STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335799	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Union Plaza Care Center	33 23 Union Street Flushing, NY 11354

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45351 Based on observation, record review and interviews conducted during the Recertification survey from 8/21/2024 to 8/28/2024, the facility did not ensure that, to the extent practicable, the resident or resident representative participated in the development, review and revision of the comprehensive care plan. Specifically, Resident #54 and/or Designated Representative were not afforded the opportunity to participate in quarterly care plan meetings. This was evident in 1 out of 1 residents reviewed for Resident Assessment (Resident #54). The findings are: The facility's policy and procedure titled Care Plan reviewed 4/8/2024 documented: interdisciplinary team will meet to discuss and review the comprehensive care plan of each resident on admission, by 21 day, quarterly, annually for any significant change and as needed. Resident/family/responsible party will be invited to participate in the meeting. Resident #54 was admitted to the facility with diagnosis of Diabetes Mellitus, Hyperlipidemia and Non-Alzheimer's Dementia. The Quarterly Minimum Data Set, dated dated dated [DATE] documented resident has moderately impaired cognition. Resident and family participated in the assessment. On 8/28/2024 at 11:11 AM, Resident #54 stated they do not recall getting invited or participating in a meeting to discuss their treatments/care needs. The Comprehensive Care Plan meeting sign in sheet for Resident #54 contained no signatures from Resident #54 or their representative for the quarterly care plan meeting held on 3/8/2024. A review of Social Service notes revealed care plan meeting for significant change was held for Resident #54 on 3/8/2024. There is no documented evidence Resident #54 and/or their Designated Representative were invited to the quarterly care plan meeting on 3/8/2024. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/2024 at 11:12 AM, Registered Nurse Supervisor #5 was interviewed and stated, the care plan meeting is held by the interdisciplinary team for initial/annual, significant change or when a psychotropic med is initiated. Resident #54 and/or their Designated Representative are invited to these meetings. Registered Nurse Supervisor #5 stated the interdisciplinary team do not hold care plan meetings quarterly, but every department is responsible to review/update resident's care plans quarterly. Currently, there is no quarterly care plan meeting happening for residents and their designated representatives. On 8/27/2024 at 10:01 AM, the Director of Social Service was interviewed and stated there are no quarterly care plan meetings held by the interdisciplinary team, only when requested. Director of Social Service stated they have not been doing any meetings with the resident/designated representative for quarterly care plan review. It has not been the facility's practice to offer residents to participate every quarter. On 8/28/2024 at 11:07 AM, the Director of Nursing was interviewed and stated, the interdisciplinary team does not have quarterly meetings for care plan review. Resident/designated representative have not been invited to care plan meetings quarterly. However, care plans are reviewed and updated every quarter by the departments. 10 NYCRR 415.11(c)(2)(i-iii)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48907 Based on observation, record review, and interviews conducted during the Abbreviated survey (NY00320628 and NY00346784) and Recertification survey from 8/21/24 to 8/28/24, 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. This was evident in 3 out of 38 residents sampled (Residents #22, #147, and #44). Specifically, on 07/21/2023 approximately 5 minutes apart, Resident #22 and Resident #147 (who are roommates) reported that they were rough handled and hit by Certified Nursing Assistant #1. The facility did not report the allegations of abuse within 2 hours to New York State Department of Health. 2) Resident #44 reported an allegation of abuse that was not reported within 2 hours to the New York State Department of Health. The Facility's Policy and Procedure on Resident Freedom from Abuse, Neglect, and Mistreatment revised 09/05/2023, documented that it is the policy of this facility to ensure that every resident be free from verbal, sexual, physical, and mental abuse. The policy further documented if, at any point during the investigation, a determination is made that there is reasonable cause, sufficient evidence for a prudent person to believe that abuse occurred, the Administrator/Designee will immediately report the allegations to the Department of Health. The Facility's Policy and Procedure on Accident/Incident Reporting Protocol revised 12/21/2023, documented that it is the policy of this facility to ensure an environment that is free from accidents, hazards, and provides supervision and assistive devices to each resident to prevent avoidable accidents. The policy further documented to report of an alleged violation involving abuse OR resulting in serious bodily injury immediately, but not later than two hours after the allegation is made, to the administrator of the facility and to other officials, including to the State survey and certification agency. 1) Resident #22 was admitted to the facility with diagnoses including Heart Failure, Respiratory Failure, and Diabetes Mellitus. The Minimum Data Set (an assessment tool), dated 06/24/2023, documented Resident #22 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 12 associated with moderately impaired cognition. A Comprehensive Care Plan for abuse dated 05/27/2023, documented interventions to provide supportive services and emotional reassurance as needed and encourage resident to promptly report any negative interactions with peers, staff , or family. Resident #147 was admitted to the facility with diagnoses including Coronary Artery Disease, Non-Alzheimer's Dementia, Heart failure, and Depression. The Minimum Data Set (an assessment tool), dated 06/05/2023, documented Resident #147 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 11 associated with moderately impaired cognition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan for abuse dated 04/26/2023, documented interventions to provide supportive services and emotional reassurance as needed and encourage resident to vent/verbalize feelings. The facility's Investigation Summary dated 07/25/2023 documented that at approximately 7:20 am Resident #22 reported to Registered Nurse Supervisor that the night shift (11:00 pm-7:00 am shift) Certified Nursing Assistant was rough during care and hit them in their buttocks and face. On 07/21/2023 at approximately 7:25 am, Resident #147 (roommate of Resident #22) reported to Registered Nurse Supervisor that Certified Nursing Assistant #1 was rough during care and hit them in the face and shoulder. The investigation documented that Resident #22 and Resident #147 were assessed. There were no visible injuries noted. The investigation concluded that the allegation could not be verified because of insufficient information. During an interview on 08/23/2024 at 3:18 pm, Administrator stated any abuse allegation should be reported within two hours. Administrator stated they do not know why the incident was not reported within the time frame. During a telephone interview on 08/26/2024 at 1:45 pm, Registered Nurse Investigator stated they were under the impression that if there is bodily injury, an allegation of abuse should be reported to New York State Department of Health within 2 hours. Registered Nurse Investigator stated they reported the incident to New York State Department of Health within 24 hours of being aware.) 44842 2) Resident #44 was admitted to the facility with diagnoses including Diabetes Mellitus, Cerebral Infarction, and Age-related cognitive decline. The Minimum Data Set (an assessment tool), dated 06/30/2024, documented Resident #44 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 13 associated with intact cognition. A Comprehensive Care Plan for abuse dated 06/23/2024, documented interventions to provide supportive services and emotional reassurance as needed and encourage resident to promptly report any negative interactions with peers, staff, or family. The facility's Accident/Incident Summary dated 07/08/2024 documented that Resident #44 reported on 06/29/2024 that two different black men on two different occasions touched their shoulders and breast. The investigative findings documented that Resident #44 was assessed and there were no visible injuries or emotional distress noted. The investigation concluded that the allegation could not be verified because there was not sufficient evidence to support that abuse occurred. During an interview on 08/28/2024 at 9:51 am, the Director of Nursing stated the abuse allegation was reported 2 hours late and it should have been reported within 2 hours. The Director of Nursing further stated they do not know why the incident was reported late since the Administrator conducted the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/30/2024 at 1:02 PM, the Administrator who is also the Investigator stated they reported the sexual abuse allegation late because they were on site in Resident #44's room spending time with Resident #44, their offspring, and the police officers. The Administrator stated next time they will notify the New York State Department of Health immediately with whatever information they have. The Administrator further stated staff has been inserviced that abuse allegations have to be reported within two hours. 10 NYCRR 415.4(b)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 45351 Based on record review and interviews conducted during the Recertification survey from 8/21/2024 to 8/28/2024, the facility did not ensure Minimum Data Set 3.0 (MDS) comprehensive and non-comprehensive assessments were submitted and transmitted into the Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) system timely. This was evident in 1 (Resident #54) out of 1 resident reviewed for Resident Assessment. Specifically, the quarterly Minimum Data Set 3.0 assessment for Resident #54 was not submitted and transmitted within 14 calendar days from the assessment complete date. The findings are: The facility's policy and procedure titled MDS Assessment/Submission revised 12/21/2023 documented on a quarterly basis, a MDS assessment is to be completed by appropriate interdisciplinary clinicians in accordance with Federal and State regulations. Resident #54's quarterly Minimum Data Set 3.0 with assessment reference date of 6/2/2024 and completion date of 6/9/2024. The assessment was not submitted as of 8/26/2024. On 8/27/2024 at 11:03 AM, Minimum Data Set Coordinator was interviewed and stated, that the computer software automatically schedules the assessment in the system for every resident. The Minimum Data Set Coordinator stated department staff will complete their part of the assessment within the due date and upon completion. The Minimum Data Set Coordinator will submit it within 14 days. The Minimum Data Set Coordinator stated Resident #54's quarterly assessment was last submitted on 3/12/2024. Upon reviewing, the assessment did not populate in the scheduler for Resident #54. The Minimum Data Set Coordinator further stated the assessment should have been completed and submitted every three months, which is overdue now. On 8/28/2024 at 11:07 AM, Director of Nursing was interviewed and stated, the assessment is scheduled automatically for every resident and staff are responsible to complete their section in the assessment in a timely manner. The Minimum Data Set Coordinator ensures the assessment is completed and submitted in a timely manner. Director of Nursing further stated the system did not populate an assessment for Resident #54's scheduler; therefore, staff were not aware that assessment was not submitted until it was pointed out by the surveyor. 10 NYCRR 415.11

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50894 Based on observation, record review and staff interviews conducted during the recertification survey from 08/21/2024 to 08/28/2024, the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion. This was evident for 1 (Resident #190) of 2 residents reviewed for Activities of Daily Living out of 38 sampled residents. Specifically, Resident #190 was not provided hand rolls for bilateral hand contractures in accordance with physician's orders. The findings are: The facility's policy and procedure titled Adaptive Devices/Positing Devices revised 12/20/2023 documents that it is the policy of Union Plaza Care Center to provide residents with adaptive/positioning devices as necessary. The device will be checked daily by the nurse aide. If any adaptive or positioning device is malfunctioning or missing, nursing will notify Occupational Therapy using a Nursing to Occupational Department notification form. Resident #190 was admitted to the facility with diagnoses that included Non-Alzheimer's Dementia, frontotemporal neurocognitive disorder, and malnutrition. The Quarterly Minimum Data Set, dated dated dated [DATE] documents that Resident #190 is rarely/never understood by others and is rarely/never able to understand others. Resident #190 has a short-term memory problem, and a long-term memory problem, and their cognitive skills for daily decision making is severely impaired. Resident #190 has upper extremity limitations on both sides and requires dependent level assistance for: eating, oral hygiene, toileting, showering/bathing, upper and lower body dressing, personal hygiene, bed mobility, and transfer. Physician's Treatment Order #289576 initiated 09/20/2023 and renewed on 08/27/2024 documents: Hand roll to both hands. Remove during ADL care to check skin integrity each shift. Care Plan titled Osteoporosis, risk for spontaneous fracture effective 02/10/2022 and updated 08/09/2024 documents an intervention of Hand rolls to both hands. Care Plan titled Self Care Deficit effective 02/10/2022 and updated 08/09/2024 documents an intervention of: Hand rolls to both hands. On 08/21/2024 at 12:55 PM, an interview was conducted with Resident #190's spouse who stated that the resident is supposed to use hand rolls in both hands due to hand contractures but the facility has failed to ensure the resident receives these on multiple occasions. Resident #190's spouse stated that they would alert the staff on the unit when this was observed and the device would be provided daily for a few weeks following the inquiry, but would then fail to be provided again. On 08/21/2024 at 12:55 PM, Resident #190 was observed in bed with both hands clenched in a closed fist position with no hand rolls in place. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/27/2024 at 11:16 AM, Resident #190 was observed in bed with both hands clenched in a closed fist position with no hand rolls in place. On 08/27/2024 at 11:17 AM, Registered Nurse Supervisor #1 was interviewed and stated that Resident #190 requires hand rolls in both hands at all times other than during care that involves cleaning the hands. Registered Nurse Supervisor #1 was observed entering Resident #190's room and looking in the resident's bed sheets for the devices. The devices were not located in the bed sheets. Registered Nurse Supervisor #1 left Resident #190's room and returned with two new hand rolls that were then inserted into the resident's hands. On 08/27/2024 at 12:39 PM, Certified Nursing Assistant #1 was interviewed and stated that Resident #190 requires total care assistance with all activities of daily living. Certified Nursing Assistant #1 stated that they gave Resident #190 a shower on 08/27/2024 at around 09:00 AM. Certified Nursing Assistant #1 stated that after giving Resident #190 a shower, they typically wait about 20 minutes to return the hand rolls to Resident #190's hands to give the skin a little rest. Certified Nursing Assistant #1 stated that they had planned to return the hand rolls to Resident #190's hands 20 minutes after the shower on 08/27/2024, but had to assist another resident and was unable to return to Resident #190's room by the time that the observation was made at 11:16 AM. On 08/27/2024 at 12:54 PM, Registered Nurse Supervisor #1 was interviewed and stated that Resident #190 was given a shower by Certified Nursing Assistant #1 earlier in the day on 08/27/2024. Registered Nurse Supervisor #1 stated that they believed that after Certified Nursing Assistant #1 provided Resident #190 with a shower, they may have forgotten to replace the hand devices. Registered Nurse Supervisor #1 stated that the contracture devices should have been replaced as soon as the resident's hands were dried after the shower and should have been returned to the resident's hands before the observation on 08/27/2024 at 11:16 AM. On 08/27/2024 at 3:10 PM, the Director of Nursing was interviewed and stated that Resident #190 requires the use of hand rolls in both hands at all times other than when staff are providing care that is related to the hands, such as showering or hand washing. The Director of Nursing stated that after that care is provided, the hand rolls should be returned to the hands as soon as they are dry, which would typically be within the span of a few minutes. The Director of Nursing stated that if Certified Nursing Assistant #1 showered Resident #190 around 09:00 AM on 08/27/2024, that the hand rolls should have been returned to the resident's hands before the observation on 08/27/2024 at 11:16 AM. On 08/28/2024 at 09:59 AM, the Director of Rehabilitation was interviewed and stated that Resident #190 has very limited mobility and uses hand rolls for contractures in both hands, which were recommended based on the rehabilitation department's evaluation of the resident. The Director of Rehabilitation stated that in rest position, Resident #190 clenches both fists and this can cause skin breakdown on the inner part of the hand due to the fingernails digging into the skin. The use of hand rolls prevents this. The Director of Rehabilitation also stated that hand rolls are used to ensure that the contractures do not become more severe, and to allow the resident to maintain their current functional ability while preventing decline. The Director of Rehabilitation stated that Resident #190 is supposed to use hand rolls in both hands at all times other than when receiving care that affects the hands. The Director of Rehabilitation stated that as soon as that care is completed, the hand rolls should be returned to the hands. 10 NYCRR 415.12(e)(2)

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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 record review and interviews conducted during the Abbreviated (NY#00339083) and Recertification survey from 8/21/2024 to 8/28/2024, the facility did not ensure resident was free from accidents. This was evident in 1 (Resident #26) of 7 residents reviewed for Accident. Specifically, Resident #26 sustained 2 cm skin cut to the eyebrow during toileting when staff assisted without a second staff member. The findings are: The facility's policy titled Abuse, Neglect and Mistreatment reviewed 9/5/2023 documented every resident be free from verbal, sexual, physical, mental abuse, corporal punishment, misappropriation of property and involuntary seclusion. The facility's policy titled Fall Prevention Program reviewed 12/20/2023 documented to identify residents who are at fall risk through use of standardized criteria and to assist interdisciplinary committee in developing a care plan for preventions. Maximize resident's mobility and reduce the threat of injury from falls. Resident #26 was admitted to the facility with diagnosis of Alzheimer's Disease, Diabetes Mellitus, and Hypertension. The Minimum Data Set, dated dated dated [DATE] documented Resident #26 had severely impaired cognition and was dependent for toilet transfer/toileting and resident utilized wheelchair for mobility. The Comprehensive Care Plan for Falls/Injuries initiated 7/1/2019, revised 7/1/2024 documented but not limited to keep Resident #26 in a highly supervised area when awake, encourage, and place resident in common areas, increased observations due to poor safety awareness, non-compliance with transfer, and incontinence care every 2-4 hours. The Nursing Instruction for Certified Nurse Aid revised 5/6/2024 documented Resident #26 is dependent for toileting and incontinent care every 2-4 hours, as needed. The Nursing Note dated 6/21/2024 documented on 6/21/2024 at 2:57PM, Resident #26 in bathroom located inside of the dining room, noted with skin cut on left eyebrow, measured about 2 cm in length with minimal amount of bleeding and redness around left cheek observed. Certified Nurse Aid #13 was also noted next to the Resident #26. Resident is very confused and unable to tell what happened. Family notified and transferred resident to hospital for evaluation to rule out head injury. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility's Incident Report completed 6/25/2024 revealed that the Certified Nurse Aid #13 was in the dining room when Certified Nurse Aide #13 noticed Resident #26 attempting to self-propel their wheelchair and made gesture to use the bathroom. Certified Nurse Aid #13 safely transfer Resident #26 to the bathroom and on to the toilet seat. When Resident #26 was bending over to wipe themselves in seated position, losing balance falling forward. Certified Nurse Aid #13 was able to hold resident's trunk and preventing from falling. However, Resident #26's left eyebrow made contact with the edge of leg rest of wheelchair placed next to the toilet. This resulted in a superficial skin cut measuring 2 cm in length and 0.5 cm in depth with minimal amount of bleeding and redness around the area. No other injuries noted. The investigation concluded that there is no reasonable cause to believe that resident was abused, neglected. However, Certified Nurse Aid #13 who was not primary certified nurse aid for Resident #26, assisted toileting without checking resident's plan of care and instructions. Certified Nurse Aid #13 was provided with written warning and education to ensure reviewing plan of care and nursing instructions prior to providing resident care. On 8/27/2024 at 10:52 AM, Certified Nurse Aid #14 stated Resident #26 has been on their assignment for some time now and was assigned to them on 6/21/2024. Resident #26 has been incontinent and is total dependent for incontinent care. Resident #26 is on schedule for incontinent care every 2 to 4 hours, as needed. Certified Nurse Aid #14 recalled Resident #26 was provided incontinent care in the room with another staff's assistance prior to wheeling Resident #26 to the dining room around 2:15PM. Certified Nurse Aid #14 then left work early for a personal matter. On 8/27/2024 at 10:40 AM, Certified Nurse Aid #13 stated they were watching residents in the dining room on 6/21/2024 when Resident #26 gestured to go to the toilet and attempting to wheel to the bathroom located inside the dining room. Certified Nurse Aid #13 wanting to help, transferred resident safely to the bathroom and to the toilet seat. Resident #26 was observe falling forward when resident trying to wipe themselves, so Certified Nurse Aid #13 reacted quickly to prevent resident falling to the floor. However, Resident #26's left eyebrow made contact with the wheelchair leg rest, resulting in a superficial skin cut in the area. Certified Nurse Aid #13 stated they had taken care of Resident #26 previously but did not know Resident #26 required two persons for toileting. Certified Nurse Aid #13 stated that they should have asked the nurse supervisor about resident's care needs but did not do so. On 8/22/2024 at 10:24 AM, Registered Nurse Supervisor #7 stated Resident #26 is confused, forgetful at time and who has been up getting out of bed without assistance. Due to the functional declining, resident doesn't get up as often. Resident #26 had an incident on 6/21/2024 around 3PM when resident had a fall incident during toileting. Resident #26 was assisted in transferring and toileting by Certified Nurse Aid #13. Certified Nurse Aid #13 who was not the primary aid assisted the resident to toileting without checking the nursing instructions. Resident #26 is dependent for toileting at the time of incident on 6/21/2024; had schedule for incontinent care every 2 to 4 hours. Certified Nurse Aid #13 has provided care in the past but not always assigned to cover on this unit. Certified Nurse Aid #13 didn't check Resident #26's plan of care prior to assisting the resident for toileting. Resident #26 has been dependent for incontinent care every 2 hours, placed floor mats, lowered the bed and staff are making rounds every hour for resident's safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/2024 at 10:49 AM, Director of Nursing stated they were not aware of this incident, but Certified Nurse Aid #13 should have asked for Resident #26's care instruction prior to assisting the resident. Staff responded quickly to assist resident for toileting, but resident fell and hit their head on the wheelchair. The incident was not resulted from abuse, or neglect but it was an accident that occurred for this resident on 6/21/2024. 10 NYCRR 415.12(h)(1)