensed Practical Nurse #7 did not don a gown prior to providing Foley catheter care to Resident #276. On 04/19/2024 at 09:58 AM, Licensed Practical Nurse #7 was interviewed and stated they were not aware they needed to wear a gown for Enhanced Barrier Precautions when providing Foley catheter care to residents. They were just inserviced regarding this infection control requirement today. 2) Resident #127 had diagnoses of dysphagia and gastrostomy status. The Physician's Order dated 1/5/2024 documented Resident #127 received Metformin 500 milligrams via gastrostomy tube twice daily. The Physician's Order dated 3/8/2024 documented Resident #127 received Enulose solution 30 milliliters via gastrostomy Tube once daily every Monday, Wednesday, and Friday. On 04/19/2024 at 09:38 AM, Licensed Practical Nurse #8 was observed entering Resident #127's room to administer medication to Resident #127 via gastrostomy tube. Licensed Practical Nurse #8 checked for patency, administered the medications via gastrostomy tube, and flushed the gastrostomy tube. Licensed Practical Nurse #8 did not don a gown prior to administering medication to Resident #127 via their gastrostomy tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/2024 at 09:45am, Licensed Practical Nurse #8 was interviewed and stated they were not aware of Enhanced Barrier Precautions and did not know they were supposed to don a gown prior to administering medications to residents with a gastrostomy tube. On 04/19/2024 at 10:06 AM, Registered Nurse #4 was interviewed and stated inservices regarding Enhanced Barrier Precautions were currently being provided and they were not aware that Enhanced Barrier Precaution were in effect. On 04/19/2024 at 11:27 AM, the Assistant Director of Nursing was interviewed and stated they were newly hired as the Infection Preventionist and realized the facility had not initiated Enhanced Barrier Precautions. They were in the process of inservicing staff to ensure they followed Enhanced Barrier Precautions protocol. On 04/23/2024 at 12:19 PM, the Director of Nursing was interviewed and stated Enhanced Barrier Precautions were actively being implemented but the facility was awaiting the delivery of some supplies to fully implement the protocol. 415.19(b)(4)