STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335677	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheepshead Nursing & Rehabilitation Center	2840 Knapp St 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an Abbreviated Survey (538273), the facility failed to ensure that an alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later that two (2) hours after the allegation is made, if the events that caused the allegation involved or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involved abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency and adult protective services where state law provides for judications in long term care facilities) set forth at S483.12(c)(1). This was evident for one (1) out of three (3} residents sampled (Resident #1). Specifically, on 01/31/2025, the Director of Nursing received a call from a detective at the Attorney General's office stating after Resident #1 was discharged , they reported that sometime between 01/09/2025 and 01/16/2025 staff at the facility pulled their arm. The facility investigated the alleged allegation of abuse but did not report it to New York State Department of Health. The findings are:The facility's policy and procedure titled Abuse dated 01/2020 stated all employees will be trained and knowledgeable about the facility's abuse prevention policy. Training will be provided upon hire, annually and as needed. Suspicion of an abuse will be reported to Law Enforcement and the State Survey Agency. If the crime involves serious bodily injury, it must be reported immediately but no later than two hours after forming the suspicion. In addition, If the crime does not appear to cause serious bodily injury, it must be reported withing 24 hours. The policy stated, Public Health Law 2803-d requires that reports of physical abuse, mistreatment or neglect must be reported to the New York State Department of Health.Resident #1 was admitted to the facility on [DATE] with diagnoses including schizophrenia, transient cerebral ischemic attack, and hypertension.The Minimum Data Set {an assessment tool} dated 12/03/2024, documented Resident #1 had moderately impaired cognition.The facility's Summary of Accident/Incident Report dated 02/02/2025, documented that facility received a complaint from the Office of Attorney General on 01/31/2025 stating that Resident #1 reported that two unknown males and one female pulled their arm between 01/09/2025 and 01/16/2025-. Resident #1 was discharged to the group home on [DATE]. The facility investigation concluded that abuse did not occur. A review of nursing/medical/social workers' notes from 12/2024 through 01/13/2025 revealed no documented evidence of reported abuse. No documented evidence of Resident #1 being assessed with any bruising, redness, or injuries of unknown source. There was no documented evidence that the facility reported the alleged abuse to the State Agency (New York State Department of Health).During an interview on 02/19/2026 at 10:00 AM, the complainant stated they worked at the group home as a dietitian. Resident #1 was discharged from the nursing home on [DATE]. On 01/16/2025, Resident #1 told them between 01/09/2025/and 01/16/2025, two males and a female pulled their arm, and it hurt. The dietitian reported the allegation to an agency. During an interview on 02/19/2026 at 12:30 PM, Certified Nursing Assistant #2 stated they were assigned to Resident #1 from 01/09/25 on the 7:00 am to 3:00 PM shift until Resident #1 was discharged on 01/13/2025. Certified Nursing Assistant #2 stated Resident #1 was alert, confused and was mainly in (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their wheelchair. They stated Resident #1 did not complain of pain or anyone pulling their arm. Certified Nursing Assistant #2 stated they recalled three weeks after Resident #1 was discharged , The Director of Nursing interviewed them and asked if they received any complaints from Resident #1 about pain or staff pulling their arm. Certified Nursing Assistant #2 stated they could not recall any complaints. They stated that they received in-service on abuse prior to the allegation. During an interview on 02/19/2026 at 1:30 PM the Director of Nursing stated on 01/31/2025, they received a call from a Detective assigned to the Attorney General's office. The Detective stated they received complaint from the Department of Health stating that Resident #1 complained about staff pulling their arm sometime between 01/09/2025 and 01/16/2025. The Director of Nursing stated Resident #1 was discharged from the facility on 01/13/2025. The Director of Nursing stated they interviewed staff who were assigned to Resident #1 during that period and alleged abuse was unknown. The Director of Nursing stated the Office of Attorney General told them no further action was needed by the facility, and the Department of Health had the allegation. The Director of Nursing stated they were aware of the guidelines for reporting to the Department of Health but were guided that it was not necessary to report since the Department of Health already received the complaint from the Office of Attorney General. The Director of Nursing stated the Administrator was aware. During a follow up interview on 02/19/2026 at 2:30 PM, the Director of Nursing stated they investigated the allegation on 02/02/2025 and interviewed/collected statements from staff. The Director of Nurses stated the investigation concluded there was no evidence that abuse occurred. During an interview on 02/19/2026 at 2:00 PM, the Administrator stated they could not recall the incident nor the report from the Office of Attorney General. However, based on the information, it was not necessary to report the complaint to the New York State Department of Health since the resident was discharged . 10 New York Codes Rules and Regulations 415.4 (b)