STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335174	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobble Hill Health Center Inc	380 Henry Street Brooklyn, NY 11201

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 - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observation, record review and interview, the facility failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source are reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation result in serious bodily injury, to the State Survey Agency. This was evident in one (1) (Resident #370) of five (5) residents reviewed for accidents. Specifically, Resident #370 had an unwitnessed fall on 03/20/2026 and was later diagnosed with an acute subcapital left hip fracture on 03/23/2026. The resident had severe cognitive impairment and was unable to provide information regarding the circumstances of the fall. Despite the unwitnessed nature of the incident and discovery of a major injury, the facility failed to report the incident to the New York State Department of Health.The findings Include:The facility's policy and procedure titled Resident Abuse, Neglect, Mistreatment, Involuntary Seclusion, Misappropriation of Property, Injury of Unknown Origin with a last revised date of 07/01/2025 stated that initial report of alleged or actual abuse, neglect, or injury of unknown origin are reported according to the State and Federal requirement upon receipt by the Director of Nursing, Assistant Director of Nursing, or the Administrator.Resident #370 had diagnoses that included Atrial Fibrillation, Coronary Artery Disease, and Heart failure.The admission Minimum Data Set (a resident assessment tool) dated 03/13/2026 documented that Resident #370 had severe impairment in cognition. The assessment documented that the resident required supervision or touching assistance for eating, partial/moderate assistance for oral and personal hygiene, and substantial/maximal assistance of staff for other activities of daily living.The facility's investigative summary completed by the Assistant Director of Nursing and reviewed by the Director of Nursing and Administrator documented that on 03/20/2026 at approximately 10:30 AM, the nursing staff was notified by the resident's roommate that Resident #370 was on the floor. The resident was evaluated by Medical Doctor #1 with no treatment orders. On the evening following the initial fall, Resident #370 was observed with some discomfort on the left lower extremity, x-rays of the left leg including ankle and knee were completed with no acute abnormalities. On 03/23/2026, Resident #370 was noted with increased pain, moaning and groaning when left leg is touched. [NAME] worder was obtained for x-ray of left hip which revealed acute sub capital fracture. On 05/19/2026 at 10:12 AM, Assistant Director of Nursing #1 was interviewed and stated the incident was not reported because they believed the fracture was due to the fall. They stated that they interviewed Resident #370's roommate who observed the resident on the floor but did not know how Resident #370 fell.On 05/19/2026 at 11:11 AM, Director of Nursing was interviewed and stated that the incident was not reported to the New York State Department of Health because the fracture was related to the fall and therefore is not considered as injury of unknown origin.05/19/2026 at 10:53 AM, the Administrator was interviewed and stated that Resident #370's injury was not reported because they believed Resident #370's fracture was related to the fall and although the fall incident was not witnessed, the injury was not suspicious.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335174	A. Building B. Wing	05/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobble Hill Health Center Inc	380 Henry Street Brooklyn, NY 11201

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised following a significant change in condition and ongoing pain management interventions. This was evident in one (1) of three (3) residents reviewed for pain management out of 35 total sampled residents. Specifically, Resident #1's comprehensive care plan for potential pain was not reviewed and revised despite the resident exhibiting actual pain.The findings include:The facility policy titled Comprehensive Care Plan and Baseline Comprehensive Care Plan with a last reviewed date of 04/2026 documented the interdisciplinary team will review and revise the care plan upon a change in condition and as needed.Resident #1 had diagnoses that included osteoarthritis, vertebral low back pain, and hypertension.The Quarterly Minimum Data Set, dated [DATE] documented Resident #1 had intact cognition, required assistance with activities of daily living and was not on pain management.A physician's order last renewed on 04/30/2026 included acetaminophen 1000 milligrams every eight hours as needed for chronic pain, Asper Creme Lidocaine 4% patch to the left knee daily, and Gabapentin 300 milligram twice daily for pain.A nurse's progress note dated 04/13/2026 at 1:38 pm documented that Resident #1 reported left knee pain rated 6/10 at 11:30 AM. After receiving Tylenol, the resident continued to complain of worsening left knee pain rated at 10/10. The physician was notified and ordered a STAT dose of ibuprofen and a STAT left knee x-ray.A pain management consultation dated 04/14/2026 at 11: 59 AM documented Resident #1 had complaints of acute intermittent left knee pain aggravated by activities of daily living and requiring multiple pain management interventions, including medication adjustments. The stated goals were to reduce pain to a manageable level and improve function, endurance, and range of motion.The care plan titled Pain, Potential effective 02/06/2025, was last evaluated on 03/12/2026 with interventions such as monitoring for pain and avoiding activities that exacerbate pain, monitor behaviors and assess for pain/discomfort if change in behavior is noted, promote proper body alignment.Record review revealed that following Resident 1's complaints of significant left knee pain, pain management consultation, medication changes, and ongoing treatment, the care plan was not reviewed or revised to reflect the resident's actual pain condition, pain location, goals, or interventions. The resident continued to have a Potential Pain care plan despite documented evidence of active pain requiring treatment.On 05/15/2026 at 1:47 PM, Registered Nurse #4 stated that Resident #1 complained of left knee pain, initially rated 6/10 and later 10/10 despite intervention. Registered Nurse #4 acknowledged that Resident #1 should have had an actual pain care plan rather than a potential pain care plan and stated that nursing staff were responsible for updating the care plan. Registered Nurse #4 could not explain why the care plan had not been revised.On 05/20/2026 at 12:21 PM, Registered Nurse #8, who was the Unit Manager, stated that residents receiving pain management should have an actual pain care plan in place and stated they were not sure what happened as to why Resident #1's care plan was not revised.On 05/20/2026 at 12:12 p.m., the Director of Nursing stated that Unit Managers oversee care plan completion and monitor compliance through meetings and audits but could not explain why Resident #1's care plan had not been updated.10 New York Code, Rules and Regulations 415.11