STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335703	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bushwick Center for Rehabilitation and Health Care	50 Sheffield Avenue Brooklyn, NY 11207

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 interview and record review conducted during an Abbreviated Survey (NY00377880), on the facility), the facility did not ensure that an alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency). This was evident for one (1) out of seven (7) residents (Resident #5) reviewed for falls. Specifically, Resident #5 was observed on the floor into their room on [DATE] at 10:30 AM unresponsive, without vital signs, and a hematoma on their forehead. 911 was called and Resident #5 was pronounced by the emergency service team at 11:16 AM on [DATE]. Registered Nurse Supervisor #1 did not report the unwitnessed fall and injury to the Administrator and the fall was not reported to the New York State Department of Health. The findings include: The facility Policy and Procedure titled Accident- Incidents dated 06/2024 document an incident is any occurrence not consistent with the routine operation of the center. The occurrence may be a fall, skin tear, bruise, new pressure ulcer and may involve abuse, neglect, and mistreatment or injury of unknown origin. The incident may be a theft or misappropriation of resident property. The Nursing Supervisor/Charge Nurse, is responsible for assessing, reviewing, documenting and reporting of the incident and or accident. The Director of Nursing and Administrator are responsible to review incident/investigation and Conclusion to determine if incident requires reporting to outside agencies such as Department of Health etc. Resident #5 was admitted to the facility with diagnoses including Neoplasm of Lung, Neoplasm of Prostrate, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease. The Minimum Data Set (a resident assessment tool) dated [DATE] documented that Resident #1 had intact cognition. (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	Record review and interviews with Registered Nurse #1 and Licensed Practical Nurse #1 revealed that on [DATE] at 10:30 AM Resident #5 was observed lying on the floor face down and unresponsive in their room. Resident #5 also had a hematoma on their forehead. 911 was called at 10:30 AM and the emergency medical team and the New York Fire Department arrived at the facility at 10:40 AM and took over the code. Resident #5 was pronounced at 11:16 AM by the emergency medical team. Registered Nurse Supervisor #1 stated that Resident #5's fall was not reported to the Director of Nursing, nor the Administrator and they did not initiate an investigation into the fall. The Intake Information dated [DATE] at 3:45 PM revealed that this incident was reported by Resident #5's next of kin (complainant). The complainant reported to the Department of Health that the facility called them and reported that Resident #5 had just died after being found unresponsive. The complainant reported that when they unzipped the bag, they immediately saw a bruising on Resident #5's head and blood on their face. The nursing home was unable to explain the blood and bruising. An autopsy was ordered by the family. Review of the Accident/Incident Reports from [DATE] to [DATE], revealed there were no incident report related to Resident #5 being found unresponsive on the floor in their room on [DATE]. According to the Forensic Pathologist and Neuropathologist Pathology findings dated [DATE]: Resident #5's cause of death was due to Bronchogenic lung adenocarcinoma, hypertension, and emphysema with congestive heart failure. The report also documented Resident #5 had a slight contusion measured one-half inch and a superficial laceration measured less than one-quarter inch and that there was no evidence of significant trauma. During an interview with the complainant on [DATE] at 10:02 AM, the compliant stated they were unsure of staff names, but that they received a call from a facility staff who stated that Resident #5 was found unconscious and cardiopulmonary resuscitation was initiated. The complainant stated they received another call from a staff stating Resident #5 died. The complainant stated within fifteen minutes they arrived at the facility and Resident #5 was in a body bag. The complainant stated that when the staff opened the body bag, they saw a bruise and blood on Resident #5's face and forehead. The complainant stated that the staff was not able to explain the injury. The complainant stated that they took pictures and requested for an autopsy to be done. During a telephone interview on [DATE] at 1:40 PM, Registered Nurse Supervisor #1 stated Resident #5 was found face down on the floor next to their bed unresponsive, and pulseless, by Licensed Practical Nurse #1 at 10:30 AM on [DATE]. Registered Nurse Supervisor #1 stated Resident #5 was observed with a hematoma on their forehead. Registered Nurse Supervisor #1 stated cardiopulmonary resuscitation was initiated by Licensed Practical Nurse #1 and Nurse Practitioner #1 and 911 was called at 10:30 AM. The emergency medical team and the New York Fire Department arrived at 10:40 AM and took over the code. Resident #5 was pronounced at 11:16 AM by the emergency medical team. Registered Nurse Supervisor #1 stated that Resident #5's fall was not reported to the Director of Nursing, nor to the Administrator and they did not initiate an investigation into the fall. During an interview on [DATE] at 3:30 PM, the Director of Nursing stated that they were not in the facility on [DATE] and was not notified of the fall and injury. The Director of Nursing stated they were notified that 911 was called and that Resident #5 was pronounced in the facility. The Director of Nursing stated because they were not aware of the fall, the fall incident was not reported to the New York State Department of Health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 1:20 AM, the Administrator stated they were not aware of the fall or that Resident #5 sustained injury. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during an Abbreviated Survey (NY00377880), the facility failed to investigate a fall accident that had resulted in injuries. This was evident for one (1) out of seven (7) residents (Resident #5) reviewed for falls. Specifically, on [DATE] at 10:30 AM Licensed Practical Nurse #1 observed Resident #5 lying face down on the floor next to their bed unresponsive, and without vital signs. Resident #5 also had a hematoma to their forehead. cardiopulmonary resuscitation was initiated and 911 was called. Resident #5 was pronounced at 11:16 AM by the Emergency Medical Team. Registered Nurse Supervisor #1 did not investigate the unwitnessed fall and injury to rule out care plan violation. The findings include: The facility policy and procedure titled Accident- Incidents dated 06/2024 document an incident is any occurrence not consistent with the routine operation of the center. The occurrence may be a fall, skin tear, bruise, new pressure ulcer and may involve abuse, neglect, and mistreatment or injury of unknown origin. The incident may be a theft or misappropriation of resident property. The Nursing Supervisor/Charge Nurse, is responsible for assessing, reviewing, documenting and reporting of the incident and or accident. The Director of Nursing and Administrator are responsible to review the incident/investigation and conclusion to determine if incident requires reporting to outside agencies such as Department of Health etc. Resident #5 was admitted to the facility with diagnoses including Neoplasm of Lung, Neoplasm of Prostrate, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease. The Minimum Data Set (a resident assessment tool) dated [DATE] documented that Resident #1 had intact cognition. The Intake Information dated [DATE] at 3:45 PM revealed that this incident was reported by Resident #5's next of kin (complainant). The complainant reported to the Department of Health that the facility called them and reported that Resident #5 had just died after being found unresponsive. The complainant reported that when they unzipped the bag, they immediately saw a bruising on Resident #5's head and blood on their face. The nursing home was unable to explain the blood and bruising. An autopsy was ordered by the family. Review of the Accident/Incident Reports from [DATE] to [DATE], revealed there were no incident report related to Resident #5 being found unresponsive on the floor in their room on [DATE]. According to the Forensic Pathologist and Neuropathologist Pathology findings dated [DATE]: Resident #5's cause of death was due to Bronchogenic lung adenocarcinoma, hypertension, and emphysema with congestive heart failure. The report also documented Resident #5 had a slight contusion measured one-half inch and a superficial laceration measured less than one-quarter inch and that there was no evidence of significant trauma. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the complainant on [DATE] at 10:02 AM, the compliant stated they were unsure of staff names, but that they received a call from a facility staff who stated that Resident #5 was found unconscious and cardiopulmonary resuscitation was initiated. The complainant stated they received another call from a staff stating Resident #5 died. The complainant stated within fifteen minutes they arrived at the facility and Resident #5 was in a body bag. The complainant stated that when the staff opened the body bag, they saw a bruise and blood on Resident #5's face and forehead. The complainant stated that the staff was not able to explain the injury. The complainant stated that they took pictures and requested for an autopsy to be done. During a telephone interview on [DATE] at 1:40 PM, Registered Nurse Supervisor #1 stated Resident #5 was found face down on the floor next to their bed unresponsive, and pulseless, by Licensed Practical Nurse #1 at 10:30 AM on [DATE]. Registered Nurse Supervisor #1 stated Resident #5 was observed with a hematoma on their forehead. Registered Nurse Supervisor #1 stated cardiopulmonary resuscitation was initiated by Licensed Practical Nurse #1 and Nurse Practitioner #1 and 911 was called at 10:30 AM. The emergency medical team and the New York Fire Department arrived at 10:40 AM and took over the code. Resident #5 was pronounced at 11:16 AM by the emergency medical team. Registered Nurse Supervisor #1 stated that Resident #5's fall was not reported to the Director of Nursing, nor to the Administrator and they did not initiate an investigation into the fall. During an interview on [DATE] at 3:30 PM, the Director of Nursing stated that they were not in the facility on [DATE] and was not notified of the fall and injury. The Director of Nursing stated they were notified that 911 was called and that Resident #5 was pronounced in the facility. During a telephone interview on [DATE] at 1:20 AM, the Administrator stated they were not aware that Resident #5 had fallen and sustained injuries. 10 NYCRR 483.12(c)(4)