STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335411	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sea Crest Nursing and Rehabilitation Center	3035 West 24th St Brooklyn, NY 11224

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 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** Number of residents sampled: 5Number of residents cited: 1 Based on record review and interview conducted during the Recertification survey, the facility did not ensure that a resident's comprehensive care plan was reviewed and revised to accurately reflect the needs of the resident and in response to current interventions. This was evident for one (Resident #163) of five residents reviewed for Unnecessary Medication out of 38 sampled residents. Specifically, Resident #163's comprehensive care plan did not document that Resident's anticoagulant medication was changed.The findings are:The facility policy and procedure titled Care and Treatment of Residents - Care Planning Process dated 03/2017, last revised 07/2022, stated the facility shall have a care planning process that is person centered which includes integrating assessment findings, developing an interdisciplinary care plan, regularly reviewing and revising the care plan, providing the care and documenting the care. The policy also stated the services provided by the facility will be provided by qualified persons in accordance with each resident's written plan of care. The policy further stated the care plan is revised by the members of the interdisciplinary team based on changing goals, preferences and needs of the resident and in response to current interventions.Resident #163 was re-admitted to the facility with diagnoses that included Atrial fibrillation, Heart failure, and Hypertension.The Significant Change in Status Minimum Data Set, dated [DATE] documented Resident #163 was not taking Anticoagulant medication.The Comprehensive Care Plan with focus Potential for bleeding initiated on 07/11/2025 documented Resident has Potential for bleeding related to Anticoagulation therapy-Apixaban (Eliquis). Goals included Resident will be free of signs/symptoms of bleeding, such as bleeding gums, tarry stool, epistaxis, hematuria, petechiae bruising. Interventions included reinforce safety measures to prevent injury/bleeding, watch for signs of bleeding, report changes to Nurse/Physician, instruct staff/resident to notify nurse if bleeding gums, nose bleeds, tarry stools, hematuria, petechiae or bruising is noted.The Physicians Order dated 07/11/2025 documented Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet via PEG-tube one time a day for A-fib.The Medical Progress note dated 08/02/2025 documented 07/28/25 Cardiology consult reviewed with recommendation to restart Eliquis 5 mg twice daily for Atrial Fibrillation.The Medical Progress note dated 08/03/2025 documented nursing staff reported small amount of hematuria noted on resident's brief; complete blood count, complete metabolic panel, urine analysis/culture and sensitivity ordered. The Physician's order dated 08/18/2025 documented Aspirin 81mg Oral Tablet Chewable 1 table daily for DVT PPX (Deep Vein thrombosis prophylaxis). The Medication Administration Record dated July 2025 documented Resident #163 received Apixaban 5mg via Tube feeding for Atrial Fibrillation on 07/01/25, 07/02/2025, medication was held 07/03/2025-07/05/2025 and discontinued on 07/06/2025. The Medication Administration Record dated July 2025 also documented Resident #163 received Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet via PEG-tube one time a day for A-fib. The Medication Administration Record dated August 2025 documented Resident #163 received Aspirin 81mg via Tube feeding daily for Atrial Fibrillation. There was no documented evidence the care plan on Anticoagulant was updated to reflect Apixaban (Eliquis) was discontinued for Resident (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#163, and Aspirin was started on 07/11/2025. On 08/21/2025 at 12:01 PM, Registered Nurse #1 was interviewed and stated Resident #163 had been taking Eliquis, but it was discontinued, and they were started on Aspirin. Registered Nurse #1 also stated they were not aware that Resident #163's care plan was not updated when Eliquis was discontinued. Registered Nurse #1 further stated the nurse on duty when Eliquis was discontinued should have updated the care plan to indicate the reason for the discontinuation. Registered Nurse #1 stated they were not regular on the unit, and was not aware the care plan had been not updated. On 08/22/2025 at 10:28 AM, Registered Nurse #2 was interviewed and stated Resident #163 was admitted on [DATE] and was prescribed Eliquis 5mg every 12 hours for Atrial Fibrillation, which was discontinued on 07/05/2025 as there was blood noted in the urine and they were started on Aspirin 81 mg. Registered Nurse #2 also stated Resident #163 has a care plan related to the risk for bleeding due to Eliquis, which was updated on 05/31/2025, 07/11/2025 and 07/31/25, and there is no documentation Eliquis was discontinued. Registered Nurse #2 further stated the nurses caring for Resident #163 when bleeding was noted and Eliquis discontinued, or the supervisor on duty at that time could have updated the care plan to indicate Eliquis was discontinued due to bleeding, but they cannot explain why it was not updated. On 08/22/2025 at 11:45 AM, the Director of Nursing was interviewed and stated the nurse on the unit is responsible for updating the care plan, and the unit supervisor is to oversee that a resident's care plan is updated as soon as there is a change in resident's condition or resident's plan of care. The Director of Nursing also stated they do spot checks to see that everything is in order, but they were unaware this care plan was not updated when Resident #163's anticoagulant therapy was changed. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews conducted during the Recertification survey, the facility did not ensure infection control practices were maintained to prevent the transmission of foodborne illness. This was evident during Dining Observation on the 3rd Floor, [NAME] side, dining room. Specifically, two Certified Nursing Assistants were observed assisting multiple residents with hand hygiene without performing hand hygiene in between residents. The findings are: The facility policy titled Meal Service-Assistance of Residents last revised 04/2016 stated residents who are unable to feed themselves or require feeding assistance to finish meals will be served and assisted with their meals. Offer and/or assist resident to cleanse their hands with a hand wipe. The facility policy titled Hand Hygiene Protocol effective 11/2017 stated the facility will follow a hand hygiene protocol in preventing the spread of potential pathogens on the hands. The policy also stated the guidelines for hand hygiene as before and after eating and before and after each resident/patient contact, and resident hand hygiene should be performed after toileting and before meals. On 08/19/2025 from 11:43 AM to 11:57 AM, dining was observed on the 3rd floor dining room on the [NAME] side. Certified Nursing Assistant #6 was observed donning gloves and giving handwipes to residents in the dining room. Certified Nursing Assistant #6 assisted Resident #308, Resident #235, Resident #40, Resident #108, Resident #115, Resident # 280 to clean their hands using the same gloves. Certified Nursing Assistant #6 then placed a paper placemat on the table for Resident #280 table and then assisted Resident #63, and Resident #258 with hand hygiene and did not change their gloves. In addition, Certified Nursing Assistant #5 was observed assisting both Resident #88 and Resident #157 with hand hygiene while wearing the same unchanged gloves. On 08/19/2025 at 11:56 AM, Certified Nursing Assistant #6 was observed washing their hands in the sink after taking off gloves. On 08/19/2025 at 11:57 AM Certified Nursing Assistant #5 was observed washing their hands in the sink in the dining room. During an interview on 08/19/2025 at 3:09 PM, Certified Nursing Assistant #6 stated that they noticed they did not do hand hygiene, and this was their first time assisting in the dining room. Certified Nursing Assistant #6 also stated they completed training on hand hygiene online, and did recall completing any hand hygiene observation competency. Certified Nursing Assistant #6 further stated hand hygiene should be done to remove germs, so they do not get residents infected with germs from another resident. During an interview on 08/19/2025 at 02:59 PM, Certified Nursing Assistant #5 stated that they forgot to clean their hands between residents. Certified Nursing Assistant #5 also stated they are supposed to clean their hands so they do not transmit any kind of infection to residents. Certified Nursing Assistant #5 further stated they had hand hygiene inservice last week. During an interview on 08/22/2025 at 3:02 PM, Registered Nurse #6 stated that they monitor dining every time residents are fed, and Certified Nursing Assistants clean resident's hands before they begin eating. Registered Nurse #6 also stated frequent in-services have been done downstairs with the Assistant Director of Nursing who is the in-service Coordinator. During an interview on 08/22/2025 at 3:30 PM, the Assistant Director of Nursing was interviewed and stated hand hygiene should be performed before donning gloves, after taking gloves off, and after assisting residents with dining. During an interview on 08/26/2025 at 1:34 PM, the Director of Nursing stated that they do facility rounds 5 times during a shift and observe preparation of residents for dining including the cleaning of resident hands. The Director of Nursing also stated if gloves are used, they should be changed between residents, and if gloves are not used hands should be sanitized between residents and washed after. During an interview on 08/26/2025 at 1:59 PM, the Infection Preventionist was interviewed and stated they do random infection control audits and monitor infection control in the resident dining rooms. The Infection Preventionist also stated staff are supposed to do hand hygiene before dining, after removing gloves, and after assisting residents with hand hygiene. 10 NYCRR 415.14 (h)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and interviews conducted during the Recertification survey, the facility failed to ensure the nursing staff information posting was accurate and complete. This was evident during the Nursing Staffing Task. Specifically, the daily nurse staffing information posting did not include the total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift.The findings include:The facility policy titled Posting of Nursing Staff with effective date of 08/2025 documented it is the policy of the facility to provide sufficient nursing staff with the appropriate competencies and skills to provide nursing and related services. The facility shall post daily and by the shift, number of licensed and unlicensed nursing staff working, who are directly responsible for resident care. Staffing information shall consist of the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift.During observations from 08/19/2025 at 9:15 AM to 08/23/2025 at 1:00 PM, the facility Daily Staffing posting information sheets were observed at the security front desk and the 2 [NAME] elevators. The Daily Staffing sheets documented the date, census at the start of shift, the number of registered nurses, licensed practical nurse, and certified nurse aides, and shift supervisors, but did include the total number and actual hours worked by the Registered Nurses, Licensed Practical Nurses, and Certified Nurse Aides.On 08/22/2025 at 3:02 PM, the Staffing Coordinator was interviewed and stated that their job includes posting the daily staffing and making sure the morning supervisors post the Daily Nursing Staffing Information sheets for the day shift, they post the evening staffing sheet in the evening after 3:00 PM, and the night supervisors do the posting on the night shift. The Staffing Coordinator also stated the daily staffing is posted at the 2 South elevator, reception desk, and the 2 [NAME] elevators, and is split into shifts 7 AM-7 PM, 7 AM to 3 PM, and 3 PM to 11 PM, 7 PM to 7 AM and 11 PM to 7 AM as the Registered Nurses work 12-hour shifts and Certified Nurse Aides work 8 hours. The Staffing Coordinator further stated the current census per shift is also documented on the staff posting, and the nurses and Certified Nurse Aides for each floor is documented. The Staffing Coordinator stated they were not aware that the total number and actual hours worked had to be included on the posting.On 08/22/2025 at 3:03 PM, the Administrator was interviewed and stated they were not aware the daily staffing posted had to document total number and actual hours worked.On 08/22/2025 at 3:29 PM, the Director of Nursing was interviewed and stated that on the previous survey there was an issue with the daily staffing not being posted, but they were not aware they were posting incorrect information. The Director of Nursing also stated they were not aware the total number and actual hours worked by nursing staff had to be included on the posting. 10 NYCRR 415.13