STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335673	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Nursing and Rehabilitation Center	1555 Rockaway Parkway Brooklyn, NY 11236

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure sufficient nursing staff were available to provide nursing and related services to assure resident safety to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, review of the weekend staffing and the Payroll Based Journal Staffing Data Report revealed low weekend staffing.The facility Payroll Based Journal Staffing Data Report for the Quarter 4 2025 dated July 1 - September 30 documented that excessively low weekend staffing triggered on the report. The facility Payroll Based Journal Staffing Data Report for the Quarter 1 2026 dated October 1 - December 30 also documented that excessively low weekend staffing triggered on the report. The facility's policy and procedure titled Staffing, Sufficient and Competent Nursing dated 01/2026, stated the facility provides sufficient number of staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The policy also stated staffing numbers, and the skill requirements of direct care staff are determined by the needs of the residents based on each resident assessment, residents care plans, and the facility assessment. The policy further stated factors considered in determining appropriate staffing ratios and skills include an evaluation of the disease, conditions, physical or cognitive limitations of the resident population, and acuity. The facility document titled Facility Assessment-Targeted Nursing stated facility staffing is census based, which fluctuates based on admission/discharges. The facility units include the following: 2nd Floor-Rehabilitation, 3rd Floor-Dialysis Residents, 5th Floor Trach/Ventilator, and 4th, 6th, and 7th floors Long Term Care. On team entrance to the facility for the Recertification survey on 02/24/2026, the facility census was 266 residents. The Facility assessment dated [DATE] documented par levels for nursing staff as follows:Day Shift (7:00 AM - 3:00 PM): 2nd Floor (bed capacity of 46): three (3) Licensed Nurses, five (5) Certified Nursing Assistants. 3rd Floor (bed capacity of 45): two (2) Licensed Nurses, five (5) Certified Nursing Assistants. 4th Floor (bed capacity of 45): three (3) Licensed Nurses, four (4) Certified Nursing Assistants. 5th Floor (bed capacity of 43): three (3) Licensed Nurses, five (5) Certified Nursing Assistants. 6th Floor (bed capacity of 45): two (2) Licensed Nurses, four (4) Certified Nursing Assistants. 7th Floor (bed capacity of 45): two (2) Licensed Nurses, four (4) Certified Nursing Assistants. Evening Shift (3:00 PM - 11:00 PM): 2nd Floor: three (3) Licensed Nurses, four (4) Certified Nursing Assistants. 3rd Floor: two (2) Licensed Nurses, four (4) Certified Nursing Assistants. 4th Floor: two (2) Licensed Nurses, four (4) Certified Nursing Assistants. 5th Floor: two (2) Licensed Nurses, four (4) Certified Nursing Assistants. 6th Floor: two (2) Licensed Nurses, four (4) Certified Nursing Assistants. 7th Floor: two (2) Licensed Nurses, four (4) Certified Nursing Assistant. Night Shift (11:00 PM - 7:00 AM): 2nd Floor: three (3) Licensed Nurses, three (3) Certified Nursing Assistants. 3rd Floor: two (2) Licensed Nurses, three (3) Certified Nursing Assistants. 4th Floor: one (1) Licensed Nurses, three (3) Certified Nursing Assistants. 5th Floor: two (2) Licensed Nurses, three (3) Certified Nursing Assistants. 6th Floor: one (1) Licensed Nurses, three (3) Certified Nursing Assistants. 7th Floor: one (1) Licensed Nurse, three (3) Certified Nursing (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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assistant. Review of the actual weekend staffing schedule from July 1st, 2025, through September 30th, 2025, documented the following:On Saturday July 5th, 2025, on the day shift, the 2nd floor was short of one (1) Licensed Nurse, and the 3rd and 5th floors were short of one (1) Certified Nursing Assistant. On the evening shift, the 2nd and 5th floors were short of one (1) Licensed Nurse and one (1) Certified Nursing Assistant, and the 4th floor was short of two (2) Licensed Nurses. On the night shift, the 2nd floor was short of one (1) Licensed Nurse and the 4th, 5th, 6th, and 7th floors were short of one (1) Certified Nursing Assistant. On Sunday July 6th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed Nurse, and one (1) Certified Nursing Assistant. On the evening shift, the 2nd and 5th Floors were short of one (1) Licensed Nurse, and one (1) Certified Nursing Assistant. On the night shift, the 3rd, 5th, and 6th floors were short of one (1) Certified Nursing Assistant. On Saturday July 12th, 2025, on the day shift, the 2nd, 4th, and 5th floors were short of one Licensed Nurse, and the 5th floor was short of one (1) Certified Nursing Assistant. On the evening shift, the 5th floor was short of one (1) Certified Nursing Assistant. On the night shift, the 2nd and 5th floors were short of one (1) Licensed Nurse, and the 5th, 6th, and 7th floors were short of one (1) Certified Nursing Assistant. On Sunday July 13th, 2025, on the day shift, the 2nd, 4th, and 5th floors were short of one (1) Licensed Nurse, and the 3rd and 5th floors were short of two (2) Certified Nursing Assistants. On the night shift, the 4th, 5th, 6th, and 7th floors were short of one (1) Certified Nursing Assistant. On Saturday July 19th, 2025, the day shift, the 2nd, 4th, and 5th floors were short of one (1) Licensed Nurse, and the 3rd and 5th floors were short of one (1) Certified Nursing Assistant. On the evening shift, the 5th floor was short of one (1) Certified Nursing Assistant. On the night shift, the 5th, 6th, and 7th floors were short of one (1) Certified Nursing Assistant. On Sunday July 20th, 2025, on the day shift, on the 2nd, 4th, and 5th floors were short of one (1) Licensed Nurse, and two (2) Certified Nursing Assistants. On the night shift, the 2nd floor was short of one (1) Licensed Nurse, and the 5th, 6th, and 7th floors were short of one (1) Certified Nursing Assistant. On Saturday July 26th, 2025, on the day shift, the 2nd, 4th and 5th floors were short of one (1) Licensed Nurse, and the 5th floor was short of one (1) Certified Nursing Assistant. On the evening shift, the 2nd and 4th floors were short of one (1) Licensed Nurse, and the 5th floor was short of one (1) Certified Nursing Assistant. On the night shift, the 3rd, 4th, 5th, and 6th floors were short of one (1) Certified Nursing Assistant, and the 7th floor was short of two (2) Certified Nursing Assistants. On Sunday July 27th, 2025, on the day shift, the 3rd floor was short of two (2) Certified Nursing Assistants; the 4th floor was short one of (1) Licensed Nurse and one (1) Certified Nursing Assistant, and the 5th floor was short one of (1) Licensed Nurse and three (3) Certified Nursing Assistants.On the evening shift, the 2nd and 5th floors were short of one (1) Licensed Nurse, and the 4th and 5th floors were short of two (2) Certified Nursing Assistants. On the night shift, the 2nd floor was short of one (1) Licensed Nurse, the 3rd floor was short of two (2) Certified Nursing Assistants, and the 5th, 6th and 7th floors were short of one (1) Certified Nursing Assistant. On Saturday August 2nd, 2025, on the day shift, the 2nd, 4th, and 5th floors were short of one (1) Licensed Nurse.On the evening shift, the 2nd and 5th floors were short of one (1) Licensed Nurse, and the 5th floor was short of one (1) Certified Nursing Assistant. On the night shift, the 2nd and 7th floors were short of two (2) Certified Nursing Assistants, and the 3rd, 4th, 5th and 6th floor were short of one (1) Certified Nursing Assistant. On Sunday August 3rd, 2025, on the day shift, the 2nd, 4th, 5th, and 7th floors were short of one (1) Licensed Nurse, and the 2nd, 4th, and 5th floors were short of one (1) Certified Nursing Assistant. On the evening shift, the 4th floor was short of one (1) Licensed Nurse. On the night shift, the 2nd, 3rd, and 5th floors were short of one certified Nursing Assistant, and the 6th floor was short of two (2) Certified Nursing Assistants. On Saturday August 9th, 2025, on the day shift, the 2nd, 4th, 5th, and 6th floors were short of one (1) Licensed Nurse, and the 2nd and 5th floors were short of one (1) Certified Nursing Assistant. On the evening shift, the third 3rd floor was short of one (1) Certified Nursing Assistant, and the 5th floor was short of two (2) Licensed Nurses and two (2) Certified Nursing Assistants. On the night shift, the 2nd floor was short of one (1) Licensed Nurse, the 5th floor was (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	short of two (2) Licensed Nurses, and the 6th and 7th floors were short of one (1) Certified Nursing Assistant. On Sunday August 10th, 2025, on the day shift, the 2nd and 4th floors were short of one (1) Licensed Nurse, and one (1) Certified Nursing Assistant, and the 5th floor was short of two (2) Licensed Nurse and one (1) Certified Nursing Assistant. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse. On the night shift, the 2nd floor was short of one (1) Licensed Nurse, and the 6th floor was short of one (1) Certified Nursing Assistant. On Saturday August 16th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Certified Nursing Assistant (1), the 3rd floor was short of two (2) Certified Nursing Assistant, and the 5th floor was short of one (1) Licensed Nurse. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse. On the night shift, the 2nd floor was short of one (1) Licensed Nurse, and the 4th, 5th, 6th and 7th floors were short of one Certified Nursing Assistant. On Sunday August 17th, 2025, on the day shift, the 2nd, 5th, and 7th floors were short of one (1) Licensed Nurse, and the 2nd and 5th floors were short of one (1) Certified Nursing Assistant. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse. On the night shift, the 2nd and 3rd floors were short of one Licensed Nurse, the 5th floor was short of two (2) Licensed Nurses, and the 3rd, 4th, and 6th floors were short of one (1) Certified Nursing Assistant. On Saturday August 23rd, 2025, on the day shift, the 2nd and 4th floors were short of one (1) Licensed Nurse, the 5th floor was short of two (2) Certified Nursing Assistants, and the 6th and 7th floors were short of one (1) Certified Nursing Assistant. On the night shift, the 2nd, 5th, and 6th floors were short of one (1) Licensed Nurse and one (1) Certified Nursing Assistant. On Sunday August 24th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed Nurse, the 4th floor was short of two (2) Licensed Nurses, the 2nd, 3rd, 4th, 6th, and 7th floors were short of one (1) Certified Nursing Assistant, and the 5th floor was short of two (2) Certified Nursing assistants. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse. On the night shift the 2nd and 3rd floors were short of one (1) Licensed Nurse, and one (1) Certified Nursing Assistant, and the 5th floor was short of one (1) Certified Nursing Assistants. On Saturday August 30th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed Nurse and one (1) Certified Nursing Assistant. On the evening shift, the 3rd and 5th floors were short of one Certified Nursing Assistant. On the night shift, the 5th, 6th and 7th floors were short of one certified Nursing Assistant. On Sunday August 31st, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed and one (1) Certified Nursing Assistant, and the 3rd floor was short of one (1) Certified Nursing Assistant. On the evening shift, the 2nd, 3rd, 5th, 6th and 7th floors were short of one (1) Certified Nursing Assistant. On the night shift, the 3rd, 4th, 5th, and 7th floors were short of one (1) Certified Nursing Assistant. On Saturday September 6th, 2025, on the day shift, the 2nd floor was short of one Licensed Nurse and one (1) Certified Nursing Assistant. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse. On the night shift, the 2nd floor was short of one (1) Licensed Nurse. On Sunday September 7th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed Nurse, fourth Floor: two (2) Licensed Nurses. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse and two (2) Certified Nursing Assistants. On the night shift, the 3rd floor was short of one (1) Certified Nursing Assistant. On Saturday September 13th, 2025, on the day shift, the 5th and 4th floors were short of one (1) Licensed Nurse, and the 5th floor was short of two (2) Certified Nursing Assistants. On the evening shift, the 5th floor was short of one (1) Licensed Nurse. On Sunday September 13th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed Nurse and one (1) Certified Nursing Assistant. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse. On Saturday September 20th, 2025, on the day shift, the 2nd and 5th floors were short of one (1) Licensed Nurse and one (1) Certified Nursing Assistant. On the evening shift, the 2nd floor was short of one Licensed Nurse. On Sunday September 27th, 2025, on the day shift, the 2nd, 4th and 5th floors were short of one (1) Licensed Nurse, and the 2nd and 5th floors were short of one (1) Certified Nursing Assistant. On the evening shift, the 2nd floor was short of one (1) Licensed Nurse, and the 3rd and 6th floor were short of one (1) Certified Nursing Assistant. On Saturday September 28th, 2025, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the 2nd, 4th and 5th floors were short of one (1) Licensed Nurse, and the 2nd and 5th floors were short of one (1) certified Nursing Assistant. On the evening shift, the 7th floor was short of one (1) Certified Nursing Assistant. During an interview on 03/03/2026 at 12:27 PM, Registered Nurse #1 stated they are a supervisor, and work on the 3rd, 4th, and 5th floors. Registered Nurse #1 also stated the 2nd, 3rd and 5th floors are a priority when it comes to staffing and must have five (5) Certified Nursing Assistants on the day shift. Registered Nurse #1 further stated the rest of the units can work with four (4) Certified Nursing Assistants on the day shift. Registered Nurse #1 stated staff report that on weekends they are working with less than the required number of Certified Nursing Assistants and nurses at times. Registered Nurse #1 also stated due to chronic staff call outs, which are often late, it becomes difficult to replace the absent staff. Registered Nurse #1 further stated staffing has improved since the new Director of Nursing came to the facility. Registered Nurse #1 stated the facility is tracking and disciplining staff who call out chronically, or are no call, no shows. Registered Nurse #1 also stated it is not easy for a floor that needs five (5) Certified Nursing Assistants to work with three, but staff get the work done. During an interview on 03/03/2026 at 10:24 AM, Certified Nursing Assistant #6 stated the staffing is not good, especially on the weekends. Certified Nursing Assistant #6 also stated they work on the Trach/Vent unit, and at times missing even one Certified Nursing Assistant can make a difference. Certified Nursing Assistant #6 further stated staffing can be much better. Certified Nursing Assistant #6 stated when working with less than the required staff, they must work together to get the care done, because most of the residents on the unit are two plus person assist. Certified Nursing Assistant #6 also stated they have worked in this facility for four years and the staffing is poor, although it recently has gotten better because the state inspectors are here. During an interview on 03/03/2026 at 9:48 AM, Licensed Practical Nurse #9 stated the staffing, especially on the weekends, is not good for the Certified Nursing Assistants. Licensed Practical Nurse #9 also stated at times on the weekends missing one or two Certified Nursing Assistants for the unit makes it difficult for them to administer care, especially when two-person assistance is needed. Licensed Practical Nurse #9 further stated the nurses then must do other duties, including dining room monitoring, help with feeding, help with patient care if two people are needed to administer care, or even do patient care to assist the Certified Nursing Assistants to complete their tasks. Licensed Practical Nurse #9 stated they must assist especially if short two Certified Nursing Assistants, and as a result their nursing work is not done timely, as patient care is important. Licensed Practical Nurse #9 also stated staffing has improved since the new Director of Nursing came to the facility, and there have been talks with the union about staffing but not much has changed. During an interview on 03/03/2026 at 8:58 AM, the Administrator stated they were aware of the one-star staffing rating and excessively low staffing on the weekend for the facility in the past. The Administrator also stated once the current Director of Nursing came to the facility, the Director has been aggressive in bringing in staff by working with multiple agencies, recruitment of staff, advertisements and monthly orientation to staff the facility. The Administrator stated the staffing has improved and continues to improve. During an interview on 03/02/2026 at 10:27 AM, the Director of Nursing stated they took over the position in May 2025 and did a review of the staffing par levels for the facility and did not like the staffing pattern. The Director of Nursing also stated immediately started working with four (4) different agencies to correct the staffing pattern. The Director of Nursing further stated the facility had an issue with staffing, but they believe the issue is now corrected. The Director of Nursing stated they have monthly orientation to bring in new staff, and this has significantly improved the staffing for the facility at present. The Director of Nursing also stated they could not work with the previous staffing pattern and corrected this to improve the staffing as it is today. During an interview on 03/02/2026 at 10:15 AM, the Staffing Coordinator stated the current staffing has improved and stated that during the summer months from July to September staff were on vacation, many staff called out on the weekends, and staff often called out when they are scheduled to work. The Staffing Coordinator also stated there are par levels for each unit which are (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	given to them by the Director of Nursing. The Staffing Coordinator further stated they placed the staff on the unit based on the par levels, and if census is low, they will change the levels to lower the number of staff needed or do not replace a staff who calls out. The Staffing Coordinator stated at times there may be extras on the floor due to residents on one-to-one supervision, or increased census. The Staffing Coordinator also stated there are also Paid Unit Assistants who help to monitor the dining room, feed the residents, or do one to one supervision. The Staffing Coordinator further stated the facility continues to work with some staffing agencies; however, staffing is a constant struggle due to the staff call outs on the weekends. The Staffing Coordinator stated the supervisors will call staff to see who is available to work, as well as ask staff if they want to work overtime to replace the call outs or to replace the no calls, no shows. The Staffing Coordinator also stated the facility uses a lot of overtime, and staff call out more on the weekends than on the weekdays. Union staff are required to pay back the weekend they called out on, but this does not work because they are usually scheduled to work the next weekend anyway. The Staffing Coordinator further stated that despite working with multiple agencies, the no call, no shows, and call outs contributed to the less-than-optimal staffing. During an interview on 03/02/2026 at 9:26 AM, Certified Nursing Assistant #7 stated staffing on the weekend is not good and the facility does try to give enough staff. Certified Nursing Assistant #7 also stated they work short at times at the weekend and when they work short, they will leave the residents in bed or will put off showers for another day. Certified Nursing Assistant #9 further stated staff work together to get the work done, but multiple residents will be left in bed due to the shortage of staff. During an interview on 03/02/2026 at 9:36 AM, Licensed Practical Nurse #6 stated good staffing depends on the day. Licensed Practical Nurse #6 also stated they work every other weekend, and on the weekends, staff call out and the unit often works short. Licensed Practical Nurse #6 further stated if the unit is supposed to have five (5) Certified Nursing Assistants, the unit would have four (4) or sometimes three (3) because of call outs. Licensed Practical Nurse #6 stated the staff will take residents who need monitoring for falls out of bed, and some residents will remain in bed because of the shortage of staff. During an interview on 03/02/2026 at 9:49 AM, Certified Nursing Assistant #8 stated the staffing is very bad, especially on the weekends and at times work with three (3) staff for 45 residents. Certified Nursing Assistant #8 also stated the staffing has been very bad, especially this winter. Certified Nursing Assistant #8 further stated staff works the best they can, and they make sure the residents eat, and are not wet and stated when short residents may not be taken out of bed. Certified Nursing Assistant #8 stated there is so much to do when working with only three (3) staff so some residents will be taken out of bed, such as those who are at risk of falls as they will try and get out of bed on their own, and the other residents will remain in bed. Certified Nursing Assistant #8 also stated when working short the nurse will help by feeding the residents and monitoring the dining room. 10 New York Codes, Rules, and Regulations 415.13(a)(1)(i-iii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 2 Based on observation, interviews, and record review conducted during the Recertification survey conducted, the facility did not ensure residents unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene. This was evident for two (2) of 5 (five) residents (Resident #86 and Resident #253) reviewed for Activities of Daily Living out of 38 total sampled residents. Specifically, Resident #86 and Resident #253 were unable to cut their own fingernails and did not receive staff assistance to do so. The findings are:The facility policy titled Activities of Daily Living (ADL) last reviewed 11/12/2025 stated the facility is to ensure that all residents receive assistance with Activities of Daily Living. It also documented Activities of Daily Living include, but is not limited to grooming 1). Resident #86 had diagnoses which included hemiplegia and hemiparesis following cerebral infarction (weakness on one side of the body after a stroke) affecting the right dominant side, and muscle weakness. The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #86 had severely impaired cognition, did not reject care, and required partial/moderate assistance of staff for personal hygiene. On 02/24/2026 at 11:22 AM, Resident #86 was observed with fingernails that were approximately a half inch long beyond their fingertips. Resident #86 was interviewed and stated they were not able to cut their fingernails and required assistance. Resident #86 also stated no staff had provided them with the necessary assistance to cut their fingernails since their admission to facility in late November 2025. Resident #86 further stated their child would cut their fingernails when they were in the community. During multiple observations from 02/24/2026 at 11:22 AM to 03/02/2026 at 9:47 AM, Resident #86 was observed having their fingernails uncut. Resident #86 stated no staff asked or offered the necessary nail care to them during the period. The comprehensive care plan Activities of Daily Living All Tasks - Total Assistance initiated 11/28/2025 documented Resident #86 requires total assistance in all tasks related to weakness and debility following hospitalization. On 03/03/2026 at 9:29 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #86 was alert and oriented and did not refuse care. Certified Nursing Assistant #1 also stated they observed Resident #86 had long fingernails recently. Certified Nursing Assistant #1 further stated they asked Resident #86 one (1) time about three (3) weeks ago if they wanted fingernails to be cut and Resident #86 refused. Certified Nursing Assistant #1 stated they did not ask Resident #86 about cutting fingernails since then. Certified Nursing Assistant #1 also stated the fingernails were not that long three (3) weeks ago. Certified Nursing Assistant #1 further stated they should have asked Resident #86 to cut fingernails regularly when the fingernails grew beyond the fingertips. Certified Nursing Assistant #1 further stated nail clippers available at the nursing station. On 03/02/2026 at 10:32 AM, Licensed Practical Nurse #4 was interviewed and stated the certified nursing assistants were responsible for cutting the fingernails for residents. Licensed Practical Nurse #4 also stated Resident #86 was transferred to the unit for one (1) month now. Licensed Practical Nurse #4 further stated they did not pay attention to Resident #86's fingernails when administering medications. Licensed Practical Nurse #4 made an observation of Resident #86's fingernails, which were approximately a half inch long beyond their fingertips, with the State Surveyor. Licensed Practical Nurse #4 stated the certified nursing assistant should have cut Resident #86's fingernails and that there are nail clippers for residents available at the nursing station. 2). Resident #253 had diagnoses which included Alzheimer's disease. The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #253 had moderately impaired cognition, did not reject care, and required partial/moderate assistance for personal hygiene. On 02/24/2026 at 10:38 AM, Resident #253 was observed with fingernails that were approximately a half inch beyond their fingertips. Resident #253 was interviewed and stated they required staff to cut their fingernails for them and had not had their fingernails cut for a few weeks. Resident #253 also stated they wanted their long fingernails to be cut. During multiple (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations from 02/24/2026 at 10:38 AM to 03/02/2026 at 9:50 AM, Resident #253 was observed with uncut fingernails. Resident #253 stated no staff asked or offered the necessary nail care to them during the period. The comprehensive care plan titled Activities of Daily Living/Rehab: Functional Abilities (Self-care) initiated 12/16/2025 documented Resident #253 had self-care limitations related to metabolic encephalopathy (change in brain function due to changes in the body) and Alzheimer's disease and required partial/moderate assistance for personal hygiene.On 03/02/2026 at 10:04 AM, Certified Nursing Assistant #2 was interviewed and stated Resident #253 was alert and able to make needs known. Certified Nursing Assistant #2 also stated they checked fingernails for residents when providing care. Certified Nursing Assistant #2 further stated they were able to cut fingernails for residents. Certified Nursing Assistant #2 stated fingernails were considered long when they grew beyond fingertips. Certified Nursing Assistant #2 also stated they observed Resident #253 had fingernails about half inch beyond their fingertips. Certified Nursing Assistant #2 further stated they did not ask Resident #253 if they wanted their fingernails to be cut or offered nail care because they were busy with other things. On 03/02/2026 at 10:13 AM, Licensed Practical Nurse #5 was interviewed and stated they did not recall if Resident #253 had long fingernails when they administered medications to them. Licensed Practical Nurse #5 also stated they were not sure if Certified Nursing Assistant should cut fingernails for residents. On 03/02/2026 at 11:18 AM, Registered Nurse #2 was interviewed and stated it was the responsibility of the certified nursing assistant to check fingernails during resident care and cut the fingernails when they were long. Registered Nurse #2 also stated nail clippers were available for each resident at nursing station. Registered Nurse #2 further stated the fingernails were considered long when they were beyond the fingertips. On 03/02/2026 at 12:35 PM, the Director of Nursing was interviewed and stated the certified nursing assistant was responsible for providing basic fingernail care including cutting long fingernails. The Director of Nursing also stated the fingernails were considered long when they grew beyond the fingertips unless the residents wanted the long nails. 10 New York Code, Rules, and Regulations 415.12(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335673	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Four Seasons Nursing and Rehabilitation Center	1555 Rockaway Parkway Brooklyn, NY 11236

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review, and staff interview conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled in accordance with currently accepted professional principles. This was evident for one (1) prescription eye drop bottle on Unit 6 and one (1) prescription eye drop bottle on Unit 3 observed during the Medication Storage task. Specifically, two (2) opened (Latanoprost) prescription eye drops currently being used were not dated when opened. The findings are: The facility policy titled Policy on Storage of Over-The-Counter Medications on Units approved June 2008, stated that it is the policy of the facility that all medications deliver to the medication units will be stored according to federal and state guidelines. The facility policy included information on the storage of controlled substances, refrigerated medication storage, the emergency box, and over-the-counter medications but did not include policies related to prescription eye drops. The Xalatan Package Insert for Xalatan latanoprost ophthalmic solution dated August 2011 documented once a bottle is opened for use, it may be stored at room temperature up to 25 C (77 F) for 6 (six) weeks. On 03/02/2026 at 10:04 AM, during the Medication Storage task, an observation was made on Unit 6 of Resident #220s Latanoprost 0.005% prescription eye drops with an expiration date of 09/2027. The eye drops were open and in use but were not dated with an open date.Licensed Practical Nurse #1 was interviewed immediately and stated that they do not ever label eye drops when they open them and that they use the printed expiration date on the eye drop bottle to determine when to dispose of it.On 03/03/2026 at 09:51 AM, during the Medication Storage task, an observation was made on Unit 3 of Resident #102's Latanoprost 0.005% prescription eye drops with an expiration date of 10/2028. The eye drops were open and in use but were not dated with an open date. Licensed Practical Nurse #2 was interviewed immediately and stated that they do not label eye drops in the facility with open dates because the eye drops used in the facility are safe to use until the printed expiration date on eye drop bottle. Licensed Practical Nurse #2 also stated they did not know when the Latanoprost eyedrops were opened.On 03/03/2026 at 12:00 PM, Registered Nurse #4 was interviewed and stated that the nurse who opens the eye drops is responsible for labeling them with the open date. Registered Nurse #4 also stated nurses receive annual training related to this, and that they also verbally remind the nurses who they supervise. On 03/03/2026 at 12:48 PM, Registered Nurse #1 was interviewed and stated that all eye drops must be labeled with an open date by the person who opens them because some eye drops have their own expiration dates that differ from the bottle's expiration date, based on their stability and shelf life. Registered Nurse #1 also stated the pharmacy department reviews the carts on the unit daily to ensure compliance. Registered Nurse #1 further stated that they also try to review the cart each shift to ensure compliance. On 03/03/2026 at 12:56 PM, the Director of Pharmacy was interviewed and stated that the Latanoprost prescription eye drops require an open date to be labeled on the prescription bottle because they must be discarded after six (6) weeks of opening them. The Director of Pharmacy also stated they do unit evaluations at least once per month where they review the medication carts, including eye drop medications, and they had not previously identified unlabeled Latanoprost eyedrops to be an occurring concern on the units. On 03/03/2026 at 01:00 PM, the Director of Nursing was interviewed and stated that the Latanoprost prescription eye drops should be labeled with an open date, so staff know when to dispose of them. The Director of Nursing also stated nurses receive quarterly in-service education related to medication storage, including education on eye drop storage and labeling. 10 New York Code, Rules, and Regulations 415.18(e)(1-4)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335673	A. Building B. Wing	03/03/2026

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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 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 interviews conducted during the Recertification survey, the facility did not ensure that infection control protocols were followed. This was evident for one (1) of one (1) resident (Resident #8) reviewed for Respiratory Care out of 38 sampled residents. Specifically, Resident #8 was being maintained on contact precautions and Certified Nursing Assistant #6 did not don appropriate Personal Protective Equipment (PPE), including gown and gloves, when entering their room and also failed to perform hand hygiene prior to exiting the room. The findings are:The facility policy titled Infection Prevention and Control Guidelines revised on 08/2025 stated the facility establishes and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The policy also stated hand hygiene is to be done before and after entering an isolation precaution setting. The policy further stated Contact Precautions requires the use of appropriate Personal Protective Equipment (PPE), including a gown and gloves upon entering the contact precaution room. Prior to leaving the contact precaution room the Personal Protective Equipment is removed, and hand hygiene is performed. Resident #8 was admitted to the facility with diagnosis that includes Candida Auris and Multidrug-Resistant Organism.A Physician's Order dated 01/05/2026 documented Resident #8 is on contact isolation precautions for Candida Auris. On 02/26/2026 at 09:00 AM, a sign was observed on the front of the Resident #8's room door that indicated Contact Isolation and that gloves, and gowns are required prior to entering the room. A compartment holder that contained blue gowns and gloves, and masks was observed on the door.On 02/26/2026 at 09:00 AM, Certified Nursing Assistant #6, who was holding a container of wipes, entered Resident #8's room without first donning personal protective equipment. Certified Nursing Assistant #6 was then observed handing Resident #8 a wipe and then exited the room without performing hand hygiene. Certified Nursing Assistant #6 was then observed donning a blue gown and entered another resident room without performing hand hygiene. On 02/26/2026 at 09:05 AM, Certified Nursing Assistant #6 was interviewed and stated they did observe the Contact Isolation sign on Resident #8's room door. Certified Nursing Assistant #6 further stated they were only handing Resident #8 a wipe and stated they know that they should have put on the personal protective equipment before going into the room. On 02/26/2026 at 09:10 AM, Registered Nurse #1, the Nursing Supervisor for the unit, was interviewed and stated the facility process for infection control when entering a room where a resident is on contact precautions is that staff are to knock on the door to make sure it is okay for them to enter and then they are to put on Personal Protective Equipment (PPE) that includes a gown, gloves, and mask. Registered Nurse #1 also stated that before staff leave the room, they have to remove the Personal Protective Equipment and wash their hands. On 02/26/2026 at 09:30 AM, the Infection Control Preventionist was interviewed and stated they had heard what had occurred and are in the process of in-servicing the staff. The Infection Control Preventionist also stated staff are supposed to wear a gown when entering the residents' room on contact precautions to prevent spreading infection from one resident to another resident. 10 New York Code, Rules, and Regulations 415.19 (a)(1-3)(b)1