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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335125 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/11/2025 |
| NAME OF PROVIDER OR SUPPLIER Spring Creek Rehabilitation & Nursing Care Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 660 Louisiana Ave Brooklyn, NY 11239 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285</p> <p>Based on record review and interviews conducted during an abbreviated survey (NY00351563), the facility did not permit a resident to return to the facility following hospitalization . This was evident for one (1) of six (6) residents (Resident #1). Specifically, on 09/10/2024 Resident #1 was transferred to the hospital for an evaluation of severe dysphagia. During an interview with Resident #1's Representative on 02/07/2025 at 11:50 AM, they stated that the facility refused to readmit Resident #1 to the facility. Additionally, the facility did not notify Resident #1, or their representative, and the Long-term Care Ombudsman in writing of the discharge, including notification of appeal rights. The hospital transferred Resident #1 to another facility.</p> <p>The findings include:</p> <p>The facility policy and procedure titled Admissions Process dated 10/2024 documented Resident-applicants to the facility will be screened to determine the applicant the level of care available at the facility. Residents returning to the facility within 24 hours following a hospital emergency room evaluation are not classified as a readmission. Readmission is same as admission protocol.</p> <p>The facility policy and procedure titled Discharge Planning: Discharge Notification to Resident/Family dated 08/2024 documented it is the policy of this facility and to the best of the ability of the Facility's discharge planning Social Worker, to plan and facilitate a resident's discharge in recognition of the residents right to receive considerate and timely notice of such plan; in collaboration and coordination with the resident and his or her representative, so as to best insure appropriate placement for the resident who has care needs that cannot be met by the Facility.</p> <p>The facility policy and procedure did not identify a protocol for a resident who was transferred to the hospital from the facility but is not being accepted back into the facility.</p> <p>Resident #1 was admitted to the facility on with diagnoses of Cerebral Infarction, Cardiovascular Accident with left sided weakness, and left hemiparesis.</p> <p>The Minimum Data Set (an assessment tool) dated 08/05/2024 documented Resident #1 was cognitively intact.</p> <p>The Minimum Data Set, dated dated dated [DATE] titled Nursing Home Discharge documented return anticipated.</p> <p>(continued on next page)</p> |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A nursing progress note dated 09/10/2024 at 11:55 AM by Registered Nursing Supervisor #1 documented Resident #1 was seen and assessed by the medical doctor post a swallowing test that was performed by Speech Therapist. The test result showed Resident #1 was not able to tolerate their diet. Family was contacted and made aware that resident needs further evaluation and possible feeding tube placement. Resident #1 was transferred to hospital on 09/10/2024 for severe dysphagia.</p> <p>A Physician's progress note dated 09/10/2024 at 11:13 AM documented they met with the Interdisciplinary Team and discussed the findings of the swallowing test results and that it was not safe to continue a diet of any consistency. The swallowing test results were discussed in detail with Resident #1's representative. Recommendation was made for Resident #1 to be transferred to the hospital for an additional dysphagia evaluation and an alternative method of feeding (such as feeding tube) if necessary. The family verbalized understanding.</p> <p>A Transfer/Discharge document dated 09/10/2024 at 12:47 PM by Registered Nurse Supervisor #1 documented Resident #1 was being transferred to the hospital for severe dysphagia, possible tube placement.</p> <p>A Hospital and Community Patient Review Instrument dated 09/10/2024 documented primary diagnoses as Dehydration and Dysphagia. According to the Patient Review Instrument Resident #1 was observed, tested, and evaluated for the ability to orally consume solid foods and liquids. A modified barium swallow test was done. Impressions: Resident presents with mild-moderate oropharyngeal dysphagia with noted silent aspiration across trials of liquids (aspiration eliminated given use of chin tuck maneuver). Recommendations: initiate diet of soft and bite sized solids, and mildly thick liquids with consistent use of chin tuck for intake of liquids. Maintain aspiration precautions (head of bed elevated to 90 degrees during oral intake and no less than 45 degrees for 30 minutes following oral intake, small bite, small sips, slow pacing). Speech-language pathologist to follow up for dysphagia management and training in consistent use of chin tuck maneuver.</p> <p>A documented titled CarePort - Printable Review Referral dated 09/13/2024, revealed several email communications between the facility and hospital staff. Email dates ranged from 09/13/2024 through 09/19/2024. Email entry dates from 09/18/2024 to 09/19/2024 showed documentation from the facility to the hospital stating they are unable to accept Resident #1 due to care needs exceeding current capacity.</p> <p>There is no documented evidence that a written Notice of Discharge with appeals rights was sent to Resident #1 or their representative. There is no documented evidence that the Ombudsman was notified of Resident #1's discharge and appeals rights.</p> <p>During an interview on 02/07/2025 at 11:50 AM, Resident #1's representative stated Resident #1 was transferred to the hospital for a feeding tube placement and the facility refused to readmit Resident #1. Resident #1's Representative stated that the hospital physician stated Resident #1 did not need a feeding tube and the facility refused to accept Resident #1 back to the facility. Resident #1's Representative stated that the facility did not give them nor Resident #1 a discharge notice with appeals rights.</p> <p>(continued on next page)</p> | | |

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| <p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on 02/07/2025 at 2:48 PM, the Director of Social Service stated a meeting was held on 09/10/2024 with Resident #1's representative regarding the Resident changed in condition. The Director of Social Service stated that the swallowing evaluation and test result was discussed with the family by Medical Doctor. The Director of Social Service stated that Resident #1's family member was notified that Resident #1 was high risk for aspiration pneumonia and cannot have anything by mouth. The Director of Social Worker stated that the Medical Doctor recommended Resident #1 to be transferred to the hospital for further evaluation. The Director of Social Service stated that they did not send Resident #1 nor their representative a 30-day notice of discharge with appeals rights. The Director of Social Service stated the Medical Doctor spoke with Resident #1's representatives and explained to them that it would be medically unsafe to accept Resident #1 back at this time.</p> <p>During an interview on 02/07/2025 at 2:55 PM. Admission Staff #1 stated that they received a Hospital and Community Patient Review Instrument from the hospital for Resident #1's return on 09/13/2024. Admission Staff #1 stated that the Patient Review Instrument was reviewed by the medical team including the Medical Director and it was determined that Resident #1 would not be returning to the facility.</p> <p>During an interview on 02/10/2025 at 3:00 PM, the Medical Doctor stated that they were involved in the decision to transfer Resident #1 to the hospital on 09/10/2024 for possible Gastronomy Tube. The Medical Doctor stated that they had some concerns regarding Resident #1 being at high risk for aspiration. The Medical Doctor stated Resident #1 was status post stroke and was placed on a puree diet with thicken liquid, but Resident #1 and their family was not compliant with the diet. The Medical Doctor stated that the dietician and speech therapist had numerous conversations with the family regarding the safest possible diet for the dysphagia to prevent aspiration pneumonia. The Medical Doctor stated that the test result reveals that Resident #1 was at risk for aspirating in all consistency. The Medical Doctor stated that they recommended Resident #1 to be transferred to the hospital for a follow up evaluation to determined how to move forward. The Medical Doctor stated that they spoke with the hospital staff and informed them that Resident #1 was transfer for evaluation and to treat the dysphagia and, if possible, to determine safe feeding practices. The Medical Doctor stated the team had decided until the dysphagia issues were addressed or corrected the facility would not be able to take care of Resident #1. Resident #1 did not come back to the facility.</p> <p>10NYCRR415.3(e)(2)(ii)(d)</p> | | |