STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335791	A. Building B. Wing	05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queens Boulevard Extended Care Facility	61 11 Queens Boulevard Woodside, NY 11377

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 40565 Based on interviews and record review conducted during the Recertification survey from 05/18/22 to 05/25/22, the facility did not ensure a resident was provided information to formulate advanced directives (AD). This was evident for 1 (Resident #417) of 1 resident reviewed for ADs out of a sample of 37 resident reviewed. Specifically, there was no documented evidence Resident #417 received education and formulated ADs. The findings are: The facility policy titled Advance Directives dated October 21, 2008, documented the Social Worker (SW) will discuss and distribute to all new resident and/or Designated Representatives, information about Advance directives; and document that information was given. Resident #417 was admitted to the facility 05/17/2022 with diagnoses of diabetes mellitus and chronic obstructive pulmonary disease. On 05/23/22 at 12:27 PM, Resident #417 was interviewed and stated they were admitted to the facility approximately one week ago and no one has educated them regarding ADs. On 05/23/22 at 12:56 PM, the Registered Nurse (RN) # 1 was interviewed and stated Social Workers (SW) is responsible for immediately educating alert and oriented residents re: ADs when the resident is newly admitted to the facility. SW contacts the resident's family and discusses AD wishes when the resident is unable to make decisions. On 05/23/22 at 02:13 PM, SW was interviewed and stated they are responsible for educating newly admitted , alert and oriented residents re: ADs within 24-48 hours of admission to the facility. The resident's representative (RR) is contacted to discuss ADs when a resident is unable to make decisions. Then an AD care plan is initiated. There was a delay in providing Resident #417 with AD education because the facility has a lot of new admissions, and the SW is unable to meet with all of them. On 05/24/22 at 08:10 AM, The Director of Social Service was interviewed and stated the SW educates the resident or RR as soon as possible upon admission but no later than 72 hours. 415.3(e)(1)(ii)

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observation, record review, and interview conducted during the Recertification Survey from 5/18/22 to 5/25/22, the facility did not ensure the Minimum Data Set 3.0 (MDS) assessment accurately reflected the resident's status. This was evident for 1 (Resident #65) of 5 residents reviewed for Unnecessary Medications. Specifically, the MDS did not document Resident #65's evaluation for Gradual Dose Reduction (GDR) of psychotropic drugs. The findings are: The facility undated policy titled MDS 3.0 documented the facility will ensure MDS Coordinators work with floor Nurses to ensure accurate documentation. Resident #65 had diagnoses of non-Alzheimer's dementia, depression, and psychotic disorder. The MDS dated [DATE] and 02/09/2022 documented Resident #65 was severely cognitively impaired, received antipsychotic and antidepressant medication within 7 days prior to the MDS date, and a GDR had not been attempted or documented physician (MD) as clinically contraindicated. Psychiatric Evaluation Progress note dated 12/03/2021 documented Resident #65 was examined, and GDR was not attempted because the resident's symptoms were not resolved, the resident was at risk for psychiatric decompensation, and at risk for impaired functioning or increased dysphoria if the resident received a lower dose. MD Order dated 5/12/2022 documented Resident #65 received quetiapine 50 mg tablet twice daily for schizophrenia and trazodone 100 mg tablet once daily at bedtime for major depressive disorder. On 5/23/22 at 11:33 AM, the MDS Coordinator (MDSC) was interviewed and stated Resident #65 resident is frequently seen by the Psychiatrist for medication review. The Psychiatrist documented on 12/3/2021 that GDR for Resident #65 was contraindicated, and this was wrongly coded on the MDS. 415.11(b)

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	335791	A. Building B. Wing	05/25/2022

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350 Based on observations, interviews, and record review conducted during the Recertification Survey from 05/18/2022 to 05/25/2022, the facility did not ensure the development of a comprehensive, person-centered care plan (CCP) consistent with the resident's medical, nursing and mental and psychosocial needs. This was evident in 1 (Resident #264) of 1 resident reviewed for constipation. Specifically, Resident #264 was receiving psychotropic and constipation medication, and related CCPs were not developed. The findings are: The undated facility policy titled Care Planning - Interdisciplinary documented the comprehensive care plan will facilitate the inclusion of the resident and/or RR and will include an assessment of the resident's strengths and needs. Resident #264 had diagnoses of constipation and anxiety Disorder. The Minimum Data Set (MDS) dated [DATE] documented Resident #264 was cognitively intact. The Physician Order as of 5/23/2022 documented Resident #264 received Celexa 40 mg once daily for anxiety. The resident was also ordered docusate sodium 100 mg daily, lactulose 10 gm/15 ml twice daily, polyethylene glycol 17 gm once daily, senna 86 mg 2 tabs at bedtime, and disposable enemas as needed for constipation. A CCP related psychotropic drugs was initiated on 04/22/2022 and a CCP related to constipation was initiated on 04/23/2022 for Resident #264. There were no documented interventions on the CCPs related to psychotropic drugs and constipation. On 05/23/2022 at 2:28 PM, Registered Nurse #5 was interviewed and stated they are responsible for filling out the CCPs for Resident #264 and they were unaware the CCPs related to psychotropic drug use and constipation were not completed and had no interventions listed. This was an oversight. 415.11(c)(1)

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Queens Boulevard Extended Care Facility	61 11 Queens Boulevard Woodside, NY 11377

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43350 Based on interviews and record reviews conducted during a Recertification and Complaint (NY00294185) Survey from 05/18/2022 to 05/25/2022, the facility did not ensure that a resident's representative (RR) was involved in revision of a resident's person-centered plan of care (CCP) with the interdisciplinary team (IDT). This was evident in 1 (Resident #48) of 35 residents reviewed. Specifically, the facility did not involve Resident #48's RR in revision of the resident's CCP to address Resident #48's ongoing refusal to be transferred out of bed and to receive showers. The findings are: The undated facility policy titled Care Planning - Interdisciplinary documented the comprehensive care plan will facilitate the inclusion of the resident and/or RR and will include an assessment of the resident's strengths and needs. Resident #48 had diagnoses of cerebral infarction and non-Alzheimer's dementia. The Minimum Data Set 3.0 (MDS) dated [DATE] documented the Resident #48 was severely cognitively impaired, was totally dependent on two people for assistance with bed mobility, transfers and toileting, and required extensive assistance of one person for personal hygiene. On 04/13/2022, the Aspen Complaint Tracking System documented a complaint Resident #48 was not being taken out of bed or showered. The CCP related to Activities of Daily Living (ADL) initiated 10/15/2019 and revised 12/01/2021 documented Resident #48 received showers twice weekly or as preferred. A CCP related to noncompliance initiated 10/21/2019 and revised 03/12/2022 documented Resident #48 refused to get out of bed. Documented interventions included to checking resident's unmet needs, encouraging family to visit, encouraging participation in ADLs, monitoring behavior, notifying the physician for the resident to be assessed medically for signs of inappropriate behavior, orienting to daily routines, providing reorientation through verbal cues and calendars, and redirecting negative behaviors and use a calm approach. There was no documented evidence the IDT involved Resident #48's RR to review and revise Resident #48's CCP related to refusals to be transferred out of bed or shower. On 05/23/2022 at 9:30 AM, Registered Nurse (RN) #2 was interviewed and stated Resident #48 is encouraged to come out of bed but the resident fears the mechanical lifter and geri-chair. Resident #48's RR was informed of the resident's refusal to come out of bed and have showers. RN #2 could not recall the last time they spoke with Resident #48's RR and was unable to provide documented evidence RN #2 included the resident's RR in the CCP process relating to Resident #48's refusals to get out of bed and shower. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/2022 at 9:56 AM, Certified Nursing Assistant (CNA) #2 was interviewed and stated Resident #48 has not gotten out of bed for several months, has not been weighed, and has not left the bed to have the linens changed. This is the resident's choice. CNA #2 has not spoken with Resident #48's RR. On 05/24/2022 at 8:49 AM, CNA #3 was interviewed and stated the Resident #48 was never given a shower but was always bathed in bed due to daily refusals to come out of bed. On 05/24/2022 at 9:00 AM, RN #3 was interviewed and stated they have never seen Resident #48 taken out of bed and Resident #48 received bed baths instead of showers. RN #3 is primarily the medication nurse and spoke with the Resident #48's RR once. If there are any concerns, the charge nurse is responsible for addressing them with the RR. On 05/24/2022 at 9:11 AM, the Social Worker (SW) was interviewed and stated they have been assigned to Resident #48 for approximately 2 months and spoke with Resident #48's RR twice. The SW did not discuss Resident #48's refusal to get out of bed or shower with the RR because the SW was unaware Resident #48 was displaying this behavior. Resident #48's refusal to get out of bed could be addressed by revising CCP interventions to include scheduling showers on days the RR visits; however, the IDT did not meet and discuss interventions for Resident #48's behavior. On 05/25/2022 at 10:06 AM, the Director of Nursing (DON) was interviewed and stated if a resident's refusals become a pattern the family must be involved in the care planning process. The IDT spoke with Resident #48's RR on numerous occasions. The DON was unable to provide documented evidence Resident #48's RR was involved in the revision of the resident's CCP related to refusal to get out of bed and shower. 415.11(c)(2)(i-iii)

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	335791	A. Building B. Wing	05/25/2022

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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** 39136 Based on observation, interviews, and record review conducted during the Recertification survey from 5/18/22 to 5/25/22, the facility did not ensure a residents environment remained free of hazards. This was evident for 1 (#516) of 4 residents reviewed for respiratory care. Specifically, a large Oxygen Cylinder (OC) at Resident #516's bedside was not properly secured. The finding includes: The facility policy titled Oxygen Administration/Therapy dated 07/20/2021 documented when using oxygen cylinders, secure oxygen cylinders at the bedside by using a tank holder/chain. Tighten around the cylinder's base or placing the cylinder carrier vertically, making sure the cylinder is strapped or chained to the carrier and the wheels on a carrier are folded flat against the cylinder. On 05/18/2022 at 11:59 AM, 05/19/2022 at 10:10 AM, and 05/20/2022 at 9:58 AM, a large OC was observed on the right side of Resident #516's bed. The large OC was not secured in a carrier or chained to the wall. Resident # 516 was admitted on [DATE] and had diagnoses asthma and acute embolism/thrombus. On 05/2020/22 at 2:23 PM, the Director of Maintenance (DOM) was interviewed and stated the large OC is secured with a chain at bedside. The large OC at Resident # 516's bedside is not secured, and it should have been secured. Whenever Maintenance brings a large OC to the floor, it is supposed to be secured with a chain for safety. On 05/20/2022 at 2:37 PM, the Registered Nurse Supervisor (RNS) was interviewed and stated the central supply office and Maintenance department are responsible for checking and ensuring that the OC is secured. The large OC comes in a stand or is chained to the wall for safety. The RNS stated they did not notice the large OC at Resident # 516's bedside was not secured and did not inform maintenance. On 05/24/2022 at 4:30 PM, the Administrator was interviewed and stated the central supply office ensures that large OCs are placed it in a holder and secured to the wall with a chain for safety. The nursing staff should have immediately notified Maintenance when the unsecured OC was left at the bedside. 415.12(h)(1)

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	335791	A. Building B. Wing	05/25/2022

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on observation, record review, and interviews conducted during the Recertification survey from 05/18/2022 to 05/25/2022, the facility did not ensure residents with respiratory care were provided such care consistent with professional standards of practice. This was evident for 1 (Resident #516) of 4 residents reviewed for respiratory care. Specifically, Resident #516 was observed several times being administered oxygen therapy via nasal cannula (NC) without a Medical Doctor Order (MDO). The findings are: The facility policy titled Care of Oxygen Equipment dated 07/15/2020 documented the licensed nurse implements oxygen delivery orders per MDO and according to the plan of care. Resident # 516 was admitted on [DATE] and had diagnoses asthma and acute embolism/thrombus. On 05/18/2022 at 11:59 AM, 05/20/2022 at 9:58 AM, and 05/20/2022 at 9:58 AM, Resident # 516 was observed with oxygen 2 liters per minute (lpm) via NC running from a concentrator to the resident's nose. On 05/20/2022 at 1:55 PM, Resident # 516 was interviewed and stated their inhaler was not available upon admission and the nurse gave Resident #516 oxygen therapy. There was no documented evidence Resident #516 was ordered to have oxygen therapy. On 05/20/2022 at 1:50 PM, Registered Nurse # 2 (RN) was interviewed and stated Resident # 516 receives oxygen 2 lpm via NC. RN #2 was unable to provide documented evidence Resident #516 had an MDO to receive oxygen therapy. On 05/20/2022 at 2:37 PM and 05/24/2022 at 10:52 AM, the Registered Nurse Supervisor (RNS) was interviewed and stated the nurse assesses residents with difficulty breathing, initiates oxygen 2 lpm via NC and calls the Medical Doctor (MD) to obtain an MDO. Oxygen is administered according to MDO, and Resident #516 does not have a MDO for oxygen therapy. The RNS called the MD and obtained an order for Resident #516 to receive oxygen therapy on the evening of 05/15/2022 because the resident requested oxygen but forgot to transcribe the MDO. Any nurse working with Resident #516 would have seen the resident being administered oxygen and should have checked to ensure there was an MDO. On 05/25/2022 at 1:11 PM, the MD was interviewed and stated the nurse initiates oxygen based on their assessment of the resident and then calls the MD for an MDO. The nurse called the MD but forgot to transcribe the MDO. On 05/25/22 at 1:38 PM, the Director of Nursing (DON) was interviewed and stated RNs must promptly obtain an MDO for oxygen therapy and document the MDO in the resident's medical record. All nurses thereafter ensure the resident receives oxygen therapy according to MDO. 415.12(k)(6)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45988 Based on observation, record review, and interviews conducted during the Recertification Survey from 5/18/2022 to 5/25/2022, the facility did not ensure a resident was adequately equipped to call for assistance through a communication system. This was evident for 1 (Resident #29) of 35 residents reviewed. Specifically, there were multiple observations of Resident #29 without an operating Call Bell (CB) next to their bed. The findings are: The facility's policy titled Call Lights/Bells dated 9/2005 documented the CB system is the primary means of communication between residents and nursing staff. CBs will be operable, accessible, and within resident's reach. Resident #29 had diagnoses of heart failure, blindness of the right eye, and hearing loss. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #29 had mild cognitive impairment, required extensive assistance of one person for bed mobility, transfers and personal hygiene, and required limited assistance of one person for dressing and toilet use. On 05/18/22 at 10:13 AM, Resident #29 was interviewed and stated their CB was disconnected from the wall and not functioning. Resident #29 reported the disconnected CB to a staff member the previous evening and was told someone would come repair it. During the interview the CB was observed dislodged from the wall and hanging on a chair next to the resident's bed. On 05/19/22 at 09:40 AM and 05/20/22 at 09:29 AM, Resident #29 was observed in bed and their CB was disconnected from the wall. There was no documented evidence a request to fix Resident #29's CB was written in the Maintenance work order book prior to 05/20/22. On 05/20/22 at 09:38 AM, Certified Nursing Assistant (CNA) #6 was interviewed and stated CNA #6 was assigned to Resident #29 and was unaware the CB next to Resident #29's bed was disconnected and not functioning. Resident #29 is alert and rings the CB for assistance, uses their walker to ambulate to the bathroom unassisted, and used the CB in the bathroom to call CNA #6 yesterday. Maintenance is responsible for checking CBs are functional. On 05/20/22 at 02:13 PM, Licensed Practical Nurse (LPN) #2 was interviewed and stated Maintenance checks the CBs periodically. LPN #2 was unaware Resident #29's CB was not functioning and did not know if Resident #29 informed staff. There is no way for staff to know the CB is not functioning unless Resident #29 alerts staff. On 05/23/22 at 02:51 PM, Maintenance Worker (MW) #13 was interviewed and stated there is a work order book where staff alert MWs to CBs in need of repair and staff can immediately contact MWs by paging them on the overhead system. (continued on next page)

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	335791	A. Building B. Wing	05/25/2022

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	415.29