

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335381	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2024
NAME OF PROVIDER OR SUPPLIER Schulman and Schachne Inst for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 555 Rockaway Parkway Brooklyn, NY 11212	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38306</p> <p>Based on observation, interviews, and record review during an abbreviated survey (Case #NY00332762, NY00332416) the facility did not ensure that the resident's representative was notified of changes to a resident skin. This was evidenced in one of three residents sampled (Resident #1). Specifically, on 01/29/2024, Resident #1's designated family member was visiting Resident #1 and saw healing abrasions to the front of the legs below the knees (shins). The family member was not aware of the skin changes.</p> <p>The Findings are:</p> <p>The facility's policy titled, Change in Resident Condition, dated 8/2023, documented Circumstances Requiring Notification are: 1. Accidents resulting in injury 2. Potential to require physician intervention.</p> <p>Resident #1 was admitted on [DATE], with diagnoses include Dementia, (memory loss), Cerebrovascular Accident (a stroke) with Left side weakness, and Seizures. Resident #1 was non-verbal, legally blind, and aphasic (unable to speak).</p> <p>The Minimum Data Set (MDS-tool used to determine level of care required) dated 12/16/2023, documented Resident #1 was dependent for all activities of daily living and was non-ambulatory (unable to walk). The Brief Interview for Mental Status (BIMS-a scored tool used to determine cognition) documented Resident #1 was severe cognitively impaired.</p> <p>Nursing Progress notes dated 01/19/2024 and 01/27/2024 to 01/31/2024 revealed no documented evidence of changes in Resident #1's skin.</p> <p>A Nursing Progress Note, by Registered Nurse #2, dated 01/29/2024 during the 7 AM to 3 PM shift, documented, Resident #1's adult child visited and expressed concerns regarding Resident #1's skin to both legs. Resident #1's skin was assessed and noted with healing lacerations to both shins. The right shin was six centimeters by one-centimeter dry skin area, the Left shin had dry healing scabs.</p> <p>The Skin Check Form dated 01/26/2024 to 01/29/2024 documented G for good skin on Resident #1's skin check form for all shifts. On 01/29/2024 during the 7 AM to 3 PM shift, the skin check form documented B for broken skin, with no indication as to where the skin was broken.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physician 's progress note dated 1/29/2024, documented resident with linear abrasions on both shins, no erythema, no bleeding, no discharge. Apply Bacitracin topically and cover with dry sterile dressing for seven days.</p> <p>The Results of the X-ray of the right and left leg dated 01/31/2024, documented no evidence of fractures or soft tissue swelling.</p> <p>During a telephone interview on 06/11/2024 at 11:32 AM, the assigned Certified Nursing Assistant #1 who works the 3 PM to11 PM shift but was assigned to work the 7 PM to 3 PM shift on 01/29/2024, stated they never saw any injuries or skin changes on Resident #1 prior to 01/29/2024. The skin changes were observed during care on the morning of 01/29/2024, there were long lines on each of the Resident #1's leg and they were dry, hard scabs, no swelling, no bleeding. Certified Nursing Assistant #1 stated they forgot to tell the assigned nurse, License Practical Nurse #1 on the dayshift. The family member arrived, saw the Resident #1's legs, and spoke with the Nursing Supervisor.</p> <p>During telephone interview on 06/11/2024 at 1:55 PM, the Registered Nurse / Unit Manager #1 stated they were at the nurses' station with Registered Nurse #1 when the family member expressed their concern. Resident #1 was assessed by the Unit Manager #1 and Registered Nurse #1 and observed the healing abrasions on both shins. The Unit Manager #1 acknowledge and concluded that the injuries may have occurred within 72 hours and the family member was upset because they did not get a call from the facility to inform them of Resident #1's skin changes.</p> <p>During an interview on 06/07/2024 at 6:30 PM, the Director of Nursing and the Administrator, stated that it is not acceptable that the Certified Nursing Assistants who provided care to Resident #1 did not observe that Resident #1's legs had wounds or injury at the front of the legs below the knees.</p> <p>10 NYCRR 415.3(e)(2)(ii)(b)</p>		