STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335513	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seagate Rehabilitation and Nursing Center	3015 W 29 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews conducted during an abbreviated survey (2616960, 439261, and 439285), the facility failed to ensure that residents are free from resident-to-resident abuse. This was evident for four (4) of 12 residents (Resident #1, #3, #7, and # 8) sampled for abuse. Specifically, 1) on [DATE] at 9:55 PM, Certified Nursing Assistant #2 discovered Resident #1 lying in bed bleeding from their head after being physically assaulted by Resident #2. Resident #1 was transferred to the hospital and later expired. 2) On [DATE] at 3:45 AM, Resident #4 was observed striking Resident #3 with their cane while Resident #3 was sitting on the floor in Resident #4's bathroom. Resident #3 was later diagnosed with an acute right hip fracture. 3) On [DATE] at 3:21 PM, Resident #7 reported Resident #8 wandered to their room and struck them with their walker. Resident #7 sustained redness under their right eye and complained of pain. This resulted in actual harm and the death of Resident #1, serious injury and harm to Resident #3, and Resident #7 that was Immediate Jeopardy. The findings are: A review of the facility's policy on Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident's Property with an effective date of [DATE] and a review date of [DATE] with no revisions noted, documented the facility shall provide the residents with considerate and respectful care designed to promote the resident's independence and dignity. Each resident has the right to be free from abuse, mistreatment, neglect and misappropriation of property. This includes the identification of residents and the development of intervention strategies to prevent occurrence, monitoring of changes that would trigger abusive behavior, and reassessment of the interventions on a regular basis. 1) Resident #1 was admitted to the facility with diagnoses including major depressive disorder, cerebral infarction (necrotic tissue in the brain), and diabetes.A review of the Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #1's cognition was severely impaired. A review of the Comprehensive Care Plan for Abuse Prevention dated [DATE] documented interventions to ensure one-to-one social service visits as needed and to encourage the resident to verbalize their feelings. Resident #2 was admitted to the facility with diagnoses including dementia, and cerebral infarction.Resident #2 did not have a Minimum Data Set completed due to being admitted on [DATE].A review of the Comprehensive Care Plan for Abuse Prevention dated [DATE] documented interventions to ensure the resident is asked about preferences for care routines. A review of Resident #2's medical record revealed that the resident was admitted to the facility on [DATE] after an evaluation and four (4) day stay in a hospital psychiatric emergency department. A review of the Hospital Psychiatric Emergency Department Consult report, dated [DATE] at 3:27 PM, revealed Resident #2 was admitted from home to the hospital psychiatric emergency department on [DATE] with history of worsening dementia, being agitated and confrontational with family, being paranoid, and delusional. The chief complaint was aggressive and paranoid behavior. A review of the Hospital Medication Administration Record documented Resident #2 received Olanzapine (an antipsychotic medication used to treat Bipolar and Schizophrenia disorders) 2.5 milligram by mouth on [DATE] at 5:49 PM and 5 milligrams sublingually on [DATE] at 8:00 PM. On [DATE] at 1:08 AM they received Olanzapine 10 milligrams intramuscularly, and at 6:45 PM received an additional 5 milligrams of Olanzapine intramuscularly. The hospital medication discharge orders recommended Depakote Delayed Release 125 milligrams every 12 hours and Olanzapine 2.5 milligram every 12 hours upon discharge to the facility on [DATE]. The facility did not conduct effective monitoring of Resident #2 upon admission. The facility did not develop a baseline care plan for Resident #2 to identify and address potential aggressive behavior towards others.A review of the Physician's Order Activity Detail Report, dated [DATE] through [DATE], revealed there was no written order in the electronic medical record for psychiatric consult. There was an order dated [DATE] for psychotherapy evaluation, however, there was no documented evidence the psychotherapy evaluation was conducted.The facility's investigation dated [DATE] documented that Resident #2 physically assaulted Resident #1 with their wheelchair footrest. On [DATE] at approximately 9:55 PM, Certified Nursing Assistant #2 was conducting rounding and found Resident #1 in their room bleeding fresh, warm blood from their head. Blood was splattered throughout the room. Resident #2 was observed cleaning themself in the bathroom. Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 responded immediately, and First Aid was applied to Resident #1. 911 was called and New York Police Department took over the scene. Resident #1 was transferred to the hospital and subsequently expired on [DATE]. The facility concluded that there was reasonable cause to believe that abuse, mistreatment, neglect, or quality of care concern occurred. A review

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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 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 (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during an Abbreviated Survey (ID# 2616960), the facility did not ensure a baseline care plan was developed within forty eight (48) hours of a resident's admission and implemented for the resident that includes the instructions needed to provide effective person-centered care that meets professional standards of quality of care. This was evident for one (1) out of twelve (12) residents (Resident #2) sampled for baseline care plan. Specifically, on [DATE], Resident #2 was admitted to the facility with the chief complaint of aggressive and paranoid behavior that was not addressed in a baseline care plan. On [DATE] at 9:55 PM, Resident #2 physically assaulted Resident #1 with their wheelchair footrest, who later expired in the hospital. Additionally, the facility did not provide the resident and their representative with a summary of the baseline care plan. The findings are:The facility's policy and procedure titled Resident's Baseline Care Plan, with review date [DATE], documented it is the facility policy to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of quality of care. All clinical disciplines review all admission documents and documentation and meets with resident for initial assessment. Completes all sections within 48 hours of admission and makes arrangement to provide written copy of the Baseline care plan to resident and/or family. Review care plan as necessary to ensure care-plan is resident centered and according to the resident's needs and wants.Resident #2 was admitted to the facility on [DATE] with diagnoses of Dementia, Cerebral Infarction, and Hypertension.There was no Minimum Data Set (an assessment tool) completed. Resident #2 was admitted on [DATE].A Hospital Psychiatric Emergency Department Consult report dated [DATE] at 3:27 PM, revealed Resident #2 was admitted from home to the hospital psychiatric emergency department on [DATE] with a history of worsening Dementia, being agitated and confrontational with family, being paranoid, and delusional. The chief complaint was aggressive and paranoid behavior. A review of the Baseline Care Plan dated [DATE], with no completed date, revealed no documented evidence that the chief complaint, aggressive and paranoid behavior, was addressed in the Baseline Care Plan. Review of Resident #2's electronic medical record revealed no documented evidence that the facility provided Resident #2 and their representative with a summary of the baseline care plan.A facility's investigation dated [DATE] documented that Resident #2 physically assaulted Resident #1 with their wheelchair footrest. Resident #1 was transferred to the hospital and subsequently expired on [DATE]. During an interview on [DATE] at 10:15 AM, Resident #2's family member stated they were not given a copy of the baseline care plan or received any documentation from the facility upon Resident #2's admission. The family member stated they were not aware of what a baseline care plan was all about. During an interview on [DATE] at 3:02 PM, Registered Nurse Supervisor #2 stated they admitted Resident #2 on [DATE] and initiated a baseline care plan. Registered Nurse Supervisor #2 stated they never provided a copy of the baseline care plan to Resident #2 of their family member. Registered Nurse Supervisor #2 stated they did not address the behavior because Resident #2 was admitted with no behavior. Registered Nurse Supervisor #2 stated the nurses and social workers are responsible for providing a copy of the baseline care plan to family members. During an interview on [DATE] at 12:51 PM, the Director of Social Work stated either the nurse or they can initiate the baseline care plan upon admission. The Director of Social Work stated they never saw Resident #2 because they sent them to the hospital. The Director of Social Work stated they or the nurse can give a copy of the baseline care plan to the resident or the resident's family member. Director of Social Work, they were not sure if Resident #2's family member received a summary of the baseline care plan.During an interview on [DATE] at 1:18 PM, the Director of Nursing stated the baseline care plan was developed, and it was a template generated in their system. The Director of Nursing stated the baseline care plan must be developed within 48 hours of the resident's admission to the facility. The Director of Nursing stated either the nurse or the social worker can provide a summary of the baseline care plan to Resident #2's family member. The Director of Nursing stated they were not sure if a copy of the baseline care plan was provided to the family member.10 NYCRR 415.11

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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. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews conducted during an abbreviated survey (439285), from 09/22/2025 to 10/01/2025 the facility did not ensure that a resident's care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This was evident in one (1) out of twelve (12) residents (Resident #7) sampled. Specifically, Resident #7 had a quarterly assessment conducted on 04/03/2025 and documented on the Minimum Data Set 3.0 (a resident assessment tool). The resident was assessed as having wandering behavior, and agitation, with severely impaired cognition. The resident's comprehensive care plan was developed on 03/07/2025. On 04/27/2025 Resident #7 had a physical altercation with another resident after wandering in their room. The comprehensive care plan was not reviewed until 09/09/2025. There were no revisions to the interventions after the incident.The findings are:The facility policy titled Care Planning dated 12/11/2024 documented it is the policy of the facility to provide an individualized comprehensive care plan for each resident based on assessments done at the time of admission, quarterly, annually and when there is a change in condition. A Comprehensive care plan will be reviewed and revised as needed upon re-admission(less than 30 days), quarterly and upon significant change. Care plans will be updated to reflect episodic issues/problems as they arise.Resident #7 was admitted to the facility on [DATE] with diagnoses of Dementia, Major Depressive Disorder, and Agitation.The Quarterly Minimum Data Set 3.0 assessment tool dated 04/03/2025 documented Resident #7 has severely impaired cognition. Resident #7 required setup/supervision with all activities of daily living care.A Care plan Behavior as evidenced by wandering, verbal aggression directed towards others and physically abusive dated 03/07/2025 and revised 09/09/2025. Interventions included: we will provide you with reality orientation, we will redirect you away from dangerous situations, and we will separate you from the situation by direct intervention of staff.The care plan was not updated to reflect the resident-to-resident altercation on 04/27/2025. Record review reveals there were no new interventions implemented since 09/21/2024.An Occurrence Investigation Form (no date) documented on 04/27/2025 at 3:55 PM Resident #7 reported Resident #8 wandered into their room looking for something, they asked Resident #8 to leave, and Resident #8 hit them with their rolling walker in their right eye. Resident #7 was observed with red mark near their right eye. Registered Nurse Supervisor #5 was notified. Registered Nurse Supervisor #5 assessed Resident #7, no other visible injury observed. Facility conclusion documented Resident #8 wandered into Resident #7 room and then immediately came out of the room closing the door as they leaves. Resident #8 was ambulating in the hallway when Resident #7 came out of their room with their slippers in their hand and struck Resident #7 on their left upper arm. Resident #7 face was hit with the walker. Both residents were separated. 911 was called and responded. Two Police Officers arrived at the facility and took statement then left without filing any report.A Psychiatry note dated 04/24/2025 documented Resident #7 admitted and treated with worsening dementia, wandering with aggression and agitation.During an interview on 10/07/2025 at 4:04 PM, Registered Nurse Supervisor #5 stated they were informed by Director of Nursing regarding the resident-to-resident altercation. Registered Nurse Supervisor #5 stated when they arrived on the unit, they observed Resident #7 sitting at the nursing station. Registered Nurse Supervisor #5 stated Resident #7 was observed with redness under their right eye. Registered Nurse Supervisor #5 stated Resident #7 was taken to their room and full body assessment done; no other visible injury was observed. Registered Nurse Supervisor #5 stated they wrote their nursing progress note but did not update the behavior care plan. Registered Nurse Supervisor #5 stated the Unit Nurse on the floor was supposed to review and update the behavior care plan.During an interview on 10/07/2025 at 4:11 PM, the Director of Nursing stated that anyone can update the care plan, including Licensed Practical Nurses, once the care plan has been initiated by a Registered Nurse. The Director of Nursing stated the staff member who did the incident report should have updated the care plan.10 NYCRR 415.11(c)(1)