STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335609	A. Building B. Wing	02/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Heights Center for Nursing and Rehab	810 20 St Marks Avenue Brooklyn, NY 11213

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews conducted during an abbreviated survey (2699587), the facility failed to ensure the designated resident's representative was notified of changes in the resident's condition. This was evident for one (1) of six (6) residents sampled (Resident #1). Specifically, on 12/06/2025 at 5:00 PM Occupational Therapist Assistant #1 documented they saw Resident #1 sliding from the wheelchair to the floor. There is no documented evidence that the facility notified Resident 1's representative that Resident #1 was seen sliding out of the wheelchair to the floor.The findings are:The Facility's Policy on Notification of Changes dated on 12/2024, documented it is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). The resident and/or their representatives will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident.Resident #1 was admitted to the facility with diagnoses including constipation, chronic pain syndrome, and history of falling.Minimum Data Set (a resident assessment tool) dated 11/22/2025, documented Resident #1 had moderately impaired cognition.There was no documented evidence that Resident #1's representative was notified on 12/06/2025 that Resident #1 was observed sliding from their wheelchair to the floor.During an interview on 12/30/2025 at 9:28 AM, Registered Nurse Supervisor #2 stated during body assessment of Resident #1 there were no visible injury, trauma, or skin changes. Registered Nursing Supervisor #2 stated the medical doctor or Resident #1's representative was not informed that Resident #1 slide out of the wheelchair to the floor on 12/06/2025.During an interview on 12/29/2025 at 1:42 PM, Director of Nursing stated Registered Nurse Supervisor #2 must notify the medical doctor and Resident #1's family representative when Resident #1 slide out of the wheelchair to the floor on 12/06/2025.10 NYCRR 415.3(e)(2)(ii)(b)

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, record review and interview during an Abbreviated Complaint Survey (Complaint # 2699587), the facility failed to ensure resident's care plan was reviewed and revised by the interdisciplinary team after each assessment. This was evident for one (1) out of six (6) residents sampled (Resident #1). Specifically, on 12/06/2025 at 5:00 PM Occupational Therapist Assistant #1 documented they saw Resident #1 sliding from the wheelchair to the floor. Registered Nurse Supervisor #2 was notified on 12/06/2025. There was no documented evidence that Resident #1's care plan was reviewed and revised with new interventions after Resident #1 slide from the wheelchair to the floor on 12/06/2025. The findings include:The facility policy titled Care Plan Comprehensive dated 12/2024, documented an Individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Also care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly.Resident #1 was admitted to the facility with diagnoses including constipation, chronic pain syndrome, and history of falling.Minimum Data Set (a resident assessment tool) dated 11/22/2025, documented Resident #1 had moderately impaired cognition.Resident #1's care plan for actual fall dated 08/29/2025, with interventions including keeping personal items within the reach, neuro checks, physical therapy and routine rounding. There is no documented evidence that the care plan was updated after Resident #1 slide out of the wheelchair to the floor on 12/06/2025. There was no documented evidence that a team meeting was done to discuss the sliding out of the wheelchair.On 12/06/2025 at 5:10 PM, Occupational Therapist Assistant #1 documented on the facility's statement form, Resident #1 was seen sliding off their wheelchair. Occupational Therapist Assistant #1 reported the incident to the Licensed Practical Nurse #1.During an interview on 12/30/2025 at 11:09 AM, Occupational Therapist Assistant #1 stated on 12/06/2025 at 5:10 PM, as they were getting off the elevator on the 3rd floor on 12/06/2025 and saw Resident #1 sliding off their wheelchair on to the floor. Occupational Therapist Assistant #1 stated Resident #1 got up by themself and sat on the wheelchair, then slide off the wheelchair again to the floor. Occupational Therapist Assistant #1 stated Licensed Practical Nurse #1 was informed and stayed with Resident #1.During an interview on 12/30/2025 at 9:28 AM, Registered Nurse Supervisor #2 stated on 12/06/2025 during the 7:00 AM - 7:00 PM shift they received notification from Licensed Practical Nurse #1 that Resident #1 slide from the wheelchair to the floor. Registered Nurse Supervisor #2 stated Resident #1 said they did not fall. Registered Nursing Supervisor #2 stated they performed a full body assessment and there were no injuries, no trauma, and Resident #1 denied any pain. Registered Nurse Supervisor #2 stated they did not document Resident #1 sliding from the wheelchair to the floor. Registered Nurse Supervisor #2 stated they did not updated Resident #1's care plan on 12/06/2025.During an interview on 12/29/2025 at 1:42 PM, Director of Nursing stated they were not aware that Resident #1 slide out of the wheelchair to the floor on 12/06/2025. Director of Nursing stated Registered Nurse Supervisor #2, who was working on the shift at that time should have done a full body assessment. Director of Nursing stated Registered Nurse Supervisor #2 should have done an incident report and update the care plan with new interventions.10 NYCRR 415.11

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during an Abbreviated Complaint Survey (Complaint # 2699587), the facility failed to ensure Resident #1 received treatment and care in accordance with professional standards of practice. This was evident for one (1) of six (6) residents sampled (Resident #1). Specifically, on 12/19/2025 License Practical Nurse #2 administered a stool softener to Resident #1 without a physician's order for the stool softener. License Practical Nurse #2 did not document the administration of the stool softener to Resident #1. The findings include:The facility policy titled Administering Oral Medication dated 12/2024, documented the purpose of this procedure is to provide guidelines for the safe administration of oral medications. Verify, that there is a physician's medication order for this procedure.Resident #1 admitted to the facility with diagnoses included constipation, chronic pain syndrome, and history of falling.Minimum Data Set (a resident assessment tool) dated 11/22/2025 documented Resident #1 had moderately impaired cognition.Resident #1's care plan for bowel incontinent with interventions including check resident every two (2) hours and assist with toileting as needed, observe pattern of incontinence, and initiate toileting schedule if indicated.A nursing progress note dated 12/19/2025 at 11:11 AM, written by Licensed Practical Nurse #1 documented Resident #1 asked for stool softener and the medication was given and tolerated well.Review of the physician's order dated from 12/01/2025 to 12/29/2025 revealed no physician's order for any stool softener.The Emergency Department note dated 12/19/2025, documented Resident #1 presented to the emergency department from the facility for constipation. Resident #1 has intermittent cramping and abdominal pain. Resident #1 reported they had no bowel movement in 3 days. Resident #1 was given medication at the facility and had a bowel movement right before coming to the emergency department. In the emergency department while being evaluated, Resident #1 had a large bowel movement, after the bowel movement Resident #1 stated they felt better and denied any further abdominal pain. There was no bowel obstruction.During an interview on 12/29/2025 at 9:50 AM, Resident #1 stated they went to the hospital on [DATE] because they were constipated. Resident #1 stated they informed Licensed Practical Nurse #2 and was given some medication for the constipation. Resident #1 stated they were still having pain; the medication did not work so they called 911 and went to the hospital. Resident #1 stated at the hospital they have a large bowel movement, felt better and went back to the facility on the same day.During an interview on 12/30/2025 at 9:43 AM Licensed Practical Nurse #2 stated on 12/19/2025 at 11: 11AM, Resident #1 asked them for something to move their bowel. Licensed Practical Nurse #2 stated they give Resident #1 two tablets for constipation. Licensed Practical Nurse #2 stated there was no physician's order for the medication.During an interview on 12/29/2025 1:58 PM, Medical Doctor #1 stated they review Resident #1's medical record and noted when Resident #1 was admitted to the facility on [DATE] Resident #1 was on bowel regiment for 30 days. Medical Doctor #1 stated after the 0 days medication was completed, there were no further complaints of constipation. Medical Doctor #1 stated there were no call requesting an order for a stool softener for Resident #1 on 12/19/2025.During an interview on 12/30/2025 at 2:14 PM, Administrator stated Licensed Practical Nurse #2 should have contacted Resident #1's medical doctor, explained the symptoms and request the order for a stool softener. The Administrator acknowledged Licensed Practical Nurse #2 administered a stool softener to Resident #1 without a physician's order.10 NYCRR 415.12

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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. Based on observation, record review and interview during Abbreviated Complaint Survey (Complaint #2699587), the facility did not ensure that each resident receives adequate supervision and assistance devices to prevent accidents. This was evident for one (1) out of six (6) residents sampled (Resident #1). Specifically, Resident #1 was a high risk for falls, the physician's order dated 11/11/2025 documented Resident #1 may be out of bed to standard wheelchair with bilateral elevating leg rests and with manual transfer of one (1) person. On 12/06/2025 at 5:00 PM, Occupational Therapist Assistant #1 documented Resident #1 was seen sliding from the wheelchair to the floor. There is no documented evidence on the Documentation Survey Report or on the Resident Nursing Instruction form instructing staff members on how to supervise Resident #1 to prevent fall.The findings include:The facility policy titled Fall Risk assessment dated 12/2024, documented the nursing staff, in conjunction with the attending physician, consultant pharmacist, therapy staff, and others, will seek to identify and document resident risk factors for falls. Also, the attending physician and nursing staff will evaluate the resident's vital signs, assess the resident for medical conditions (such as those that cause dizziness or vertigo) or sensory impairments (such as decreased vision and peripheral neuropathy) that may predispose to falls.Resident #1 was admitted to the facility with diagnoses included constipation, chronic pain syndrome, and history of falling.Minimum Data Set (a resident assessment tool) dated 11/22/2025, documented Resident #1 had moderately impaired cognition.A physician's order dated 11/11/2025, documented Resident #1 may be out of bed to standard wheelchair with bilateral elevating leg rest and with partial to moderate assistance during manual transfer by one (1) person.There was no documented evidence on the Documentation Survey Report or on the Resident Nursing Instructions form with instructions on how to supervise Resident #1 to prevent falls.On 12/06/2025 at 5:10 PM, Occupational Therapist Assistant #1 observed Resident #1 sliding off their wheelchair. Occupational Therapist Assistant #1 reported the incident to Licensed Practical Nurse #1 and wrote a statement.There is no documented evidence that a body assessment was done, and medical doctor or the family was notified. There is no documented facility's investigation of Resident #1 sliding out of a wheelchair to the floor.During an interview on 12/29/2025 at 9:50 AM, Resident #1 stated they did not fall. Resident #1 reported they dropped something on the floor and tried to pick it up when Occupational Therapist Assistant #1 saw them on the floor.During an interview on 12/30/2025 at 11:09 AM, Occupational Therapist Assistant #1 stated on 12/06/2025 at 5:10 PM, as they were getting off the elevator on the 3rd floor, they saw Resident #1 sliding off their wheelchair. Occupational Therapist Assistant #1 stated Resident #1 got up by themself, sit on the wheelchair then slide off again. Occupational Therapist Assistant #1 stated they informed Licensed Practical Nurse #1, who stayed with Resident #1. Occupational Therapist Assistant #1 then went in search of Registered Nurse Supervisor #2 and did not find them. Occupational Therapist Assistant #1 stated they wrote a statement and leave it at the nursing station.During an interview on 12/30/2025 at 9:28 AM, Registered Nurse Supervisor #2 stated on 12/06/2025 (not sure of time), they were informed by Licensed Practical Nurse #1 that Occupational Therapist Assistant #1 reported on the third floor, Resident #1 slide out of the wheelchair on to the floor. Registered Nurse Supervisor #2 stated Resident #1 was asked what happened, and Resident #1 reported that they did not fall. Registered Nursing Supervisor #2 stated they performed body assessment on Resident #1 but did not document the fall assessment because there was no trauma, no injuries or skin changes. Registered Nursing Supervisor #2 stated they did not informed the medical doctor about the fall by sliding out of the wheelchair.During an interview on 12/29/2025 at 1:42 PM, Director of Nursing stated they were not aware that Resident #1 had a fall by sliding (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of the wheelchair on 12/06/2025. Director of Nursing acknoleged that Registered Nurse Supervisor #2 should have initiated an incident report, collected statements from the staff members and reported the fall to the medical doctor and resident's family representative.10NYCRR415.12(h)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, record review and interview during Abbreviated Complaint Survey (Complaint #2699587), the facility failed to ensure that medical records were maintained in accordance with accepted professional standards and practices and were accurately documented. This was evident for one (1) out of six (6) residents sampled (Resident #1). Specifically, on 12/06/2025 at 5:00 PM Occupational Therapist Assistant #1 documented they saw Resident #1 sliding from the wheelchair to the floor. There was no nursing or medical doctor's documentation in Resident #1's medical record indicating that Resident #1 was assessed after Resident #1 slide out of the wheelchair to the floor on 12/6/2025.The findings are:The facility policy titled Charting and Documentation dated 01/2026 documented all services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record. Also documented all incidents, accidents, or changes in the resident's condition must be recorded.Resident #1 admitted to the facility with diagnoses included constipation, chronic pain syndrome, and history of falling.Minimum Data Set (a resident assessment tool) dated 11/22/2025 documented Resident #1 had moderately impaired cognition.During review of medical records from 12/01/2025 through 12/30/2025, there were no documented evidence that Resident #1 was assessed after slided out of a wheelchair to the floor.During an interview on 12/30/2025 at 9:28 AM, Registered Nurse Supervisor #2 stated on 12/06/2025 (not sure of time) they were informed Resident #1 slide out of the wheelchair to the floor. Resident #1 said that they did not fall. Registered Nurse Supervisor #2 stated they did not write any progress note in Resident #1's medical record.During an interview on 12/29/2025 at 1:42 PM Director of Nursing stated Registered Nurse Supervisor #2 was working at the time. Director of Nursing stated Registered Nurse Supervisor #2 should have written a nursing progress note in Resident #1 medical record. 10 NYCRR 415.22(a)(1-4)