STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335245	A. Building B. Wing	03/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caton Park Rehab and Nursing Center, L L C	1312 Caton Avenue Brooklyn, NY 11226

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on observation, record review, and interviews conducted during an Abbreviated survey (NY00323120), the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice. This was evident in 1 out of 3 residents (Resident #1) sampled. Specifically, Resident #1 was observed with facial grimacing and pointed to their right leg while being cared for by Certified Nursing Assistant #1 on 08/27/23 at approximately 06:00pm. Licensed Practical Nurse #1 and Nurse Supervisor #1 both stated that they observed Resident #1 with facial grimacing, right leg swollen and warm to touch on 08/27/23. There was no documented evidence to support that Resident #1 was assessed and the medical doctor was notified on 08/27/23. A nursing note dated 08/28/23 at 10:41pm documented that an x-ray of Resident #1's right knee was done. The x-ray result dated 08/28/23 documented no fracture subluxation. Additionally, Resident #1, who was severely impaired, was not assessed appropriately and was not transferred to the hospital timely. The nursing notes from 08/28/23 to 08/30/23 documented continuous facial grimacing and complaints of pain. A medical note, by Nurse Practitioner #1 dated 08/29/23 at 09:59am documented that Resident #1 had facial grimacing, guarding to right hip and knee, mild swelling to the right knee and right thigh. Resident #1 was reexamined by Nurse Practitioner #1 on 08/30/23 and was observed with external rotation and shortening of the right leg. Resident #1 was transferred to the hospital on 08/30/23 at 09:39pm. The hospital diagnostic test results dated 08/30/23 documented that Resident #1 had an acute comminuted and distracted intertrochanteric facture of the right hip. The hospital medical notes dated 09/05/23 documented that Resident #1 was status post right hip intramedullary nail on 08/31/23. The findings are: The facility Policy and Procedure titled Documentation in the Medical Record reviewed 04/22/22 that it is the policy of the facility to ensure that licensed professionals document changes in resident condition, accident and incidents, transfers, discharges, expirations, and leaves against medical advice to ensure that all events of the resident stay are included. The Licensed Professional must maintain medical record on each resident in accordance with acceptable professional standards and practices that are complete and accurately documented. The Licensed Nurse will document in the medical record and notify the physician, resident representative, and resident when there is significant change in resident's physical, mental and psychosocial status in either life threatening conditions or clinical complications. Resident #1 was admitted to the facility with diagnoses including Cerebrovascular Accident with Right Hemiparesis and Type 2 Diabetes Mellitus. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set, dated dated dated [DATE] documented that Resident #1 had severely impaired cognition. A review of Resident #1's medical record revealed that an appropriate assessment of Resident #1 was not done timely to ascertained if Resident #1 had sustained a fracture. From 08/27/23 to 08/30/23, only two Registered Nurse Supervisors documented on Resident #1. Registered Nurse Supervisor #3 (who worked on 08/28/23 from the 08:00am - 04:00pm) documented that Resident #1 complained of pain to their right knee and cried out in pain upon palpation. Registered Nurse Supervisor #4 (worked on 08/30/23 from 03:00pm - 11:00pm) documented right leg pain without cessation after administration of Tylenol and that the medical doctor was notified. All other notes were written by Licensed Practical Nurses who continues to document that Resident #1 had facial grimacing, complaints of pain, swollenness to right leg, and Tylenol administered. A Radiology Report (done in facility) result dated 08/29/23 documented that an x-ray was done of Resident #1's right knee and revealed no fracture subluxation. Osteopenia and Degenerative changes noted. Nurse Practitioner #1's note dated 08/29/23 at 09:49am documented that an x-ray of Resident #1's right knee and Tylenol were ordered. Resident #1 was assessed with positive facial grimacing, guarding to right hip and knees, mild swelling to right knee and right thigh, and no bruising. The x-ray documented no fracture. Osteopenia and degenerative changes. Nurse Practitioner #1's note dated 08/30/23 at 08:10pm, documented that Resident #1 was reexamined with facial grimacing, guarding to right hip and knee persist, and external rotation of the right leg with shortening. Resident #1 to be transferred to the hospital. A hospital x-ray report dated 08/30/23 revealed findings of an Acute Comminuted and Distracted Intertrochanteric fracture of the right hip. Mild osteopenia consistent with mild osteoporosis. A Hospital discharged note dated 09/05/23 documented that Resident #1 was status post Right hip intramedullary nail on 08/31/23. During a telephone interview on 02/01/24 at 03:35pm, Certified Nursing Assistant #2 stated that they worked on 08/27/23 on the evening shift (03:00pm - 11:00pm). Certified Nursing Assistant #2 stated that Resident #1 started complaining of pain at around 6:00pm while they were providing care to Resident #1's lower extremities. Certified Nursing Assistant #2 stated that Resident #1 pointed to their right leg that was observed with mild swelling. Certified Nursing Assistant #2 stated that they notified Licensed Practical Nurse # 1. During a telephone interview on 01/31/24 at 11:03am, Licensed Practical Nurse #1 (worked a double shift on 08/27/23 from 03:00pm - 11:00pm and 11:00pm - 07:00am on 08/28/23) stated that they were called by Certified Nursing Assistant #2 to check on Resident #1. Licensed Practical Nurse #1 stated that they observed Resident #1's right leg to be swollen and warm to touch. Licensed Practical Nurse #1 stated that they called Registered Nurse Supervisor #1. Licensed Practical Nurse #1 said that they received instructions from Registered Nurse Supervisor #1 to give Tylenol to Resident #1 for pain that was relieved. Licensed Practical Nurse #1 stated that Registered Nurse Supervisor #1 assessed Resident #1. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow up interview was done on 02/29/24 at 12:25pm with Licensed Practical Nurse #1 who stated that on 08/28/23 (does not recall time) Certified Nursing Assistant #3 notified them that Resident #1 complained of pain to their right leg and that Registered Nurse Supervisor #2 was notified. During a telephone interview on 01/31/24 at 05:00pm, Registered Nurse Supervisor #1 stated that they assessed Resident #1 on 08/27/23 on the evening shift (04:00pm-12:00am). Registered Nurse Supervisor #1 stated that Resident #1 was observed with slight swelling to the leg (stated can't remember which leg) and that it was painful to touch. Registered Nurse Supervisor #1 stated that they called Nurse Practitioner #1 and obtained an order to give Tylenol 650 mg tablet by mouth for one dose. Registered Nurse Supervisor #1 stated that they did not document their observation and interventions implemented. Registered Nurse Supervisor #1 stated that they had endorsed Resident #1's condition to incoming Registered Nurse Supervisor #2. During a telephone interview on 01/31/24 at 09:54am, Registered Nurse Supervisor #2 stated that they worked on the night shift on 08/27/23 (from 12:00am to 08:00am on 08/28/23). Registered Nurse Supervisor #2 stated that Registered Nurse Supervisor #1 endorsed to them that Resident #1 had pain in their right leg and that pain medication was administered at 06:45pm by Licensed Practical Nurse #1. During an interview on 01/30/23 at 01:40pm, Registered Nurse Supervisor #3 (worked on 08/28/23 from 08:00am-04:00pm) stated that they were notified by Licensed Practical Nurse #2 and Certified Nursing Assistant #4 on 08/28/23, between 09:00am and 10:00am, that Resident #1 has pain on right leg. According to Registered Nurse Supervisor #3, they assessed Resident #1 and there was a small bruise on Resident #1's right shin area. Registered Nurse Supervisor #3 stated that Resident #1 cried out in pain when Resident #1's right knee was touched. Registered Nurse Supervisor #3 stated that they notified Nurse Practitioner #1 between the time of 09:00m-10:00am on 08/28/23 and a telephone order was obtained for a right knee x-ray and Tylenol 650mg every six hours as needed for pain. During an interview on 01/31/24 at 11:19am, Nurse Practitioner #1 stated that they don't recall receiving a phone call from Registered Nurse Supervisor #1 on 08/27/23. Nurse Practitioner #1 stated that they received the first phone call on 08/28/23 (does not recall time) from Registered Nurse Supervisor #3. Nurse Practitioner #1 stated that Registered Nurse Supervisor #3 reported that Resident #1 complained of pain to the right knee and that Resident #1 had facial grimacing. Nurse Practitioner #1 stated that they ordered Tylenol as needed for one week and an x-ray of Resident #1's right knee. Nurse Practitioner #1 stated that they first assessed Resident #1 on 08/29/23 at approximately 09:00am and observed that Resident #1 had facial grimacing. Resident #1 was also guarding their right hip and knee. Nurse Practitioner #1 went on to say that Resident #1 also had mild swelling to their right knee and thigh with no bruising. Nurse Practitioner #1 stated that they review the x-ray (of Resident #1's right knee) result received on 08/28/23 and it showed that Resident #1 had no fracture but had osteopenia and degenerative changes. Nurse Practitioner #1 stated that they discussed Resident #1's condition with the Medical Doctor and additional x-rays were ordered of bilateral hip. Nurse Practitioner #1 stated that they reassessed Resident #1 on 08/30/23 during the evening (does not recall time) and observed that Resident #1 had external rotation and shortening of their right leg. Nurse Practitioner #1 stated that they conducted a video call with the Medical Doctor who ordered to transfer Resident #1 to the hospital to rule out fracture. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview with the Director of Nursing on 03/12/24 at 03:23pm, the Director of Nursing stated that the Registered Nurse Supervisors on all shifts should have conducted a thorough physical assessment of Resident #1 to rule out fracture and report their findings to the doctor. The Director of Nursing stated that the Registered Nurse Supervisors should have conducted range of motion, assessed for swelling, discoloration, pain, and if Resident #1 is able to move their extremities. The Director of Nursing stated that the supervisors should have also assessed for shortening of limb. According to the Director of Nursing, the Registered Nurse Supervisors should have monitored Resident #1 and documented their findings and interventions implemented. 10 NYCRR 415.11(C)(3)(i)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49081 Based on observation, interview and record review conducted during an Abbreviated Survey (NY00323120), the facility failed to ensure that pain management was provided to residents who require such services, consistent with professional standards of practices, the comprehensive person-centered care plan, and the resident's goals and preferences. This was evident for 1 out of 3 residents (Resident #1) sampled. Specifically, Resident #1, who had severely impaired cognition, was on pain management for diagnoses of pain in other joints. An initial pain assessment was not done on 08/27/23. A medical record review also revealed that Resident #1 continued to complain of pain from 08/28/23 to 08/30/23, but there were no changes in pain management. Additionally, there was no documented evidence that Resident #1's pain level was monitored before and after each pain medication was administered to determine effectiveness. The findings are: The Policy and Procedure on Pain Management reviewed 10/09/22, the procedure states a Pain Risk Assessment will be done on admission, re-admission, quarterly and with a change in condition to identify risk factors that could result in pain and resident will be assess for the presence of pain utilizing the 0-10, [NAME] pain scale, or PAINAD. Prior to administering pain medication, the nurse will identify the resident's level of pain and the nurse will re-assess the resident's response to the pain medication and inform the Primary Medical Doctor (PMD) if it was not effective. Resident #1 was initially admitted to the facility with diagnoses including Cerebrovascular Accident with Right Hemiparesis and Type 2 Diabetes Mellitus. The Minimum Data Set, dated dated dated [DATE] documented that Resident #1 had severely impaired cognition. The Comprehensive Care Plan for Pain Management dated 08/04/21 documented alteration in comfort. The interventions included: on-going assessment of Resident #1's pain with emphasis on the onset, location, description, intensity of the pain and alleviating and aggravating factors. Administrator medications as ordered by Medical Doctor, monitor Resident #1's behavior and assessed for pain/discomfort. A Physician's Order dated 08/27/23 at 06:35pm documented Tylenol 325mg tablet give 2 tablets (650 mg) by oral route as one dose. There was no physician's order for monitoring of pain. The August 2023 Medication Administration Record documented that Resident #1 was given Tylenol 325mg tablet, 2 tables by oral route once on 08/27/23 at 06:35pm on the 03:00pm - 11:00pm shift. There was no documented evidence that pain medication was administered to Resident #1 from 08/27/23 from 11:00pm to 07:00am 08/28/23. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The August 2023 Medication Administration Record documented that Tylenol 325mg 2 tablets every 6 hours as needed was administered 4 times from 08/28/23 at 03:19pm to 08/30/23. The Medication Administration Record dated 08/28/23 documented that Resident #1 received Tylenol 650 milligram, however, the time of administration was not documented. A nursing note dated 08/28/23 at 03:32pm documented that Resident #1 complained of pain above the right knee and that Resident #1 cried out in pain upon palpation. The Medical Doctor (Nurse Practitioner #1) was notified and ordered an x-ray of Resident #1's right knee. There was no documented evidence that Resident #1's pain levels were assessed using a pain scale prior to and after pain medications were administered for the effectiveness. There was no documented evidence that Resident #1 was assessed for pain management after Resident #1 continued to complain and cried out in pain. There were no changes made to Resident #1's pain medication. During a follow up interview on 02/29/24 at 12:25pm, Licensed Practical Nurse #1 (worked on 08/27/23 on both the 03:00pm - 11:00pm and 11:00pm - 07:00am) stated that Resident #1 was unable to rate their pain scale. Licensed Practical Nurse #1 stated that Resident #1 had facial grimacing and that they used the Wong-Baker faces rating scale to identify Resident #1's pain level. Licensed Practical Nurse #1 stated that they were not sure if they had documented the pain scale. Licensed Practical Nurse #1 also stated that Certified Nursing Assistant #3 notified them that Resident #1 continued to complain of pian to the right leg during the morning tour (unable to recall the time) of 08/28/23 and that Registered Nursing Supervisor #2 was notified. Licensed Practical Nurse #1 stated that they gave Resident #1 Tylenol 325 milligram 2 tablets, and that Resident #1 had some pain relief because Resident #1 was observed sleeping. During a telephone interview on 01/31/24 at 9:54am, Registered Nurse Supervisor #2 stated that they worked on 08/27/23 on the night shift (12 midnight - 08:00am). Registered Nurse Supervisor #2 stated that Registered Nurse Supervisor #1 endorsed to them that Resident #1 had pain in their right leg and that pain medication was administered by the Licensed Practical Nurse #1 on 08/27/23 at 6:45pm. Registered Nurse Supervisor #2 stated that they observed Resident #1 sleeping when they conducted rounds (don't recall time) and that no one reported that Resident #1 complained of pain. During a telephone interview on 01/31/24 at 05:00pm, Registered Nurse Supervisor #1 stated that they assessed Resident #1 on 08/27/23 on the evening shift (04:00pm-12:00am). Registered Nurse Supervisor #1 stated that Resident #1 was observed with slight swelling to the leg (stated can't remember which leg) and that the leg was painful to touch. Registered Nurse Supervisor #1 stated that they called Nurse Practitioner #1 and obtained an order to give Tylenol 650 mg tablet by mouth for one dose. Registered Nurse Supervisor #1 stated that they did not document their observation and was not sure a pain evaluation was done. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/30/23 at 01:40pm, Registered Nurse Supervisor #3 (worked on 08/28/23 (from 08:00am-04:00pm) stated that they were notified that Resident #1 had pain in their right leg by Licensed Practical Nurse #2 and Certified Nursing Assistant #4 on 08/28/23 between 09:00am and 10:00am. According to Registered Nurse Supervisor #3, they assessed Resident #1 and there was a small bruise on Resident #1's right shin area. Registered Nurse Supervisor #3 stated that Resident #1 cried out in pain when Resident #1's right knee was touched. Registered Nurse Supervisor #3 went on to say that they notified Nurse Practitioner #1 between 09:00am and 10:00am on 08/28/23 and received a telephone order for a right knee x-ray and Tylenol 650mg every six hours as needed for pain. Registered Nurse Supervisor #3 stated that a pain assessment for Resident #1 was not done and that it was an oversight. During an interview on 01/31/24 at 11:19am, Nurse Practitioner #1 stated that they don't recall receiving any phone calls from Registered Nurse Supervisor #1 on 08/27/23. Nurse Practitioner #1 stated that they received the first phone call on 08/28/23, sometime during the morning (does not recall time), from Registered Nurse Supervisor #3. Nurse Practitioner #1 stated that Registered Nurse Supervisor #3 stated that Resident #1 complained of pain to the right knee and that Resident #1 had facial grimacing. Nurse Practitioner #1 stated that they ordered Tylenol as needed for one week and an x-ray of Resident #1's right knee. Nurse Practitioner #1 stated that they initially assessed Resident #1 on 08/29/23 at approximately 09:00am and observed Resident #1 with facial grimacing. Resident #1 was also guarding their right hip and knee. Nurse Practitioner #1 went on to say that Resident #1 had mild swelling to their right knee and thigh with no bruising. Nurse Practitioner #1 stated that they review the x-ray (of Resident #1's right knee) result received on 08/28/23 and it showed that Resident #1 had no fracture but had osteopenia and degenerative changes. Nurse Practitioner #1 stated that they discussed Resident #1's condition with the Medical Doctor and additional x-rays were ordered for bilateral hip x-rays. Nurse Practitioner #1 stated that they reassessed Resident #1 on 08/30/23 during the evening (does not recall time) and observed that Resident #1 had external rotation of their right leg. Nurse Practitioner #1 stated that they conducted a video call with the Medical Doctor who ordered to transfer Resident #1 to the hospital to rule out fracture. Nurse Practitioner #1 stated that no one reported to them that Resident #1 had severe pain. Nurse Practitioner #1 stated that they were thinking that Resident #1 had arthritis because of the x-ray result of the right knee showing that Resident #1 had degenerative changes with hypertrophic spur formation of patella and no fracture subluxation. Nurse Practitioner #1 stated that when they assessed Resident #1 on 08/29/23, Resident #1 was not in any excruciating pain and there was no shortening of the right leg. During a telephone interview on 02/13/24 at 03:26pm, the Director of Nursing stated that pain medication must have a pre and post pain scale, prior administration, to monitor for the effectiveness. The Director of Nursing stated that they reviewed and observed that the Medication Administration Record for Resident #1 had no pain scale assessment documented. The Director of Nursing went on to say that there was no initial assessment documented for Resident #1 by Registered Nursing Supervisor #1 on 08/27/23. 10 NYCRR415.2