STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335582	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookhaven Rehab & Health Care Center L L C	250 Beach 17th Street Far Rockaway, NY 11691

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interviews conducted during an Abbreviated Survey (NY00352779), the facility did not ensure that the alleged violations involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property were reported immediately, but not later that two (2) hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not involve serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency). This was evident for one (1) out of four (4) residents (Resident #1) sampled. Specifically, Resident #1 was observed on the floor in their room bleeding from their nostrils at around 7:03 AM on 08/20/2024. Resident #1 was transferred to the hospital and was diagnosed with nasal bone fracture. Resident #1 was re-admitted to the facility on [DATE] with diagnosis of nasal fracture. The facility did not report the unwitnessed fall with injury to New York State Department of Health after becoming aware on 08/23/2024. The findings are: The facility's Policy and Procedure titled of Abuse Prevention review date of 11/2024 documented the facility residents will be protected from Abuse, Neglect, Mistreatment, Exploitation, or Misappropriation of resident's property in accordance with State and Federal Regulations. All alleged or suspected incidents of Abuse, Neglect, Mistreatment, Exploitation, or Misappropriation of resident's property will be thoroughly investigated, and findings documented. All allegations of abuse must be immediately reported to the Administrator and no later than two (2) hours to other officials (including to the State Survey Agency) after the allegation is made, if the events that caused the allegation involved abuse or results serious bodily injury. The violations must be reported no later than 24 hours to State Survey Agency if the events that caused the allegation do not involve abuse and do not result in serious bodily injury. The facility's Policy and Procedure titled title Fall, Accident and Incident Report with a last review dated of 2/2024. documented that the Nursing Supervisor must be informed of any resident related incident. A fall risk assessment will be completed for all residents upon admission, readmission, quarterly, annually, significant change in status, and after an accident/Incident has occurred. The Registered Nurse will assess resident's condition and render immediate first aide. If Registered Nurse assess that resident's has a fracture or other injury which requires that the resident not be moved, the resident is to be kept as comfortable as possible until 911 arrives. The policy also states the accident/ incident will be investigated and report within two (2) hours per New York State Department of Health regulations. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 was admitted to the facility on with diagnoses including Cerebral Ischemia, Cerebral Vascular Accident, Non-Alzheimer's Disease. The Minimum Data Set, an assessment tool, dated 05/09/2025 documented Resident #1 cognition was severely impaired. A Nursing Progress note by Registered Nurse Supervisor #1 dated 08/20/2024 at 8:31 AM documented Resident #1 was lying on their right side in a pool of coagulating blood. An icepack was applied to the nose and face. Medical Doctor #1 was notified and ordered Resident #1 to be transferred to the hospital. An Unwitnessed Fall Report (Accident/Incident) and Summary of Report dated 08/20/2024 at 7:03 AM documented at around 7:03 AM Certified Nursing Assistant #1 observed Resident #1 on the floor in a right-side lying position on the right side of their bed bleeding from their nose. Body assessment revealed a hematoma to the forehead and bleeding from both nostrils. Resident #1 was transferred to the hospital. The facility investigation concluded that abuse, mistreatment, or neglect did not occur. The Hospital Discharge summary dated [DATE] documented Resident #1 had a computed tomography scan of the facial bone which showed a fracture of the right nasal bone. During an interview on 04/21/2025 at 2:39 PM, the Director of Nursing stated they were informed of the incident on 08/20/2024 by Registered Nurse Supervisor #1. The Director of Nursing stated that the facility was only aware Resident #1 had a nosebleed and that Resident #1 was transported to the hospital for medical evaluation. The Director of Nursing stated the incident was not reported to the New York Stated Department of Health because Resident #1 was on an anticoagulant and that there were no indications of a fracture. The Director of Nursing stated they became aware of the x-ray result and nasal fracture after receiving the Patient Review Instrument and the hospital discharge summary on 08/23/2024. The Director of Nursing stated the incident would have been reported to the Department of Health within 2 hours if the injury was of unknown origin or if they had suspected abuse. The Director of Nursing stated that their investigation concluded that abuse, mistreatment, or neglect did not occur. The Director of Nursing added that Resident #1's impaired cognition and being unaware of their surroundings might have contributed to fall. During a telephone interview on 04/29/2025 at 4:33 PM, the Administrator stated they were notified of the incident on 08/20/2024 at around 9:30 AM during their morning meeting. The Administrator stated it was determined that Resident #1 had an unwitnessed fall and was found on the floor. The facility was not aware Resident had a nasal fracture. The facility became aware three days after Resident #1 was discharged from the hospital. The Administrator stated when they became aware of the fracture on 08/23/2024, the timeframe had already passed, and they did not believe they needed to report the accident. 10 NYCRR 415.4 (b)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during an abbreviated survey (NY00352779), the facility did not ensure that each resident received adequate supervision to prevent accidents. This was evident in one (1) out four (4) residents (Resident #1) sampled. Specifically, Resident #1 who was at risk for fall, was observed on the floor next to their bed bleeding from their nostrils at around 7:03 AM on 08/20/2024 during morning round. Resident #1 was transferred to the hospital on [DATE] and was readmitted to the facility on [DATE] with diagnosis of nasal bone fracture. Record review of Resident #1's plan of care revealed Resident #1 has had multiple falls into their room, however, the facility had no documented evidence that the effectiveness of the interventions implemented were evaluated. Additionally, there were no documented evidence of the frequency of monitoring. The findings include: The facility's Policy and Procedure titled title Fall, Accident and Incident Report with a review date of 02/2024 documented that the Nursing Supervisor must be informed of any resident related incident. A fall risk assessment will be completed for all residents upon admission, readmission, quarterly, annually, significant change in status, and after an accident/Incident has occurred. The Registered Nurse will assess resident's condition and render immediate first aide. If Registered Nurse assess that resident's has a fracture or other injury which requires that the resident not be moved, the resident is to be kept as comfortable as possible until 911 arrives. The policy also states the accident/ incident will be investigated and report within 2-hours per New York State Department of Health regulations. Resident #1 was admitted to the facility on with diagnoses including Cerebral Ischemia, Cerebral Vascular Accident, Non-Alzheimer's Disease. The Minimum Data Set, an assessment tool, dated 05/09/2024 documented Resident #1 cognition was severely impaired. Resident #1 was non-ambulatory and used a wheelchair. Resident #1 was dependent on one staff for toileting and had had one fall. Resident #1 also required partial/moderate assistance for bed mobility. A Fall Risk Assessment/Safety Measures dated 02/16/2024 documented Resident #1 was at risk for fall related to confusion, mobility deficits, altered elimination status, medications and Cardiovascular accident. Safety measures implemented included orienting resident to their room, unit, safety precaution, call bell usage, call bell and frequently used items within reach, attempt to keep resident in high visibility area when out of bed, non-skid footwear, and Psych evaluation. The Fall Risk Assessment did not identify the level of fall risk. An Actual Fall Care Plan dated 03/30/2024 documented Resident #1 was observed on the floor on the left side of their bed. The resident was observed with a small bump on the left forehead. The interventions documented to monitor the resident every 30 minutes as order by Medical Doctor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Nursing Instruction dated 03/30/2024 documented fall precaution, frequent room checks for safety, ensure pathway in room clutter free, assist with toileting every 2-hours throughout the day and night for safety; toilet one assist early in the morning around 5:00 AM to 6:00 AM for safety and as needed. The Individual Monitoring sheet dated 03/30/2024 to 04/01/2024 showed Resident #1 was monitored every 30 minutes for 48-hours post fall. An updated Fall Care Plan dated 06/20/2024 at approximately 5:25 AM documented Resident #1 was observed lying on their left side next to their bed with no visible injury. The interventions documented to always keep room well lit, placed call bell within easy reach, placed bed in lowest position, and placed the resident in a high visibility area during waking hours for safety. The Individual Monitoring sheet dated 06/20/2024 at 5:45 AM to 06/22/2024 at 6:30 AM showed Resident #1 was monitored every 30 minutes for 48-hours post fall. The Resident Nursing Instruction dated 06/20/2024 documented fall precaution, frequent room checks for safety. Ensure pathway in room is clutter free. Assist to toilet every 2-hours throughout the day and night for safety. One assist for toileting early in the morning at around 5:00 AM to 6:00 AM for safety and as needed. A Nursing Progress note by Registered Nurse Supervisor #1 dated 08/20/2024 at 8:31 AM documented Resident #1 was lying on their right side in a pool of coagulating blood. An icepack was applied to the nose and face. Medical Doctor #1 was notified and ordered Resident #1 to be transferred to the hospital. A Nursing Progress late entry note dated 08/20/2024 at 8:39 PM by Licensed Practical Nurse #1 documented Resident #1 was observed lying on their right side (on the floor) on the right side of their bed. Resident #1 was alert with confusion. Resident #1 had a full body assessment done with positive range of motion to all extremities and was able to follow commands. Resident #1 had a hematoma to their forehead and was bleeding from both nostrils. A cold compress was applied, and neurological check was initiated. Resident #1 had no facial grimacing or grunting when checked for pain. An Unwitnessed Fall Report (Accident/Incident) and Summary of Report dated 08/20/2024 documented at around 7:03 AM Certified Nursing Assistant #1 observed Resident #1 on the floor in a right-side lying position on the right side of the bed with blood coming from their nose. Body assessment revealed a hematoma to the forehead and bleeding from both nostrils. Resident #1 was transferred to the hospital. The facility investigated the fall and concluded that abuse, mistreatment, or neglect did not occur. The updated Fall Care Plan dated 08/23/2024 documented Resident #1 was sent to the hospital and was admitted on [DATE] status post fall with nose bleeding. A computed tomography scan diagnostic test was and showed Resident #1 sustained a nasal bone fracture. Resident #1 was readmitted on [DATE]. Safety precaution maintained. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Fall Risk Assessment interventions dated 03/30/2024, 06/06/2024, and 08/23/2024, revealed that the interventions remained the same. The interventions documented Orient the resident to room, unit, and safety precautions, call-bell usage, call-bell and frequently used items within reach, every 30 minutes monitoring times 48-hours, and physical/Occupation Screen/Evaluation. The facility did not have documented evidence that they evaluated the effectiveness of the interventions implemented. There was no documented evidence of the frequency of monitoring after 48-hours post fall. During a telephone interview on 04/24/2025 at 8:56 AM Certified Nursing Assistant #2 stated they were assigned to Resident #1 on 08/19/2024 from 11:00 PM-7:00 AM. Certified Nursing Assistant #2 stated at the beginning of their shift (at 11:00 PM) they notice Resident #1 kept hanging their feet off the bed while verbalizing ground. Certified Nursing Assistant #2 stated they informed assigned Registered Nurse #1 and that they stayed close by the resident's room for most of their shift. Certified Nursing Assistant #2 stated that they made rounds every 30 minutes for safety precaution. Certified Nursing Assistant #2 stated they provided care to Resident #1 between 5:00 AM-5:30 AM and left Resident #1 sleeping in bed that was in the lowest position. Certified Nursing Assistant #2 stated that they last saw Resident #1 at 6:35 AM sleeping. During a telephone interview on 04/23/2025 at 2:00 PM, Certified Nursing Assistant #1 stated during their morning rounds at the start of their shift at 7:00 AM, they observed Resident #1 lying on the floor next to the right side of their bed. Certified Nursing Assistant #1 stated Resident #1 had blood coming out of their nose and they immediately notified Licensed Practical Nurse #1. During a telephone interview on 04/24/2025 at 9:30 AM Registered Nurse #1 stated they were assigned to Resident #1 on 08/19/2024 on the 11:00 PM-7:00 AM shift. Registered Nurse #1 stated they were aware Resident #1 was confused and was on fall precaution. Registered Nurse #2 stated Resident #1 was frequently monitored by the assigned Certified Nursing Assistant #1 during their shift. Registered Nurse #1 stated they saw Resident #1 in their bed asleep at 6:00 AM during medication pass. Registered Nurse #1 stated at approximately 7:00 AM, Licensed Practical Nurse #1 who worked on the 7:00 AM - 3:00 PM shift informed them Resident #1 was observed on the floor. During an interview on 04/18/25 a5 2:52pm, Registered Nurse Supervisor #1 stated they were notified by Licensed Practical Nurse #1 (exact time unsure) that Resident #1 was found on the floor. Registered Nurse Supervisor #1 stated they went into Resident's room and observed Resident #1 lying on the floor in coagulated blood and bleeding from their nostrils. Registered Nurse Supervisor #1 stated they assessed Resident #1 and observed swelling to the resident's nose and forehead. Registered Nurse Supervisor #1 stated they applied an icepack to the nose and placed Resident #1 back in bed. Registered Nurse Supervisor #1 stated that the Physician ordered for Resident #1 to be transferred to the hospital for further evaluation. Registered Nurse Supervisor #1 stated that Resident #1 was kept in a highly visible area when they were out of bed and was monitored every 30 minutes to every hour. Registered Nurse Supervisor #1 stated that staff anticipated the resident's need and safety. Registered Nurse Supervisor #1 stated Resident #1's bed was kept in the lowest position and the call bell was within reach. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 04/23/2025 at 11:12 AM the Assistant Risk Manager stated Resident #1 had severe cognitive impairment, dementia, unaware of their physical boundaries, and had a history of noncompliance to safety. They investigated the accident and abuse, mistreatment, and neglect was ruled out. The Assistant Risk Manager also stated Resident #1 was on visual monitoring. During an interview on 04/21/2025 at 2:39 PM, the Director of Nursing stated they were informed of the incident on 08/20/2024 by Registered Nurse Supervisor #1. The Director of Nursing stated after the resident fell on [DATE] and 06/20/2024 the resident was placed on every 30 minutes monitoring for two days to see if additional monitoring was need and no additional monitoring was no indication, and the resident remained safe for those two days. The Director of Nursing stated after the fall incident on 03/30/2024, Resident #1 was encouraged to stay in the dayroom with activities, but Resident #1 refused and wanted to stay in their room and that was when the fall occurred on 06/20/2024 incident occurred. The Director of Nursing stated they became aware of the x-ray result and nasal fracture after receiving the Patient Review Instrument and the hospital discharge summary on 08/23/2024. The Director of Nursing stated that the incident was not reportable because it was not an injury of unknown origin. The resident sustained the fracture from the fall. The Director of Nursing stated that their investigation concluded that abuse, mistreatment, or neglect did not occur. The Director of Nursing added that Resident #1's impaired cognition and being unaware of their surroundings contributed to fall. During a follow-up interview with the Director of Nursing on 05/20/2025 at 2:50 PM, the Director of Nursing stated that the Fall Risk Assessment does not capture the risk level jut the risk factors. The Director of Nursing stated that all the residents in the facility is at risk for fall. During a telephone interview on 04/28/25 at 2:07PM, the Assistant Director of Nursing stated on 08/20/24 at 9:00 AM they received a report that Resident #1 was transfer the hospital for nosebleed after being observed on the floor. Resident #1 resided in a private room that was close to the nursing station. The Assistant Director of Nursing stated Resident #1's unawareness of their physical surroundings and impaired balance and gait might have contributed to the fall. The Assistant Director of Nursing stated they initiated 30 minutes monitoring for 48-hours after Resident #1 was re-admitted on [DATE], ensuring safety. The Assistant Director of Nursing stated Resident #1 was also offered toileting every 2-hours to see if their toileting needs had change from 5:00 AM-6:00 AM and staff to anticipate toileting needs every two-hours. The Assistant Director of Nursing stated most of Resident #1's fall was between 5:00 AM and 7:00 AM and that staff performs frequent rounds to anticipate Resident needs. The Director of Nursing stated Resident #1 was frequently monitor by the validation of the unit nurse who ensures that the assigned staff are adhering to Resident Nursing Instruction and signing of the Resident Nursing Instruction. The Assistant Director of Nursing stated Certified Nursing Assistants have been educated and instructed to let the nurses know any changes in Resident's condition immediately. The Assistant Director of Nursing stated frequent monitoring means every 2-hours and that is the facility's standard of time for monitoring Resident #1. 10NYCRR415.12(h)(1)