STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335545	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Center for Nursing and Rehabilitation	2266 Cropsey Avenue Brooklyn, NY 11214

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain the residents' right to a safe, clean, and comfortable homelike environment. Specifically, housekeeping and maintenance services were not maintained in Units 2, 3, 4, 5, and 8. The findings include but are not limited to: The facility's undated Maintenance Policy and Procedure Manual stated that the building will be maintained in good repair and kept free of hazards. The responsibility for all maintenance and all preventive maintenance rests with the Maintenance Services Director, who reports directly to Administration. The undated Cleaning Resident and Non-Resident Area policy documented that the purpose of the policy was to improve sanitation and ensure the highest level of cleanliness throughout the facility. Frequent environmental cleaning of all frequently touched surfaces will be performed daily. 1.) During observation from 09/24/2025 to 10/01/2025, the following were observed: a. The resident's closet in room [ROOM NUMBER] had rusty metal legs, the radiator had brown spots and chipped paint, and there were holes noted in the wallpaper close to the curtain. b. The chair was ripped in room [ROOM NUMBER]. c. The bedside tables in room [ROOM NUMBER] had rusty edges. d. The radiator in room [ROOM NUMBER] had areas with missing paint. e. The chair in room [ROOM NUMBER] was ripped and the table had a crack. f. Unit 2 dining room had dusty air conditioning units, ripped wallpapers, there was a gap between the wall and the air-conditioning unit. g. The frame of the raised toilet bowl in the residents' bathroom in Unit 2 had rust. h. Unit 3 dining room had ripped wallpaper, and the air-conditioning unit were in disrepair and had stains. During an interview on 10/01/2025 at 12:02PM, the Maintenance Director stated that the leg of the raised toilet needs to be changed. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/01/2025 at 1:40 PM, the Director of Nursing stated they identified some of the residents' air-conditioning units needed repair. They stated that renovations were ongoing, and the goal was to complete the renovations for all rooms. 2.) The following were observed during in Unit 4 on 09/24/2025 at 10:30 AM: a. The residents' dining room had brownish, sticky substance on the corner of the floor next to the heating/cooling system, the silver paper towel holder had brownish, tarnish stains, and there were six (6) ripped window screens. b. room [ROOM NUMBER] was observed with ripped widow screens, bed with chipped wood, and the floor had debris. c. room [ROOM NUMBER] had brown stains on the window shades, the heating/cooling system had silver and black tape covering the sides and bottom, there was a white colored towel over the top, the walls were chipped, and the ceiling tiles had brown stains. d. room [ROOM NUMBER]'s heating/cooling system had brown stains. e. room [ROOM NUMBER] was observed with scuffed walls behind the resident's bed, the base board was tarnished, and the window screens were either ripped or missing a piece. f. room [ROOM NUMBER]P had brownish/black stains on the vent of the heating/cooling system. The walls have whitish patches, cracked floor tile, the window shade had brownish stains, the walls have peeling paint. The resident's television had blurry picture. The resident's bathroom had mismatched tile, cracked tiles, and some tiles were falling off the wall. There is a green colored metal base board with brownish stains, missing tile on the bathroom floor, stains in the ceiling, and the wall had paint bubble. g. room [ROOM NUMBER]'s bathroom light was not working. h. room [ROOM NUMBER]'s heating/cooling system had brown / black stains, and debris in the grooves and on the sides. On 09/25/2025 at 1:15 PM, the handheld shower in the residents' bathroom was observed with a slow water stream and the shower head that was on the bathroom wall had water spewing out from the sides of the shower head. On 09/29/2025 at 10:10 AM, an interview was conducted with the Maintenance Director, who stated that residents in 4th floor are putting food in the vents and were pushing food trays out of the windows that was why the window screens are ripped. The Director stated that there are a lot of maintenance work to do but sometimes they are short of staff. They stated that repairs in the building started in 2024, but they do not know when it will be completed. They stated that repairs/constructions on the 3rd and 4th floor have not been completed because it is difficult to get the residents out of their rooms. On 09/29/2025 at 10:43 AM, the Housekeeping Director was interviewed and stated that it is the housekeeping staff's job to clean the unit, mop, wash the beds, empty trash, and dust. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/30/2025 at 2:45 PM, the Administrator was interviewed and stated that they have noticed that some of the air conditioning units need cleaning and repainting. They stated they started renovation of residents' rooms in 2024, and plans to redo all the rooms. 3.) Observations made during the day tour in Unit 3 at 9:00 AM on 09/24/2025 and all throughout the Recertification Survey noted the following: a. In room [ROOM NUMBER], there was a large, dented hole in the closet door and a rusted radiator. b. In rooms [ROOM NUMBERS], there were rusted and stained radiators. c. In room [ROOM NUMBER], there were two (2) cracked tiles on the floor, cracked bottom wall on the end side with chipped and peeling paint. On 10/01/2025 at 11:47 AM, the Director of Maintenance was interviewed and stated that the rusty radiator is due to a contracting company who did not properly prime the radiator before painting it. The Director of Maintenance stated that they were aware of the rusted radiator and is currently awaiting the contractor to return and repaint it. The Director of Maintenance further stated that it takes 3 weeks for 1 room to be remodeled, and room remodeling is an ongoing project. 4.) During multiple observations from 09/24/2025 through 09/30/2025, room [ROOM NUMBER] was observed with brown stains and blackened areas on tiles in the bathroom and above Resident #23's bed. On 09/30/2025 at 12:04 PM, an observation was conducted with the Director of Maintenance and the same was observed. On 09/30/2025 at 12: 04 PM, the Director of Maintenance stated they were not aware that the tiles in room [ROOM NUMBER]P needs to be replaced. They stated that there was no log in the maintenance book for this issue. The Director of Maintenance stated that brown spots and blacked areas occurs because of condensation, and the effects of the cooling towers in the building. The Maintenance Director stated it also comes from the water pipe drip pan being clogged causing a leak. The Maintenance Director stated they make monthly rounds and had not observed this issue in room [ROOM NUMBER]P. On 10/01/2025 at 11:55 AM, the Administrator stated it is challenging to do the repairs in room [ROOM NUMBER] because the resident is not cooperating and do not want to come out of the room. They stated that residents must not be in the room during repairs. 5.) During observation from 09/24/2025 at 12:16 PM to 09/26/2025 at 2:22 PM, the top grille of the radiator in Resident #137's room was observed full of rust. On 09/29/2025 at 10:10 AM, the Maintenance Director was interviewed and stated they were sometimes short of staff and had a lot of maintenance work to do. They had no explanation on why the top grille of the radiator was full of rust. 10 NYCRR 415.5(h)(2)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, during the Recertification and Complaint (#523045) Survey, the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the New York State Department of Health. This was evident for 3 (Residents #63, 145, and 12) of 4 residents reviewed for Accidents out of 35 total sampled residents. Specifically, 1.) On 11/25/2024, Resident #63 had an unwitnessed incident when they were observed on the floor and complained of pain to the left hip. The resident was transferred to the hospital and was found to have sustained left intertrochanteric fracture. This incident was not reported to the New York State Department of Health. 2.) On 04/06/2025, Resident #145 was found sitting on their bed with a laceration to the right side of the head. There was no witness on how Resident #145 sustained the injury, and the resident was unable to explain the occurrence. This incident was not reported to the New York State Department of Health. 3.) Resident #12 had unwitnessed fall incidents on 05/30/2025 and 06/24/2025. The resident sustained injury on both incidents and was unable to explain the occurrence. These incidents were not reported to the New York State Department of Health.The findings included: The undated facility's policy titled Reporting Abuse to State Agencies documented that all alleged / suspected violations or crimes and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities or individuals as may be required by law. The policy also stated should there be reasonable cause to believe that abuse, neglect, mistreatment, or exploitation has occurred, the facility administrator, his designee or any person must report the incident to the New York State Department of Health and local enforcement agency as indicated. Reporting occurs not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or no later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. 1.) Resident #63 had diagnoses of Rheumatoid Arthritis and Non-Alzheimer's Dementia. A nurse's progress note dated 11/25/2024 documented that Resident #63 was found on the floor with altered mental status. Resident was safely transferred to bed and complained of hitting their head and left hip. A nurse's progress note dated 11/25/2024 documented that around 1:29 PM, they were told by the nursing supervisor that the Resident #63 had an unwitnessed fall. The resident was transferred to the hospital. The Accident / Incident Investigation dated 11/29/2024 documented that Resident #63 was observed on the floor in their room, complained of left hip pain and headache. The resident was sent to the hospital and was admitted . Resident had an upper acute fracture of the left intertrochanteric. The resident was treated in the hospital. There was no delay in treatment. Resident was treated with analgesic for pain. Resident #63 was last seen prior to incident at 12:50 PM and incident occurred at 1:29 PM. The facility concluded that the investigation had revealed there was no cause to believe any alleged resident abuse, mistreatment, or neglect has occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that the facility reported Resident #63's unwitnessed fall incident, resulting in major injury, to the New York State Department of Health. On 10/01/2025 at 2:58PM, the Director of Nursing Services was interviewed and stated they were not the Director of Nursing at the time that Resident #63 sustained the fall with injury in November of 2024. The Director of Nursing Services stated that based on review of the incident report, Resident #63 was noted to have fallen in the room and noted to have swelling to their hip. The Resident #63 was referred to the hospital where they were found with a hip fracture. The Director of Nursing Services further stated that injuries of unknown origin are reportable to the state including abuse concerns, sentinel events and death. They stated that unwitnessed falls with injury are not reportable to the New York State Department of Health. On 10/01/2025 at 10:42 AM, the Administrator was interviewed and stated that unknown injuries which includes a large bruise, laceration or fracture on a resident are reported to the New York State Department of Health. If a resident had an unwitnessed fall with injury and a conclusion as to how they sustained that injury is reached quickly, then it will not be reported to the state because it is clear to the facility as to what happened. 2.) Resident #145 had diagnoses of Vascular Dementia, Muscle Weakness, and Personal History of Traumatic Brain Injury. The Significant Change Minimum Data Set 3.0 assessment dated [DATE] documented Resident #145 had severely impaired cognition. A nurse's note dated 04/06/2025 at 5:56 AM documented that Resident #145 was found sitting on their bed with a cut to their head, with confusion and restlessness. There was no spills or hazard on the bedside. There was no change in range of motion and no loss of consciousness. The facility Resident Incident/Accident report dated 04/06/2025 documented that Resident #145 had a laceration to right side of head. The incident was unwitnessed, and Resident #145 was unable to explain what happened due to confusion. There was no documented evidence that the facility reported Resident #145's injury of unknown source to the New York State Department of Health. On 09/30/2025 at 10:26 AM, the Director of Nursing stated during the interview that they were not the Director of Nursing when the incident involving Resident #145 occurred. They stated that allegations of abuse and injury of unknown origin must be reported to the New York State Department of Health within 2 hours of being made aware. On 09/30/2025 at 10:38 AM, the Administrator was interviewed and stated they were not aware of the incident until 09/26/2025 when the State Surveyor requested the incident report. The Administrator stated that the facility had to report injury of unknown origin within 2 hours to the New York State Department of Health. The Administrator further stated the Director of Nursing was responsible for reporting. 3.) Resident #12 was admitted to the facility with diagnosis of Unspecified Dementia with behavioral disturbances. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Minimum Data Set assessment dated [DATE] documented Resident #12 had severely impaired cognition and required supervision with ambulation. A nurse's progress note dated 05/30/2025 at 3:00 PM documented that the Registered Nurse was called to the unit and upon arrival noted Resident #12 lying on their left side in the hallway by room [ROOM NUMBER]P. The resident was noted with bleeding from the nose and left eyebrow laceration. The resident was sent to the hospital. The Accident/Incident Investigation dated 06/05/2025, documented that on 05/30/2025 at approximately 2:40 PM, the nurse who was in room [ROOM NUMBER] responded to a sound from the hallway, and observed Resident #12 lying on the floor with active bleeding noted from the nose and the left side of the forehead. The resident was observed walking in the hallway at around 2:30 PM. Computed tomography scan performed at the hospital showed facial fracture and the facial laceration required five stitches. The facility concluded that the investigation had revealed there was no cause to believe an alleged resident abuse, mistreatment, or neglect had occurred. A nurse's progress note dated 06/24/2025 at 7:42 PM documented that the unit manager was called to the unit at approximately 5:45 PM and found Resident #12 on the floor next to their bed with bleeding noted from the top of their head. The resident was assessed with 2 lacerations approximately 1 centimeter each. The resident was transferred to the hospital. The Accident/Incident Investigation dated 06/30/2025 documented Resident #12 had an unwitnessed fall and was unable to tell what had happened. Resident #12 was found lying on the floor next to their bed. Bleeding noted on top of Resident #12 head. Area cleaned with normal saline and bandaged. Resident #12 was documented to have 2 (two) lacerations at 1cm. Resident #12 Designated Representative was notified. Resident #12 was transferred to the hospital and returned with a diagnosis of Subdural Hematoma along with 3 (three) staples to the top of the head. There was no documented evidence that the 2 fall incidents with injury were reported to the New York State Department of Health. On 10/01/2025 at 1:00 PM, the Administrator was interviewed and stated that an incident must be reported to the New York State Department of Health when a resident had an unwitnessed fall, and the resident cannot explain what happened. 10 NYCRR 415.4(b)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview and record review conducted during the Recertification Survey from 09/24/2025 to 10/01/2025, the facility did not ensure a comprehensive person-centered care plan was reviewed and revised to address a resident's needs. This was evident for 2 (Residents #164 and #116) of 38 total sampled residents. Specifically, 1) Resident #164's comprehensive care plan was not reviewed and revised to reflect Resident #164's behavior problem, and 2) Resident #116's comprehensive care plans were not reviewed and revised to reflect the elopement/wandering behavior.The findings include: The undated facility policy titled Care Plans - Comprehensive documented the care plans are revised as changes in the resident's condition dictate. The policy also documented care plans are reviewed at least quarterly. 1.) Resident #164 was admitted to the facility with diagnoses which included Unspecified Dementia, Schizoaffective Disorder, and Anxiety Disorder. The Significant Change Minimum Data Set assessment dated [DATE] documented Resident #164 was severely impaired cognition and had no behavior symptoms. The Minimum Data Set also documented Resident #164 and their representative participated in the assessment. The comprehensive care plan related to behavior problem (screaming/yelling/cursing) was initiated 03/30/2021 and last reviewed 05/05/2022 documented the interventions included to administer medications as ordered, monitor/document side effects and effectiveness of medications, and anticipate and meet needs. The Behavior Note dated 05/02/2025 documented Resident #164 was observed screaming, yelling foul languages, attempting to hit staff, and throwing fluids on the floor. The Behavior Note dated 05/09/2025 documented Resident #164 was observed screaming loud outburst using inappropriate language towards staff. The Behavior Note dated 05/09/2025 documented Resident #164 was noted screaming and yelling loud, using profanities at the staff while in the dining room. It also documented Resident #164 having some outburst towards other residents in the dining room. The Behavior Note dated 05/27/2025 documented Resident #164 was noted using foul language towards staff and screaming and yelling at staff while in dining room. The Behavior Note dated 06/5/2025 documented Resident #164 was screaming, yelling, and shouting profanities. There was no documented evidence Resident #164's comprehensive care plan related to behavior problem was reviewed and/or revised to reflect Resident #164's behavior problem status after 05/05/2022. On 09/29/2025 at 10:42 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #164 was alert and oriented to person and place. Certified Nursing Assistant #1 also stated Resident #164 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	once a while screams and curses the staff when they do not get they want. On 09/29/2025 at 11:29 AM, Registered Nurse #1 was interviewed and stated Resident #164 was easily agitated and required more redirection. Registered Nurse #1 also stated that Resident #164 curses at staff. Registered Nurse #1 stated the unit registered nurse supervisor was responsible to review the comprehensive care plans at least every 3 months and as needed to address resident's care. Registered Nurse #1 reviewed the care plan of behavior problem and stated it documented that thee last review was on 05/05/2022. On 09/30/2025 at 10:17 AM, the Director of Nursing was interviewed and stated care plans had to be reviewed at least every 3 months and as needed and must sign off on each reviewed care plan. 2.) Resident #116 was admitted to the facility with diagnosis that included Hypertension, Non-Alzheimer's Dementia, Anxiety, Psychotic Disorder, Syphilis, [NAME] Matter Disease, Human Immunodeficiency Disease and Mood Disorder. The Quarterly Minimum Data Set assessment dated [DATE] identified Resident #116 with severe impairment in cognition. The assessment documented that Resident #116 required supervision or touch assistance for activities of daily living and have no behaviors, with wander guard in place. The physician's order dated last reviewed 9/23/2025 documented order for Wander guard on right wrist check for placement every shift. A review of Resident #116's administration records dated 6/2025, 7/20205, 8/2025 and 9/2025 documented that wander guard was checked every shift. A resident comprehensive care plan for elopement risk/wanderer related to disoriented to place, Dementia, dated was created for Resident #116 on 09/17/2023 and last reviewed 10/9/2024. A medical progress notes dated 09/04/2025 documented to continue to monitor, evaluate, assess, treat, Resident #116, continued to have psychotic behavior, wandering in hallway this morning, easily redirectable. There was no documented evidence that Resident #116's elopement risk/wanderer care plan was reviewed and revised since 10/09/2024 after each Minimum Data Set assessments or to reflect Resident #11's ongoing wandering behavior. On 09/29/2025 at 11:41 AM, Registered Nurse #3 was interviewed and stated they are responsible for initiating and updating all care plans in the unit. They stated that care plans are updated quarterly, annually, significant change and after episodic occurrences. The Registered Nurse stated they do not document the updates directly in the care plan, but they make one general note in the resident's progress notes. Registered Nurse #3 stated that Resident #116's last quarterly assessment was this past June, so they wrote general note stating the care plan was reviewed. On 10/01/2025 at 11:55 AM, the Director of Nursing was interviewed and stated that Registered Nurses are responsible to review and update care plans at least quarterly, annually, and when there is significant change. The Director of Nursing stated when a resident's care plan is reviewed, the Registered Nurse will sign off that the care plans were reviewed and place a summary note in the care plan. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interviews, the facility failed to store, prepare, and serve food in accordance with professional standards for food safety. This was evident during the kitchen observation task and dining observation for one (1) (Unit 8) of 7 units observed. Specifically, 1.) The kitchen staff's facial hair was not fully covered during food preparation, 2.) Enteral feedings were not discarded past it's used by date, and 3.) Certified Nursing Assistant #8 was handling residents' food with bare hands. The findings include:1.) The facility policy and procedure titled Dietary/Food Handling dated 01/2025 documented clean uniforms must be worn daily. Hairnets or caps must be worn effectively to keep hair from contacting exposed food, clean equipment, utensils and linens. On 09/24/2025 at 9:40 AM, [NAME] #1 was observed chopping chicken with their beard net not fully covering their beard. On 09/26/2025 at 10:07 AM, [NAME] #1 was observed cooking fish on the stove with their sideburns not properly covered and their beard restraint was not fully covering their beard. During an interview on 09/26/2025 at 10:33 AM, [NAME] #1 stated they were not aware that their facial hair was not fully covered. On 09/29/2025 between 11:20 AM and 11:40AM, Dietary Aide #2 was inspecting the tray line with their mustache not properly covered. The Assistant Administrator was also in the kitchen with no hair net. During an interview on 09/29/2025 at 11:39 AM, Dietary Aide #2 stated their mustache should be covered so hair would not fall in resident's food. During an interview on 09/29/2025 at 11:41 AM, the Assistant Administrator stated that they were in the kitchen to inspect the trays and was not aware they are supposed to wear a hair net. During an interview on 10/01/2025 at 10:42 AM, the Food Service Director stated they did not notice the Assistant Administrator not wearing a beard net while they were on the tray line. However, hair and beard nets must be used in the kitchen and that the beard net should cover all beards, mustache, and sideburns. 2.) The undated facility policy and procedure titled Food Storage documented all foods will be properly stored in a safe, sanitary manner. Foods are to be rotated using the First-In, First-Out method. On 09/24/2025 at 10:02 AM, a box of shredded lettuce with a best if used by date of 09/20/2025 was observed in the refrigerator. A box of cucumber that were soft and moldy were also noted in the kitchen refrigerator. During an interview on 09/26/2025 at 10:37 AM, Dietary Aide #3 stated that they inspect the food items every week and throw the old ones. They stated they did not notice the expired food items in the refrigerator. During an interview on 09/26/2025 at 10:45 AM, the Food Service Supervisor stated they inspect the kitchen for expired food items twice weekly, on Mondays and Fridays. They stated they toss any expired food. During an observation on 09/24/2025 at 10:25 AM, enteral feedings with a used by date of 09/01/2025 was stored in the dietary emergency food storage area. During an interview on 09/24/2025 at 10:31 AM, the Central Supply Coordinator stated they get weekly delivery of enteral feeding supplies, and they store the new deliveries behind the old ones. On 10/01/2025 at 11:55 AM, the Administrator was interviewed and stated that enteral feedings with a use by date of 09/2025 can be used until the end of September. 3.) The facility policy and procedure titled Serving of Food dated 08/2025 documented food shall be prepared and served in a manner that prevents food borne illness. On 09/24/2025 between 12:18 PM and 12:33PM, Certified Nursing Assistant #8 was observed peeling a banana for Resident #210 with bare hands. The aide was also observed unwrapping Resident #131's bread with bare hands. They did not perform hand hygiene between residents. During an interview on 09/24/2025 at 2:52 PM, Certified Nursing Assistant #8 stated they did not realize they were touching the resident's food with their bare hands. During an interview on 09/24/2025 at 2:58 PM, Licensed Practical Nurse #1 stated they monitor the dining room during mealtimes. They stated that staff should not touch food with bare hands. On 09/30/2025 at 9:57 AM, the Infection Preventionist was interviewed and stated hand hygiene is very important and must be adhered to by all staff in the facility. 10 NYCRR 415.14 (h)

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	335545	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Center for Nursing and Rehabilitation	2266 Cropsey Avenue Brooklyn, NY 11214

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that all injuries of unknown origin were thoroughly investigated. This was evident for 1 (Resident #145) of 3 residents reviewed for Notification of Change out of 38 sampled residents. Specifically, on 04/06/2025, Resident #145 was observed with a laceration on the right side of their head. The facility initiated the investigation but failed to thoroughly investigate the incident to rule out abuse and/or neglect. The findings include:The facility policy titled Investigating Unexplained Injuries which was last revised on 12/2024 documented an investigation of all unexplained injuries (including bruises, abrasions, and injuries of an unknown source) will be conducted by the risk manager, director of nursing services, and/or other individual appointed by the administrator, to ensure that the safety of the residents had not been jeopardized. Resident #145 had diagnoses of Vascular Dementia, Muscle Weakness, and Personal History of Traumatic Brain Injury.The Significant Change Minimum Data Set 3.0 assessment dated [DATE] documented Resident #145 had severely impaired cognition, no behavior symptoms, and one major injury of falls since admission or Prior assessment. A nurse's note dated 04/06/2025 at 5:56 AM documented that Resident #145 was found sitting on their bed with a cut to their head, with confusion and restlessness. There was no spills or hazard on the bedside. There was no change in range of motion and no loss of consciousness. The facility Resident Incident/Accident report dated 04/06/2025 documented that Resident #145 had a laceration to right side of head. The incident was unwitnessed, and Resident #145 was unable to explain what happened due to confusion. A review of the facility investigation revealed that the investigation was not completed to rule out abuse and / or neglect. On 09/30/2025 at 10:26 AM, the Director of Nursing was interviewed and stated they were not Director of Nursing when the alleged incident with Resident #145 happened. On 09/30/2025 at 10:38 AM, the Administrator was interviewed and stated they were not aware of the incident until 09/26/2025 when the State Surveyor requested the incident report. The Administrator stated they reviewed the incident report and found the investigation was not completed. The Administrator further stated the investigation had no documentation about the environment in Resident #145's room and had no facility investigation summary. The Administrator stated they have a different Director of Nursing when the incident occurred, and they were not able to explain why the incident was not investigated thoroughly.10 NYCRR 415.4(b)(3)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a comprehensive person-centered care plan for each resident was developed and implemented, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs. This was evident in 1 of 8 residents reviewed for Accidents (Resident #116) and 1 out of 5 residents reviewed for Unnecessary Medications (Resident #164). Specifically, 1.) Resident # 116 had no comprehensive care plan developed to address ongoing disruptive behaviors. 2.) Resident #164 had no comprehensive care plan developed for anticoagulant therapy. The findings include: The undated facility policy and procedure titled Comprehensive Care Plans documented a comprehensive care plan includes measurable objectives, and timetables to meet the resident's medical, nursing, mental and physiological needs to develop for each resident. The policy further documented that the facility would develop and maintain a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. 1.) Resident #116 was admitted to the facility with diagnoses that included Hypertension, Non-Alzheimer's Dementia, Anxiety, Psychotic Disorder, Syphilis, [NAME] Matter Disease, Human Immunodeficiency Disease and Mood Disorder. The resident Quarterly Minimum Data Set assessment dated [DATE] identified Resident #116 with severe impairment in cognition. Resident #116 required supervision or touch assistance for activities of daily living, living, had no behaviors, and with wander alert device in place. On 09/24/2025 at 10:52 AM, Resident #116 was observed yelling and screaming in the hallway using profanity stating they will get a gun and shoot. The resident constantly walked back and forth on the unit. The staff redirects the resident but still continued to walk back and forth on the unit. 09/24/2025 12:25 PM, Resident #116 was in the dining area using profanity, and stated they have a grenade and will blow someone's head off. The Unit Manager had to step in front of resident to redirect behavior, and the resident left the dining area. 09/29/2025 at 11:04 AM, Resident #116 was observed yelling and screaming on the unit without reason. The staff moved Resident #116 away from other residents. The resident was easily redirected. A nurse's progress note dated 05/30/2025 at 9:41 PM documented that Resident #116 continues with behavioral monitoring. The resident continues to curse, yell and scream at staff and other residents for no apparent reasons. A nurse's progress note dated 06/24/2025 documented that Resident #116 was monitored for behavior issues; was noted to have outburst in the first-floor dining room screaming. A nurse's progress notes dated 07/21/2025 at 11:18 PM documented that Resident #116 displayed radical behavior during the shift, was very aggressive with neighbor residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's progress note dated 09/28/2025 at 12:54 PM documented that Resident #116 was screaming and yelling. A review of Resident #116's comprehensive care plan had no documented evidence that a care plan was created to address resident #116 behaviors of verbal aggression, yelling screaming, using profanities or threatening behaviors. On 09/29/2025 at 11:41 AM Registered Nurse #3 was interviewed and stated resident is alert to self on most days and on some day is totally disoriented. Registered Nurse #3 stated at times resident conservation cannot be understood, and have behaviors of yelling screaming, cursing, goes in and out of room's weather invited or not, not aggressive physically but very aggressive verbally. Registered Nurse #3 stated resident at times verbalize says someone will shoot the place or did you not see they come with the gun. Registered Nurse stated resident will verbalize someone have knife at throat and will redirect the resident and resident is easily redirected if staff remains calm and the resident will become calm. Registered Nurse #3 stated the resident's behavior is constant and staff must constantly redirect the resident. Resident Manger stated is responsible for initiating and updating all care plans for the units. They stated that Resident #116 had no care plan developed to address their behavior and that this was an oversight. On 10/01/2025 at 11:55 AM, the Director of Nursing was interviewed and stated the unit registered nurses were responsible to create applicable care plans for the residents. Director of Nursing also stated a care plan is required for a resident with ongoing behaviors such as Resident #116. 2) Resident #164 was admitted to the facility with diagnoses which included Unspecified Dementia, Unspecified Atrial Fibrillation, and Acute Embolism and Thrombosis of Unspecified Deep Veins. The Significant Change Minimum Data Set assessment dated [DATE] documented Resident #164 was severely impaired cognition, had diagnosis of atrial fibrillation and deep venous thrombosis, and was taking anticoagulant. The physician order initiated 06/27/2025 documented Resident #164 was prescribed Eliquis 5 milligrams, 1 tablet by mouth two times a day for deep venous thrombosis. The Medication Administration Record for September 2025 documented Eliquis 5 milligrams, 1 tablet was administered twice daily every day. A review of the current Comprehensive Care Plans revealed that a care plan for anticoagulant and deep venous thrombosis was developed for Resident #164. On 09/29/2025 at 11:29 AM, Registered Nurse # 1 was interviewed and stated the unit registered nurse supervisor was responsible for creating the comprehensive care plan. Registered Nurse #1 also stated a comprehensive care plan was required if a resident was taking anticoagulant to monitor for bleeding status. Registered Nurse #1 reviewed the care plans for Resident #164 and was not able to find any care plan related to anticoagulant therapy for Resident #164. On 09/30/2025 at 10:17 AM, the Director of Nursing was interviewed and stated the unit registered nurses were responsible to create applicable care plans to address residents' care and needs. They stated that a care plan is required for resident's taking anticoagulant like Eliquis. Director of Nursing reviewed the care plans for Resident #164 and stated they were not able to explain why the care plan (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to anticoagulant was not developed for Resident #164. 10 NYCRR 415.11(c)(1)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview the facility failed to ensure that infection control prevention practices and procedures were maintained to provide a safe and sanitary environment to help prevent the development and transmission of communicable diseases and infections. This was evident in one (1) of 1 resident observed for respiratory care. Specifically, on 09/25/2025, Enhanced Barrier Precautions were not maintained during tracheostomy suctioning. The findings include:The facility's policy and procedure titled Enhanced Barrier Precautions with a revised date of 03/24/2025 documented that in addition to standard precautions, Enhanced Barrier Precautions will be considered for residents who are at high risk of both acquisition of and colonization with Centers for Disease Control and Prevention multidrug resistant organisms. The Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Resident #1 was admitted to the facility with diagnosis that included Multiple Sclerosis and Epilepsy. A medical progress note dated 09/28/2025 documented that Resident #1 had tracheostomy. On 09/25/2025 at 12:27 PM, Respiratory Therapist #1 was observed in Resident #1's room performing tracheal suctioning and was only wearing gloves and surgical mask. During an interview on 09/25/2025 at 12:30 PM, Respiratory Therapist #1 stated that they went to check on Resident #1, and the resident was pointing to their throat and needed suctioning. They stated they normally would put on face shield and gown when suctioning a resident. During an interview on 10/01/2025 at 1:18 PM, the Director of Respiratory Services stated that respiratory therapists must wear a gown, face shield, mask, and gloves during respiratory suctioning. They stated Enhanced Barrier Precaution signs are posted in resident's room if they are on precautions. 10 NYCRR 415.19 (a) (1-3)