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	04/24/2024

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49169 Based on record review and interviews conducted during the Recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure that resident and/or resident's designated representative were offered the opportunity to participate in the revision and/or review of the comprehensive care plan. Specifically, resident and/or resident's designated representatives were not invited to participate in their care plan meetings. This was evident for 3 of 4 residents reviewed for Care Plan (Residents #82, #111, and #104). The findings are: The facility Policy and Procedure titled Comprehensive Care Plan reviewed 01/2024 documented that the resident and/or responsible party are members of interdisciplinary care team and are encouraged to actively participate in the development and review of comprehensive care plan. It also documented that each resident and responsible party will be notified by the Social Service department of the date and time for each interdisciplinary care team meeting. 1) Resident #82 was admitted with diagnoses that include Peripheral Vascular Disease and Coronary Artery Disease. The Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #82 was moderately cognitively impaired. On 4/17/24 at 10:57 AM, Resident #82 was interviewed and stated they had not been invited to attend any care plan meeting. The comprehensive care plan form located in the paper chart was blank. The Care Plan Meeting Report dated 7/7/2023 to 4/24/2024 documented that Resident #82 was scheduled for care plan meeting on 7/07/2023, 7/27/23, 10/26/2023, 1/18/2024, and 4/16/2024. The Care Plan Meeting Report dated 4/16/2024 documented that Resident #82, their representative, Nurse #1, Attending Physician, Rehab, Registered Dietician #1, the Director of Rehab, and Social Worker #1 were in attendance at the care plan meeting. (continued on next page)

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The notice of the Comprehensive Care Meeting dated 10/16/2023 was addressed to Resident #82's Representative and documented that meeting was scheduled to be on held on that same date (10/16/23) between 10:30am and 11:30am. A copy of the envelope mailed to Resident #82's Representative was dated October 16 2023. The notice of the Comprehensive Care Meeting dated 4/8/24 was addressed to Resident #82's Representative and documented that meeting was scheduled to be on held on 4/18/24 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #82's Representative was dated April 08 2024. There was no documented evidence Resident #82 was invited to participate in their care planning meetings. On 04/19/24 at 12:58 PM, Social Worker #1 was interviewed and stated that Resident #82 has been attending care plan meeting. Social Worker#1 also stated that Resident #82 was notified verbally in person and on the phone about upcoming meetings. Social Worker #1 further that stated since Resident #82 has been on the current unit they may have participated in the care plan meeting once. On 04/19/24 at 12:58 PM, Registered Nurse #1 was interviewed and stated they attended the care plan meeting held with Resident #82 on 4/18/24. Registered Nurse #1 also stated that Resident #82's representative was present. Registered Nurse #1 further stated that the meeting on 4/16/2024 was held on the second-floor conference room where Social Worker #1 was present. Registered Nurse #1 stated they were in the meeting for 10 minutes, answered nursing related questions and then left the meeting. On 04/19/24 at 2:47 PM, Registered Dietician #1 was interviewed and stated they meet in Social Worker #1's office for care planning meetings. Registered Dietician #1 also stated that they think they attended the care plan meeting on 4/16/2024. On 04/19/24 03:22 PM, an interview was conducted with the Attending Physician who stated they participated in the April 16 care planning meeting via telephone. The Attending Physician also stated that according to Social Worker #1, Resident #82 was present and the meeting was held in Social Worker #1's office on the third floor. Attending physician stated they heard Resident #82's voice in the meeting. On 04/19/24 at 02:54 PM, an interview was conducted with the Director of Rehab who stated that the care plan meeting on 4/16/2024 was held in the Social Service office on the 3rd floor. The Director of Rehab stated Resident #82 did not attend the meeting on 04/16/2024 and only the Director or Rehab and Social Worker #1 were present at the meeting. 2) Resident #111 was admitted with the diagnoses that included Non-Alzheimer's Dementia, Parkinson's Disease. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented that Resident #111 was moderately cognitively impaired. On 04/19/24 at 10:37 AM, an interview was conducted with Resident #111's Representative who stated that they have not been called to attend a care plan meeting. Resident #111's Representative also stated they received a letter in the mail for care plan meeting, but the letter arrived late after the meeting occurred and were not called to schedule a care plan meeting. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Care Plan Meeting Report dated 1/10/2023 to 4/23/2024 documented that Resident #82 was scheduled for care plan meeting on 1/24/23, 3/30/2023, 7/6/23, 10/02/2023, 01/02/2024, 03/26/2024. The Care Plan Meeting Report dated 10/02/2023, 01/02/2024, 03/26/2024 documented that Resident #111's Representative was in attendance at the care plan meeting. The notice of the Comprehensive Care Meeting dated 01/17/2023 was addressed to Resident #111's Representative and documented that meeting was scheduled to be on held on 01/24/2023 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #111's Representative was dated January 13 2023 which was four days before the date of the letter. The notice of the Comprehensive Care Meeting dated 03/21/23 was addressed to Resident #111's Representative and documented that meeting was scheduled to be on held on 03/30/2023 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #111's Representative was dated March 21 2023. The notice of the Comprehensive Care Meeting dated 06/26/2023 was addressed to Resident #111's Representative and documented that meeting was scheduled to be on held on 07/06/23 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #82's Representative was dated June 16 2023, which was 10 days before the date of the letter. The notice of the Comprehensive Care Meeting dated 09/25/2023 was addressed to Resident #111's Representative and documented that meeting was scheduled to be on held on 10/02/2023 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #111's Representative was dated September 20 2023 which was 5 days before the date of the letter. The notice of the Comprehensive Care Meeting dated 12/27/2023 was addressed to Resident #111's Representative and documented that meeting was scheduled to be on held on 01/02/2024 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #111's Representative was dated December 15 2023 which was 12 days before the date of the letter. The notice of the Comprehensive Care Meeting dated 03/19/2024 was addressed to Resident #111's Representative and documented that meeting was scheduled to be on held on 03/26/2024 between 10:30am and 11:30am. A copy of the envelope mailed to Resident #111's Representative was dated March 19 2024. The facility could provide no evidence on when the notices for the meetings were actually mailed out from the facility. On 04/19/24 at 12:15 PM, an interview was conducted with the Director of Discharge Planning (also the Social Worker for the unit) who stated that family members are sent invitations to care plan meetings by mail which are sent 10-14 days before the meeting date. The Director of Discharge Planning also stated that they will follow up with the family within a week and on the day of meeting they will contact the family member again. The Director of Discharge Planning further stated that the secretary sends out the invitation letter to family member for upcoming care plan meetings. The Director of Discharge Planning stated they have unused postage stamps that they have not used in the past so date on the postage stamp cannot be used as the date letter was sent and the date of the invitation is what should be used. The Director of Discharge Planning stated that they never received a response from Resident # 111's Representative regarding care plan meetings. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/24 at 12:47 PM, an interview was conducted with Social Worker #1 who stated no family has attended care planning meeting and Resident #111's Representative has been invited to care plan meetings. On 4/19/24 at 3:00pm, the Director of Discharge Planning was re-interviewed and stated that what is documented in the medical record may not reflect actual attendance at meetings. The Director of Discharge Planning stated that sometimes after the meetings are conducted with the various disciplines, if family or resident was not in attendance at the meeting they would be informed about what was discussed. This is then reflected in the electronic medical record as their participation in the meeting. 44843 3. Resident #104 had diagnoses which included Acute Respiratory Failure with hypoxia, Depression, and Hypothyroidism. The Admission Minimum Data Set assessment dated [DATE] documented Resident #104 was cognitively intact and only Resident #104 participated in the assessment. On 04/17/2024 at 10:41 AM, Resident #104 was interviewed and stated they were admitted to the facility in January 2024. Resident #104 stated that they would like to participate in care planning meetings but had not been invited. Resident #104 further stated that their Representative received a letter of invitation to attend, however Resident #104 was at therapy when the care plan meeting was held with Resident #104's representative instead. Resident #104 stated the Director of Discharge Planning (also the Social Worker for the unit) did not meet with them on that day or any time after to discuss their comprehensive care plans with them. The Social Services notes from 1/25/2024 to 3/13/2024 did not document Resident #104 was invited to the care plan meeting or that the Social Worker met with Resident #104 to discuss their comprehensive care plans. The Social Services note dated 2/6/2024 documented it was the initial care plan meeting and Resident/Family were present at the meeting. The Care Plan Meeting Report dated 2/6/2024 documented Resident #104 and Resident's Representative attended the care plan meeting. On 04/17/2024 at 10:52 AM, the Resident Representative was interviewed and stated that they received a letter of invitation and attended the care plan meeting scheduled on 2/6/2024. The Resident Representative stated that Resident #104 was at therapy and the interdisciplinary team did not wait for Resident #104 to come to the meeting, so Resident #104 did not participate in the care plan meeting at all. On 04/22/2024 at 10:49 AM, Registered Nurse #2, (also the nursing supervisor for the floor) was interviewed and stated Resident #104 was alert and oriented and made decisions for themselves. Registered Nurse #2 also stated that the Social Worker was responsible for inviting the resident and/or their designated representative to the care plan meeting. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/22/2024 at 11:34 AM, the Director of Discharge Planning (also the Social Worker for the unit) was interviewed and stated Resident #104 was cognitively intact and made decisions for themselves. Resident #104 did not attend the initial care plan meeting on 2/6/2024 because they were receiving therapy when the care plan meeting was held, so the care plan meeting was held with the Resident #104's Representative only. The Director of Discharge Planning also stated that they invited Resident #104 to the care plan meeting verbally and mailed the invitation to the representative. The Director of Discharge Planning further stated that they did not document in the medical record that Resident #104 was invited to the care plan meeting. The Director of Discharge Planning stated that although Resident #104 did not attend the care plan meeting on 2/6/2024, they checked Resident #104 as present for the care plan meeting because they met and discussed the care plans with Resident #104 later on in the day when Resident #104 returned from therapy. On 04/22/2024 at 01:46 PM, the Administrator was interviewed and stated the staff should document what they did for the resident or what happened to the resident in the medical record. The Administrator also stated if it was not documented, it was considered not done. The Administrator had no explanation why the Social Worker documented Resident #104 attended the initial care plan meeting on 2/6/2024 while they actually had not been present at the meeting. 10 NYCRR 415.3(f)(1)(v)

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observations and interviews conducted during the Recertification survey from 4/17/24 to 4/24/24, the facility did not ensure that information regarding the Ombudsman program and the New York State Nursing Home Complaint Hotline were posted in a manner accessible to residents and resident representatives. Specifically, notices were posted in a bulletin board on one side of the unit only that was frequently obstructed by medication carts. The findings are: On 04/19/24 at 10:02 AM, the Resident Council meeting was held with nine residents. Six out of nine residents who regularly attended the meetings stated that they did not know where the Ombudsman's contact information was posted and how to formally complain to the State about the care they are receiving. Observations were made on 04/19/24 AM between 09:20 AM and 02:33 PM on all units (Units 1 to 5) of the facility. Notices were observed on resident units that documented the information related to contacting both the Ombudsman's office and the New York State Nursing Home Complaint Hotline however, the notices were displayed in an enclosed bulletin board on the right hand side of the unit. Notices were not observed posted in a centralized location where they could be seen by residents and family members of residents residing on both sides of the unit. On 4/22/24 at 11:30 AM, 4/23/24 at 03:05 PM and 04/24/24 at 12:48 PM, and during multiple other observations of all five resident units (Units 1-5), a bulletin board was observed on the right side of the unit. Multiple postings were observed in the bulletin board, but access to each bulletin board was obstructed by a medication cart which was stored under the bulletin board when the medication cart was not in use. On 04/24/24 at 12:04 PM, the Resident Representative for Resident #185 was interviewed and stated that Resident #185 had been admitted a number of times since 2022, and they did not know where to find information on how to contact the Ombudsman. On 04/24/24 at 12:35 PM, an interview was conducted with the Resident Representative for Resident #5 who stated they have visited the facility for [AGE] years and did not know who the Ombudsman was and where that information was located. On 04/24/24 at 12:43 PM, the Resident Representative of Resident #176 who was recently admitted was interviewed and stated they did not know where to find the information to contact the Ombudsman. On 04/19/24 at 02:50 PM, the Director of Recreation was interviewed and stated that Administration is responsible for ensuring signs are posted in the facility. The Director of Recreation also stated that this information may have been discussed in Resident Council meetings and notices were given prior to the resident's admission. (continued on next page)

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/19/24 03:16 PM, the Assistant Administrator was interviewed and stated that they thought all the residents were aware about the Department of Health hot line number and Ombudsman agency information. The Assistant Administrator also stated that there is a sign on each floor telling them where to locate information. 10 NYCRR 415.3 (1)(c)(1)(vi)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33315 Based on observations and interview conducted during the Recertification survey from 4/17/24 to 4/24/24 the facility did not ensure that the most recent survey results and plan of correction were posted in a place readily accessible to residents, family members, and legal representatives of residents and did not post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. Specifically, survey results were posted in the Family Room on the 2nd Floor and notices regarding the availability of the survey results were not readily accessible. In addition, members of the Resident Council were interviewed and reported that they did not know where survey results were posted or accessible for residents to review. The findings are: On 04/19/24 at 10:02 AM, the Resident Council meeting was held with nine residents. The residents were asked if they had knowledge of where the most recent survey results were posted or located, and all the nine residents stated that they did not know where to locate the survey results. On 04/19/24 at 01:45 PM, a binder containing the survey results were observed in the 2nd floor family room. The 2nd floor Family Room is located near the day room, and the door was observed closed. On 4/22/24 at 11:30 AM, 4/23/24 at 03:05 PM and 04/24/24 at 12:48 PM, and during multiple other observations of all five resident units (Units 1-5), a bulletin board was observed on the right side of the unit. Multiple postings were observed in the bulletin board, Included among the postings was a notice which contained information about visiting hours, survey results being located in the 2nd Floor Family Room, CMS Star Rating and Compliance Box. The font was not easily readable from a distance or from a wheelchair in the hallway. In addition, access to the bulletin board was obstructed by a medication cart which was stored under the bulletin board when the medication cart was not in use. 42101 On 04/24/24 at 11:46 AM, the Resident Representative for Resident #29 was interviewed and stated that when they come into they come into the building, they walk to the elevator and they have no idea where to find the survey results. Resident Representative for Resident #29 also stated that the survey results are important so they know how residents are being treated and what is going on in the building. 44843 On 04/24/24 at 11:48 AM, the Resident Representative for Resident #141 was interviewed and stated they visited Resident #141 almost every day since the admission to facility in 2022 and they did not know where to find the state survey results in the facility. On 04/24/24 at 12:04 PM, the Resident Representative for Resident #185 was interviewed and stated that Resident #185 had been admitted a number of times since 2020, and they did not know where to find the survey results if they wanted to read it. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49169 On 04/24/24 at 12:35 PM, the Resident Representative for Resident #5 and stated that they have visited their relative at the facility for over [AGE] years and did not know where the survey results were located and had never seen them. On 04/19/24 at 02:50 PM, an interview was conducted with the Director of Recreation who stated that the Family Room is used for multipurpose events like parties, religious event, and arts and crafts. The Director of Recreation also stated that the room is always close but not locked, and that anyone can go to the room at any time. The Director of Recreation further stated that they usually let the residents know that the survey results are in the binder in family room. The Director of Recreation stated that they do not go to every floor to inform residents of the location of the survey results but only informed residents when they go to the 2nd floor. On 04/19/24 at 03:16 PM, the Assistant Administrator was interviewed and stated that the New York State Department of Health survey results are located on the 2nd floor Family Room. The Assistant Administrator also stated that there is a sign on each floor telling them where to locate the binder so, they can go to the 2nd floor if they want to see it and they have access and can get a copy of the results if they need one. 10 NYCRR 415.3(d)1)(v)

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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** 44843 Based on observation, interviews, and record review conducted during the Recertification survey from 4/17/2024 to 4/24/2024, 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 2 (Resident #169 and Resident #171) of 3 residents reviewed for Activities of Daily Living out of 38 total sampled residents. Specifically, Resident #169 and Resident #171 were observed with quarter to one-third inch fingernails beyond fingertips and did not receive staff assistance for trimming of long nails. The findings are: The facility policy titled Assisting the Resident with Activities of Daily Living (ADL) with a revised date of 01. 2024 documented the residents will be expected to maintain reasonable standards of hygiene and grooming during their stay at the facility. The policy also documented that the care staff will provide the necessary support in all activities of daily living functioning when autonomy and independence are no longer possible or feasible for the residents. 1. Resident #169 had diagnoses of Chronic Obstructive Pulmonary Disease and Anxiety Disorder. On 04/17/2024 at 11:03 AM, Resident #169 was interviewed and stated they had long fingernails and needed someone to trim the fingernails for them Resident #169 also stated that they asked the staff to trim the fingernails and the Certified Nursing Assistant told them that it was not their responsibility to trim the fingernails for residents. Resident #169's fingernails were observed to be about a quarter inch beyond their fingertips. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #169 required supervision or touching assistance for personal hygiene. The Comprehensive Care Plan titled ADL (Activities of Daily Living) - Self Care initiated 1/22/2024 documented Resident #169 required supervision/touching assistance for personal hygiene. The Certified Nursing Assistant Accountability Records from January 2024 to April 2024 had no documentation about fingernail trimming for Resident #169. The nursing progress notes dated 1/21/2024 to 4/22/2024 did not document Resident #169's fingernails were trimmed. On 04/22/24 at 10:03 AM, Certified Nursing Assistant #1 was interviewed and stated Resident #169 was cognitively intact, did not refuse care, and required assistance for personal hygiene. Certified Nursing Assistant #1 also stated they only trimmed the resident's fingernails if the nurse tells them to do so and they inform the nurse if the resident had long fingernails that needed to be trimmed. Certified Nursing Assistant #1 further stated that they considered fingernails beyond the fingertips to be long. Certified Nursing Assistant #1 stated they reported to the nurse on the unit that Resident #169's fingernails needed to be trimmed but they could not recall when they had reported. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) Resident #171 had diagnoses of Unspecified Atrial Fibrillation and Pain in right knee On 04/17/2024 at 11:15 AM, Resident #171 was interviewed and stated that their fingernails had not been trimmed since their admission to the facility about 2 months ago. Resident #171 also stated that they asked the Certified Nursing Assistant to trim them and staff had not trimmed the fingernails yet. Resident #171's fingernails were observed to be about a quarter to one-third of an inch beyond their fingertips. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident # 171 had no rejection of care and was dependent for personal hygiene. The Comprehensive Care plan titled ADL (Activities of Daily Living)-Self Care initiated 2/26/24 documented Resident #171 was dependent for personal hygiene. The Certified Nursing Assistant Accountability Record from [DATE] to April 2024 had no documented evidence that fingernails were trimmed for Resident #171. The nursing progress notes from 2/23/2024 to 4/22/2024 did not document that Resident #171's fingernails were trimmed. On 04/22/2024 at 10:20 AM, Certified Nursing Assistant #2 was interviewed and stated Resident #171 was cognitively intact and did not refuse care. Resident #171 required staff assistance for all activities of daily living. Certified Nursing Assistant #2 also stated that the nurse was responsible for trimming the resident's fingernail, and they reported to the nurse when the fingernails were beyond the fingertips as they were considered long and needed to be trimmed. Certified Nursing Assistant #2 further stated that they reported to the nurse on the unit that Resident #171 had long fingernails that needed to be trimmed but they could not recall when they had reported. On 04/22/2024 at 11:17 AM, Registered Nurse #1 was interviewed and stated they were the nurse assigned to both Resident #169 and Resident #171. Registered Nurse #1 also stated they were responsible for trimming the fingernails for residents or they supervised the Certified Nursing Assistants to do so. Registered Nurse #1 further stated that fingernails were considered long and needed to be trimmed when they grew beyond the fingertips, and they had observed Resident #169 and Resident #171 had long fingernails when they provided treatment and gave medications to them. Registered Nurse #1 stated that it was their error that Resident #169's and Resident 171's fingernails were trimmed in a timely manner. On 04/22/2024 at 11:55 AM, the Director of Nursing was interviewed and stated both the Certified Nursing Assistant and the nurse should trim resident's fingernails if they were long. The Director of Nursing also stated that fingernails needed to be trimmed if they grew beyond the fingertips. The Director of Nursing further stated they made rounds to the unit at least 3 times a day, they were not aware Resident #169 and Resident #171 had fingernails that were extending beyond the fingertips. 10 NYCRR 415.12(a)(3)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 49169 Based on interview and record review conducted during a Recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure that residents received proper treatment and assistive devices to maintain vision abilities. This was evident for 1 (Resident #82) of 1 resident reviewed for Communication/Sensory out of 38 total sampled residents. Specifically, Resident #82 did not receive an Ophthalmology consult in accordance with Medical Doctor order in a timely order. The findings are: The policy and procedure titled Consultations revised 1/2024 documented that it is the policy of Sheepshead Nursing and Rehabilitation Center to provide care and services including medical consultations to the residents to maintain or improve their highest practicable mental, psychosocial, and physical functional status. On 04/17/24 at 11:05AM, an interview was conducted with Resident #82 who stated that they have a small cataract on their eye and reported it to nurse. Resident #82 also stated that they had not been seen by the eye doctor. The Comprehensive Care Plan titled Vision created 07/10/2023 revised 04/10/2024 documented goal of resident will maintain current vision times 90 days. Interventions included assess, monitor, record, report to MD as needed, vision loss, vision changes, daily functions limited by visual problem. Assist/make arrangement for vision/eye consults ordered by MD and follow up as necessary. The Medical Doctor order dated 02/13/24 documented Ophthalmology consult, diagnosis decreased vision. The Ophthalmology consult dated 02/13/2024 for decreased vision documented on 03/05/2024 patient in shower not available. The consult also documented on 03/25/2024 that resident out of facility today. On 04/23/24 at 04:11 PM, an interview was conducted with Registered Nurse MDS (covering the unit as a supervisor) who stated that when residents are to be seen by in-house consultants the nurse prepares the consult and leaves it in the office. Registered Nurse MDS also stated that when the consultant arrives at the facility, they retrieve the pending consults from the office and then go to the unit to examine the resident. Residents are then informed by the nurse that the consultant is there to see them. Registered Nurse MDS further stated that they were not sure if they were given advance notice about when they would be seen by the consultant and whether or not appointments were scheduled or not. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 01:29, an interview was conducted with the Director of Nursing who stated that the doctor will place an order for the consultation, the nurse will pick up the order and place into the consult book and the consultant will be called to see the resident. The Director of Nursing also stated that the facility does not always know when the consultants are coming, and many times the nurses on the unit do not even know that the consultant is in the building. The Director of Nursing further stated that because they do not have a schedule for the consultant, it is difficult to let the residents know in advance when they will be seen so the resident can be prepared for the appointment. 10 NYCRR 415.12 (a)(3)(b)(1-3)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48711 Based on observations, record reviews, and staff interviews, during the Recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure that a resident received care consistent with professional standards of practice to prevent pressure ulcers. This was evident for 1 (Resident #150) of 3 residents reviewed for Pressure Ulcer. Specifically, during multiple observations, Resident #150 was observed without multipodus boot/brace in place as ordered. The findings are: The facility policy and procedure titled Heel Protectors: Application & Maintenance revised 1/2024 documented that the purpose of heel protectors is to provide comfort and protection to the resident's heel, prevent skin irritation, and maintain proper skin hygiene. Resident #150 was admitted with diagnoses which include Pressure Ulcer of left heel, unstageable, Dementia, and Depression. The Annual Minimum Data Set, dated dated dated [DATE] documented Resident #150 was severely cognitively impaired, required substantial/maximal assistance with toileting, putting/taking off footwear, and personal hygiene and was at risk of developing pressure ulcers. The Physician's orders entered 4/27/2023 and revised 4/27/2024 documented Left Multipodus Boot (brace) to be worn when out of bed for heel pressure relief. Remove for skin check and hygiene. On 4/23/2024 at 10:13 AM, Resident #150 was observed in the wheelchair after wound care was performed with no multipodus boot observed in place. On 04/24/24 at 10:36 AM, Resident #150 was observed sitting in the wheelchair in the dining room with yellow socks and open toe shoes. No multipodus boots were observed in place. On 04/24/24 at 11:17 AM, Licensed Practical Nurse #7 entered Resident #150's room and retrieve the multipodus boot from the closet. A blue boot contained in a clear plastic bag was obtained. On 04/24/24 at 11:20 AM, Licensed Practical Nurse # 7 applied the multipodus boot on Resident #150 while Resident #150 was seated in wheelchair in the dining room. On 4/24/2024 at 11:21 AM, an interview was conducted with Certified Nurse Assistant #10 who stated that it was not stated during morning report that Resident #150 required any equipment, braces, or boots but the use of the floor mats as the bed is in the low position. Certified Nurse Assistant #10 stated that they saw the boot in the closet and did not ask about the boot. On 04/24/2024 at 11:31 AM, Licensed Practical Nurse #7 was interviewed and stated they were not the regular nurse assigned to Resident #150, and was aware that Resident #150 needed the boot applied today. Licensed Practical Nurse #7 also stated that they noticed that Resident #150 did not have the multipodus applied. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/2024 at 11:39 AM, an interview was conducted with Licensed Practical Nurse #8 who stated that the Certified Nurse Assistants oversee putting on the booties following wound treatment. The Certified Nurse Assistants who are acquainted with Resident #150 are aware that they are responsible for applying the boot; this instruction is occasionally provided during morning rounds, and occasionally it may be forgotten. Licensed Practical Nurse #8 also stated the nurses need to document in the Treatment Administration Record when the bootie is applied, and it should be applied when the resident is not in bed. Licensed Practical Nurse #8 further stated that they were not sure why it was not applied. Licensed Practical Nurse #8 stated when the boot is applied, it is recorded in the kiosk by the Certified Nurse Assistants. On 4/24/2024 at 11:54 AM, during an interview the Director of Nursing stated that when a resident needs a piece of equipment or a device, the nurse has to verify the order and let the Certified Nursing Assistant know that the resident has a special device that needs to be used in accordance with the resident's doctor's orders. The Director of Nursing also stated that the Certified Nursing Assistant is supposed to check the kiosk to see whether the resident needs a device and record placement of the device there. The Director of Nursing further stated that use of devices should be communicated to the Certified Nurse Assistants during the morning report and Certified Nursing Assistants that are not regular staff members on the unit, should be given a thorough report. The Director of Nursing stated it is possible that the nurse forgot to give the nursing assistants the report on the multipodus boot. 10 NYCRR 415.12(c)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40652 Based on observations, record reviews and interviews conducted during the Recertification survey from 4/17/24 to 4/24/24, the facility did not ensure that a resident with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion. This was evident for 1 (Resident #60) of 2 residents reviewed for Position/Mobility out of a sample of 38 residents. Specifically, Resident #60 had an active Physician order for a left hand palm protector and was observed without left hand palm device on multiple occasions. The findings are: Resident # 60 diagnoses include Atrial Fibrillation, Coronary Artery Disease, Coronary Vascular Accident and Hemiplegia. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #60's cognitive level as moderately impaired. Resident #60 had impairment in one side of the upper extremities and impairments in both side of the lower extremities. Resident #60 required maximal assistance for eating, toileting, upper and lower body dressing. Physician order initiated on 7/3/20 and last renewed on 4/5/2024 documented the resident to always wear left hand palm protector except for hygiene, range of motion exercises and skin checks. The Comprehensive Care Plan titled Activities of Daily Living- Self Care initiated on 12/18/23 revised on 03/18/24 documented the resident to always wear left hand palm protector except for hygiene care, range of motion exercises and skin checks. On 04/17/24 at 10:10 AM and at 02:28 PM, 04/18/24 at 08:41 AM, 04/22/24 at 09:29 AM, 12:41 PM and 02:54 PM, and on 04/23/24 11:31 AM, Resident #60 was observed with contracture of left hand. The left-hand palm protector was not in place. On 04/22/24 at 09:30 AM, Resident #60 stated that the palm protector is supposed to be placed on the left hand. Resident #60 stated the device is in the drawer, and because they are not able to apply the device independently, the Certified Nursing Assistant is supposed to apply it. On 04/23/24 at 11:48 AM, Certified Nursing Assistant #5 was interviewed and stated that they are aware that Resident #60 is supposed to wear a device on their left hand due to a contracture, but Resident #60 would say that they prefer that the rehabilitation staff put on the device for them. Certified Nursing Assistant #5 also stated that Resident #60 does not like the Certified Nursing Assistants to put on the device, and would say the left-hand palm grip can be applied during rehab. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/23/24 at 12:10 PM, Licensed Practical Nurse #3 was interviewed and stated that residents are checked to ensure that they have all the devices they are supposed to have. Resident #60 is supposed to have a palm grip in their left hand and had been refusing the device for the past three days. Sometimes, the resident would tell us not to apply the device as they prefer to put on the device during rehab therapy. Licensed Practical Nurse #3 also stated that Resident #60's refusal of the application of the palm grip should have been documented. During an interview on 04/23/24 at 12:31 PM, Registered Nurse #3 stated they make rounds periodically on the unit, and they initiate and update care plans as needed, and check on residents to ensure all residents are safe. Registered Nurse #3 also stated that if a resident has a Physician order for a device, it should be applied. If a resident refuses to have a device applied, it is supposed to be brought to my attention so that a refusal care plan can be initiated. Registered Nurse #3 further stated that Resident #60 did not refuse the palm grip today and staff are supposed to document under progress notes when the resident refuses any care. On 04/23/24 at 12:58 PM, the Director of Rehabilitation was interviewed and stated Resident #60 is supposed to wear the left palm grip at all times and they were not aware that Resident #60 had said that rehab staff only should apply the palm grip. The Director of Rehabilitation also stated that they added the device to the resident's Activities of Daily Living care plan and explained to Resident #60 that the device needs to be worn at all times except during hygiene care. Resident #60 verbalized understanding. The Director of Rehabilitation further stated that the care plan for Activities of Daily Living dated 12/18/23 mentioned that the left-hand palm grip needs to be always applied and the nursing staff had not reported to them that Resident #60 was refusing to wear the device. During an interview on 04/23/24 at 02:47 PM, the Director of Nursing Services stated that the charge nurse is supposed to check to ensure that all residents are wearing their devices. The Director of Nursing Services also stated that if the resident constantly refuses care the Certified Nursing Assistant would need to inform the nursing staff that the resident is refusing to wear the device and we would initiate a care plan for refusal. The Rehab department would need to be informed as well. The Director of Nursing Services further stated that the facility policy is that we must ensure all Physician orders and care plans are being always implemented. 10 NYCRR 415.12(e)(2)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 42101 Based on observation, record review, and interviews conducted during the Recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure timely identification and removal of expired medications. Specifically, seven individual expired Heparin lock flush syringes were stored on medication carts. This was evident on 2 of 5 units. (2nd and 4th floor) The findings are: The facility policy titled Ordering, Distributing and Storage of Supplies revised 01/2024 documented that nurses shall check every medication for the expiration date before administration. All unused or expired drugs are to be removed by the medication nurse from the medication room, carts and refrigerators and discarded per policy. On 04/17/2024 at 02:42 PM, five Heparin Lock Flush syringes were observed in the medication cart on the 4th floor. On 04/17/2024 at 03:33 PM, the Registered Nurse Supervisor (Registered Nurse #2) was interviewed and stated that the nurse on the unit and the Pharmacist check the carts. They check for expired medications and locked carts are functioning properly and if they need to reorder medications. They cover the whole building and if there is an issue they are informed by the nurses. You don't want to give resident an expired medication the effectiveness is diluted over time, and it is not as effective. The medication cart checked on the unit 1 months ago and no expired items were noted. On 04/17/2024 at 03:43 PM, the medication cart #2 on the 2nd floor was observed with Licensed Practical Nurse #4 and there were two Heparin 50 units USP flushes with expiration date of 04/01/2024 noted. Licensed Practical Nurse #4 stated that Licensed Practical Nurse #5 was responsible for the cart on the previous shift. During an interview on 04/17/2024 at 03:52 PM, Licensed Practical Nurse #5 stated that the Heparin flush expired on 04/01/2024, and they did not check the date as there were no residents receiving a flush at this time on the unit. Licensed Practical Nurse #5 also stated that the night shift nurse should check, and all staff should check at the beginning of the shift and it was an oversight. During an interview on 04/22/2024 at 01:50 PM, the Pharmacy Supervisor was interviewed and stated their staff look at the wall storage area and medication cart for dating of medications, to make sure they are no expired medications. Heparin vials should be used by the manufacturer expiration date. The review for April was done yesterday and everything was in order. The Heparin flushes are for single use. No expired medication should be given, and it should be discarded and not used past the date per the manufacturer. The Pharmacy Supervisor also stated that the pharmacy representative would have removed it from the cart if dated past 4/01/2024 during their monthly review. The monthly pharmacy review was done in March 2024, and it was not expired. It would be removed on the monthly pharmacy check. The Heparin vial should have been discarded on 4/2/2024 and nurse should have seen and discarded it. When the pharmacy representative did the April 2024 review it would have been discarded. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/2024 at 12:55 PM, the Director of Nursing was interviewed and stated the medication carts, medication rooms, and refrigerator are checked to make sure all the medications for residents are available before medication administration. Nurses double check dates are current for medication and make sure medications are not expired. The Director of Nursing also stated we have a pharmacy consultant who inspects the medication cart and medication room on a monthly basis, and they throw out expired medication. Periodically nurses order supplies and throw out expired medications and there is no set time frame. The Director of Nursing further stated that sometimes they do random check of medication carts but could not remember when last they had looked at items in the medication cart. It is a matter of safety for the residents that they do not have expired medications. 10 NYCRR 415.18(a)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49169 Based on record review and interviews conducted during the Recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure that clinical records were accurately documented in accordance with accepted professional standards and practices. Specifically, resident and/or resident's designated representatives who did not participate in their care plan meetings were documented as present in the care plan meetings. This was evident for 3 of 4 residents reviewed for Care Plan (Residents #82, #111, and #104). The findings are: The facility policy and procedure titled Medical Records Systems and Charts with revised date 1/2024 documented that the facility will maintain medical record systems that ensure appropriate chart generation and accurate documentation related to the health and wellbeing of each resident. 1) Resident #82 was admitted with diagnoses that include Peripheral Vascular Disease and Coronary Artery Disease. The Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #82 was moderately cognitively impaired. On 4/17/24 at 10:57 AM, Resident #82 was interviewed and stated they had not been invited to attend any care plan meeting. The comprehensive care plan form located in the paper chart was blank. The Care Plan Meeting Report dated 4/16/2024 documented that Resident #82, their representative, Nurse #1, Attending Physician, Rehab, Registered Dietician #1, the Director of Rehab, and Social Worker #1 were in attendance at the care plan meeting. The medical record did not accurately document who attended the care planning meetings. On 04/19/24 at 2:47 PM, Registered Dietician #1 was interviewed and stated they meet in Social Worker #1's office for care planning meetings. Registered Dietician #1 also stated that they think they attended the care plan meeting on 4/16/2024. On 04/19/24 at 02:54 PM, an interview was conducted with the Director of Rehab who stated that the care plan meeting on 4/16/2024 was held in the Social Service office on the 3rd floor. The Director of Rehab stated Resident #82 did not attend the meeting on 04/16/2024 and only the Director or Rehab and Social Worker #1 were present at the meeting. 2) Resident #111 was admitted with the diagnoses that included Non-Alzheimer's Dementia, Parkinson's Disease. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #111 was moderately cognitively impaired. On 04/19/24 at 10:37 AM, an interview was conducted with Resident #111's Representative who stated that they have not been called to attend a care plan meeting. Resident #111's Representative also stated they received a letter in the mail for care plan meeting, but the letter arrived late after the meeting occurred and they were not called to schedule a care plan meeting. The Care Plan Meeting Report dated 10/02/2023, 01/02/2024, 03/26/2024 documented that Resident #111's Representative was in attendance at the care plan meeting. The medical record did not accurately document who attended the care planning meetings. On 04/19/24 at 12:47 PM, an interview was conducted with Social Worker #1 who stated no family has attended care planning meeting and Resident #111's Representative had been invited to care plan meetings. On 4/19/24 at 3:00 PM, the Director of Discharge Planning was re-interviewed and stated that what is documented in the medical record may not reflect actual attendance at meetings. The Director of Discharge Planning stated that sometimes after the meetings are conducted with the various disciplines, if family or resident was not in attendance at the meeting they would be informed about what was discussed. This is then reflected in the electronic medical record as their participation in the meeting. On 04/24/24 at 01:29 PM, an interview was conducted with the Director of Nursing who stated that residents should be physically present or on a conference call to participate in care plan meetings. The Director of Nursing also stated that if the family member is not able to attend the Social Worker will document that. The Director of Nursing further stated that if the family members or residents were not present at the meeting, then it should be document that the family members were not present. 44843 3. Resident #104 had diagnoses which included Acute Respiratory Failure with hypoxia, Depression, and Hypothyroidism. The Admission Minimum Data Set assessment dated [DATE] documented Resident #104 was cognitively intact and only Resident #104 participated in the assessment. On 04/17/2024 at 10:41 AM, Resident #104 was interviewed and stated that they would like to participate in care planning meetings but had not been invited. Resident #104 further stated that their Representative received a letter of invitation to attend, however Resident #104 was at therapy when the care plan meeting was held with Resident #104's representative instead. Resident #104 stated the Director of Discharge Planning (also the Social Worker for the unit) did not meet with them on that day or any time after to discuss their comprehensive care plans with them. The Social Services note dated 2/6/2024 documented it was the initial care plan meeting and Resident/Family were present at the meeting. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The Care Plan Meeting Report dated 2/6/2024 documented Resident #104 and Resident's Representative attended the care plan meeting. On 04/17/2024 at 10:52 AM, the Resident Representative was interviewed and stated that they received a letter of invitation and attended the care plan meeting scheduled on 2/6/2024. The Resident Representative also stated that Resident #104 was at therapy and the interdisciplinary team did not wait for Resident #104 to come to the meeting so Resident #104 did not participate in the care plan meeting at all. The medical record did not accurately document who attended the care planning meetings. On 04/22/2024 at 11:34 AM, the Director of Discharge Planning (also the Social Worker for the unit) was interviewed and stated that Resident #104 did not attend the initial care plan meeting on 2/6/2024 because they were receiving therapy when the care plan meeting was held so the care plan meeting was held with Resident #104's Representative only. The Director of Discharge Planning stated that although Resident #104 did not attend the care plan meeting on 2/6/2024, they checked Resident #104 as present for the care plan meeting because they met and discussed the care plans with Resident #104 later on in the day when Resident #104 returned from therapy. On 04/22/2024 at 01:46 PM, the Administrator was interviewed and stated the staff should document what they did for the resident or what happened to the resident in the medical record. The Administrator also stated if it was not documented, it was considered not done. The Administrator had no explanation why the Social Worker documented Resident #104 attended the initial care plan meeting on 2/6/2024 when they actually had not been present. 10 NYCRR 415.22(a)(1-4)

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	04/24/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 48711 Based on observation, record review and interview conducted during the Recertification survey from 4/17/2024 to 4/24/2024, the facility did not ensure that infection prevention and control program was maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Specifically, residents were not offered appropriate hand hygiene prior to lunch meal being served. This was evident for 2 (Resident #39 and Resident #111) of 18 residents observed during the Dining observation on Unit 2. Resident #39 and Resident #111 were observed being wheeled into the dining area, placed at the dining table, and served a lunch meal without being offered or provided hand hygiene. The findings are: The facility policy and procedure titled Hand Washing and Hand Sanitizers revised 1/2024. documented hands should be washed before eating. On 04/17/24 at 12:25 PM, an observation was made on the 2nd floor dining area where lunch was being served. There were 18 residents, 5 Certified Nursing Assistants and 2 Licensed Practical Nurses in the dining room. Certified Nursing Assistant #9 wheeled Residents #39 and Resident #111 into the dining room and positioned them at the dining room table. Resident #111 was then observed touching the wheels of their wheelchair. Certified Nursing Assistant #9 then served both residents their lunch meal. Certified Nursing Assistant #9 was observed not performing hand hygiene on residents prior to serving the lunch meal. On 04/22/24 at 10:15 AM, an interview was conducted with Certified Nurse Assistant #9 who stated that staff and residents are supposed to wash hands before and after meals. Certified Nurse Assistant #9 also stated that some of the residents do not want to use any wipes, and some residents will ask for their hands to be washed. Certified Nurse Assistant #9 further stated that they are not sure why the residents did not have their hands washed or sanitized. On 04/22/24 at 11:18 AM, an interview was conducted with the Infection Control Preventionist, who stated that the staff has been educated and in-serviced on hand washing for staff and the residents. The Infection Control Preventionist also stated that the facility policy is that the staff are to sanitize the resident hands before and after meals no matter what the circumstances are. Residents that are alert are provided hand sanitizing wipes or are given the choice to go to the restroom to wash their hands with soap and water. Residents that are not cognitively alert are assisted by the staff with the hand sanitizing wipes, and the staff are to perform hand hygiene also before, during and after meals. The Infection Control Preventionist further stated that residents entering the dining room should be assessed to see if their hands have been washed or sanitized before entering the dining area. 10 NYCRR 415.19 (b)(4)