

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Seagate Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3015 West 29th Street 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure that each resident was screened for a mental disorder or an intellectual disability prior to admission. This was evident for one resident (Resident #373) of three residents reviewed for Preadmission Screening and Resident Review out of a total sample of 38 residents. Specifically, the Preadmission Screening and Resident Review was not completed for Resident #373 prior to admission to the facility. The findings include: The facility's policy and procedure titled Screen and PASSAR reviewed 08/01/2025, documented that all individuals applying for new admission to the facility must be screened to identify serious mental illness or mental retardation/developmental disability per New York State Department of Health regulations. All applicants who are positive for the Level I criteria will have a comprehensive Level II assessment with determination/recommendations completed prior to admission to the facility. If a resident was identified as having a mental illness and or mental retardation/developmental disability on their admission screen Level I review and met the criterion for categorical determination (convalescent care, seriously physically ill, terminally ill, or provisional emergency admission) requires a length of stay longer than the appropriate physician documented number of days a Screen and Level II Evaluation must be completed. Resident #373 was admitted to the facility on [DATE] with diagnoses that included Rhabdomyolysis (damaged muscle tissue) chronic kidney disease (decline in kidney function) and hypertension (elevated blood pressure).The Minimum Data Set (a resident assessment tool) dated 03/14/2026 documented that Resident #373 was admitted to the facility from an acute hospital, was currently considered by the state Preadmission Screening and Resident Review Level II process to have a serious mental health and or intellectual disability and had an intellectual disability.The Level I Review for possible mental illness and possible mental retardation and developmental disability on the SCREEN DOH-695 form completed on 03/14/2026 documented that Resident #373 had a serious mental illness and had a diagnosis or documented history of mental retardation and or a developmental disability, manifesting itself prior to age [AGE], and is likely to continue indefinitely, resulting in substantial functional limitations in three or more areas of major life activity. The Categorical Determination, item #27, documented that Resident #373 qualified for convalescent care.An Office for People with Developmental Disabilities Preadmission Screening and Resident Review Level II Referral Response Letter dated 03/17/2026 documented that based on information obtained by the Level I Screen, the Patient Review Instrument , and other materials received from the referral entity, an abbreviated Level II Assessment was required to determine eligibility. The Categorical Determination is convalescent care (not to exceed 120 days). Need for specialized services. Services of a lesser intensity, provided through the nursing facility, are recommended. The Nursing facility level of care is needed because the individual's medical condition requires the level of skilled care provided by the facility. There was no documented evidence that the (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required Preadmission Screening and Resident Review Level II Assessment with determination was completed prior to the Resident #373's admission to the facility on [DATE]. On 07/28/2026 at 10:44 AM, an interview was conducted with the Social Services Director who stated that a Level I Screen is performed prior to a resident being admitted to the facility which will identify if the resident has a developmental disability or a serious mental health diagnosis and requires a Level II review prior to being admitted to the nursing home. The Social Services Director also stated that the Level I screen was completed in the hospital for Resident #373 on 03/14/2026 identifying that they had a developmental disability or mental retardation, and the Preadmission Screening and Resident Review Level II screen then should have been completed by the Office for People with Developmental Disabilities while Resident #373 was in the hospital. The Social Services Director further stated the Level II Determination Screen and Recommendation was completed on 03/17/2026 by the Office for People with Developmental Disabilities after Resident #373 was admitted to the facility on [DATE]. The Social Services Director stated there was some confusion as Resident #373 was not newly diagnosed and the facility should have obtained the Preadmission Screening and Resident Review Level II determination and recommendation prior to the admission to the facility. On 07/29/2026 at 11:32 AM, an interview was conducted with Minimum Data Set Assessor #1 who stated they documented in Section A of the assessment that Resident #373 had an intellectual disability and required a Preadmission Screening and Resident Review Level II Screen Determination. The Minimum Data Set Assessor #1 also stated that the Level II Screen Determination should have been performed prior to Resident #373 being admitted to the facility to ensure their appropriateness for nursing home level of care. On 07/30/2026 at 4:32 PM, an interview was conducted with the Facility Administrator who stated that the Preadmission Screening and Resident Review Level II Screen and Determination for Resident #373 should have been completed and received by the facility prior to admission. The Facility Administrator also stated that the referral was received on a weekday, and the resident was admitted on the weekend and the staff should have waited to receive the determination prior to the admission to ensure that services in the facility were deemed necessary and appropriate for Resident #373 who had an intellectual disability. 10 New York Code, Rules and Regulation 415.11(e)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Number of residents sampled:7Number of residents cited:1 Based on observations, record review and interviews, the facility failed to ensure that a resident received treatment and care in accordance with professional standards of practice that were based on the comprehensive assessment, person-centered care plan, and the resident's choice. This was evident for one of seven residents (Resident #129) reviewed for Accidents out of a total sample of 38 residents. Specifically, Resident #129 reported they fell during the early morning hours on 06/27/2026, however, Licensed Practical Nurse #3 did not inform the Registered Nurse Supervisor on duty during the shift. Resident #129 was not assessed until 11:00 AM when Resident #129 directly informed Registered Nurse #3 that they had had a fall earlier in the morning and felt pain to the left side upper back and hip. The findings include:The facility policy and procedure titled Resident Occurrence last revised 01/2026 states that it is the responsibility of all staff to report all incidents and accidents that occur at the facility. All occurrences are investigated in a timely manner and preventive measures are initiated. Staff will notify the Nursing Supervisor immediately when an incident occurs. The Nursing Supervisor will immediately initiate an investigation into all accidents/incidents. The investigation will include written statements from staff members caring for the residents and from people who have knowledge of the event. Resident #129 had diagnoses of colon cancer (uncontrollable growth of cells in the large intestine), prostate cancer (uncontrollable growth of cells in the prostate gland), and Benign Prostatic Hyperplasia (non-cancerous growth of the prostate gland).The Minimum Data Set Assessment (a resident assessment tool) dated 06/24/2026 documented Resident #129 was cognitively intact, had an indwelling catheter, and required substantial assistance for toileting hygiene and toilet transfer.The Comprehensive Care Plan titled Nursing: Urological Functioning: Foley Catheter with effective date of 06/17/2026 included an interventions of toileting every 2-4 hours and as needed.The nursing progress note written by Registered Nurse #3 dated 06/27/2026 documented that the incident was reported at 11:00 AM and Resident #129 alleged they had a fall in the bathroom by the toilet, range of motion noted within residents known limitations, no bruises, redness or swelling. The nursing progress note also documented Resident #129 stated they were ringing the bell for assistance and after no one came, they got up from their bed at 4:15 AM/4:20 AM to empty their foley catheter, lost their balance and fell near the toilet. The nursing progress note further documented the unit nurse reported when they went to Resident #129's room to administer medication around 11:00 AM, Resident #129 reported they fell in their bathroom and they felt pain to the left side upper back. On assessment, no bruises, skin intact, no redness or swelling noted. Resident #129 is able to get up and walk around using their rolling walker. Doctor made aware and ordered a left hip x-ray. Pain medications were administered this morning.The investigation summary dated 06/27/2026 documented that on 06/27/2026 at approximately 11:00 AM, Resident #129 claimed they turned on their call light to have the foley catheter bag emptied between 4:15 AM and 4:20 AM but no one responded to the call light. Resident #129 stated that they got out of bed, lost their balance and fell near the toilet. On assessment by the 6AM-2PM shift Registered Nurse #3, no apparent injury was noted but there was complaint of pain to the left hip. The Doctor ordered an x-ray of the left hip. X-ray results demonstrated no acute fracture, no dislocation, and the joint spaces are normal. The soft tissues are unremarkable. Resident #129 received scheduled Dilaudid 4 milligrams at 3:30 AM and 6:30 AM. The staff who worked overnight stated every time the call light was turned on, the staff responded in a timely manner, and no one observed Resident #129 on the floor. The nurse stated that Resident #129 did not fall. There is no reasonable basis to substantiate allegations of abuse, neglect, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mistreatment, misappropriate property, or concerns related to the quality of care provided. On 07/26/2026 at 10:28 AM, Resident #129's Representative was interviewed and stated that Resident #129 has a catheter and approximately three weeks ago, Resident #129 fell when they went to drain the urinary bag by themselves as they kept ringing the call bell and no one answered. On 07/30/2026 at 11:00 AM, Licensed Practical #3 was interviewed and stated that around 4 AM on 06/17/2026, they were informed by the Certified Nursing Assistant #15 that Resident #129 fell. Licensed Practical #3 also stated they felt this was not true as Certified Nursing Assistant #15 had checked on Resident #129 multiple times throughout the shift and observed them in bed. Licensed Practical Nurse #3 further stated that once this incident was brought to their attention, they had gone to Resident #129's room and observed Resident #129 sleeping in bed. Licensed Practical Nurse #3 stated that they had also checked Resident #129 several times throughout the night and had last given pain medications around 3:00 PM/3:30 PM at which time Resident #129 told them not to come back. Licensed Practical Nurse #3 stated that they checked in on Resident #129 a few times during the night following Certified Nursing Assistant #15's reporting of the incident and observed Resident #129 resting in bed. Licensed Practical Nurse #3 also stated that they did not think Resident #129 fell as Resident #129 was observed in bed multiple times, by both them and Certified Nursing Assistant #15. Licensed Practical Nurse #3 stated that they did not inform the Registered Nurse supervisor on duty as they figured Resident #129 was confused and did not think that Resident #129 had actually fallen. Licensed Practical Nurse #3 further stated that if they were certain Resident #129 had fallen, they would have reported it to the Registered Nurse Supervisor. On 07/30/2026 at 1:09 PM, Certified Nursing Assistant #15 was interviewed and stated they could not recall the incident and directed the State Surveyor to their statement. On 07/30/2026 at 11:20 AM, the Assistant Director of Nursing was interviewed and stated that they had completed the investigation for this incident, and they first became aware of this incident on 06/27/2026 around 11:00 AM when Registered Nurse #3 on the unit reported the incident and had already completed the assessment. The Assistant Director of Nursing also stated they reviewed the staff statements but it did not occur to them that Licensed Practical Nurse #3 had not reported the incident to the Registered Nurse earlier in the day, as an assessment had been done by the time it was brought to the attention of the Assistant Director of Nursing around 11:00 AM. The Assistant Director of Nursing further stated that when a resident reports a fall, even if the resident is found in bed and asleep, the incident should still be treated as a fall, and the registered nurse should be informed. The Assistant Director of Nursing stated that Licensed Practical Nurse #3 should have reported the fall to the Registered Nurse Supervisor, so that an assessment could be completed. On 07/30/2026 at 11:30 AM, the Director of Nursing Services was interviewed and stated that if a resident reports a fall, the protocol is that the licensed practical nurse should call the registered nurse supervisor to complete the assessment, and the registered nurse supervisor will then report the incident to the doctor. The Director of Nursing Services also stated that the Licensed Practical Nurse #3 should have reported the fall to the registered nurse supervisor on duty during the shift so that the registered nurse supervisor could complete an assessment. 10 New York Code, Rules and Regulations 415.12		