STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335178	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn Ctr for Rehab and Residential Health Care	170 Buffalo Avenue Brooklyn, NY 11213

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an Abbreviated Survey (#2652750 and #2610252), the facility failed to ensure that all alleged violations involving abuse, exploitation, or mistreatment, including injuries of unknown source are reported immediately but not later than two 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 of 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) in accordance with State law through established procedures. This was evident for two (2) out of five (5) residents (Resident #1, Resident #2) reviewed. Specifically, 1). On 10/23/2025, Resident #1 fell to the floor during a transfer with a mechanical lift and sustained a fracture in left humerus (a break in the long bone in the upper arm) which was not reported to the New York State Department of Health until 10/26/2025, and 2). On 09/05/2025, Resident #2 fell to the floor during a transfer with a mechanical lift and sustained a fracture in the right femur (a break in the long bone between the hip and knee) which was not reported to the New York State Department of Health until 09/06/2025. The findings are: The facility's policy titled Abuse Policy revised 07/18/2025 documented the Administrator and The Director of Nursing are responsible for investigation and reporting. The policy also documented notification to the local law enforcement and appropriate State Agency(s) immediately no later than two (2) hours after allegation/identification of allegation by Agency designated process after the identification of alleged/suspected incident, and initiate process according to the Elder Justice Act and State specific regulations. 1.Resident #1 was admitted to the facility with diagnoses including heart failure and anxiety. A review of the Minimum Data Set (a resident assessment tool) dated 10/08/2025 documented Resident #1 had intact cognition, and they required dependent assistance for toileting, showers, and transfers. The nursing progress note written by Licensed Practical Nurse #5, dated 10/24/2025 at 9:36 PM, documented resident returned from the Emergency Room, where they transferred for post-fall evaluation. The resident was diagnosed with a humerus fracture (a break in the long bone in the upper arm), which is being treated with immobilization. (continued on next page)

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
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The medical progress note written by the Medical Director dated 10/24/2025 documented Chief Complaint/Nature of Presenting Problem: Evaluation post fall Resident is seen today for evaluation on post fall. Resident present in acute distress and pain due to fall. Resident reported pain of right temple, left upper eyelid, and swelling and left forearm pain. No shortness of breath or chest pain. Plan of care discussed with resident. Neuro check within normal limits at baseline. The Hospital Discharge summary dated [DATE] documented Discharge Diagnosis: fall fracture of the humerus (disorder). Humerus fracture treated with immobilization follow up with orthopedics in two (2) to three (3) days. Return for any complication. The Department of Health Nursing Home Facility Incident Report Submission Report documented submitted on 10/26/2025 at 1:45 AM, and the incident occurred on 10/23/2025 at 1:00 PM. On 10/31/205 at 10:21 AM, the Regional Director of Nursing was interviewed and stated they were responsible for the facility at the time of the incident because the Director of Nursing was not available. The Regional Director of Nursing also stated on 10/26/2025 they read the hospital discharge summary and realized Resident #1 had been diagnosed with a fracture, so they reported it to the New York Department of Health then. The Regional Director of Nursing further stated they are aware this incident needed to be reported within two hours and gave no reason why it was reported late. On 11/03/2025 at 2:50 PM, the Associate Administrator was interviewed and stated they became made aware of the incidents after they occurred and is aware these incidents need to be reported within two (2) hours after they occurred. The Associate Administrator also stated they did not know the incidents had been reported late as these incidents should be reported within two hours, and they did not know why they were not reported within two hours. 2.Resident #2 was admitted to the facility with diagnoses that included Coronary artery disease, Cerebrovascular accident, and Seizure disorder. The Minimum Data Set (an assessment tool) dated 07/16/2025 documented Resident #2 had severe cognitive impairment, had impairment on one side of the upper extremity and lower extremity (hip, knee, ankle, foot) and was totally dependent on staff for activities of daily living. The Facility Investigation Report dated 09/10/25 documented date/time of event when Nursing became aware of event of Resident #2's fall during a mechanical lift transfer was 09/05/2025 at 01:59 PM. The Radiology Results Report dated 09/05/2025 at 10:55 PM, documented Resident #2 had an acute fracture in the right femur. The Facility Submission Report documented a report was submitted to the New York State Department of Health on 09/06/2025 at 07:13 AM. The report was submitted more than 17 hours after the incident occurred and more than 8 hours after x-ray results confirmed Resident #2 had sustained a fracture as a result of the incident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/03/2025 at 11:03 AM, Registered Nurse Unit Manager #1 was interviewed and stated when they were notified of Resident #2's fall on 09/05/2025, the facility fall protocol was observed by assessing the resident and reported to the Assistant Director of Nursing and calling for stat X-ray as per doctor's order. Registered Unit Manager #1 also stated they were not sure if they should report the incident to the Department of Health. On 11/03/2025 at 12:36 PM, the Director of Nursing was interviewed and stated they were not in the facility when the incident with Resident #2 occurred. The Director of Nursing also stated a stat x-ray was ordered on 09/05/2025 at 1:58 PM, and the facility received the results on 09/05/2025 at 10:55 PM, and it was reviewed by the supervisor on duty at that time. Attempts to contact the physician were unsuccessful until the morning of 09/06/2025 when the physician ordered to send the resident to the hospital on [DATE]. The Director of Nursing further stated the incident was reported to the Department of Health on 09/06/2025 because that was when the x-ray results were received. On 11/03/2025 at 12:48 PM, the Regional Director of Nursing was interviewed and stated the incident occurred on 09/05/2025 and stat x-ray was ordered, and they thought the x-ray result was reported on the same day. The Regional Director of Nursing also stated they were not aware Resident #2 had a fractured hip until the morning of 09/06/2025. The Regional Director of Nursing further stated they submitted the report to Department of Health on 09/06/2025 after Resident #2 was sent to the hospital. On 11/03/2025 at 2:01 PM, the Medical Director was interviewed and stated they did not receive the call about Resident #2's fracture until the morning of 09/06/2025. The Medical Director also stated the nursing staff did not need their approval and should have notified the Department of Health when the result was received. On 11/03/2025 at 2:30 PM, Associate Administrator was interviewed and stated they Resident #2's injury should be reported within two hours, and it is the nursing department's responsibility to submit the online report. The Associate Administrator also stated they were not aware the reports had not been submitted on time. 10 NYCRR 415.4(b)(2)

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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 record review and interview during the abbreviated survey (#2265750), the facility did not ensure a comprehensive person-centered care plan for each resident was reviewed and revised based on changing goals, preferences and needs of the resident and in response to current interventions. This was evident for one (1) out of five (5) residents (Resident #1) reviewed. Specifically, the comprehensive care plan for Resident #1 was not reviewed or revised after Resident #1 fell from a mechanical lift during transfer and sustained injury. The finding is: The facility policy titled 'Care Plan Comprehensive' reviewed 8/2/2024 documented assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change. Resident #1 had diagnoses which included Heart failure and Anxiety. A review of the Minimum Data Set (a resident assessment tool) dated 10/08/2025 documented Resident #1 had intact cognition, and they required dependent assistance for toileting, showers, and transfers. The Minimum Data Set also documented Resident #1 had no history of falls. On 10/31/2025 at 1:25 PM, the State Surveyor observed Resident #1 sitting in a wheelchair in their room. Resident #1 was wearing a blue sling on their left arm and swelling the size of quarter was observed over the left eyebrow area. Resident #1 denied pain and stated the injury occurred when they fell from the hoyer lift when one (1) staff transferred them without assistance of another staff person. The Hospital Discharge summary dated [DATE] documented Discharge Diagnosis: fall fracture of the humerus (disorder). Humerus fracture treated with immobilization follow up with orthopedics in two (2) to three (3) days. Return for any complication. The nursing progress note written by Licensed Practical Nurse #5, dated 10/24/2025 at 9:36 PM, documented resident returned from the Emergency Room, where they transferred for post-fall evaluation. The resident was diagnosed with a humerus fracture (a break in the long bone in the upper arm), which is being treated with immobilization.The care plan titled had an actual fall related to history of falls reviewed on 11/5/2024 with had interventions which included anticipate and meet the resident needs, be sure the resident's call light is within reach and encourage to use it for assistance as needed and provide well-lit environment.There was no documented evidence that the comprehensive care plan was reviewed or revised to include interventions after the fall that occurred on 10/23/2025. On 10/31/2025 at 1:40 PM, Registered Nurse #1 Unit Manger was interviewed and stated they did not know about the incident with Resident #1 until they returned to work on 10/24/2025. Registered Nurse #1 also stated they are responsible for completing and updating all care plans on the unit and that the care plans was updated at the time of the incident, however they were unable to provide a copy of the updated care plan. On 11/03/2025 at 11: 15 AM, the Director of Nursing was interviewed and stated the Registered Nurses are responsible for initiating, and updating care plans and the Licensed Practical Nurses can update if they discuss this with the Registered Nurses. The Director of Nursing logged into the computer and stated the care plan was not updated. The Director of Nursing further stated the fall Care Plan was last updated on 10/16/2025 prior to the fall and could not explain why the fall care plan had not been updated after the fall incident. 10 NYCRR 415.11(c)(2)(i-iii)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during the abbreviated survey (#2610252) the facility did ensure residents were provided with treatment and care in accordance with professional standards of practice. This was evident for one (1) of five (5) residents (Resident #2) sampled. Specifically, Resident #2, who fell and sustained a fracture of the hip during a mechanical lift transfer from bed, was not assessed and evaluated by a registered nurse before being transferred from the floor back to bed.The findings are: The facility policy titled 'Accident Incidents' last reviewed 01/01/2024, documents it is the policy of the facility to monitor and evaluate all occurrences of accidents and incidents or adverse events occurring on the facility premises which is not consistent with the routine operation of the facility or care of a particular resident. The policy also documented if assistance is needed, summon help and if the employee cannot leave the victim, ask someone to report to the nurse's station that help is needed, or if possible, use the call bell system located in the resident room to summon help. The policy further documented should an employee witness an accident, or find it necessary to aid an accident victim, the employee should render immediate assistance, do not move the victim until resident has been examined by a nurse for possible injuries. Resident #2 was admitted to the facility with diagnoses that included coronary artery disease (when the heart's blood supply is blocked or interrupted), cerebrovascular accident (interruption in the flow of blood to cells in the brain), and seizure disorder. The Minimum Data Set, dated [DATE] documented Resident #2 had severe impairment in cognition and impairment on one side of upper extremity and lower extremity (hip, knee, ankle, foot). The Minimum Data Set also documented Resident #2 was dependent on staff (resident does none of the effort to complete the activity, staff does all the effort or requires the assistance of two (2) or more staff to complete the activity) for all Activities of Daily Living. The Kardex Report as of 11/03/2025 documented Resident #2 was dependent on two (2) or more staff (at least two (2) provide hands-on care) for Bed-to-Chair Transfer. The Kardex Report also documented two (2) or more helpers complete all of the activity. The Care Plan Progress note dated 09/05/2025 at 3: 12 PM written by Registered Nurse Manager #1, documented Writer notified by the Certified Nursing Assistant that Resident #2 sustained a fall during transfer. Facility fall protocol in place. Vital signs measured. Monitoring continues. The Facility Investigation Report dated 09/10/2025 documented at approximately 2:30 PM, Registered Nurse Manager #1 was made aware Resident #3 fell during a mechanical transfer. The investigation revealed Certified Nursing Assistant #6 did not follow Resident #3's plan of care and attempted to transfer Resident #3 via mechanical lift without a second certified nursing assistant despite the facility direction that mechanical lift transfers require two (2) staff for safety. Resident was assessed, Medical Director and family were notified, x-ray ordered which determined Resident #3 sustained a right trochanter (hip) fracture that required surgical intervention. The facility investigation concluded that there is reasonable cause to believe that resident abuse, neglect or mistreatment may have occurred.There was no documented evidence Resident #2 was assessed and evaluated by a nurse before being placed back to bed following a fall. On 10/31/2025 at 11:11 AM, Certified Nursing Assistant #7 was interviewed, and stated they were looking for a shower chair and went into Resident #3's room to check for the chair and observed Resident #3 on the floor and Certified Nursing Assistant #6 standing by the resident's side. Certified Nursing Assistant #6 told them they were trying to transfer Resident #3 from bed to chair with the mechanical lift when Resident #3 fell and asked Certified Nursing Assistant #7 to help them pick up Resident #2 from the floor. Certified Nursing Assistant #7 stated they helped Certified Nursing Assistant #6 pick Resident #3 up from the floor and put them back to bed, and then they immediately went to notify the charge nurse. Certified Nursing Assistant #7 also stated Certified Nursing Assistant #6 did not call them to help assist in use of the mechanical lift for the transfer. Certified Nursing Assistant #7 further stated they were suspended for helping to pick up Resident #3. On 10/31/2025 at 12:15 PM, Certified Nursing Assistant #6 was interviewed and stated they were transferring Resident #3 from the bed to the recliner chair alone when the hoyer lift canvas loosened, and Resident #3 fell out to the floor. Certified Nursing Assistant #7 walked in and assisted them in putting Resident #3 back into the bed. Certified Nursing Assistant #6 stated they decided to transfer Resident #3 alone after trying to find someone to help without any success as the other four (4) Certified Nursing Assistants on the unit were busy with their assigned residents and the two (2) nurses were busy giving medications to the residents. Certified Nursing Assistant #6 stated they knew they should call for another staff to help and they tried to look for someone but

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview conducted during the abbreviated survey (2610252), the facility did not ensure residents with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This was evident for one (1) of five (5) residents (Resident #2) reviewed. Specifically, Resident #2 was observed not wearing a right knee or elbow brace as per the plan of care. The findings are:The facility policy titled 'Appliances/Devices - Splints, braces, slings' last updated 09/08/2025 documented the facility will maintain the safe application, monitoring, and maintenance of resident appliances (such as splints, braces, and slings) in accordance with current standards of practice, manufacturer's instruction for use and state and federal regulations.Resident #2 was admitted to the facility with diagnoses that included Coronary artery disease, Cerebrovascular accident, Hemiplegia (weakness on one side of the body).The Minimum Data Set, dated [DATE] documented Resident #2 had severe impairment in cognition and impairment on one side of upper extremity and lower extremity (hip, knee, ankle, foot). The Minimum Data Set also documented Resident #2 was dependent on staff (resident does none of the effort to complete the activity, staff does all the effort or requires the assistance of two (2) or more staff to complete the activity) for all Activities of Daily Living.The Comprehensive Care Plan titled 'Contracture' revised 09/10/2025 documented Resident #3 has limited physical mobility related to cerebral infarction, had a goal of resident will remain free of complications related to immobility, including contractures and interventions which included Right knee brace to be worn at all times as tolerated except skin check and hygiene care, Right elbow brace to be worn at all times as tolerated remove for skin checks and hygiene care. On 10/31/2025, between 09:55 AM and 02:30 PM, Resident #2 was observed in bed, noted with contractures on both upper and lower extremities. There was no device applied to Resident #2's elbow or knee. On 11/03/2025, between 09:00 AM and 12:00 PM, Resident #2 was observed in bed, there is no device applied on Resident #2's elbow or knee. The Resident Nursing Instruction Form 'Kardex Reports as of 11/3/2025' (contains instructions for Certified Nursing Assistants) documented Resident Care: Adaptive Device: Right knee brace to be always worn as tolerated except skin check and hygiene care. The Kardex Report did not include instructions for the elbow brace.There was no documented evidence in the Certified Nursing Assistant Task reviewed from September 2025 to November 2025 that an elbow or knee brace was being applied for Resident #2. On 10/31/2025 at 10:06 AM, Certified Nursing Assistant #8 stated they have been assigned to Resident #2 when floated to the unit, and they were not aware Resident #2 was supposed to have a device for the knee or elbow. Certified Nursing Assistant #8 also stated they had never seen or applied any device to Resident #2's elbow or knee. On 10/31/2025 at 10:16 AM, Certified Nursing Assistant #9 was interviewed, stated that they have been assigned to Resident #2 in the past. Certified Nursing Assistant #9 also stated they were not aware Resident #2 had any device to be applied on the elbow or knee, and they had not seen or placed any device on Resident #2's knee or elbow during care. On 10/31/2025 at 10:22 AM, Licensed Practical #3 was interviewed and stated they occasionally floated to Resident #2's unit, and they had not observed Resident #2 with any hand brace or knee brace, and they were not aware Resident #2 was to be provided with such devices.On 11/03/2025 at 10:35 AM, Certified Nursing Assistant #10 was interviewed and stated they have been taking care of Resident #2 since re-admission to the unit in September 2025. Certified Nursing Assistant #10 also stated they did not know Resident #2 had a device and had not seen any device in their daily tasks in the electronic medical records. Certified Nursing Assistant #10 further stated that such devices used to be visible to them when signing off tasks performed for the residents, but they are no longer seeing those devices in the electronic medical record, and they do not know how to check the instructions when documenting tasks performed in the electronic medical record. On 11/03/2025 at 10:46 AM, Licensed Practical Nurse #4, who was the charge nurse on the unit, was interviewed and stated the instructions on the resident's splint devices are supposed to be visible to the Certified Nursing Assistant in the Kardex so they know what needs to be done for the residents. Licensed Practical Nurse #4 also stated they were not aware the Certified Nursing Assistants are not able to view and implement instructions as per the residents' plan of care. Licensed Practical Nurse #4 further stated they have not seen Resident #2 with any devices because the Certified Nursing Assistant had not been applying it. On 11/03/2025 at 11:49 AM, the Rehabilitation Director was interviewed and stated that Resident #2 was issued both hand and knee braces to be applied at all times, and to be removed during care

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during the abbreviated surveys (#2652750, and #2610252) the facility failed to ensure that each resident received adequate supervision to prevent accidents. This was evident for two (2) of five (5) residents (Resident #1 and Resident #2) sampled. Specifically, 1). On 10/23/2025, Resident #1 who required a two (2) person mechanical lift transfer out of bed was transferred with one (1) staff only and sustained a fracture of the left hand, and 2). On 09/05/2025, Resident #2 who required a two (2) person mechanical lift transfer out of bed was transferred with one (1) staff only and sustained a fracture of the hip. This resulted in actual harm to Resident #1 and Resident #2 that was not Immediate Jeopardy. The findings are: The facility policy titled 'Accident Incidents' last reviewed 01/01/2024, documents it is the policy of the facility to monitor and evaluate all occurrences of accidents and incidents or adverse events occurring on the facility premises which is not consistent with the routine operation of the facility or care of a particular resident. The policy also documented if assistance is needed, summon help and if the employee cannot leave the victim, ask someone to report to the nurse's station that help is needed, or if possible, use the call bell system located in the resident room to summon help. The policy further documented should an employee witness an accident, or find it necessary to aid an accident victim, the employee should render immediate assistance, do not move the victim until resident has been examined by a nurse for possible injuries. 1.Resident #1 was admitted to the facility with diagnoses including heart failure and anxiety. A review of the Minimum Data Set (a resident assessment tool) dated 10/08/2025 documented Resident #1 had intact cognition, and they required dependent assistance for toileting, showers, and transfers. On 10/31/2025 at 1:25 PM, the State Surveyor observed Resident #1 sitting in a wheelchair in their room. Resident #1 was wearing a blue sling on their left arm and swelling the size of quarter was observed over the left eyebrow area. Resident #1 denied pain and stated the injury occurred when they fell from the Hoyer lift when one (1) staff transferred them without assistance of another staff person. Resident #1 also stated they felt helpless at the time of the incident and is shaking more than before when they talk about the incident. The Kardex report as of 10/23/2025 documented Resident #1 required dependent care of two (2) or more staff (at least two provide hands-on care), for toileting, hygiene, and transfers, and resident does not use own strength for any part of the activity. The Kardex report also documented two (2) or more use own strength to lift or hold the resident's body, arms, and legs during the entire activity, and the resident does not use own strength for any part of the activity. The nursing progress note written by Licensed Practical Nurse #5, dated 10/24/2025 at 9:36 PM, documented resident returned from the Emergency Room, where they transferred for post-fall evaluation. The resident was diagnosed with a humerus fracture (a break in the long bone in the upper arm), which is being treated with immobilization. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The medical progress note written by the Medical Director dated 10/24/2025 documented Chief Complaint/Nature of Presenting Problem: Evaluation post fall Resident is seen today for evaluation on post fall. Resident present in acute distress and pain due to fall. Resident reported pain of right temple, left upper eyelid, and swelling and left forearm pain. No shortness of breath or chest pain. Plan of care discussed with resident. Neuro check within normal limits at baseline. The Radiology Results Report for left wrist dated 10/24/2025 at 4:24 PM documented no acute fracture/dislocation. The Hospital Discharge summary dated [DATE] documented Discharge Diagnosis: fall fracture of the humerus (disorder). Humerus fracture treated with immobilization follow up with orthopedics in two (2) to three (3) days. Return for any complication. The facility Quality Assurance Report dated 10/24/2025 documented fall was lift related and a witnessed fall and incident occurred on 10/23/2025 at 12:30 PM. The Quality Assurance Report documented Resident #1 reported they fell from the mechanical lift while Certified Nursing Assistant #1 was transferring Resident #1 alone, and Certified Nursing Assistant #1 placed Resident #1 back in bed and then transferred Resident #1 with Recreation Aide in the room. The Quality Assurance Report documented Recreation Aide admitted they were in the room during the second transfer but did not assist with the transfer and observed Resident #1 with ice on their face and Resident #1 reported they fell from the mechanical lift when Certified Nursing Assistant #1 was transferring Resident #1 out of bed alone. Resident #1 was evaluated with neuro checks, facility x-rays and then transferred to the emergency room for computer tomography scan (an advanced x-ray that takes detailed pictures inside the body) and returned to the facility on [DATE] with a left humerus fracture. The Quality Assurance report also documented review of the resident's bed exit device revealed Resident #1 had bed exit between 12:00 PM to 1:00 PM and 1:00 PM to 2:00 PM, and documented based on Resident #1's report, Recreation Aide statement and review of the bed exit report for 10/23/2025, the facility concluded Certified Nursing Assistant #1 ignored facility polity and independently transferred Resident #1 without the assistance of a second certified nursing assistant and was terminated from the facility. The Bed Exit Alarm Report dated 10/23/25 documented Resident #1 exited the bed twice on 10/23/2025, once exit between 12:00 PM and 1:00 PM and the other exit between 1:00 PM and 2:00 PM. On 10/31/2025 at 9:50 AM, Certified Nursing Assistant #4, regularly assigned to Resident #1 on the night shift, stated Resident #1 is dependent on staff for care and always requires two (2) staff to give care including being taken out of bed with a Hoyer lift. Certified Nursing Assistant #4 stated they observed the swelling and bruising on Resident #1's face on 10/24/2025 around 7:00 AM when they entered Resident #1's room with Licensed Practical Nurse #3. On 10/31/2025 at 9:55 AM, Licensed Practical Nurse #2 stated they worked on the day shift on 10/23/2025 and was not aware Resident #1 fell on [DATE]. Licensed Practical Nurse #2 stated they were in the dining area until 4:00 PM, and neither Resident #1 nor staff reported Resident #1 fell. Licensed Practical Nurse #2 further stated Certified Nursing Assistant #1 did not ask for assistance and did not tell Licensed Practical Nurse #2 that Resident #1 fell. (continued on next page)

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	335178	A. Building B. Wing	11/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn Ctr for Rehab and Residential Health Care	170 Buffalo Avenue Brooklyn, NY 11213

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/31/2025 at 11:18 AM, Licensed Practical Nurse #1 was interviewed and stated they worked on the unit the date of the incident (10/23/2025) but they were not aware of what occurred. Licensed Practical Nurse #1 stated they saw Resident #1 in the dining area and also saw Certified Nursing Assistant #1 on the unit, but no one reported a fall, or any incident to Licensed Practical Nurse #1. Licensed Practical Nurse #1 further stated when they saw Resident #1 in the dining area, Resident #1 did not have an ice pack, there was no swelling, and Resident #1 did not appear to be in pain. On 10/31/2025 at 12:40 PM, Recreation Aide #1 was interviewed and stated at approximately 1:40 PM, they came to the unit to pick up Resident #1 to attend bingo. Recreation Aide #1 stated when they entered Resident #1's room, they observed Resident #1 holding an ice pack on their face and Resident #1 stated Certified Nursing Assistant #1 dropped Resident #1 from the Hoyer lift to the floor when trying to take Resident #1 out of bed. Recreation Aide #1 stated Resident #1 stated they were scared and wanted the Recreation Aide to stay in the room with them, and Resident #1 was shaking while holding the ice pack to their face. Recreation Aide #1 stated a few minutes later, Certified Nursing Assistant #1 came into the room and proceeded to use the mechanical lift to transfer Resident #1 alone. Recreation Aide #1 stated they thought the incident had been reported to the nurse because Resident #1 was holding the ice pack when Recreation Aide #1 entered their room. On 10/31/2025 at 1:25 PM, Resident #1 was interviewed and stated their arm hurts, but they get medication which helps. Resident #1 also stated on the day of the incident, Certified Nursing Assistant #1 tried to transfer Resident #1 with the mechanical lift, but the lift turned as Certified Nursing Assistant #1 was transferring them alone, and the resident fell between the chair and the bed hitting their head and arm. Resident #1 stated Certified Nursing Assistant #1 pulled them up by their arms and placed them back into the bed. Resident #1 stated Certified Nursing Assistant #1 then gave them ice in a glove to put on the left side of their face, and they were very scared, nervous, felt helpless, and were shaking much more than before the fall. Resident #1 stated Recreation Aide #1 came to their room, and they asked Recreation Aide #1 to stay with them because they were scared. Resident #1 also stated Recreation Aide #1 did not assist in any transfer and left the room when Certified Nursing Assistant #1 returned. Resident #1 stated they did not report this incident to the nurse or any staff. On 10/31/2025 at 2:40 PM, Certified Nursing Assistant #1 was interviewed via telephone and stated they did not transfer Resident #1 alone and transferred Resident #1 with Recreation Aide #1 who was in the room at the time. Certified Nursing Assistant #1 stated Recreation Aide #1 assisted in placing the sling under Resident #1, helped placed the hooks on the sling, and put Resident #1 in the chair just as a certified nursing assistant does. Certified Nursing Assistant #1 further stated they did not give Resident #1 an ice pack and only gave Resident #1 a cup of ice because they are new to the facility and did not know where to find anything. Certified Nursing Assistant #1 stated the Recreation Aide #1 offered to help and there was no reason for them to refuse the help. Certified Nursing Assistant #1 stated they were inserviced on the mechanical lift and knew two (2) persons are needed to transfer residents from the bed to the chair. Certified Nursing Assistant #1 also stated they did not transfer Resident #1 alone, and that Resident #1 did not fall on 10/23/2025 when they were assigned to them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/3/2025 at 12:52 PM, the Director of Recreation was interviewed and stated Recreation Aide #1 reported to them they saw Resident #1 with an ice pack, and they spoke to Resident #1 who informed them they fell and were picked up by the nurse. The Director of Recreation stated they just assumed if the nurse picked up Resident #1, then it was reported to Nursing. The Director of Recreation further stated Recreation Aides are not allowed to assist in transfers especially with mechanical lifts and Recreation Aide #1 denied they assisted in transferring Resident #1. On 11/04/2025 at 11:02 AM, Licensed Practical Nurse #3, who reported the incident, was interviewed by telephone and stated they worked the 4:00 PM-12:00 AM shift on 10/23/2025, and the 12:00 AM – 8:00 AM shift on 10/24/2025. Licensed Practical Nurse #3 stated the evening shift was uneventful, they gave Resident #1 medications and Resident #1 did not complain about anything and they did not notice any injury to Resident #1's face on 10/23/2025. Licensed Practical Nurse #3 stated that 10/24/2025 around 7:00 AM, they went into Resident #1's room to administer medications and observed a large swollen area and a long scratch mark above Resident #1's left eye. Licensed Practical Nurse #3 stated Resident #1 told them they fell from the mechanical lift the day before and Certified Nursing Assistant #1 was aware. 2. Resident #2 was admitted to the facility with diagnoses that included coronary artery disease (when the heart's blood supply is blocked or interrupted), cerebrovascular accident (interruption in the flow of blood to cells in the brain), and seizure disorder. The Minimum Data Set, dated [DATE] documented Resident #2 had severe impairment in cognition and impairment on one side of upper extremity and lower extremity (hip, knee, ankle, foot). The Minimum Data Set also documented Resident #2 was dependent on staff (resident does none of the effort to complete the activity, staff does all the effort or requires the assistance of two (2) or more staff to complete the activity) for all Activities of Daily Living. The Kardex Report as of 11/03/2025 documented Resident #2 was dependent on two (2) or more staff (at least two (2) provide hands-on care) for Bed-to-Chair Transfer. The Kardex Report also documented two (2) or more helpers complete all of the activity. The Care Plan Progress note dated 09/05/2025 at 3:12 PM written by Registered Nurse Manager #1, documented Writer notified by the Certified Nursing Assistant that Resident #2 sustained a fall during transfer. Facility fall protocol in place. Vital signs measured. Monitoring continues. The Physician's order dated 09/05/2025 written by the Medical Director documented x-ray of hips, bilateral with pelvis when performed, two (2) views. The Radiology Results Report dated 09/05/2025 documented Resident #2 sustained acute fracture in the right femur (bone of the upper leg between the hip and the knee). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Facility Investigation Report dated 09/10/2025 documented at approximately 2:30 PM, Registered Nurse Manager #1 was made aware Resident #2 fell during a mechanical transfer. The investigation revealed Certified Nursing Assistant #6 did not follow Resident #2's plan of care and attempted to transfer Resident #2 via mechanical lift without a second certified nursing assistant despite the facility direction that mechanical lift transfers require two (2) staff for safety. Resident was assessed, Medical Director and family were notified, x-ray ordered which determined Resident #2 sustained a right trochanter (hip) fracture that required surgical intervention. The facility investigation concluded that there is reasonable cause to believe that resident abuse, neglect or mistreatment may have occurred. The Hospital Discharge summary dated [DATE] documented Resident #2 was admitted to the hospital 09/06/2025 after fall incident. The imaging hip x-ray indicated acute right displaced femoral spiral fracture and was admitted for intertrochanteric spiral hip fracture. On 10/31/2025 at 11:11 AM, Certified Nursing Assistant #7 was interviewed, and stated they were looking for a shower chair and went into Resident #2's room to check for the chair and observed Resident #2 on the floor and Certified Nursing Assistant #6 standing by the resident's side. Certified Nursing Assistant #6 told them they were trying to transfer Resident #2 from bed to chair with the mechanical lift when Resident #2 fell and asked Certified Nursing Assistant #7 to help them pick up Resident #2 from the floor. Certified Nursing Assistant #7 stated they helped Certified Nursing Assistant #6 pick Resident #2 up from the floor and put them back to bed, and then they immediately went to notify the charge nurse. Certified Nursing Assistant #7 also stated Certified Nursing Assistant #6 did not call them to help assist in use of the mechanical lift for the transfer. Certified Nursing Assistant #7 further stated they were suspended for helping to pick up Resident #2. On 10/31/2025 at 12:15 PM, Certified Nursing Assistant #6 was interviewed and stated they were transferring Resident #2 from the bed to the recliner chair alone when the Hoyer lift canvas loosened, and Resident #2 fell out to the floor. Certified Nursing Assistant #7 walked in and assisted them in putting Resident #2 back into the bed. Certified Nursing Assistant #6 stated they decided to transfer Resident #2 alone after trying to find someone to help without any success as the other four (4) Certified Nursing Assistants on the unit were busy with their assigned residents and the two (2) nurses were busy giving medications to the residents. Certified Nursing Assistant #6 stated they knew they should call for another staff to help and they tried to look for someone but could not readily get anyone, and they thought Resident #2 had been in bed too long, so they just went ahead and did it alone to ensure Resident #2 was taken out of bed on time. On 10/31/2025 at 11:26 AM, Licensed Practical Nurse #1 was interviewed and stated they were waiting to assist Certified Nursing Assistant #7 with a resident's shower when Certified Nursing Assistant #7 came to inform them Resident #2 fell when Certified Nursing Assistant #6 was trying to transfer resident from bed by themself with the mechanical lift. Registered Nurse Manager #1 was immediately notified and assessed Resident #2, the doctor was notified and an order for stat x-ray was obtained. Licensed Practical Nurse #1 also stated Certified Nursing Assistant #6 did not call for help before using the mechanical lift to transfer Resident #2 by themself. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/31/2025 at 11:52 AM, Registered Nurse Manager #1 was interviewed and stated they were on the unit on the day of the incident, and they were called to Resident #2's room to assess Resident #2 who reportedly fell during transfer with the mechanical lift. Registered Nurse Manager #1 also stated Resident #2 was already placed back in bed when they got to the resident's room. During assessment, Resident #2 was observed with decreased passive range of motion on the right lower extremity with facial grimacing when gentle passive range of motion was attempted. Registered Nurse Manager #1 stated a stat x-ray was done as per the physician's order and facility protocol. Registered Nurse Manager #1 stated the x-ray results revealed a right hip fracture, and Resident #2 was transferred to the hospital for further evaluation/orthopedic surgery as per the physician's order.On 11/03/2025 at 2:20 PM, the Associate Administrator was interviewed and stated they do not know why these injuries are happening and they should not be happening. On 11/03/2025 at 3:08 PM, the Medical Doctor, who is also the Medical Director, was interviewed and stated they had a discussion with the Director of Nursing and the Administrator about the incidents of staff not following the plan of care causing accidents. The Medical Director stated the staff was educated, and the interdisciplinary team has weekly meetings to discuss hospitalizations, and situations that occurred leading to the hospitalization to determine if the Medical Director can assist in any way. The Medical Director further stated the Team meets weekly and discusses falls, weight loss or any high-risk issues. 10 NYCRR 415.12(h)(2)