

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Oxford Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 144 So Oxford St Brooklyn, NY 11217	

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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 - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review conducted during an Abbreviated Survey (664597 and 664596), the facility did not ensure that an alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator or the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities). This was evident for 2 (Resident #1 and Resident #2) out of 4 residents sampled for abuse. Specifically, 1) On 05/27/2025 at 8:15 PM, Resident #1 alleged staff were rough with them during a two-person transfer via Hoyer lift. The facility reported the incident to the New York Department of Health on 05/28/2025 at 08:07 PM, and 2) On 06/23/2025, at 5:30 PM, Resident #2's Next of Kin reported staff shoved Resident #2 from a sitting position to lying on the bed. The facility reported the incident to the New York Department of Health on 06/24/2025 at 02:52 PM. The findings are: The facility's policy and procedure, entitled Abuse Prevention, with a revision date of 01/16/2025, states the facility will report any incident and/or violation where abuse, neglect, or mistreatment is suspected. Based on the results of the investigation, a decision regarding reporting the allegation to the New York State Department of Health will be made by the Administration in consultation with appropriate parties and the Director of Nursing. The facility's policy and procedure, entitled Accident and Incident Reporting with a revision date of 01/16/2025 stated it is facility policy, in respond to allegations of abuse, neglect, exploitation or mistreatment of ensuring that all alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator or the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities. 1. Resident #1 was admitted to the facility with diagnoses including Adjustment Disorder, Diabetes, and Insomnia. The Minimum Data Set (MDS, a resident assessment tool) dated 04/16/2025 documented Resident #1's cognition was intact. A Nurse's Note dated 05/27/2025 at 8:34 PM, written by Registered Nurse Supervisor #1, documented at around 8:00 PM, the unit charge nurse called and reported Resident #1's allegation, claiming the charge nurse allowed two Certified Nursing Assistants to abuse them. An Accident/Incident Report dated 05/27/2025 was documented at 8:15 PM, Resident #1 alleged staff were rough with them during a two-person transfer via Hoyer lift. A Webform Submission from Nursing Home Facility Incident Report dated 05/28/2025 at 8:09 PM documented the facility submitted the Incident Report on 05/28/2025 at 08:07 PM. 2. Resident #2 was admitted to the facility with diagnoses including Syncope, Collapse, and Parkinson's disease. The Minimum Data Set assessment dated [DATE] documented Resident #2's cognition was moderately impaired. A Nurse's Note dated 06/23/2025 at 6:32 PM written by Registered Nurse Supervisor #2 documented at 5:30 PM Resident #2's Next of Kin reported Resident #2 was shoved by staff from sitting position to lying, while they were on the bed this morning. An Accident/Incident Report dated 06/23/2025, documented Next of Kin reported at 5:30 PM the staff shoved Resident #2 from a sitting position to lying on the bed. A Webform Submission from Nursing Home Facility Incident Report dated 06/24/2025 at 2:53 PM documented that the facility submitted the incident report on 06/24/2025 at 02:52 PM. During an interview on 08/29/25 at 01:57 PM, the Director of Nursing stated Registered Nurse Supervisor #1 notified them of Resident #1's allegation of abuse on 05/27/2025 between 8:00 PM and 9:00 PM. The Director of Nursing also stated they reported the incident to the New York State Department of Health within 24 hours because Resident #1 had been assessed, and no visible injury was noted. The Director of Nursing further stated they reported the incidents to the Department of Health within two hours if there was a bodily injury. The Director of Nursing stated the same thing occurred with the incident involving Resident #2, who complained on 06/23/2025 at approximately 5:30 PM, of being shoved by staff from a sitting position to lying, while they were on the bed. The Director of Nursing stated Resident #2 was assessed, and there was no injury, so they reported within 24 hours. During an interview on 08/29/2025 at 02:35 PM the Administrator stated the</p>		