

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026
NAME OF PROVIDER OR SUPPLIER Caton Park Rehabilitation and Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure that a comprehensive person-centered care plans for each resident was developed and implemented, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. This was evident for one (1) resident (Resident #22) of five (5) residents reviewed for Accidents, one (1) resident (Resident #9) of two (2) residents reviewed for Respiratory Care, one (1) resident (Resident #101) of five (5) residents reviewed for Unnecessary Medications, and one (1) resident (Resident #6) of one (1) resident reviewed for Dental Care, and out of 27 total sampled residents. Specifically, care plans were not developed for Resident #22 to address use of a wander/elopement alarm, for Resident #9 who was receiving oxygen therapy, for Resident #101 to address care of a resident with a diagnosis of depression, or for Resident #6 who had no teeth. The findings included: The facility policy titled Comprehensive Care Planning with effective date 01/26/2023 and last review date 01/26/2025 documented the facility will establish an interdisciplinary team care planning process to ensure that resident care and treatment is planned appropriately for the resident's needs and condition, impairment, disability or disease process in a timely, systematic and comprehensive manner. It also documented the facility utilizes an interdisciplinary team to provide an individualized comprehensive resident assessment and care planning process in order to maximize and maintain every resident's functional potential and quality of life. The policy further stated all initial care plans must be completed by day fourteen (14) from admission. 1. Resident #22 had active diagnoses, which include Non-Alzheimer's Dementia, Coronary artery disease, and Cerebrovascular accident. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #22 had moderate cognitive impairment. The Quarterly Minimum Data Set assessment also documented Resident #22 was not in use of a wander/elopement alarm. On 05/03/2026 at 12:29 PM, Resident #22 was observed in bed, alert and awake. Resident #22 appeared confused and was observed with a wander guard device on their right wrist. The Elopement Risk Assessments dated 02/10/2026 and 04/30/2026 documented Resident #22 had a score of 3 and was considered at risk for elopement. (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Physician Order's dated 06/14/2024 last revised on 04/16/2026 documented Wander Guard: check placement every shift (Location) Right Wrist, Wander guard check functioning daily by 11 PM -7 AM. The Medication Administration Records dated 04/01/2026 to 05/06/2026 documented observation of the wander guard device every night shift daily (11:00 PM -7:00 AM). There was no documented evidence that a comprehensive care plan was created to address wandering and use of a wander/elopement alarm. On 05/06/2026 at 2:05 PM an interview was conducted with Certified Nurse Assistant #3 who stated they have provided care for Resident #22 for about a year. Certified Nurse Assistant #3 also stated Resident is forgetful but is able to make their needs known to staff with minimal conversation. Certified Nurse Assistant #3 further stated Resident #22 walks around attempting to leave the units on several occasions but is easily redirected. Certified Nurse Assistant #3 concluded that they do not monitor the wander guard as the nurses do. On 05/06/2026 at 2:35 PM, an interview was conducted with Registered Nurse #2 who stated that the registered nurse on the unit is responsible for developing and updating care plans, creating a care plan for admission, readmission, quarterly, and episodic ones. Registered Nurse #2 also stated the Minimum Data Set assessors also help in the development of initial and quarterly care plans. Registered Nurse #2 further stated that the facility migrated from one electronic medical record to another, and they are still learning the new system. Registered Nurse #2 concluded that they have reviewed Resident #22's medical record and could not locate a care plan that addressed wandering and elopement or Resident #22's use of a wander guard device. On 05/08/2026 at 2:13 PM, an interview was conducted with the Director of Minimum Data Set who stated that they assist nurse managers in development of comprehensive care plan after completion of Minimum Data Set assessments. The Director of Minimum Data Set also stated that they are still in the process of the new electronic medical record. The Director of Minimum Data Set concluded that they are aware that a care plan that addressed wandering and elopement or use of a wander guard device were not developed for Resident #22, and they are looking into it. 2. Resident #9 had diagnoses that included Unspecified Dementia, Chronic systolic heart failure, and Shortness of breath. The Annual Minimum Data Set assessment dated [DATE] documented Resident #9 had severely impaired cognition and received oxygen therapy while residing in the facility. The Physician's Order dated 03/17/2026 documented that Resident #9 was to receive oxygen via nasal cannula at a rate of 2 liters per minute for shortness of breath. From 05/03/2026 at 9:38 AM to 05/06/2026 at 9:00 AM, Resident #9 was observed lying in bed and receiving oxygen via nasal cannula. The concentrator next to right side of bed was set to and delivering oxygen at a rate of 4 liters per minute. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that a comprehensive care plan related to oxygen therapy was developed and implemented for Resident #9. On 05/06/2026 at 9:58 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #9 was confused and always received oxygen. On 05/06/2026 at 11:11 AM, Registered Nurse #1 was interviewed and stated Resident #9 had an order to receive continuous oxygen at a rate of 2 liters per minute which began on 03/18/2026. Registered Nurse #1 also stated they were responsible for creating a care plan for residents on the floor. Registered Nurse #1 further stated a care plan related to oxygen use should be created when oxygen use was ordered. Registered Nurse #1 reviewed Resident #9's medical record and stated no comprehensive care plan related to oxygen use had been created. Registered Nurse #1 had no explanation why the care plan related to oxygen use was not developed for Resident #9. 3. Resident #101 had diagnoses of Major Depressive Disorder, Dementia, and Generalized Anxiety Disorder. The Annual Minimum Data Set assessment dated [DATE] documented Resident #101 had severely impaired cognition, had a diagnosis of Depression and was taking an antidepressant. The Physician's order started on 10/08/2025 and last renewed on 04/06/2026 documented Resident #101 was to receive Mirtazapine 15 mg 1 tablet by mouth at bedtime for depression. There was no documented evidence that a comprehensive care plan related to depression was developed and implemented for Resident #101. On 05/06/2026 at 10:58 AM, Registered Nurse #1 was interviewed and stated they were responsible for creating comprehensive care plans, and a resident taking an antidepressant medication should have a care plan for mood management or depression. Registered Nurse #1 reviewed Resident #101's medical record and was unable to find a care plan related to depression. Registered Nurse #1 stated the care plan related to depression should have been created when Resident #101 was ordered the antidepressant, and they could not explain why the care plan related to depression was not created. 4. Resident #6 had diagnoses that include Peripheral Vascular Disease, Diabetes Mellitus, Malnutrition, and Anxiety. The Significant Change Minimum Data Set assessment dated [DATE] documented Resident #6 had intact cognition, required substantial/maximal assistance for oral care and had no natural teeth or tooth fragment(s)(edentulous). The Dental consult dated 01/08/2026 documented that on the admission exam Resident #6 presented with an edentulous mouth (no teeth), no complaints and was functional. There was no documented evidence that a comprehensive care plan was created to address care for dental care for Resident #6. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 05/06/2026 at 9:53 AM, an interview was conducted with Registered Nurse #3 who stated they are also the Supervisor. Registered Nurse #3 also stated all supervisors on all shifts are responsible for initiating and updating care plans. Registered Nurse #3 further stated Resident #6 is diabetic, and they are aware Resident #6 had no teeth, and they were not sure why a dental care plan was not initiated. Registered Nurse #3 stated the facility changed from one electronic medical record to another and a number of the care plans did not migrate over. On 05/08/2026 at 2:04 PM, the Director of Nursing was interviewed and stated each care plan should be initiated by the Unit Nurse Supervisor or Registered Nurse, and the Minimum Dat Set department conducts the care planning meeting. The Director of Nursing also stated care plans are initiated on admission, and if an issue develops for a resident a care plan should be initiated, and every physician order required a care plan to address the medical concern. The Director of Nursing further stated they monitor the care plan process by discussing care plans after the morning meeting huddle. The Director of Nursing stated they periodically do spot checks in the systems, and they are not sure what happened here. 10 New York Code, Rules and Regulations 415.11(c)(1)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, record review, and interviews, the facility failed to ensure sufficient nursing staff was provided to meet the residents' needs in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being, as determined by resident assessments and individual plans of care. Specifically, 1). Review of the actual staffing schedules dated from 10/01/25 to 12/31/25 revealed that staffing assignments were consistently less than the projected staffing needs specified in the Facility Assessment for Certified Nursing Assistants and Licensed Nursing Staff, and 2.) the facility Payroll Based Journal (Quarter 1 2026 (October 1 - December 31) also triggered for excessively low weekend staffing. The findings include: The Facility Assessment dated 02/20/2026 documented the facility had a bed capacity of 119 residents with an average daily census of 116. The Facility Assessment also documented that 1st floor total bed capacity is 38-39 residents, 2nd floor is 39 to 40 residents, and 3rd floor is also 39 to 40 residents. The Facility Assessment further documented that based on the resident population and their needs for care and support, the total number of required staff needed to appropriately meet the needs of the residents at any given time were 8 Registered Nurses, Licensed Practical Nurses, and 27 Certified Nursing Assistants on a daily basis. The Payroll Based Journal Staffing Data Report Quarter 1 2026 (October 1-December 31) documented that excessively low weekend staffing was triggered. A review of the actual staffing schedules from 10/01/2025 to 12/31/2025 revealed low Certified Nursing Assistants staffing especially on weekends. This included but was not limited to: On 10/04/2025 (Saturday), on the 7:00 AM to 3:00 PM shift, there were 3 Certified Nursing Assistants instead of the 4 scheduled on Unit 3. On 10/05/2025 (Sunday), on the 7:00 AM to 3:00 PM shift, there were 3 Certified Nursing Assistants instead of the 4 scheduled, and 1 Licensed Practical Nurse was scheduled, but no Licensed Practical Nurse worked on Unit 3. On 10/26/2025 (Sunday), on the 11:00 PM to 7:00 AM shift, there was 1 Certified Nursing Assistants instead of the 2 scheduled, and 1 Licensed Practical Nurse was scheduled, but no Licensed Practical Nurse worked on Unit 1. On 11/08/2025 (Saturday), on the 3:00 PM to 11:00 PM shift, there were 2 Certified Nursing Assistants instead of the 3 scheduled for Unit 2. On 11/15/2025 (Saturday), on the 11:00 PM to 7:00 AM shift, there was 1 Certified Nursing Assistants instead of the 2 scheduled on Units 1 and 3. On 11/22/2025 (Saturday), on the 11:00 PM to 7:00 AM shift, there was 1 Certified Nursing Assistants instead of the 2 scheduled on Unit 1. On 12/06/2025 (Saturday), on the 7:00 AM to 3:00 PM shift, there were 3 Certified Nursing Assistants instead of the 4 scheduled on Unit 3. On 12/06/2025 (Saturday), on the 11:00 PM to 7:00 AM shift, there was 1 Certified Nursing Assistants instead of the 2 scheduled on Unit 3. On 12/14/2025 (Sunday), on the 3:00 PM to 11:00 PM shift, there were 2 Certified Nursing Assistants instead of the 3 scheduled for Unit 2. On 12/27/2025 (Saturday), on the 7:00 AM to 3:00 PM shift, there were 3 Certified Nursing Assistants instead of the 4 scheduled on Unit 3. On 12/27/2025 (Saturday), on the 11:00 PM to 7:00 AM, shift there was 1 Certified Nursing Assistant instead of the 2 scheduled on Unit 1. On 12/28/2025 (Sunday), on the 3:00 PM to 11:00 PM shift, there were 3 Certified Nursing Assistants instead of the 4 scheduled on Unit 1, Unit 2, and Unit 3. On 05/04/2026 at 10:31 AM, an interview was conducted with Resident #98 who stated they need partial assistance with grooming, however, they observed other residents not getting help they need on time, as at times it took 15 to 30 minutes for call bells to be answered. On 05/04/2026 at 10:55 AM, an interview was conducted with Resident #64 who stated that they are partially dependent in grooming and toileting. Resident #64 also stated that there were times when they have one (1) to (2) two Certified Nursing Assistants (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the evenings. Resident #64 further stated that they often heard other residents calling for help but could not say how long they waited before help reached them. On 05/05/2026 at 10:00 AM, an interview was conducted with Certified Nursing Assistant #4 who stated they work in the morning shifts, both days and weekends. Certified Nursing Assistant #4 also stated that Certified Nursing Assistants sometimes called out or run late. Certified Nursing Assistant #4 further stated the supervisor would try to call standby staff and sometimes they come, and sometimes they will be short staffed. Certified Nursing Assistant #4 concluded that this does not happen often, but when it does, they manage with the staff they have. On 05/08/2026 at 10:28 AM, an interview was conducted with Certified Nursing Assistant #8 who stated they work weekends and there were times when there were only one (1) to two (2) Certified Nursing Assistants working on Unit 2 during the day shift. Certified Nursing Assistant #8 also stated they try to manage, but there will be a delay in caring for residents when there is not enough staff. On 05/08/2026 at 11:45 AM, an interview was conducted with Licensed Practical Nurse #2 who stated they work five (5) days a week and the units are supposed to be staffed with four (4) Certified Nursing Assistants during the 7:00 AM to 3:00 PM shift. Licensed Practical Nurse #2 also stated they sometimes when they only have three (3) Certified Nursing Assistants working on the unit, they have to stop what they are doing to help the Certified Nursing Assistants. On 05/08/2026 at 12:00 PM, an interview was conducted with Registered Nurse #2 who stated residents had not been complaining to them about low staffing. Registered Nurse #2 also stated that there are times when they have less staff than scheduled and they have to help out. Registered Nurse #2 further stated that they have list of people to call if they need help, but they have not seen a situation they could not handle based on staffing. On 05/08/2026 at 12:30 PM, an interview was conducted with the Regional Staff Coordinator who stated that they have software that is linked with the time clock, and they export the time record from the software, and upload it for the Payroll Based Journal. The Regional Staff Coordinator stated that they would not be able to know if the facility has low staffing when they submit the Payroll Based Journal data. On 05/08/2026 at 1:30 PM, an interview was conducted with the Staff Coordinator who stated that they do have days when staff call out and they replace them right away and there are times we cannot replace them. The Staff Coordinator also stated that they create the schedule for the weekend, and the nursing supervisors are responsible for calling staff for replacement on the weekend. The Staff Coordinator further stated that they provide the nursing supervisors with a list of staff, and if they cannot find someone, they have to ask someone to stay over. On 05/08/2026 at 02:18 PM, an interview was conducted with the Director of Nursing who stated that the facility is well staffed. The Director of Nursing also stated that there might be sometimes when staff call out and they get them replaced as much as possible. The Director of Nursing concluded that the facility has not experienced a severe shortage of staff. On 05/08/2026 at 02:28 PM, the Administrator was interviewed and stated that the facility had not experienced shortage of staffing in recent times. The Administrator also stated that when staff call out, they try to get staff replaced as soon as possible. The Administrator further stated that they hire people from time to time and they rarely use outside agency because they have a quite a number of staff. 10 New York Code, Rules and Regulations 415.13(a)(1)(i-iii)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: Based on observation and interviews, the facility failed to ensure infection control practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident in two (2) medication rooms (Unit 2 and Unit 3) of three (3) medication rooms observed during the Medication Storage and Labeling task and the Central Supply room. Specifically, the medication rooms on Unit 2 and Unit 3, and the Central Supply room in the basement were observed to contain expired foley insertion trays. The findings are: The facility's policy titled Infection Control Program with last review date of [DATE] stated the facility will ensure that the Infection Prevention and Control Program is designed to prevent, identify, report, investigate, and control the spread of infections and communicable disease for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; provide a safe, sanitary and comfortable environment; and to help prevent the development and transmission of disease and infection. The facility's policy titled Maintain Central Supply with last review date of [DATE] stated that Central Supply Clerk will check expiration dates to ensure medical supplies are being used in a rotating inventory according to the date of expiration. The policy also documented that any expired medical stock, equipment or supplies will be discarded according to manufacturers' instruction. On [DATE] at 10:54 AM, the medication room on Unit 2 observed with Licensed Practical Nurse #2. Two (2) out of seven (7) Foley Insertion Trays in the medication room were found with an expiration date of [DATE]. On [DATE] at 10:59 AM, Licensed Practical Nurse #2 was interviewed and stated they did not check the medical supplies in the medication room. Licensed Practical Nurse #2 also stated the expired supplies might have been delivered to the unit this morning by the Medical Record Staff #1. On [DATE] at 11:02 AM, Medical Record Staff #1 was interviewed and stated they had not yet delivered any supplies to the units this morning. On [DATE] at 11:07 AM, Registered Nurse #2 was interviewed and stated they did not check the expiration date of medical supplies in the medication room before using them. Registered Nurse #2 also stated three (3) residents had a foley catheter inserted in [DATE] at the hospital and had no foley catheter change done at the facility yet. On [DATE] at 11:16 AM, the medication room on Unit 3 was observed with Registered Nurse #3. Nine (9) Foley Insertion Trays were observed and two (2) foley insertion tray had expiration dates of [DATE] and one (1) had an expiration date of [DATE]. Registered Nurse #3 was immediately interviewed and stated the nurses on the unit should check the medical supplies at least once every shift to make sure the medical supplies were not expired. Registered Nurse #3 could not explain why the expired foley insertion trays were still stored in the medication room. Registered Nurse #3 stated there was one resident on the unit who returned from the hospital last month with an indwelling catheter and they had not had a catheter change yet at the facility. On [DATE] at 12:28 PM, the Director of Nursing was interviewed and stated they made rounds on the units two to three times each day. The Director of Nursing also stated they checked the environment, resident care, and medication rooms during the rounds. The Director of Nursing further stated they checked if the medications and medical supplies were expired and refrigerator temperature when checking the medication rooms. The Director of Nursing stated the medication nurse on every shift was responsible for checking the medications and medical supplies in the medication room to make sure they were not expired. The Director of Nursing also stated they just checked all three (3) medication rooms last night on [DATE] and did not find any expired supplies. The Director of Nursing further stated the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expired foley insertion tray might be delivered to the unit by Medical Record Staff #1 this morning. The Director of Nursing had no explanation when they were informed the Medical Record Staff #1 interviewed earlier denied having delivered anything to the unit today. The Director of Nursing stated that the expired supplies were a concern for infection as the medical supplies were not considered sterile to use anymore. On [DATE] at 12:59 PM, an observation of the Central Supply room was made with the Director of Nursing and the Administrator. Two (2) cases containing 20 foley insertion trays were observed in the room. In one (1) case, all 20 foley insertion trays had an expiration date of [DATE]. The Director of Nursing stated the Medical Record Staff #1 was responsible for checking the expiration dates of medical supplies in the room and should discard them if they were expired. On [DATE] at 1:18 PM, Medical Record Staff #1 was interviewed again and stated their primary duties included managing medical records and purchasing supplies. Medical Record Staff #1 also stated they delivered supplies to the units every Monday and Friday and as needed. Medical Record Staff #1 further stated they had a lot of work to do, and it was hard for them to maintain and check to see if the medical supplies in the room were expired or not. Medical Record Staff #1 stated they should discard the expired medical supplies and not deliver expired medical supplies to the units. Medical Record Staff #1 stated they did not recall if they delivered the expired foley insertion trays to Unit 2 and Unit 3. On [DATE] at 8:58 AM, the Administrator was interviewed and stated that the Medical Record Staff #1 was responsible for making sure the medical supplies in the Medical Supplies room were not expired. The Administrator also stated the Medical Record Staff #1 should go through everything in the Medical Supplies room and remove the expired supplies regularly. The Administrator further stated they were not sure how often the Medical Record Staff checked the inventory in the medical supplies room. On [DATE] at 12:02 PM, the Assistant Director of Nursing was interviewed and stated they were the Infection Preventionist for the facility. The Assistant Director of Nursing also stated the unit supervisors were responsible for checking the medical supplies in the medication room once every shift and discarding the expired supplies. The Assistant Director of Nursing further stated there was no log to record the time and date the medication room was checked. The Assistant Director of Nursing stated the expired supplies were a concern for infection prevention as they were no longer sterile for use. 10 New York Codes, Rules and Regulations 415.19 (a)(1-3), (b)(4)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews, the facility to ensure that the resident was free from chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. This was evident for one (1) resident (Resident #105) of five (5) residents reviewed for Unnecessary Medications, out of 27 total sampled residents. Specifically, there was no adequate clinical indication documented in the clinical record to support the ongoing use of Aripiprazole 15 MG daily, no documentation of monitoring of behavioral symptoms, and no documented evidence that a gradual dose reduction had been attempted for Resident #105 since 09/20/2024. The findings include: The facility policy titled Psychotropic Drug Use dated 03/06/2025 stated it is the policy of the facility to utilize psychotropic drugs appropriately. The policy also stated that residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record. The policy further stated that the facility would utilize non-pharmacological methods for residents prior to the use of psychotropic drugs, and a gradual dose reduction will be attempted Resident #105 had diagnoses which include Dementia, Traumatic brain injury, Anxiety disorder, and Schizophrenia. The Annual Minimum Data Set assessment dated [DATE] documented Resident #105 had severely impaired cognition, was dependent on staff for Activities of Daily Living. On 05/03/2026 at 12:24 PM, Resident #105 was observed in bed, alert and awake. Resident #105 appeared confused, was unable to make appropriate conversation when asked about their name and did not talk or move any part of their body. On 05/04/2026 at 12:52 PM, Resident #105 was observed in bed with no eye contact when called by their name. Resident #105 appeared confused and could not communicate when called by their name. Review of physician orders revealed Aripiprazole 15 Milligrams, 1 tablet by mouth one time a day for diagnosis of schizophrenia was started on 09/20/2024 and the order was last renewed on 05/01/2026, Clonazepam 1 Milligram, 1 tablet by mouth daily for Anxiety was started on 12/30/2024, last renewed on 05/01/2026. Psychiatry notes dated 03/20/2026 and 12/21/2025 documented that Resident #105's chart was reviewed, discussed with staff, Resident #105 had a history of schizophrenia and traumatic brain injury, well managed with antipsychotic medications. Alert in bed, anxious, screams and yells on and off. The Psychiatry notes also documented Resident #105 was paranoid, delusional, responded to hallucinations, was disoriented to time and place with poor judgement. Continue Aripiprazole 15 milligram orally daily. Gradual Dose Reduction is not recommended currently. No additional psychiatric notes for 2024 or 2025 were provided to the State Surveyor. There was no documented evidence in Resident #105's medical record of behavioral symptoms they exhibited that would support ongoing use of antipsychotic medication at the current dosage. There was no documented evidence that a gradual dose reduction had been attempted for Resident #105. On 05/07/2026 at 11:33 AM, an interview was conducted with Certified Nursing Assistant #3 who has provided care for Resident #105 on and off for over two (2) years. Certified Nursing Assistant #3 stated Resident #105 is confused, cannot call for help and cannot make needs known to staff. Certified Nursing Assistant #3 also stated Resident #105 is totally dependent with care, is transferred via Hoyer lift and uses a Geri chair. Certified Nursing Assistant #3 also stated Resident #105 does not have behavioral problems other than screaming occasionally. On 05/07/2026 at 11:55 AM, an interview was conducted with Registered Nurse #2 who has worked on the unit for the past year and stated Resident #105 is confused and rarely talks, only screams at times. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Caton Park Rehabilitation and Nursing Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1312 Caton Avenue Brooklyn, NY 11226	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #2 also stated that they do not document behavioral notes unless there is a behavior reported by staff or witnessed by the nurses. Registered Nurse #2 concluded that they have reviewed medical records and could not find behavioral concerns documented anywhere. On 05/08/2026 at 10:12 AM, an interview was conducted with the Assistant Director of Nursing who stated that residents on psychotropic medications received gradual dose reduction based on the recommendation of the psychiatrist. The Assistant Director of Nursing also stated no behavioral notes were documented in the medical record unless resident exhibits such behavior, and then staff will document. The Assistant Director of Nursing stated that they will review Resident #105's, however they did not provide any additional documents to the State Surveyor. On 05/08/2026 at 11:18 AM, an interview was conducted with the Psychiatrist who stated that they see residents based on certain referrals from the facility. The Psychiatrist also stated that some residents are seen every three months for follow-up, and some are seen as needed. The Psychiatrist further stated they have been following Resident #105 for a few years, and Resident #105 is confused with psychotic features, is paranoid, delusional, psychotic and hears things that are not real. The Psychiatrist stated they obtained information about Resident #105 through direct conversations with staff members and chart review. The Psychiatrist also stated that they do not believe that the current psychotropic medications are too much for the resident, and they do not do gradual dose reductions with residents who have a psychiatry history. On 05/08/2026 at 2:15 PM, an interview was conducted with the Medical Director who stated that they do not interfere with psychiatrist evaluation of residents, and that whatever they recommend, the facility will carry out. The Medical Director also stated that any issues related to psychiatry are left up to the psychiatrist. The Medical Director also stated that they spoke with the psychiatrist about Resident #105, and the psychiatrist informed them that Resident #105 did have any side effects from the medications, and because of the resident's age, and the resident being stable on the current medications, there was no need to do a gradual dose reduction for them. 10 New York Code, Rules and Regulations 415.4(a)(1) and 415.3(d)(1)(vii)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1 Based on record reviews and staff interviews, the facility failed to ensure assessments accurately reflect the resident's status. This was evident for one (1) resident (Resident #22) out of five (5) residents reviewed for Accidents out of 27 sampled residents. Specifically, the Minimum Data Set assessment for Resident #22 did not capture the use of a wander/elopement alarm. The finding includes: Resident #22 had active diagnoses which include Non-Alzheimer's Dementia, Coronary artery disease, and Cerebrovascular accident. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #22 had moderate cognitive impairment and did not document use of wander/elopement alarm. On 05/03/2026 at 12:29 PM, Resident #22 was observed in bed, alert and awake. Resident #22 appeared confused and was observed with a wander guard device on their right wrist.The Elopement Risk Assessments dated 02/10/2026 and 04/30/2026 documented Resident #22 had a score of 3 and was considered at risk for elopement.The Physician Order's dated 06/14/2024 last revised on 04/16/2026 documented Wander Guard: check placement every shift (Location) Right Wrist, Wander guard check functioning daily by 11:00 PM -7:00 AM.The Medication Administration Records dated 04/01/2026 to 05/06/2026 documented observation of the wander guard device every night shift daily (11:00 PM -7:00 AM).On 05/06/2026 at 10:30 AM, an interview was conducted with the Minimum Data Set Coordinator who stated they did not complete the Minimum Data Set, however, they are responsible for overseeing the Minimum Data Set assessments for accuracy. The Minimum Data Set Coordinator also stated the assessors perform physical assessment and review records and interviewing staff when completing assessments. The Minimum Data Set Coordinator further stated that they should not solely rely on medical records, and they have to see the residents. The Minimum Data Set Coordinator stated the wander guard was not coded on the assessment, and they concluded it was an oversight. 10 New York Code, Rules and Regulations 415.11(b)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 1Number of residents cited: 1Based on record review and staff interviews, the facility failed to ensure that the baseline care plan was completed within 48 hours of a resident's admission. This was evident for one (1) resident (Resident #119) of one (1) resident reviewed for Discharge out of 27 sampled residents. Specifically, the baseline care plan for Resident #119 was not completed within 48 hours of admission.The findings are:The facility policy titled Comprehensive Person-Centered Care Plan/Baseline Care Plan/Plan of Care Summary effective 01/15/2017 and last reviewed on 07/02/2025 documented a baseline care plan is developed and implemented within 48 hours of a resident's admission. Resident #119 was admitted to the facility on [DATE] with diagnoses that included Wound Infection, Peripheral Vascular Disease, and Arthritis. The admission Minimum Data Set, dated [DATE] documented Resident #119 was admitted from a short-term general hospital on [DATE], was cognitively intact, and both Resident #119 and their representative participated in the assessment. The document titled Baseline Care Plan -V2 was created on 02/10/2026. Section 1 General Information and Initial Goals, Section 2 Functional Status, Section 3 Health Conditions, and Section 5 for BCP (Baseline Care Plan) Summary and Signatures were signed on 02/10/2026. Section 4, which included Dietary, Therapy, and Social Services section was not signed off. There was no lock date for the baseline care plan.On 05/06/2026 at 12:49 PM, the Minimum Data Set Coordinator was interviewed and stated they were responsible for overseeing the completion of the baseline care plans. The Minimum Data Set Coordinator also stated they check the electronic medical record daily and notify the department heads if their disciplinary sections were not completed on the baseline care plan. The Minimum Data Set Coordinator further stated they were informed by their corporation that they had three (3) days or 72 hours to complete the baseline care plan. The Minimum Data Set Coordinator reviewed the Dietary, Therapy and Social Services section of the baseline care plan for Resident #119, and stated the section was completed and not signed off. The Minimum Data Set Coordinator stated they could not tell which discipline completed the section late, and the last discipline to complete the section is responsible for signing it off as the baseline care plan was not complete until all sections were signed off. The Minimum Data Set Coordinator also stated they could not tell why the section was completed late and not signed off. The Minimum Data Set Coordinator had no explanation as to why they did not find the outstanding baseline care plan during their daily monitoring of the completion of baseline care plans. On 05/06/2026 at 2:30 PM, the Director of Nursing was interviewed and stated they did not recall the timeframe to complete the baseline care plan. The Director of Nursing also stated the baseline care plan was not considered as complete until all sections were signed off. 10 New York Code, Rules and Regulations 415.11(c)		

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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. Number of residents sampled:2Number of residents cited:1 Based on record review and interview, the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This was evident for one (1) resident (Resident #70) of two (2) residents reviewed for Activities of Daily Living out of 27 sampled residents. Specifically, the comprehensive care plan related to Activities of Daily Living for Resident #70 was not reviewed and revised after each assessment. The findings are: The facility policy titled Comprehensive Care Plan last reviewed 01/26/2026 documented the care plan is revised when appropriate to reflect the resident current needs based on evaluation and episodic changes to include but not limited to progress towards goals, response to care and treatment. Resident #70 had diagnoses that included Alzheimer's Dementia, Heart Disease, and Peripheral Vascular Disease. The Quarterly Minimum Data Set assessments dated 12/02/2025 and 2/26/2026 documented Resident #70 had intact cognition and required supervision for all activities of daily living. The Certified Nursing Assistant Task List Report dated 05/01/2026 documented Resident #70 and received showers twice a week as scheduled and at times four (4) times weekly. The care plan titled Activities of Daily Living dated created 05/18/2025 and last reviewed 10/07/2025 had interventions which included Bathing/Showering with no specific days noted in care plan, and the resident requires assistance from staff with bathing and showering as necessary. The care plan did not document what specific assistance was needed, or the number of staff needed to help with Resident #70's showers. There was no documented evidence that the Activity of Daily Living care plan had been reviewed or revised after the completion of Minimum Data Set assessments on 12/02/2025 and 02/26/2026. On 05/08/2026 at 11:06 AM, Registered Nurse #3 was interviewed and stated all nurses are responsible for initiating and updating care plans. Registered Nurse #3 also stated that they were not sure why the care plan was not updated and that the facility began using a different electronic medical record in May 2025. Registered Nurse #3 further stated when the transition occurred, not all the care plans were transferred which caused a mix up, and the facility is still working to add care plans and or update care plans as needed. On 05/08/2026 at 1:59 PM, the Director of Nursing was interviewed and stated the transition from one electronic medical record to another was a process, and staff are still learning the system and learning how to how to update care plans. The Director of nursing stated they monitor the care plan process by reviewing issues in morning meetings and doing audits as needed. 10 New York Code, Rules and Regulations 415.11(c)(2)(i-iii)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 27 Number of residents cited: 1 Based on observation, record review, and interviews, the facility failed to ensure that an ongoing program to support residents in their choice of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident was provided. This was evident for one (1) resident (Resident #63) of three (3) residents reviewed for Activities out of 27 total sampled residents. Specifically, Resident #63 was not provided with activities in their preferred language. The findings include: The facility policy titled Therapeutic Recreation effective 11/2018 and last reviewed 11/24/2025 stated the facility will strive to provide each resident with individual meaningful activities to promote engagement and enhance quality of life. The policy also stated that the interdisciplinary team would ensure residents are provided with recreational activities appropriate and meaningful based on their comprehensive assessment. Resident # 63 had diagnoses which included Stroke, Seizure, and Depression. The Annual Minimum Data Set assessment dated [DATE] documented Resident #63's preferred language was Cantonese and needed an interpreter to communicate with health care staff. The Annual Minimum Data Set assessment also documented Resident #63 had moderately impaired cognition, and it was very important for Resident #63 to have books/newspaper/magazines to read, listen to music, and do favorite activities. The Annual Minimum Data Set assessment further documented that both Resident #63 and their representative participated in the assessment. On 05/03/2026 at 09:56 AM, Resident #63 was interviewed and stated they spoke Fuzhounese and Mandarin (languages spoken in China) and they liked to have activities offered in their languages. Resident #63 also stated staff had not asked them about their activity preferences. Resident #63 further stated the facility did not have activities in their preferred language, and they could only use their smart phone to pass the idle time at the facility. On 05/03/2026 at 11:13 AM, the Resident Representative for Resident #63 was interviewed and stated Resident #63 had been at the facility for five (5) years, and no staff asked them about the activity preference for Resident #63. The Resident Representative also stated Resident #63 did not understand English and like to engage in activities like watching television, listening to music, and keeping up with news in their preferred language when at home. The Resident Representative further stated the facility had no activities to offer in the preferred language for Resident #63. From 05/03/2026 at 09:56 AM to 05/08/2026 at 9:35 AM, there were multiple observations of Resident #63 sitting in a wheelchair in their room and main dining room and there were no recreational activities provided to them in their preferred language. The Comprehensive Care Plan titled Activities initiated 05/16/2025 and last updated 03/13/2026 documented interventions which included to assist Resident #63 with independent leisure activities, provide leisure/community resources and use Mandarin translator. The Activities Quarterly assessment dated [DATE] documented Resident #63's spoken language was Mandarin, and their favorite activities included television and movies. The undated facility Television Channels documented the facility offered regular television channels (2-25). Channels 11 and 12 were Spanish language and the rest were English language channels. There was no documented evidence that Resident #63's was provided with their preferred activities in a language they understand. On 05/06/2026 at 9:48 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #63 was alert and oriented and did not refuse care. Certified Nursing Assistant #1 also stated that Resident #63 did not watch television and had no activities provided to them in their room. Certified Nursing Assistant #1 further stated Resident #63 stayed in their room most of time with their own smartphone (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and had family visits. On 05/06/2026 at 12:04 PM, Recreation Aide #1 was interviewed and stated they conducted the activity assessment for Resident #63 by calling their representative. Recreation Aide #1 also stated Resident #63 spoke Mandarin, and their preferred activity was to watch television. Recreation Aide #1 further stated they had been working at the facility for about one year and interviewed Resident #63's relative about recreational activities for Resident #63 but did not actually ask Resident #63 about their preferred activities. Recreation Aide #1 stated the television channels provided by the facility were in English and Spanish, and Resident #63 did not understand English and Spanish. Recreation Aide #1 had no explanation as to how the facility met the activity preferences of Resident #63 in their preferred language. On 05/07/2026 at 9:19 AM, the Director of Therapeutic Recreation was interviewed and stated the facility provided 23 English and 2 Spanish language television channels. The Director of Therapeutic Recreation also stated Resident #63 did not request to watch television channels in their preferred language, and they did not know if their staff asked Resident #63 about their preferred language for television and other activities. The Director of Therapeutic Recreation further stated Resident #63 was often watching videos on their smartphone. The Director of Therapeutic Recreation did not provide an explanation on how the facility was providing Resident #63 activities in their preferred language. The Director of Therapeutic Recreation stated the facility had some smart televisions which were connected to the internet, and it would be possible to watch television channels in different languages on them. The Director of Therapeutic Recreation also stated the facility did not provide a smart television to Resident #63. 10 New York Codes, Rules and Regulations 415.5(f)(1)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 1Based on observation, record review, and interviews, the facility failed to ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice. This was evident for one (1) resident (Resident #9) of two (2) residents reviewed for Respiratory Care out of 27 sampled residents. Specifically, Resident #9 was observed using oxygen via a nasal cannula at a rate of 4 liters per minute when the Physician's order was written for oxygen to be received at a rate of 2 liters per minute. The findings are: The facility's policy titled Oxygen Therapy last reviewed 09/30/2025 stated residents will be provided with oxygen therapy as ordered by the Medical Doctor. The policy also stated that the delivery of supplemental oxygen will be provided in a safe manner, and the nurse will check the liter flow on the tank and the concentrator. Resident #9 had diagnoses that included Unspecified Dementia, Chronic systolic heart failure, and Shortness of breath. The Annual Minimum Data Set assessment dated [DATE] documented Resident #9 had severely impaired cognition and received oxygen therapy while residing in the facility. The Physician's Order dated 03/17/2026 documented that Resident #9 was to receive oxygen via nasal cannula at a rate of 2 liters per minute for shortness of breath. From 05/03/2026 at 9:38 AM to 05/06/2026 at 9:00 AM, Resident #9 was observed lying in bed and receiving oxygen via nasal cannula. The concentrator next to right side of bed was set to and delivering oxygen at a rate of 4 liters per minute. On 05/06/2026 at 9:58 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #9 was confused and always on oxygen. Certified Nursing Assistant #1 also stated they did not check the concentrator for oxygen flow rate. On 05/06/2026 at 10:49 AM, Licensed Practical Nurse #1 was interviewed and stated they always checked the concentrator to make sure the oxygen flow rate was correct before administering medications to Resident #9. Licensed Practical Nurse #1 also stated the oxygen order was 2 liters per minute for Resident #9. Licensed Practical Nurse #1 had no explanation why the oxygen flow rate was observed at 4 liter per minute since 05/03/2026. On 05/06/2026 at 11:11 AM, Registered Nurse #1 was interviewed and stated Resident #9 had an order to receive continuous oxygen at a rate of 2 liters per minute starting on 03/18/2026. Registered Nurse #1 also stated that the medication nurse was responsible for ensuring that the oxygen was running at the ordered rate at the start of their shift. Registered Nurse #1 could not provide an explanation for why Resident #9's oxygen was running at an incorrect rate during observations made from 05/03/2026 and 05/06/2026. On 05/06/2026 at 2:35 PM, the Director of Nursing was interviewed and stated that for a resident on continuous oxygen, the oxygen rate should be verified at least once a shift to ensure it was running at the ordered rate. The Director of Nursing also stated it was the responsibility of the unit nurse supervisor to check at least one (1) time every shift. 10 New York Codes, Rules and Regulations 415.12(k)(6)		