

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335131	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER New Carlton Rehab and Nursing Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 405 Carlton Ave Brooklyn, NY 11238	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48876</p> <p>Based on record review and interviews conducted during the Recertification and Complaint Survey (NY00338835) from 07/09/2024 to 07/16/2024, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to the State Survey Agency in accordance with State law through established procedures. This was evident in 1 (Resident #121) of 25 total sampled residents. Specifically, on 04/07/2024, the facility received a report that Resident #121 alleged that Certified Nursing Assistant #6 roughed them up in the bathroom. The facility did not report the allegation to the New York State Department of Health.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Prevention with a revised date of 02/2024 documented that any case in which abuse, neglect, mistreatment, or misappropriation of residents' property, or exploitation has been identified via an investigation, or when a conclusion cannot be drawn, will be reported promptly to the State Department of Health. The New York State Department of Health will be notified of all cases where there is reasonable suspicion of abuse, neglect, or mistreatment within 2 hours of the incident. All facility staff are required to report any incident and/or violation where abuse, neglect, or mistreatment is suspected. The initial investigation will be started by the person in charge at the time of the occurrence.</p> <p>Resident #121 was admitted to the facility with diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Diabetes Mellitus.</p> <p>The Minimum Data Set assessment dated [DATE] documented that Resident #121 had moderately impaired cognition.</p> <p>On 07/09/2024 at 11:57 AM, Resident #121 was interviewed and stated they could not recall all the details but remembered they were taken in a closed shower and 2 aides slapped them in the face and pulled them by the arms. Resident #121 stated they could not remember who the aides were.</p> <p>The nursing progress notes by the Director of Nursing dated 04/08/2024 at 7:32 PM documented that Resident #121 has the tendency to become accusatory when her vitals were not stable.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Investigative Form dated 04/08/2024 documented that on or about 04/08/2024 a visitor stated that someone showered Resident #121 in the weekend. The facility investigation did not document Resident #121's allegation. The facility investigation concluded that based on the interview with Resident 121 who was alert and oriented and can make their needs known, there was no sufficient evidence of abuse or neglect.</p> <p>There was no documented evidence that the allegation was reported to the New York State Department of Health.</p> <p>On 07/11/2024 at 11:08 AM, Registered Nurse #3, who was the nursing supervisor on 04/07/2023 from 7:30 PM - 7:30 AM, was interviewed and stated that Certified Nursing Assistant #6 reported that Resident #121 accused Certified Nursing Assistant #6 of roughing Resident #121 in the bathroom. Registered Nurse #3 stated they spoke with Resident #121 who stated they did not know what they were talking about. Registered Nurse #3 stated they left it alone and did not report the allegation to the Director of Nursing or the Administrator. Registered Nurse #3 stated they were asked by the Director of Nursing to write a statement about Resident #121's allegation the following day.</p> <p>On 07/11/2024 at 10:41 AM, Certified Nursing Assistant #6 was interviewed and stated that they worked 2 shifts on 04/07/2023 from 7:30 AM to 11:30 PM. They stated they gave Resident #121 bed bath during the evening shift with the help of Certified Nursing Assistant #7. Certified Nursing Assistant #6 stated Resident #121 had no complaints. They stated that the Director of Nursing asked them to write a statement on 04/08/2024 because Resident #121 stated they had been beaten in the head and dragged in the bathroom.</p> <p>On 07/11/2024 at 11:24 AM, Certified Nursing Assistant #7 was interviewed and stated that they worked on 04/07/2024 from 3:30 PM to 11:30 PM and was assigned to Resident #121. They stated they had given Resident #121 a bed bath assisted by Certified Nursing Assistant #6. They stated that before they left after their shift, Registered Nurse #3 told them that Resident #121 made a complaint about the care that the Resident received that night but did not elaborate.</p> <p>On 07/11/2024 at 11:35 AM, The Director of Nursing was interviewed and stated that on 04/08/2024, Resident #121's visitor spoke to them about their issue with the shower. The Director of Nursing stated they forgot what the visitor said but stated that they completed an investigation. They stated that the allegation was not reported to the New York State Department of Health because they ruled out abuse.</p> <p>On 07/11/2024 at 12:29 PM, the Administrator was interviewed and stated that it is the Director of Nursing's responsibility to complete an investigation and to report, and to consult the Administrator if they need assistance.</p> <p>On 07/16/2024 at 1:23 PM, the Administrator stated that the allegation was not reported to the New York State Department of Health because the suspicion of abuse was ruled out in 30 minutes.</p> <p>10 NYCRR 415.4(b)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101</p> <p>Based on record review and interviews conducted during the Recertification and Complaint Survey (NY00338835) from 07/09/2024 to 07/16/2024, the facility failed to ensure that all alleged violations involving abuse were thoroughly investigated. This was evident in 1 (Resident #121) of 25 total sampled residents. Specifically, on 04/07/2024, Registered Nurse #3 received a report that Resident #121 alleged that Certified Nursing Assistant #6 roughed them up in the bathroom. Registered Nurse #3 did not initiate an investigation and did not put measures in place to ensure that further potential abuse does not occur. The investigation was initiated by the Director of Nursing on 04/08/2024. Additionally, there was no documented evidence that Resident #121 was immediately assessed to identify any potential injury as a result of the allegation.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Prevention with a revised date of 02/2024 documented that all alleged or suspected incidents of abuse will be thoroughly investigated, and findings documented in a report format. The policy documented that the initial investigation will be started by the person in charge at time of occurrence.</p> <p>Resident #121 was admitted to the facility with diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Diabetes Mellitus.</p> <p>The Minimum Data Set assessment dated [DATE] documented that Resident #121 had moderately impaired cognition.</p> <p>On 07/09/2024 at 11:57 AM, Resident #121 was interviewed and stated that they could not recall all the details but remembered they were taken in a closed shower and 2 aides slapped them in the face and pulled them by the arms. Resident #121 stated they could not remember who the aides were.</p> <p>The facility Investigative Form dated 04/08/2024 completed by the Director of Nursing documented that on or about 04/08/2024 a visitor stated that someone showered Resident #121 in the weekend. The facility investigation did not document Resident #121's allegation. The facility investigation concluded that based on the interview with Resident 121 who was alert and oriented and can make their needs known, there was no sufficient evidence of abuse or neglect. There was no documentation in the investigative form that the staff written statements were reviewed. It was not documented in the investigative form if Resident #121 had been assessed for potential injuries.</p> <p>A review of the interdisciplinary notes from 04/07/2024 through 04/09/2024 revealed no documented evidence that Resident #121 had been assessed to identify potential injury as a result of the allegation.</p> <p>(continued on next page)</p>		

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