STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335653	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menorah Home & Hospital for Aged & Infirm	1516 Oriental Blvd Brooklyn, NY 11235

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (625460), the facility did not ensure that each resident received adequate supervision to prevent accidents. This was evident for one (1) of two (2) residents (Resident #1) sampled for Injuries of Unknown Origin. Specifically, on 01/06/2024 at 5:45 AM, Resident #1 reported to Home Health Aide #1 that they had pain to their right hip. Resident #1 was assessed by Registered Nurse #1 at 8:23 AM and was observed with their right leg swollen and larger than the left. Resident #1 was transferred to the hospital at 10:25 AM and was diagnosed with an acute traumatic comminuted right femoral intertrochanteric fracture (a break in the thigh bone) with superior displacement of the femoral head (broken hip). There was a Physician's Order dated 12/08/2023 which documented one-to-one supervision for Resident #1 which was not provided on the night shift (10:00 PM - 6:00 AM) on 01/05/2024. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The findings include:The policy titled 'Fall Prevention Program' with a revision date of 08/17/2017 documented the facility and nursing care identifies risk factors relative to falls and provides adequate supervision and assistance devices to prevent falls or, where appropriate, to decrease injuries from falls. The facility and nursing care recognizes the individual resident's right to choose and to maintain their independence and balances falls prevention with those rights. The purpose is to provide guidelines for the clinical staff in the assessment and identification of resident risk factors, the protocols to follow for care planning and interventions, and the required documentation for each event. To ensure each resident receives care and services in an environment that promotes or maintains the residents highest practicable physical, mental, and psychosocial well-being. The facility did not have a policy on one-to-one supervision prior to the incident that occurred on 01/05/2024.The Policy titled 'Staffing Plan', dated 08/03/2023 documented to plan and provide sufficient staff with the appropriate competencies and skills to ensure that nursing care is provided 24 hours per day, seven (7) days per week. The staffing coordinator/designee reviews and reassigns staff according to unit activity at the beginning of each shift. Daily sick calls or other leave of absences in excess of scheduled margins are covered by part-time or per diem staff who are available for extra hours.Resident #1 was admitted to the facility with diagnoses including non-Alzheimer's dementia (group of symptoms affecting memory, thinking and social abilities that are not associated with Alzheimer's disease) , anxiety disorder, and respiratory failure. The Quarterly Minimum Data Set, (a resident assessment tool) dated 11/20/2023 documented Resident #1 had severe cognitive impairment, required substantial/maximal assistance to roll left and right in bed, and is dependent for transfer from chair/bed-to-chair.A Behavioral Monitoring Note by Licensed Practical Nurse #3 dated 08/09/2023 at 1:55 PM documented that Resident #1 had behaviors including restless and constantly up. Resident #1 was monitored through one-to-one staff supervision. A Behavioral Monitoring Note dated 09/14/2023 documented that Resident #1 had behaviors that include restlessness and continuously attempting to get up from their wheelchair.A Behavioral Monitoring Note dated 10/16/2023 documented that Resident #1 had behaviors including being fidgety, dangling their legs off the bed, and sleeping for short intervals throughout the night.A Falls Risk assessment dated [DATE] documented Resident #1 had a score of 39, denoting high risk for fall. A Psychiatry Progress Note by Psychiatrist #1 dated 12/04/2023 documented that Resident #1 had behaviors including agitation, restlessness, physical aggression towards staff, poor cognitive function, and impaired impulse control and judgement. Recommendations include considering Depakote sprinkles 125 milligram by mouth three (3) times a day, discontinue Valium. Support, reassurance, and redirection.A Fall Care plan dated 12/07/2023 documented interventions for one-to-one supervision due to periods of agitation, provide an obstacle-free and safe environment, and to keep the bed in the lowest position. A Physician's Order by Medical Doctor #2, dated 12/08/2023, documented one-to-one supervision. A Nursing Note by Licensed Practical Nurse #4 dated 01/05/2024 at 9:40 PM documented that Resident #1 had behaviors including periods of confusion and restlessness. Resident #1 was being monitored through one-to-one supervision. The Assignment Sheet dated 01/05/2024 from 10:00 PM to 6:00 AM (night shift) showed one (1) Licensed Practical Nurse, and two (2) Certified Nursing Assistants worked on Resident #1's unit. There was no documented evidence a staff member was assigned to provide one-to-one monitoring for Resident #1 during the 10:00 PM to 6:00 AM shift. The Facility Investigation Summary dated 01/06/2024 documented that Resident #1 was frequently restless and had a history of falls. It further documented that on 01/06/2024 at around 3:30 AM, Licensed

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	335653	A. Building B. Wing	11/24/2025

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interviews conducted during an abbreviated survey (NY00331104), the facility failed to ensure pain management was provided to a resident who requires such services, consistent with professional standards of practices, the comprehensive person-centered care plan, and the residents' choices. This was evident in one (1) of two (2) residents (Resident #1) sampled. Specifically, on 01/06/2024 at 5:45 AM, Resident #1 reported to Home Health Aide #1 that they had pain to their right hip. Home Health Aide #1 reported the pain to Licensed Practical Nurse #1 who instructed them to wait for the incoming shift. Licensed Practical Nurse #1 did not immediately check on Resident #1 and the resident was not immediately assessed by a Registered Nurse. Tylenol 650 milligrams were administered to the resident by incoming Licensed Practical Nurse #2 at 6:25 AM, 40 minutes after they complained of pain. Resident #1 was assessed by Registered Nurse #1 at 8:23 AM and observed with swelling to their right leg that was larger than the left. Resident #1 was transferred to the hospital at 10:25 AM on 01/06/2024 and was diagnosed in the hospital with an acute traumatic comminuted right femoral intertrochanteric fracture (a break in the thigh bone) with superior displacement of the femoral head (broken hip). The findings include:The policy titled 'Pain Management', dated 07/30/2023 documented all residents have the right to an accurate assessment and appropriate management of their pain. All residents are assessed for the presence of pain and the adequacy of pain-relieving strategies upon admission and on a regular basis. Personal, spiritual, cultural and ethnic beliefs of residents, family and staff are considered in the management of pain as well as non-pharmacologic treatment. Resident #1 was admitted to the facility with diagnoses including non-Alzheimer's dementia (group of symptoms affecting memory, thinking and social abilities that are not associated with Alzheimer's disease) , anxiety disorder, and respiratory failure. The Quarterly Minimum Data Set, (a resident assessment tool) dated 11/20/2023 documented Resident #1 had severe cognitive impairment, required substantial/maximal assistance to roll left and right in bed, and is dependent for transfer from chair/bed-to-chair.A care plan titled Pain dated 11/06/2023, documented interventions to evaluate for the presence of pain, determine the frequency of pain and to provide medical management of underlying cause. The Facility Investigation Summary dated 01/06/2024 documented that Resident #1 was frequently restless and had a history of falls. It further documented that on 01/06/2024 at around 3:30 AM, Licensed Practical Nurse #1 observed Resident #1 awake in their room, holding on to the siderail with one leg off the bed as if they were attempting to get up. Licensed Practical Nurse #1 and Certified Nursing Assistant #1 transferred Resident #1 into their wheelchair and brought them to the nurse's station. Resident #1 remained at the nursing station until at approximately 5:45 AM on 01/06/2024, when Home Health Aide #1 arrived on the unit and was assigned to provide one-to-one supervision to Resident #1. Resident #1 then reported pain in their right leg to Home Health Aide #1. Home Health Aide #1 notified Licensed Practical Nurse #1 of Resident #1's reported pain, and Licensed Practical Nurse #1 instructed Home Health Aide #1 to wait until the next shift's nurse arrived to report the concern to that nurse. The Investigation Summary further documented that on 01/06/2024 at around 6:20 AM, Home Health Aide #1 reported Resident #1's right leg pain to Licensed Practical Nurse #2, who observed Resident #1 with swollen legs and provided the resident with pain medication. On 01/06/2024 at around 6:30 AM, Home Health Aide #1 also notified Registered Nurse #1 of Resident #1's severe right leg pain. Registered Nurse #1 immediately assessed Resident #1 and noted Resident #1 to have a swollen right leg that was painful to the touch with limited range of motion. Registered Nursing Supervisor #1 and the on-call physician were then notified, and Resident #1 was transferred to the hospital for further evaluation. The facility concluded that Resident #1 could have fallen and gotten themself back onto the bed using the siderails. It is possible also that Resident #1 could have injured themself, but there is no definitive evidence. There is no reason to believe abuse, neglect, or mistreatment occurred.There was no documented evidence of any interventions being implemented by Licensed Practical Nurse #1 when they first became aware of Resident #1's complaint of pain. A Medication Administration Record for 01/06/2024 documented that Resident #1 received Tylenol 650 milligrams orally for pain at 6:25 AM on 01/06/2024.A nursing progress note dated 01/06/2024 at 8:23 AM by Registered Nurse #1, documented Resident #1's family was informed of resident complaining of severe pain to right leg. Upon assessing the resident, resident's right leg was noted larger than the left leg, noted with swelling to right hip, resident unable to move right leg on their own. When right leg was moved, the resident complained of severe pain. The note documented that the resident was unable to apply weight to right leg. The resident

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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 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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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 0725 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, and interviews conducted during an abbreviated survey (625460), the facility failed to ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing for each resident. This was evident for one (1) of five (5) residents (Resident #1) sampled. Specifically, on 01/06/2024 at 5:45 AM, Resident #1 complained of pain to their right hip and was assessed by Registered Nurse #1 at 8:23 AM and was observed with swelling to their right leg that was larger than the left. Resident #1 was transferred to the hospital at 10:25 AM on 01/06/2024 and was diagnosed in the hospital with an acute traumatic comminuted right femoral intertrochanteric fracture (a break in the thigh bone) with superior displacement of the femoral head (broken hip). A review of the physician's order dated 12/08/2023, revealed Resident #1 had a physician's order for one-to-one supervision. A review of the Assignment Sheet dated 01/05/2024 for the 10:00 PM to 6:00 AM shift revealed Resident #1 did not have a one-to-one staff assigned to them on 01/05/2024 from 10:00 PM through 01/06/2024 at 5:45 AM. This resulted in actual harm that was not Immediate Jeopardy.The findings include:As per an interview with the Administrator on 11/03/2025 at 1:07 PM, the facility developed a one-to-one ‘Observation' policy dated January 2024 after the incident on 01/06/2024. The facility policy titled, ‘Staffing Plan,' dated 07/2020 states to plan and provide sufficient staff with the appropriate competencies and skills to ensure nursing care is provided 24-hours a day, seven (7) days per week. The facility policy titled, ‘Facility Assessment,' dated 11/14/2023 documented the facility will conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. Individuals involved in the facility assessment process will include the administrator, a representative of the governing body, the medical director, the directors of nursing, and other department heads as needed.Resident #1 was admitted to the facility with diagnoses including non-Alzheimer's dementia (group of symptoms affecting memory, thinking and social abilities that are not associated with Alzheimer's disease), anxiety disorder, and respiratory failure. The Quarterly Minimum Data Set (a resident assessment tool) dated 11/20/2023, documented that Resident #1 had severe cognitive impairments. Resident #1 required substantial assistance rolling left and right in bed, and dependent level of assistance for transfers.A review of the Facility Assessment from 11/2023 to 11/2024, revealed a facility capacity of 436 residents with staffing plan by shift as follows: PAR level dated 01/05/2024 for 4-North day shift (6:00 AM - 2:00 PM) showed five (5) Certified Nursing Assistants plus one (1) Home Health Aide assigned/worked. Evening shift (2:00 PM - 10:00 PM) 4-North showed four (4) Certified Nursing Assistants plus one (1) Home Health Aide assigned/worked. Night shift (10:00 PM - 6:00 AM) 4-North showed three (3) Certified Nursing Assistants assigned and one no show. PAR level census showed 38 residents for 01/05/2024. A review of the daily ‘Staffing Sheet' from 01/01/2024 to 01/05/2024, revealed that on 01/05/2024 facility had a census of 39 residents on Resident #1's unit (4-North) which had one (1) resident on one-to-one supervision (Resident #1). On 01/05/2024, the 6:00 AM - 2:00 PM shift showed five (5) Certified Nursing Assistants worked plus one (1) Home Health Aide assigned to provide one-to-one supervision. The 2:00 PM - 10:00 PM shift showed four (4) Certified Nursing Assistants worked. A line is drawn through the one-to-one Home Health Aide's name. The 10:00 PM - 6:00 AM shift showed two (2) Certified Nursing Assistants worked. A line is drawn through the Home Health Aide's name who was scheduled as one-to-one. The physician's order dated 12/08/2023 documented Resident #1 had an order for one-to-one supervision.A review of the physician's orders from 01/01/2024 to 01/30/2024 revealed five (5) residents in the facility had orders for one-to-one supervision. There was no documented evidence Resident #1 had a Home Health Aide or Certified Nursing Assistant assigned to provide one-to-one supervision from 01/05/2024 on the 10:00 PM - 6:00 AM shift (01/06/2024).The Facility Investigation Summary dated 01/06/2024 documented that Resident #1 was frequently restless and had a history of falls. It further documented that on 01/06/2024 at around 3:30 AM, Licensed Practical Nurse #1 observed Resident #1 awake in their room, holding onto the siderail with one (1) leg somewhat off the bed as if the resident was attempting to get up. Licensed Practical Nurse #1 and Certified Nursing Assistant #1 transferred Resident #1 into their wheelchair and brought them to the nurse's station. Resident #1 remained by the nursing station until approximately 5:45 AM when Home Health Aide #1 arrived on the unit and was assigned to provide one-to-one supervision for Resident #1. Resident #1 then reported pain in their right leg to Home Health Aide #1. Home Health Aide #1 notified Licensed Practical Nurse #1 of Resident #1's reported pain, and Licensed

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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 0838 Level of Harm - Actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. (continued on next page)

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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 0838 Level of Harm - Actual harm Residents Affected - Few	Based on observation, record review, and interviews conducted during an abbreviated survey (625460), the facility failed to ensure a facility-wide assessment to determine what resources were necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility did not consider specific staffing needs for each resident and adjust as necessary based on any changes to its resident population. This was evident during review of Staffing from 01/01/2024 - 01/06/2024. Specifically, on 01/06/2024 at 5:45 AM, Resident #1 complained of pain to their right hip and was assessed by Registered Nurse #1 at 8:23 AM and was observed with swelling to their right leg that was larger than the left. Resident #1 was transferred to the hospital at 10:25 AM on 01/06/2024 and was diagnosed with an acute traumatic comminuted right femoral intertrochanteric fracture (a break in the thigh bone) with superior displacement of the femoral head (broken hip). Resident #1 had a physician's order dated 12/08/2023 documenting one-to-one supervision was required. The Assignment Sheet dated 01/05/2024 for the 10:00 PM to 6:00 AM shift, revealed no documented evidence a staff was assigned to provide one-to-one supervision to Resident #1. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.The findings are:The Facility Assessment from 11/2023 to 11/2024 documented the facility has 436 resident beds with an average of 422 beds cumulative and average census 96.74 percentage. Long Term Beds 311 and Subacute Beds 125. Average staff numbers required Licensed nurses providing direct care 124, Certified Nurse Aides 244 and Home Health Aides 9. Department Heads create assignments for their staff based on acuity (Sub-acute and Long Term), staff skills and physical location. Clinical staff have consistent assignments and coverage plans are in place. Staff are floated on an as necessary basis based on status and seniority. Efforts are made to ensure the staff are as consistent as possible.A review of the Facility Assessment from 11/2023 to 11/2024, revealed a facility capacity of 436 residents staffing plan by shift as follows: PAR level dated 01/05/2024 for 4-North day shift (6:00 AM - 2:00 PM) five (5) Certified Nursing Assistants plus one (1) Home Health Aide assigned/worked. Evening shift (2:00 PM - 10:00 PM) four (4) Certified Nursing Assistants plus one (1) Home Health Aide assigned/worked. Night shift (10:00 PM - 6:00 AM) showed three (3) assigned and one (1) no show. PAR level census showed 38 residents for 01/05/2024.A review of the daily 'Staffing Sheet' from 01/01/2024 to 01/05/2024, revealed that on 01/05/2024 facility had a census of 39 residents on Resident #1's unit (4-North) which had one (1) resident on one-to-one supervision (Resident #1). On 01/05/2024, the 6:00 AM - 2:00 PM shift showed five (5) Certified Nursing Assistants worked plus one (1) Home Health Aide assigned to provide one-to-one supervision. The 2:00 PM - 10:00 PM shift showed four (4) Certified Nursing Assistants worked. A line is drawn through the one-to-one Home Health Aide's name. The 10:00 PM - 6:00 AM shift showed two (2) Certified Nursing Assistants worked. A line is drawn through the Home Health Aide's name who was scheduled as one-to-one. Resident #1 was admitted to the facility with diagnoses including non-Alzheimer's dementia (refers to conditions like vascular dementia), anxiety disorder, and respiratory failure.The Quarterly Minimum Data Set (a resident assessment tool) dated 11/20/2023, documented that Resident #1 had severe cognitive impairments. Resident #1 required substantial assistance rolling left and right in bed, and dependent level of assistance for transfers.The Physician's Order dated 12/08/2023, revealed Resident #1 had an order for one-to-one supervision.A review of the physician's orders from 01/01/2024 to 01/30/2024, revealed five (5) residents in the facility had orders for one-to-one supervision. There was no documented evidence Resident #1 had a Home Health Aide or Certified Nursing Assistant assigned to provide one-to-one supervision on 01/05/2024 on the 10:00 PM - 6:00 AM shift (01/06/2024.)During an interview on 07/03/2025 at 10:42 AM, Certified Nursing Assistant #1 stated that on 01/05/2024 during the 10:00 PM to 6:00 AM shift, there was no one-to-one staff member assigned to Resident #1. Certified Nursing Assistant #1 stated the facility was understaffed, and they only had two (2) certified nursing assistants working on the unit on 01/05/2024 during the 10:00 PM to 6:00 AM shift. Certified Nursing Assistant #1 stated that they and Licensed Practical Nurse #1 provided hourly monitoring to Resident #1 during the night shift. Certified Nursing Assistant #1 stated that Licensed Practical Nurse #1 noticed that Resident #1 was awake and asked them to assist with transferring the resident to the nurse's station for supervision.During an interview on 07/02/2025 at 1:20 PM, the Director of Nursing stated Resident #1 was