STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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** 42101 Based on record review and interview conducted during the recertification survey from 1/29/2024 to 02/06/2024, the facility did not ensure the resident's representative was immediately notified of a need to alter the resident's treatment. This was evident for 1 (Resident #289) of 2 residents reviewed for Notification of Change out of 38 total sampled residents. Specifically, Resident #289 was ordered to start an antianxiety medication, Buspirone, and the designated representative was not immediately informed. The findings are: The facility policy titled Change in Resident's Condition or Status dated 11/2023 documented the facility will promptly notify the resident, their attending physician and representative of changes in their medical condition and/or status. Notification will be made within twenty-four hours of a change occurring. Resident #289 had diagnoses of dementia and recurrent falls. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #289 had severely impaired cognition. On 01/30/2024 at 11:40 AM, Resident #289's designated representative was interviewed and stated Resident #289 was started on Buspirone at the facility on 1/19/2024. They were not notified of the change in medication until 1/24/2024. The Medical Doctor Note dated 1/8/2024 documented Resident #289 was restless with verbal outbursts and Buspirone 5 mg will be ordered for anxiety. The Physician's Order dated 1/19/2024 documented Buspirone 5 milligrams 3 times daily for anxiety. The Orders Administration note dated 1/20/2024, 1/21/2024 and 1/22/2024 documented Resident #289 refused the Buspirone 5 mg. The Nursing Note dated 1/23/2024 at 09:38AM documented Resident #289's representative was informed the resident was ordered Buspirone 5 mg 3 times daily for anxiety. The designated representative requested the nurse have the Buspirone discontinued. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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	There was no documented evidence Resident #289's designated representative was informed when Buspirone 5 mg was ordered for anxiety. On 02/05/2024 at 12:58PM, Licensed Practical Nurse #5 was interviewed and stated the nursing supervisor was responsible for contacting the designated representative of Resident #289 when the resident was prescribed Buspirone. On 02/05/2024 at 01:02PM, Registered Nurse # 5 was interviewed and stated they did not work on 1/19/2024 when Resident #289 was prescribed Buspirone. Physician's orders for psychotropic medication required designated representative approval. On 02/05/2024 at 02:43PM, the Medical Doctor #1 was interviewed and stated Resident #289 was agitated, and they provided a telephone order to the nurse for the resident to start receiving Buspirone 5 mg. The designated representative should be contacted prior to the start of new medication so they can be aware of the risks and benefits. The designated representative could agree or disagree with a new medication order. 10 NYCRR 415.3(f)(2)(ii)(c)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864 Based on observations, interviews, and record review conducted during the Recertification Survey from 01/29/2024 to 2/06/2024, the facility did not ensure that a resident remained free of physical restraints. This was evidenced for 1 (Resident #36) resident reviewed for Physical Restraints out of 38 total sampled residents. Specifically, Resident #36 was seated in a wheelchair in the floor dining room in a boxed-in position preventing them from moving around. The findings are: The facility policy titled Restraint Usage dated 06/22 documented restraints shall only be used to treat the resident's medical symptoms and never for discipline or staff convenience. The dignity, rights and wellbeing of the resident will be maintained. Resident #36 had diagnoses of Autistic disorder, anxiety disorder, and Schizophrenia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #36 was severely cognitively impaired and exhibited behavioral symptoms not directed towards others daily. On 01/29/2024 at 12:17 PM and 01/30/24 at 12:20 PM, Resident #36 was observed sitting in a wheelchair in the floor dining room with a wall to their left and behind them, a non-ambulatory resident in a recliner to their right and an overbed table directly in front of them. A non-ambulatory resident was seated directly in front of Resident #36's overbed table, preventing Resident #36 from moving from that seated location. A Physician's Orders dated 1/16/24 documented floor ambulation program by walking with partial handheld assistance of 1 person, for a minimum of 15 minutes twice daily, for a minimum of 150 feet up to a distance as tolerated. The Comprehensive Care Plan related to Alteration in Mood and Behavior was initiated 04/20/2015 documented Resident #36 stole food from other residents and ran away stuffing food in their mouth. Resident #36 hits themselves and screams when staff intervene. Interventions included Resident #36 eating meals in the hallway outside of the floor dining room with supervision. The Comprehensive Care Plan related to Resident #36's risk of victimizing others with socially inappropriate behavior, verbal disruption, and taking other resident's foods was created 6/19/2013 documented Resident #36 should be seated at arm's length from others as needed and separated from others during socially inappropriate episodes. Social services note dated 10/25/2023 documented Resident #36 had episodes of stealing food from other residents' trays and hitting and biting themselves during staff redirection. Staff monitoring ongoing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Note dated 1/28/20 24 documented Resident #36 attempted to grab food from other resident's trays and was difficult to redirect. Resident #36 began hitting and biting themselves while seated on the floor when redirected by staff. Snacks were offered. On 02/01/2024 at 11:34 AM, Certified Nursing Assistant #10 was interviewed and stated Resident #36 had a behavior of grabbing other resident's food. Staff were able to monitor Resident #36 when they were seated in a wheelchair against the wall in the floor dining room. Resident #36 was prevented from being too close to other residents when placed in this position. There was no documented evidence Resident #36 was adequately assessed for and ordered to be restrained against a wall without being able to independently exit the area. On 01/30/2024 at 01:05 PM, Licensed Practical Nurse #2 was interviewed and stated Resident #36 was problematic, and redirection was difficult. Resident #36 had a diagnosis of mental retardation and sat quietly when placed in the seated position by the wall in the floor dining room. On 01/30/2024 at 01:13 PM, Registered Nurse Supervisor #3 was interviewed and stated placing Resident #36 in the floor dining room by the wall with a resident on each side could be considered a restraint because the resident could not get out of the area by themselves. On 02/02/2024 at 02:53 PM, the Assistant Director Social Work was interviewed and stated Resident #6's behavior of grabbing food from other resident's plates was new and performing repetitive actions with them seemed to calm the resident. On 02/06/2024 at 12:41 PM, the Chief Nursing Officer was interviewed and stated they were shocked Resident #36 was in an enclosed seating arrangement and the resident should not be hindered from moving around. 10 NYCRR 415.4(a)(2-7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 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** 48931 Based on record review and interviews conducted during the Recertification survey from 01/29/2024 to 02/06/2024, the facility did not ensure adequate supervision and an environment free from accident hazards. This was evident for 1 (Resident #88) of 4 resident reviewed for accidents out of 38 total sampled residents. Specifically, Resident #88 was observed in possession of a sharp steak knife in their room. The findings are: Resident #88 had diagnoses of congestive heart failure and diabetes. The facility policy titled Accidents/incident/Occurrence dated 4/2023 documented the Comprehensive Care Plan will be reviewed and revised as needed to reflect occurrence and prevention measures. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #88 was cognitively intact. On 01/29/2024 at 10:53 AM, Resident #88 was observed in their room in bed and a sharp metal steak knife was observed standing up in a coffee mug on their bedside table. Resident #88 was interviewed and stated they had the knife since their admission to the facility in 2020 and always store it in the coffee mug on their bedside table. They used the knife to cut their food during mealtimes. The Comprehensive Care Plan related to Accidents dated 12/08/2020 documented Resident #88 was at risk for victimization and redirection provided as needed. There was no documented evidence Resident #88's possession of a knife was identified as a hazard and addressed. On 02/05/2024 at 12:04 PM, an interview was conducted with Certified Nursing Assistant #6 who stated that they conducted rounds in Resident #88's room on the morning of 1/29/2024 and observed the knife in the resident's coffee mug and this was not the first time they saw Resident #88 had a knife in their possession. Certified Nursing Assistant #6 reported the observation of the knife in Resident #88's room a few months ago to the nurse. Certified Nursing Assistant no longer thought the knife was a concern because Resident #88 told them it was not an issue with staff previously and did not seem like a threat. On 02/01/2024 at 11:00 AM, an interview was conducted with Licensed Practical Nurse #4 who stated they were not aware Resident #88 had a metal steak knife in their room. The knife was removed, and the supervisor was informed. On 02/02/2024 at 10:51 AM, an interview was conducted with Registered Nurse Supervisor #4 who stated they became aware Resident #88 had a knife in their room on 1/29/2024. Resident #88 was alert and oriented with no previous history of suicidal or homicidal behaviors. Visual rounds were being conducted on Resident #88's unit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/05/2024 at 12:54 PM, an interview was conducted with the Assistant Director of Nursing who stated they were not aware Resident #88 had a knife in plain view in their room until 1/29/2024. On 02/06/2024 at 11:05 AM, an interview was conducted with the Chief Nursing Officer who stated the staff on Resident #88's unit fully acknowledged the responsibility to report finding a knife in a resident's room in a timely manner. 10 NYCRR 415.12(h)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on record review and interviews conducted during the Recertification survey from 1/29/2024 to 2/06/2024, the facility did not ensure the development and maintenance of policies and procedures for the monthly drug regimen review that include time frames for the different steps in the process. This was evident for 1 (Resident #78) of 5 residents reviewed for Unnecessary Medications out of 38 total sampled residents. Specifically, the facility policy for the drug monthly regimen review did not develop a timeline for the Medical Doctor to answer the pharmacist's recommendations for Resident #78. The findings are: The facility policy titled Drug Regimen Review dated 9/2021 documented the pharmacist will report any irregularities to the Medical Doctor, Director of Nursing and Medical Director. Medical Doctors will receive and respond appropriately to drug regimen reviews. Resident #78 had diagnoses of hypertension and left eye blindness. The Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #78 had moderately impaired cognition. A Physician's Order dated 8/30/2023 documented Resident #78 received 1 drop of Latanoprost Ophthalmic Solution 0.005% in their right eye daily. The Drug Regimen Review dated 10/10/2023 documented the Pharmacist recommended Resident #78 receive Latanoprost eye drops at bedtime for better efficacy. The Drug Regimen Review documented Medical Doctor #1's signed in agreement on 12/27/2023. There was no documented evidence the facility developed a timeline for attending physician response of drug regimen reviews. On 02/06/2024 at 01:47PM, the Assistant Director of Nursing #2 was interviewed and stated the drug regimen review arrived via email and were forwarded to the Medical Doctor. The response could be delayed if the Medical Doctor takes time reviewing the recommendations. Medical Doctor #2 was assigned to Resident #78 in 10/2023 but no longer worked for the facility. There was a Medical Doctor assigned to cover the facility at all times and could be asked to address a drug regimen review. On 2/01/2024 at 04:30 PM, the Pharmacist Consultant was interviewed and stated they performed the drug regimen reviews. They check the resident's profile in the medical record to ensure their drug regimen reviews were sent to the correct assigned Medical Doctor. The Pharmacist was not aware of any recent Medical Doctor changes in the facility. The Director of Nursing, Assistant Director of Nursing, and nursing supervisors received a copy of all drug regime reviews. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335505	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Care Center	91 31 175th Street Jamaica, NY 11432

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/01/2024 at 5:25PM, Medical Doctor #2 was interviewed and stated they stopped working at the facility a few months ago and Medical Director #1 took over their caseload. The drug regimen review was reviewed weekly or as they were given by the Pharmacist. The nursing supervisor also provided the Medical Doctors with a copy of the drug regimen reviews. There was also a separate drug regimen review folder for pharmacy recommendations that could be reviewed. On 02/06/2024 at 11:29 AM, Medical Doctor #1 was interviewed and stated drug regimen reviews were completed timely. Medical Doctor reviewed the drug regimen reviews and signed when they agreed with a recommendation. 10 NYCRR 415.18(c)(2)