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	12/08/2025

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

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	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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(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	Based on interviews and record review conducted during an abbreviated survey (2578058) on 11/10/2025, the facility did not ensure that all alleged violations 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 to State Survey Agency after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. This was evident for one (1) out of one (1) resident (Resident # 1) reviewed for Accidents. Specifically, on 07/28/2025, Resident #1 fell from the bed to the floor during care and the facility did not report Resident #1 was found with a laceration of the head, fracture of the third metacarpal bone at right hand, and a fracture of the middle phalanx of the left hand to the New York State Department of Health until 07/31/2025.The facility policy titled 'Abuse Prevention' with effective date 09/19/2022 and last reviewed 12/29/2023 documented the facility staff must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknow source and misappropriation of resident property immediately to the Administrator and/or Director of Nursing, who in turn must make a report to New York State Department of Health immediately, but not later than 2 hours after making aware of the alleged allegations. Resident #1 was admitted to the facility with diagnoses which included Osteoarthritis of hip, Fracture of third metacarpal bone at right hand, and Fracture of middle phalanx of left middle finger.The Quarterly Minimum Data Set (an assessment tool) documented Resident #1 required supervision or touching assistance to roll left and right in bed, and they had one (1) fall with no major injury since admission or prior assessment. The webform submission for Nursing Home Facility Incident Report documented the facility submitted the incident report on 07/31/2025 at 4:13 PM by the Director of Nursing. The submission also documented the incident happened on 07/28/2025 at 09:53 AM, and the Administrator was first made aware of the incident on 07/28/2025 at 10:00 AM. The medical note dated 07/28/2025 documented Resident #1 stated they fell off the bed after trying to change position in bed during care provided by Certified Nursing Assistant #1. The medical note also documented Resident #1 complained of severe pain to head, shoulders, and arms, and 911 was called to transfer Resident #1 to the hospital for evaluation.The hospital emergency department discharge instructions dated 07/28/2025 documented Resident #1 was diagnosed fracture of phalanx (long bone) of digit of hand, fracture of metacarpal (bone in palm of the hand), and laceration of head. The nursing note dated 07/28/2025 at 9:06 PM documented Resident #1 returned to the facility at 9:00 PM from the hospital with the findings included right wrist spiral fracture of the third metacarpal and mildly displaced fracture to the shaft of the fourth middle phalanx. On 11/10/2025 at 01:13 PM, the Director of Nursing was interviewed and stated they were notified Resident #1 fell from bed to floor during care by the nurse supervisor immediately after the incident occurred. The Director of Nursing also stated they were notified by the nurse supervisor that Resident #1 was diagnosed with multiple fractures after returning to the facility from the emergency department. The Director of Nursing further stated the Assistant of Director of Nursing, Administrator, and themselves had access to Health Commerce System to file report to Department of Health, and they should report to the Department of Health within two (2) hours of awareness if there was an allegation of abuse, neglect, exploitation or mistreatment, and if the events that caused the allegation resulted in serious bodily injury. The Director of Nursing stated they are primarily the staff responsible to report to the Department of Health and conduct the incident investigation, and while a fracture was considered as a serious bodily injury, they wanted to gather more detail before reporting to Department of Health for the incident and inadvertently missed the two (2) hours requirement for reporting. 10 NYCRR 415. 4(f)(1-4)