STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335079	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gold Crest Care Center	2316 Bruner Avenue Bronx, NY 10469

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that each resident's right to privacy and confidentiality of their personal and medical records was maintained for one (1) (Resident #48) of two (2) residents investigated for Privacy, out of 35 total sample residents. Specifically, the names, room numbers, and dietary orders of Resident #48 and 12 other residents were posted on the 3rd floor bulletin board in an area that was visible to other residents and visitors on the unit.The findings include but are not limited to:The facility policy titled Dignity and Privacy last reviewed 10/2025 documented that staff shall maintain an environment in which confidential clinical information is protected.On 01/28/2026 at 11:26 AM and 01/29/2026 at 10:35 AM, observations were made of the 3rd floor bulletin board located in the hallway outside of the dining room. The bulletin board contained a poster titled Aspiration Precaution List Updated 12/15/2025 which documented Resident #48's first and last name, room number, and that they required a Ground/Nectar Liquids diet. The Aspiration Precaution list also contained the name, room number, and diet of 12 other residents. None of these residents, including Resident #48, resided on the 3rd floor. The bulletin board also contained posters for the Ombudsman's contact information in English and Spanish, the weekly meal menu, a list of meal times per floor, the recreation activity calendar, and a poster titled Notice to Residents related to state survey results.Resident #48 had diagnoses including Cerebral Infarction, Hemiplegia and Hemiparesis, and Malnutrition.The Minimum Data Set assessment dated [DATE] documented that Resident #48 had intact cognition and was on a mechanically altered and therapeutic diet.On 01/29/2026 at 10:40 AM, Registered Nurse #2 was interviewed and stated that the Aspiration Precaution List is always posted on the bulletin board and is there so that staff know who is at risk of aspirating during meals. Registered Nurse #2 stated that they did not know if publicly posting the resident's name, room number, and dietary order was a privacy concern.On 02/02/2026 at 11:38 AM, Registered Nurse #1 was interviewed and stated that they are the Nurse Manager for the 3rd floor. They stated that the Aspiration Precaution List is posted on that bulletin board to ensure that staff know which residents are at risk for aspiration. Registered Nurse #1 stated that the list was hung on the bulletin board by the Speech Language Pathologist and that they did not believe that posting the information on the publicly facing bulletin board was a privacy concern.On 02/05/2026 at 12:00 PM, the Speech Language Pathologist was interviewed and stated that they are responsible for creating the Aspiration Precaution List, which is created to ensure that anyone who works with the residents identified as being at risk for aspiration were aware of their status. The Speech Language Pathologist stated that whenever they update the list, they physically hand it to each floor's nurse manager or leave it in the floor manager's mailbox. The Speech Language Pathologist stated that they do not personally post the lists on the unit or decide where the lists are posted.On 02/04/2026 at 11:36 AM, the Director of Nursing was interviewed and stated that the Aspiration Precaution List should have been posted behind the nurse's station to respect resident privacy while also ensuring that staff were aware of which residents were at risk of aspirating during meals. The Director of Nursing stated that the list should not have been posted on the 3rd floor bulletin board.10 NYCRR 413.3(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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, record review, and interviews the facility failed to maintain a resident's right to a safe, clean, comfortable and homelike environment. This was evident for one (1) (Unit 1) of four (4) units observed. Specifically, residents' rooms in Unit 1 were noted with worn furniture, rusted bed frames, holes in the walls, windows in disrepair, peeled wallpaper, mismatched paint, and electrical outlets that were not secured to the wall.The findings include but are not limited to:The facility's environmental policy with a reviewed date of 07/2021 stated that the facility maintains resident rooms, common areas, furnishings, fixtures, and equipment in clean, safe, and operable condition through routine housekeeping, maintenance practices, and ongoing staff awareness during daily operations.During observation from 01/28/2026 to 02/05/2026, the following were observed in Unit 1:1. In room [ROOM NUMBER], windows have black substance around them, wood around the window was in disrepair, and the electrical outlet located under the window was hanging off the wall.2. Two (2) holes were observed on the wall, in the unit hallway, located next to room [ROOM NUMBER].3. room [ROOM NUMBER] had a light fixture with a red colored piece of clothing hanging over it. The bed head and foot board were chipped, the metal bed frame had brown stains, and the wallpaper was peeling off the wall.4. room [ROOM NUMBER] had two (2) holes in the wall above the television. The room had mismatched paint, and the wood around the window was in disrepair.5. The unit dayroom had four (4) windows in disrepair, including missing shades, chipped wood, boarder around the window is missing and disrepair.6. room [ROOM NUMBER] had black and clear tape surrounding the air conditioning unit.7. The dayroom located by the entrance door had exposed grey colored wire coming out of the ceiling.8. room [ROOM NUMBER]'s bedside table was dirty and had mismatched white and grey colors.9. room [ROOM NUMBER] had a broken headboard, worn furniture.10. room [ROOM NUMBER]'s window blinds were broken, the closet door was off the hinge, furniture worn, and the bedside table had rust.On 02/05/2026 at 10:00 AM, Resident #52 stated the window was covered with tape to keep the air out.On 02/05/2026 at 10:20 AM, Housekeeper #1 was interviewed and stated their job is to make sure that the unit is clean. They stated that they report to the Maintenance Department if repairs are needed in the unit and also documents the repairs needed in the maintenance logbook.On 02/05/2026 at 10:28 AM, the Housekeeping Supervisor was interviewed and stated they oversee the housekeepers and the cleanliness of the unit. They stated that the nurses are responsible for letting the maintenance director know of repairs needed in the unit by writing them in the maintenance logbook. They stated it is not their job to report or say anything about the environment. On 02/05/2026 at 10:45 AM, the Director of Maintenance was interviewed and stated they check the maintenance logbook every morning to see if there are any issues that need to be addressed, and they do monthly rounds to see if there are any needed repairs. As for the observations made, they stated a contractor is needed to fix the windows and that the Administrator was aware of it. They stated the air conditioning unit had a tape around it to keep the cold air out. They stated that the administration is aware of the needed repairs in the building.On 02/05/2026 at 12:21 PM, the Administrator was interviewed and stated they have a plan to renovate Unit 1. They stated they were not aware of the windows in the dayroom that needed repair.10 NYCRR 415.5(h)(2)

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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** Based on record review and interviews, the facility failed to ensure that resident or resident representatives were included in all aspect of care planning. This was evident in one (1) (Resident #70) of three (3) residents reviewed for care planning out of 35 total sampled residents. Specifically, there was no evidence that Resident #70 or their representative was invited to care plan meetings. The findings are:The facility's policy and procedure titled Care Plan with a reviewed date of 02/2025 documented that the interdisciplinary team will initiate, implement and update the resident's plan of care on admission, quarterly, and as needed to meet the individual needs of each resident. It also documented the resident and family/designated representative will be involved in the care planning process.Resident #70 was admitted to the facility with diagnoses of Hypertensive heart disease with heart failure, Disease of upper respiratory tract, and Chronic pain syndrome.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #70 was cognitively intact. The Quarterly Minimum Data Set assessment also documented Resident #70, and their designated representative participated in the assessment. On 01/28/2026 at 11:03 AM, Resident #70 was interviewed and stated they made decisions for themselves. Resident #70 also stated they could not recall when was last time they attended a care plan meeting; and they cannot recall when they were last invited to attend a care plan meeting. The Care Plan Meeting schedule for 2025 documented Resident #70 had an annual care plan meeting on 04/09/2025, significant change care plan meeting on 06/18/2025, and quarterly care plan meetings on 01/22/2025, 09/17/2025 and 11/19/2025.The Care Conference Report documented Resident #70 declined to participate in the annual care plan meeting. However, there was no documented evidence in the medical record that Resident #70 and/or their designated representative were invited to participate or attend the care plan meetings. On 02/02/2026 at 12:55 PM, the Director of Social Services was interviewed and stated that the social worker is responsible for inviting residents and/or their representatives to care plan meetings. The Director of Social Services reviewed Resident #70's medical records and had no explanation why Resident #70 was not consistently invited to care plan meetings in 2025. On 02/04/2026 at 1:55 PM, the Administrator was interviewed and stated that residents and/or their representatives should be invited to all care plan meetings including admission, significant change, annual, quarterly, and as needed. The Administrator also stated they were not aware residents and/or their representative were not consistently invited to care plan meetings. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Specifically, the staff bathroom on the first floor in the dayroom had discolored tiles and cracked ceiling. The findings are:The facility's environmental policy with a reviewed date of 07/2021 stated that the facility maintains resident rooms, common areas, furnishings, fixtures, and equipment in clean, safe, and operable condition through routine housekeeping, maintenance practices, and ongoing staff awareness during daily operations. During observation conducted from 01/28/2026 to 02/05/2026, the staff bathroom on the first floor in the day room had minimal lighting, there was a cracked ceiling tile, ceiling tiles had brown discoloration, and a tile that seems it's about to fall off. On 02/05/2026 at 10:45 AM, the Director of Maintenance was interviewed and stated they do monthly rounds to see if there are any needed repairs. They stated that the administration is aware of the needed repairs in the building. 10 NYCRR 415.29

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F 0848 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on observation, record review, and interviews, the facility failed to ensure that the binding arbitration agreement provides for the selection of a venue that is convenient to both parties. This was evident for three (3) (Residents #3, #83, and #174) of three (3) residents reviewed for arbitration. The findings are:The facility's policy titled Arbitration Agreement dated June 2019 documented the facility offered a voluntary arbitration agreement in accordance with federal regulations.The Voluntary Agreement for Arbitration signed by Residents #3, #83, and #174 were reviewed. The Binding Arbitration Agreement documented that an arbitration hearing arising under the Arbitration Agreement shall be held in the county where the facility is located.On 02/04/2026 at 3:42 PM, Social Worker #1 was interviewed and stated arbitration agreement was part of admission package and that they are responsible for explaining the content of the voluntary arbitration agreement to residents and/or their representatives. Social Worker #1 stated they informed the residents and/or their representatives that arbitration hearing had to be held in the Bronx, which is the county where the facility is located, as stated in the arbitration agreement. On 02/04/2026 at 3:48 PM, the Director of Social Services was interviewed and confirmed the arbitration hearing had to take place in Bronx County where the facility was located according to the arbitration agreement. The Director of Social Services also stated the arbitration agreement was provided to them by the facility's corporation. The Director of Social Services further stated they were not aware the regulation required the binding arbitration agreement to provide for the selection of a venue that is convenient to both parties.On 02/04/2026 at 4:21 PM, the Administrator was interviewed and stated the arbitration agreement was drafted by the lawyer of the facility. The Administrator also stated they were not aware the arbitration agreement was not compliant with the regulation. 10 NYCRR 415.30