

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335648	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/14/2026
NAME OF PROVIDER OR SUPPLIER Ditmas Park Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2107 Ditmas Avenue Brooklyn, NY 11226	
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 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 record review and staff interviews during a survey, the facility failed to ensure a comprehensive person-centered care plan develop and implemented to address the residents' medical, physical, mental, and psychosocial needs. This was evident for one out of four residents (Resident #1) sampled. Specifically, a comprehensive care plan was not developed with interventions for use of diuretic medication and Resident #1's diagnoses. The findings are: The facility Policy and Procedure titled Care Plan Policy with a review date of October 1, 2025 documented It is the policy of Ditmas children's Nursing and Rehab that a Comprehensive Care Plan will be completed for each new resident in the facility, the Comprehensive Care Plan will reflect the resident's current status and must include the resident's goals and interventions that addresses the resident current needs. All care plans must require measurable and realistic objectives and timetables to meet each identified problem needs. Interdisciplinary Comprehensive Care Plan meeting will be held within 21 days of the admission date. Care planning meeting will be done quarterly, annually and whenever there is change in the resident status that requires an update in the care plan. Resident #1 was a 7-month-old infant born prematurely at 27 weeks, was admitted to the facility on [DATE] with diagnoses including Pulmonary Hypertension (blood vessels in the lungs fail to dilate after birth) of Newborn, Newborn affected by Premature Rupture of Membranes (fetal membranes rupture before the onset of labor of contractions), feeding difficulties, Interstitial Pulmonary Disease (progressive inflammation and scarring in the tissue between the air sacs of the lungs), and Congenital Hypotonia (abnormally low muscle tone that is present at birth). Review of the Physician's order dated 05/04/2026 through 06/04/2026 documented Hydrochlorothiazide (diuretic) oral suspension 10 milligrams /milliliter -give 7 milligrams every 12 hours for diuresis. There was no documented evidence that a care plan for the use of diuretics was developed with interventions. The care plan was developed post medication incident. There was no documented evidence that a care plan for above diagnoses was initiated with interventions. During an interview with Registered Nurse Unit Manager #1 on 06/10/2026 at 3:25 PM, they stated it is the responsibility of the Registered Unit Manager to initiate, revise and update care plans. Registered Nurse Unit Manager #1 stated a care plan should have been initiated for Hydrochlorothiazide medication when the medication was ordered. During a telephone interview with the Assistant Director of Nursing on 07/14/2026 at 2:33 PM, they stated nursing administration and nursing unit managers can initiate care plans. The Assistant Director of Nursing stated that care plans for residents' diagnoses are not immediately initiated on admission, but is done after a family care plan meeting, usually a week after admission. The Assistant Director of Nursing stated that a care plan for the Hydrochlorothiazide was initiated on 06/04/2026. 10 New York Code, Rules and Regulations 415.11(c)(1).		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 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 record reviews and staff interviews, during a survey the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, and comprehensive person-centered care plan. This was evident for one out of four residents (Resident #1) sampled. Specifically, Resident # 1 was given 14 milligrams of Hydrochlorothiazide (diuretic) at once at 10:00 AM on 06/04/2026, instead of 7 milligrams. Registered Nurse #1 did not follow the physician's order for Hydrochlorothiazide 7 milligrams every 12 hours. The findings are: The facility policy and procedure titled "Medication Administration and Safety in Pediatrics" last revised on 05/15/2026 states that risk in medication administration were due to unique pharmacokinetics, age and development that cause difference in drug absorption, metabolism, and elimination. The unique pediatric considerations are potential for medication errors caused by lack of process for ordering, reconciliation, communications and administration. Medication errors are preventable adverse events and Ditmas Children's nursing and rehab process for medication administration and safety that are evidenced based, safe culturally - competent and quality. Section C of the policy states on administration: Registered Nurse must calculate the dosage based on the weight of the patient prior to administration. Registered Nurse must follow the eight Rs of medication administration which includes, right medication, right dosage and right patient amongst others. On monitoring, all staff must follow the process of reporting and documenting medication adverse events that include medication errors, near misses' drug reactions, and other medications related adverse events. Resident #1, a 7-month-old infant born prematurely at 27 weeks, was admitted to the facility on [DATE] with diagnoses including Pulmonary Hypertension (blood vessels in the lungs fail to dilate after birth) of Newborn, Newborn affected by Premature Rupture of Membranes (fetal membranes rupture before the onset of labor of contractions), feeding difficulties, Interstitial Pulmonary Disease (progressive inflammation and scarring in the tissue between the air sacs of the lungs), and Congenital Hypotonia (abnormally low muscle tone that is present at birth). A Physician's Order dated 05/04/2026 through 06/04/2026 documented Hydrochlorothiazide oral suspension 10 milligrams/milliliter give 7 milligrams every 12 hours for diuretic. A review of the Medication Administration Record dated 05/2026 through 06/2026, revealed Hydrochlorothiazide scheduled to be administered at 11:00 AM and 11:00 PM. A Physician's note by Attending Physician #1 dated 06/04/2026 documented at approximately 10:00 AM they were notified by Registered Nurse #2 that a second dose of Hydrochlorothiazide was accidentally administered to Resident #1. Resident #1's Parent was at their bedside and was notified. The Hydrochlorothiazide scheduled to be given at 11:00 PM was put on hold. Medications to resume tomorrow (06/05/2026). Resident #1 was assessed and remained at baseline. A review of the facility summary of investigation done on 06/04/2026 concluded the following: The incident was promptly identified, immediately addressed and appropriately managed with physician notification. Assessment and monitoring of Resident #1 are ongoing. No adverse outcomes were observed. The investigation also determined that the error was primarily related to workflow disruptions and failure to complete a final Electronic Medical Administration Record verification before medication administration. No system-wide deficiencies in pharmacy dispensing or physician ordering were identified. Immediate corrective actions were implemented, including staff removal from assignment, re-education and suspension pending review. During this investigation, there was no evidence to support abuse, neglect, mistreatment or misappropriation. During a telephone interview on 06/12/2026 at 2:00 PM and 6:00 PM, Registered Nurse #2 stated they went back to Resident #1's room and gave them medications (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that include Hydrochlorothiazide 7 milligrams at 10:45 AM on 06/04/2026. They stated they returned to Resident #1's room at 11:00 AM and gave them two medications, including Hydrochlorothiazide 7 milligrams. They stated after Resident #1's Parent asked why they gave the resident a second dose of Hydrochlorothiazide, they checked and realized they had given a second dosage of Hydrochlorothiazide to Resident #1. They stated they immediately notified Attending Physician #1 who told them the 14 milligrams could be given at once or in divided dosages. They stated the physician's order is for Hydrochlorothiazide 7 milligrams every 12 hours (11:00 AM and 11:00 PM) so the 11:00 PM dosage was put on hold. They stated they were distracted. During an interview with Attending Physician # 1 on 06/10/2026 at 3:00 PM, they stated that the Hydrochlorothiazide could be given in one dose or divided doses, however, they ordered to hold the 11:00PM dose. They stated they went to Resident #1's room and explained and reassured the resident's Parent. They stated they examined and evaluated Resident #1 and the resident remained at baseline with no changes in regular urine output. During an interview with the Assistant Director of Nursing on 06/10/2026 at 3:15 PM, they stated as soon as they were informed of the medication error, Attending Physician #1 assessed the resident with orders to continue monitoring and to hold the 11:00PM dose. They stated they immediately removed Registered Nurse from the unit and initiated an investigation. 10 New York Codes, Rules, and Regulations 415.12		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interviews during a survey, the facility failed to ensure the physician write, sign, and date a telephone order. This was evident for one out of four residents (Resident #1). Specifically, Resident #1 was administered Tylenol suppository 240 milligrams rectally on 05/15/2026 at 9:30 PM. Resident #1 was transferred to the emergency room on [DATE] to be evaluated for Tylenol toxicity. Resident #1 returned to facility same day with no interventions recommended. Attending Physician #1 did not write, sign, or date the telephone order received by Registered Nurse #1 on 05/15/2026. The findings are: A facility policy titled 'Physician Telephone Orders and verbal Orders' dated 01/01/2026 states to ensure that physician telephone orders and verbal orders are obtained, transcribed, verified, implemented, and authenticated accurately and promptly to promote resident safety, continuity of care and regulatory compliance. All physician telephone and verbal orders shall be documented, read back for verification, and authenticated by the ordering practitioner in accordance with federal, state, and facility requirements. Subtopic: Receiving a Physician Telephone Order states - verify the identity of practitioner: full name, professional credentials, and callback verification if necessary. Secondly, verify the resident name, date of birth and/or medical record number. Read-Back Physician Telephone Orders, the nurse shall write down the order, document the order exactly as communicated before implementation. The nurse should clearly repeat the entire order back to the practitioner, including medication name, dose, and route. Subtopic: Transcribing and Implementing Orders states - after verification, the physician and nurse practitioner will enter the order into the Electronic Health Record within 24 hours. Resident #1 was a 7-month-old infant born prematurely at 27 weeks, was admitted to the facility on [DATE] with diagnoses including Pulmonary Hypertension (blood vessels in the lungs fail to dilate after birth) of Newborn, Newborn affected by Premature Rupture of Membranes (fetal membranes rupture before the onset of labor of contractions), feeding difficulties, Interstitial Pulmonary Disease (progressive inflammation and scarring in the tissue between the air sacs of the lungs), and Congenital Hypotonia (abnormally low muscle tone that is present at birth). A nursing note dated 05/15/2026, by Registered Nurse #1, who took the telephone order for Tylenol suppository, documented that at around 8:30 PM, Resident #1's parent requested Tylenol (for Resident #1) for irritation. Attending Physician #1 was called, and they gave a telephone order for Tylenol suppository 240 milligrams that was given at 9:30 PM (on 05/15/2026). At around 7:00 AM (05/16/2026), Resident #1's parent reported Resident #1 had a large emesis (vomiting) and feed was paused. There was no documented evidence that Attending Physician #1 wrote, sign, or date a telephone order for Tylenol suppositories 240 milligrams that was administered to Resident #1 on 05/15/2026. A Significant Event note dated 05/16/2026 at 9:00 AM, by Nurse Practitioner #1 documented that they were notified by Registered Nurse #1 that Resident #1 received 240 milligrams Tylenol suppository rectally at around 9:30 PM (on 05/15/2026). Resident #1's parent reported Resident #1 had multiple small episodes of emesis overnight with noted irritability. This morning, Registered Nurse #1 reported one large emesis at around 7:00 AM. Resident appeared sleepier than usual. Also documented, 240 milligrams suppository exceeds Tylenol loading dose for age and weight. Poison Control called and urged Resident #1 to be transferred to the nearest Emergency Room. They examined Resident #1 who was lethargic but arousable. Vital Signs are stable and within normal limits. Lung sounds clear bilaterally with good air entry. No adventitious breath sounds noted. Peripheral pulses are palpable and strong. Abdomen soft, flat, and non-distended. Non (continued on next page)		

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the night and they were good, and Resident #1 was at their baseline. They stated during the morning (05/16/2026) at around 7:00 AM, Resident #1's parent reported that the resident had a little vomiting with the feeding and that it was a little more than they normally spit up. Registered Nurse #1 stated they did not witness any vomitus. During a follow -up interview on 06/11/2026 at 1:20 PM, Resident #1's Parent stated that Resident #1 was vaccinated the day before (05/14/2026) and was fussy and sleepy after the vaccination. They stated after Tylenol was administered (on 05/15/2026) Resident #1 remained fussy and sleepy and vomited a few times during the night. Resident #1's Parent stated they did not call the nurse and none of the staff witnessed the vomiting. They stated they cleaned up the vomitus themselves. 10 New York Codes, Rules, and Regulations 415.15(b)(2)(iii)		