STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rutland Nursing Home, Inc	585 Schenectady Ave Brooklyn, NY 11203

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 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during survey, the facility failed to ensure a resident receiving enteral feeding received appropriate care and was monitored for complications related to tube feeding. This was evident for one (1) out of five (5) residents reviewed for enteral feeding (Resident #1). Specifically, on 02/20/2026, Resident #1 who received feeding and medications through a nasogastric tube (medical tube inserted through the nose into the stomach) had a change in their breathing pattern and was transferred to the hospital. Resident #1 was diagnosed with respiratory failure due to aspiration pneumonitis (an inflammation of the lung, which may lead to infection often presents rapidly with breathing difficulty, cough, and fever, requiring supportive care like oxygen) caused by a misplaced nasogastric tube in the left lung. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings include: The facility policy and procedure title Enteral Feeding through Gastrostomy, Mic-key, Nasogastric, Percutaneous Endoscopic Gastrostomy or Percutaneous Endoscopic Jejunostomy Tubes (different types of feeding tubes that deliver food and medication directly into the stomach or small intestine) Adult and Pediatrics, revised on 12/2024 documented always verify tube placement prior to beginning feedings and before administration of medication. Evaluate the resident's abdomen prior to initiating medication to ensure that it is not extended, and there are positive bowel sounds. The preferred method to confirm tube placement and ensure that tube migration has not occurred is to verify the exit length of the tube in centimeters. The procedure includes: the registered nurse will draw back with a 60 ml piston syringe and observe for stomach content. If stomach content is observed, the nurse will record the tube exit depth just above the disc in centimeters in Medical Administration Record or mark the tube placement just above the disc with indelible ink. On the care plan for tube feeding, the nurse will document confirmation of the tube placement in centimeters or indelible marked tube above the disc. Resident #1 was admitted to the facility on [DATE] with diagnosis of prematurity (babies born alive before 37 completed weeks of pregnancy), chronic respiratory failure, ventilator dependent, and nasogastric tube dependent. Minimum Data Set (an assessment tool) dated 02/09/2026, documented Resident #1's cognition was severely impaired. A care plan dated 02/03/2026 documented Resident #1 received fluids via a tube in the gastrointestinal tract evidenced by nasogastric tube present with interventions to check nasogastric tube placement before feeding and medication administration. An Enteral Nutrition Order Form dated 02/02/2026, documented Similac Advance or Similac Alimentum 20 kilocalorie/ounce 1000 milliliters, intermittent feeding of 250 milliliters every six (6) hours, four (4) times a day (at 6:00 AM, 12:00 PM, 6:00 PM and 12:00 AM) at 50 milliliter/hour via a pump. To make 250 milliliters of formula: mix four (4) scoops of powered mix of Similac Advance or Similac Alimentum with 240 milliliters of water.The Physician's Monthly Renewal Orders dated 02/02/2026 documented check nasogastric tube placement before and after giving medication and feeding. A Treatment Administration Record dated from 02/02/2026 to 02/20/2026 documented nursing staff must check the nasogastric tube for the correct placement before feeding and before and after medication administration. There was no documented evidence that the nasogastric tube placement (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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NAME OF PROVIDER OR SUPPLIER Rutland Nursing Home, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 585 Schenectady Ave Brooklyn, NY 11203	

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F 0693 Level of Harm - Actual harm Residents Affected - Few	was checked by nursing as per the medical doctor's order. There were no dates, no time, and no nurses' initials confirming that the nasogastric tube was checked. A review of Medication Administration Record dated from 02/02/2026 to 02/20/2026 revealed no documented evidence that the nasogastric tube placement was checked by nursing prior to medication administration.An Enteral Tube Placement Form dated 02/13/2026 documented nasogastric tube was inserted on 02/13/2026. There was no documented evidence that measurement at skin exit of nasogastric tube was documented.A review of facility's surveillance footage from a camera located in Resident #1's room for the date 02/20/2026, starting from 5:45 PM the footage revealed at 6:31 PM, Certified Nursing Assistant #1 came to the room with supplies to provide care and moved the curtain preventing the camera view of Resident #1's crib. At 6:38 PM, Registered Nurse #1 came to the room and attended to Resident #1. At 6:57 PM, Registered Nurse #1 left the room while Certified Nursing Assistant #1 was at bedside. At 6:58 PM, Registered Nurse #1 came back with round tape in their hands. Both Certified Nursing Assistant #1 and Registered Nurse #1 left the room at 7:03 PM. At 7:06 PM, Registered Nurse #1 returned to room and touched feeding pump machine and left. Between 6:51 PM and 7:30 PM, multiple staff including nurses, Respiratory Therapist #2, and Nurse Practitioner #1 entered the room while performing rounds. At 8:16 PM, Registered Nurse #2 came to the room and replaced the feed bottle and the giving set (a set of tubing that is placed into the pump and connects the feed bottle to the nasogastric feeding tube), but since the room curtain was partially drawn, the footage from the camera did not show if Registered Nurse #2 checked the residual (Gastric Residual Volume - the amount of formula, digestive juices, and secretions left in the stomach between feedings and is measured by attaching a syringe to the feeding tube to aspirate the contents, serving as a check for gastric emptying and feeding tolerance) when they replaced the feed bottle and the giving set. At 8:30 PM, the in-view ventilator monitor alarm light (flashing red light) was on and the interdisciplinary team, including four (4) Registered Nurses, Respiratory Therapist #2 and Nurse Practitioner #1, were seen coming into the room and attending to Resident #1. The footage revealed Resident #1 started having respiratory symptoms at 8:30 PM and at 10:55 PM, the emergency medical service team came into Resident #1's room and took charge of the resident's care. A Progress Note dated 02/20/2026 at 7:00 PM written by Nurse Practitioner #1 documented at the beginning of shift from 7:00 PM to 7:00 AM, Resident #1 was resting comfortably. At approximately 8:30 PM, Registered Nurse #2 reported Resident #1 had a low-grade temperature. Tylenol was given and cooling measures with cold pack were initiated. Resident #1 was tachypneic (rapid, shallow breathing) with respiration 45-50 breaths per minute and heart rate of 150-170 beats per minute. Respiratory Therapist #2 was at the bedside, oxygen therapy and frequent suctioning were done. At 10:28 PM, Resident #1 continued to be tachypneic, Heart Rate worsened to 170-210 per minute, persistent fever 101.9. Ibuprofen ordered STAT (immediately). Due to the persistent tachypnea, Resident #1 was transferred to Hospital #1. Resident #1 arrived at the emergency room on [DATE] at 11:24 PM.A Progress Note dated 02/21/2026 at 7:00 AM written by Nurse Practitioner #1 documented Resident #1 was admitted to Hospital #1 with diagnosis of pneumonia and tracheitis (inflammation of the windpipe that connects the voice box to the lungs). Hospital #1's Discharge Summary note dated 02/25/2026 attested by Hospital #1's Medical Doctor documented Resident #1 was admitted for respiratory failure secondary to pneumonia/pneumonitis (inflammation and irritation of the lung tissue) caused by a misplaced nasogastric tube (in left lung) with aspiration (liquid in the airway). Resident #1 was discharged /transferred from Hospital #1 to Hospital #2 on 02/25/2026 at 8:23 PM.Hospital #2's Infectious Diseases Consultation note dated 02/26/2026 at 10:29 AM documented Resident #1 was admitted for respiratory failure caused by aspiration pneumonitis in the setting of nasogastric tube misplacement into the left mainstem bronchus with associated fevers and leukocytosis.A Facility Investigation dated 03/04/2026 written by Director of Nursing documented on 02/20/2026 at approximately 11:00 PM, Resident #1 was transferred to Emergency Department for a sudden onset of tachycardia (resting heart rate over 160-180 beats per minute), respiratory distress, and fever. The facility investigation (continued on next page)

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F 0693 Level of Harm - Actual harm Residents Affected - Few	determined that between 6:45 PM and 7:00 PM on 02/20/2026, Registered Nurse #1 removed and re-secured the tape that was holding Resident #1's nasogastric tube while Resident #1 was receiving enteral feedings. Registered Nurse #1 admitted that after resecuring the tube, the placement of the tube was not verified prior to continuation of the feeding. Resident #1 subsequently experienced an acute change in condition and was transferred to the Emergency Department, where imaging confirmed malposition of the nasogastric tube into the left lung. During an interview on 03/09/2026 at 4:10 PM, the Medical Director stated Nurse Practitioner #1 informed them in the evening of 02/20/2026 that Resident #1 had a high heart rate, high respiratory rate, and despite medical interventions there was no improvement and 911 was called and Resident #1 was transferred to the hospital. Medical Director stated they spoke with Resident #1's parent over the phone on 02/21/2026 who said that they (parent) were told by the hospital that Resident #1's nasogastric tube was in the lung and the parent was upset. The Medical Director stated in their opinion, if the nasogastric tube was in Resident #1's lung while Resident #1 was in the facility receiving food or medication or fluids, Resident #1 would have experienced respiratory symptoms such as coughing, low oxygen, and alarm would alert for suctioning within minutes. The Medical Director stated all symptoms started around 8:30 PM when Nurse Practitioner #1 and Respiratory Therapist #2 were attending Resident #1. The symptoms were managed appropriately and when there was no improvement, 911 was called. Medical Director stated staff actions were appropriate and timely. The Medical Director called the hospital and was told Resident #1's nasogastric tube was in the left lung, and a chest tube was put in place. Medical Director added that the hospital had to perform three (3) X-rays to confirm position of the nasogastric tube. During an interview on 03/09/2026 at 3:36 PM, Certified Nursing Assistant #1 who was assigned to Resident #1 on 02/20/2026 at around 6:30 PM stated they came to provide care and stopped the feeding by pushing the button on the pump machine. Certified Nursing Assistant #1 stated Resident #1 had a lot of secretion from their nose which was common for Resident #1. They further stated the clear film dressing had a lot of secretion on it and all sides of the dressing were lifted, but the middle part was intact. Certified Nursing Assistant #1 stated they called Registered Nurse #1 who came to the room. Certified Nursing Assistant #1 stated Resident #1 was comfortable when Registered Nurse #1 removed the soiled dressing and told them to hold the tube by the nose so they can apply a fresh dressing. Certified Nursing Assistant #1 stated they were holding the tube by the finger on Resident #1's nose and there was no other tape holding the tube. Certified Nursing Assistant #1 stated Registered Nurse #1 could not find dressing tape in the room and left the room to get tape and returned quickly. Certified Nursing Assistant #1 stated they were not supposed to hold nasogastric tube because they are not a nurse. Certified Nursing Assistant #1 stated Registered Nurse #1 came with the tape and replaced the tape while they were holding the nasogastric tube by the nose. Certified Nursing Assistant #1 stated Registered Nurse #1 did not remove or re-insert the nasogastric tube. Certified Nursing Assistant #1 stated Registered Nurse #1 helped them to finish providing care and resumed the feeding. Certified Nursing Assistant #1 stated Registered Nurse #1 did not use a syringe to pull content from stomach before resuming the feeding. During a telephone interview on 03/10/2026 at 12:07 PM, Registered Nurse #1 stated they did not replace the nasogastric tube during their shift, only the soiled dressing tape was removed. Registered Nurse #1 stated they came to Resident #1's room around 6:45 PM - 7:00 PM while Certified Nursing Assistant #1 was providing care. Registered Nurse #1 stated that feeding was paused by Certified Nursing Assistant #1. Registered Nurse #1 stated they observed Resident #1's left cheek dressing that secured the nasogastric tube to left nostril and noted that it was soiled with clear secretion and needed to be changed. Registered Nurse #1 stated the nasogastric tube was in place because they observed a black mark on the tube by the left nostril. Registered Nurse #1 stated they asked Certified Nursing Assistant #1 to hold the nasogastric tube by Resident #1's nose while they were replacing the dressing. Registered Nurse #1 stated they should have called another nurse to assist with the dressing change. Registered Nurse #1 stated they could not find clear tape at Resident #1's (continued on next page)

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