STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335826	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Rehab and Nursing Center	48 Cedar Street Brooklyn, NY 11221

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure the designated resident representative was notified of and involved in a significant medication change for one (Resident #56) of one resident reviewed for notification of change. Specifically, the facility decreased Resident #56's Seroquel dose from 25 milligram three times daily to 12.5 milligram three times daily on 01/26/2026 without documented notification to or consultation with the resident's representative. The findings include:The facility policy titled Notification of Medication Changes reviewed on 12/31/2025 states that the resident, family, and/or resident representative has the right to be informed of and participate in treatment decisions. The policy further states that before initiating, discontinuing, increasing, or decreasing a medication, the resident, family, and/or representative must be informed of the benefits, risks, alternatives, and potential adverse effects. The resident has the right to accept or decline medication changes Resident #56 had diagnoses including Alzheimer's Disease, Psychotic Disorder, Depression, and Anxiety Disorder.The Quarterly Minimum Data Set, dated [DATE] documented that Resident #56 had severe cognitive impairment, was rarely or never understood, and rarely or never understood others. The assessment also documented the resident received an antipsychotic medication.A Psychiatry Consultation dated 01/20/2026 documented that Psychiatrist #1 recommended tapering Resident #56's Seroquel from 25 milligram three times daily to 12.5 milligram three times daily. The recommendation was reviewed by Registered Nurse #11 on 01/21/2026 and reviewed and agreed to by Physician Assistant #1 on 01/21/2026.The January 2026 Medication Administration Record documented that Resident #56 received Seroquel 25 milligram three times daily through 01/26/2026, when the order was discontinued. A new order dated 01/26/2026 initiated Seroquel 12.5 milligram three times daily.The facility was unable to provide documentation demonstrating that Resident #56's representative was notified of, consulted regarding, or agreed to the dosage reduction before the medication change was implemented.During an interview on 06/08/2026 at 10:20 AM, Resident #56's representative stated the facility decreased the resident's Seroquel dosage without consulting them. The representative stated they believed the resident needed the medication and would not have agreed to the dosage reduction.During an interview on 06/11/2026 at 10:54 AM, Psychiatrist #1 stated they did not notify Resident #56's representative of the Seroquel dosage reduction because notification was typically the responsibility of nursing staff or the attending medical provider. Psychiatrist #1 stated they were unaware the previous psychiatrist had communicated directly with the representative and believed miscommunication among facility staff resulted in the representative not being notified.During an interview on 06/11/2026 at 11:00 AM, Physician Assistant #1 stated they typically notify resident representatives of medication changes but were unable to locate documentation confirming notification of Resident #56's Seroquel dosage reduction and could not verify that notification occurred.During an interview on 06/10/2026 at 9:43 AM, the Director of Nursing stated that resident representatives are typically included in discussions regarding medication changes and may be notified by nursing staff, the physician, or the psychiatrist. The Director of Nursing stated Resident #56's representative usually communicated directly with the (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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychiatrist; however, they were unable to locate documentation showing the representative had been notified of the January 2026 dosage reduction and could not confirm notification occurred.10 New York Codes, Rules, Regulations 415.3(f)(2)(ii)(c)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure a resident was free from physical restraints imposed for purposes other than the treatment of a medical symptom. This was evident in one (Resident #56) of one resident reviewed for physical restraints out of 38 total sampled residents. Specifically, Resident #56 was repeatedly observed sitting in the middle of their bed with legs hanging off the side of the bed between the elevated head and foot sections of the bed while the bed was placed against a wall. The facility lacked documentation supporting the medical necessity, informed consent, assessment, or ongoing reevaluation of the bed's placement against the wall.The findings include:The facility's Use of Restraints policy last reviewed 12/31/2025, states that restraints may only be used to treat a resident's medical symptoms after less restrictive alternatives have been unsuccessful. The policy prohibits restraints for staff convenience, discipline, or fall prevention and requires physician orders, resident or representative consent, documentation of risks, benefits, and alternatives, ongoing reevaluation of continued need, quarterly review for reduction or elimination, and care planning that addresses the resident's underlying medical symptoms.Resident #56 had diagnoses including Alzheimer's disease, psychotic disorder, depression, and anxiety disorder.The Quarterly Minimum Data Set (MDS), dated [DATE], documented that Resident #56 had severe cognitive impairment, was rarely or never understood and rarely or never understood others, was dependent on staff for all activities of daily living, exhibited no physical or verbal behavioral symptoms, did not reject care, and did not use restraints.On 06/08/2026 at 9:42 AM and again on 06/09/2026 at 9:20 AM, Resident #56 was observed seated on the edge of the bed with both the head and foot sections elevated, positioned between the raised sections, with the resident's feet resting on a fall mat located on the right side of the bed. The left side of the bed was positioned directly against the wall. The bed remained positioned against the wall during multiple additional observations conducted between 06/07/2026 and 06/12/2026.The facility was unable to provide documentation demonstrating the medical necessity for positioning the bed against the wall, physician authorization, assessment of restraint use, ongoing reevaluation, or documentation that the resident's representative had been informed of the risks and benefits associated with the bed placement.On 06/08/2026 at 10:20 AM, Resident #56's representative was interviewed and stated they visited the resident daily and frequently found the resident positioned uncomfortably in bed. The representative stated they had previously observed the resident positioned between the elevated head and foot sections of the bed and believed the resident appeared uncomfortable. The representative also stated they preferred the bed remain against the wall because they believed it reduced the risk of the resident falling from bed due to limited staff supervision.On 06/09/2026 at 09:20 AM, Certified Nursing Assistant #4 observed Resident #56 in the same position as the surveyor and stated the resident was unable to operate the bed controls independently. They stated another staff member may have placed the resident in that position while feeding breakfast and stated they did not consider the position to be a restraint. On 06/09/2026 at 09:23 AM, Registered Nurse #6, who was a Registered Nurse Supervisor, observed the resident in the same position and stated Resident #56 should not have been left positioned between the elevated head and foot sections of the bed. They stated a staff member may have placed the resident in that position during feeding. They further stated that placing a bed against a wall could be considered a restraint; however, the resident's representative had requested the bed be positioned against the wall. During a follow-up interview on 06/09/2026 at 10:06 AM, Registered Nurse #6 stated they could not determine when the bed was first positioned against the wall because there was no documentation in the medical record. RN #6 stated documentation regarding the bed placement should have been present but was unsure what specific documentation the facility required.During an interview on 06/10/2026 at 9:43 AM, the Director of Nursing stated (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #56's representative requested the bed be placed against the wall because of the resident's unpredictable movements and risk of attempting to stand without assistance. The Director of Nursing stated there was no documentation identifying when the bed was placed against the wall and confirmed the facility did not complete assessments or other documentation related to beds positioned against walls because the facility did not consider this practice to be a restraint. The Director of Nursing acknowledged having worked in facilities that did consider wall placement of a bed to be a restraint but was unable to explain why this facility did not. The Director of Nursing further stated Resident #56 should not have been positioned between the elevated head and foot sections of the bed or left in that position unsupervised and could not explain why the surveyor observed the resident in that position on multiple occasions.10 New York Codes, Rules, and Regulations 415.3(d)(1)(vii)

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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, the facility did not ensure that all alleged violations involving abuse or neglect, including injuries of unknown origin, were reported immediately, but not later than 2 hours after the allegation was made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than twenty four hours if the events that caused the allegation did not involve abuse and did not result in serious bodily injury, to the New York State Department of Health. This was evident in two (Residents #56 and #241) of seven residents investigated for accidents. Specifically, the facility failed to report an unexplained facial injury sustained by Resident #56 on 08/05/2025 and an unwitnessed fall resulting in a left hip fracture sustained by Resident #241 on 10/15/2025, despite both residents being unable to explain how the injuries occurred. The findings include: The facility's Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Resident's Property policy, reviewed 12/31/2025, stated that all incidents, complaints, and injuries of unknown origin will be investigated and that the New York State Department of Health will be notified whenever abuse cannot be ruled out. 1. Resident #56 had diagnoses including Alzheimer's Disease, Psychotic Disorder, Depression, and Anxiety Disorder. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #56 had severe cognitive impairments, was rarely/never understood, and rarely or never understood others. The assessment also documented that Resident #56 did not have physical or verbal behavioral symptoms or reject care. An Occurrence Investigation Report dated 08/05/2025 documented that staff observed a bump with yellow discoloration on the left side of Resident #56's forehead at approximately 4:34 PM. Resident #56 was unable to explain how the injury occurred. The resident was transferred to the hospital, where a computed tomography scan revealed no acute findings. The investigation concluded the injury was unavoidable, found no probable evidence of abuse, neglect, or mistreatment, and documented that the incident would not be reported to the Department of Health. During an interview on 06/08/2026 at 10:20 AM, Resident #56's representative stated the facility informed them it did not know how the resident sustained the head injury and expressed concern that the resident was being abused. During an interview on 06/11/2026 at 10:24 AM, the Director of Nursing stated the facility believed the injury resulted from the resident striking their head against the bed headboard due to past behaviors. However, the Director of Nursing acknowledged there was no documentation that the resident engaged in head-banging behaviors, no documentation identifying when the injury occurred, and no evidence establishing the cause of the injury. The Director of Nursing stated the behavior should have been documented if it had occurred and acknowledged the injury of unknown origin should have been reported to the Department of Health. During an interview on 06/12/2026, the Administrator stated the facility did not consider the injury to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be of unknown origin because staff believed it was consistent with the resident's prior behaviors and therefore did not report the incident. 2. Resident #241 had diagnoses including schizophrenia (a brain disorder that can make it difficult for a person to tell you what is real and to think, feel, or behave normally), cerebral infarction (blood flow to part of the brain is blocked, causing brain cells to die or be damaged), and non-Alzheimer's dementia (a decline in memory, thinking, or reasoning). The Annual MDS dated [DATE] documented that Resident #241 had severe cognitive impairment, was rarely or never understood, and had impaired short- and long-term memory. An Occurrence Investigation Report dated 10/15/2025 documented that staff found Resident #241 on the floor beside the bed at approximately 9:30 AM. The resident complained of hip pain and headache but was unable to recall the event because of baseline confusion. Hip x-rays identified an acute left hip fracture, and the resident was transferred to the hospital for further evaluation. The investigation documented the cause of the injury as undetermined, found no probable evidence of abuse, neglect, or mistreatment, and concluded the incident would not be reported to the Department of Health. During an interview on 06/12/2026 at 12:39 PM, the Director of Nursing stated the unwitnessed fall resulting in the hip fracture had been reviewed with the Administrator. The Director of Nursing stated the resident frequently paced the hallways, occasionally sat on the floor, experienced no delay in treatment, and had no violation of the care plan. Based on those findings, the facility determined the incident did not meet reporting criteria. During an interview on 06/12/2026 at 1:46 PM, the Administrator stated the facility determined the fracture was of known origin following its internal investigation because the resident had a history of falls and interventions were already in place, including frequent monitoring. Therefore, the facility did not report the incident to the Department of Health. 10 New York Codes, Rules, Regulations 415.4

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 38Number of residents cited: 3Based on observations, record review, and staff interviews, the facility failed to ensure that a person-centered comprehensive care plan was developed and implemented to address the residents' medical, physical, mental, and psychosocial needs. This was evident for one of one resident (Resident #13) reviewed for Dialysis. One of one resident (Resident #56) reviewed for Abuse and 0ne of five residents (Resident # 203) reviewed for Respiratory Care. Specifically, 1). A comprehensive care plan was not developed and implemented for Resident #13 who was receiving dialysis treatment, 2). A comprehensive care plan was not created for Resident #56 who was exhibiting self-injurious behavior, and 3). A comprehensive care plan was not created for Resident #203 who was receiving oxygen treatment. The findings are: The facility's policy and procedure titled Comprehensive Care Plan reviewed 01/05/2026 documented an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The resident's comprehensive care plan is developed within seven (7) days of the completion of the resident's comprehensive assessment and revised as changes in the resident's condition dictate. 1.Resident #13 was admitted to the facility with diagnoses including End Stage Renal Disease. The Annual Minimum Data Set (a resident assessment tool) dated 05/11/2026 documented Resident #13 had moderately impaired cognition and was receiving dialysis treatment. The Patient Review Instrument dated 05/28/2026 documented Resident has Hemodialysis on Monday, Wednesday and Friday. The admission Nursing Note dated 05/30/2026 documented Resident #13 admitted from hospital, status post two cycles of hemodialysis and plan to resume regular hemodialysis schedule three times a week. The Physician Order initiated 06/05/2026 indicated that Resident #13 to go to Hemodialysis: three times a week and as needed as per dialysis center plan, day shift on every Monday, Wednesday and Saturday for End Stage Renal Disease. The Comprehensive Care Plans initiated 05/30/2026 did not include Resident #13's plan for undergoing dialysis treatment. On 06/11/2026 at 04:14 PM, Registered Nurse #12 stated Resident #13 was readmitted from hospital to the facility on [DATE] and they were responsible for receiving hospital paperwork and entering the admission information in the electronic medical record for admission process. Registered Nurse #12 recalled admitting Resident #13 on 05/30/2026 and checked to ensure all appropriate care plans were initiated. Registered Nurse #12 acknowledged that it was an oversight, and they must have missed the dialysis care plan. On 06/12/2026 at 10:01 AM, the Director of Nursing stated Resident #13's care plan for dialysis was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not initiated, which Registered Nurse #12 acknowledged was missed by mistake. The Director of Nursing stated Resident #13 has been in the facility, going to dialysis three times a week; therefore, the care plan should have been implemented upon readmission from hospital. 2. Resident #56 had diagnoses including Alzheimer's Disease, Psychotic Disorder, Depression, and Anxiety Disorder. The Quarterly Minimum Data Set (a resident assessment tool) dated 07/31/2025 documented that Resident #56 had severe cognitive impairments, was rarely/never understood, and was rarely/never able to understand others. The assessment also documented that Resident #56 did not have physical or verbal behavioral symptoms or reject care. The Occurrence Investigation Report dated 08/05/2025 documented that on 08/05/2025 at approximately 04:34 PM, staff observed a bump with yellow discoloration on the left side of Resident #56's forehead. Resident #56 was unable to report what caused the injury and was transported to the hospital and had a CT scan completed with no acute findings. The Occurrence Investigation Report further documented that on 07/22/2025 and 07/24/2025, Resident #56 was noted as being resistive to care, combative during care, and had grabbed and pulled on staff members. The Occurrence Investigation Report documented that the injury was not reported to the Department of Health. The Comprehensive Care Plan with a focus of Resident demonstrates problem behavior of putting himself on the floor mattress last revised 10/17/2025 documented that Resident #56 had a behavior of rolling from side to side in bed on 08/20/2025. This care plan did not address head banging behavior or interventions that were supposed to be in place to assist the resident when exhibiting this behavior. On 06/11/2026 at 10:24 AM, the Director of Nursing was interviewed and stated on 08/05/2025, Resident #56 was observed by staff to have a bump and bruise on their head. The Director of Nursing also stated that the injuries were not reported to the Department of Health because Resident #56 had a habit of banging their head against their headboard in bed. The Director of Nursing further stated that there was no Comprehensive Care Plan related to behaviors of head banging because Resident #56 had a care plan that documented that Resident #56 rolled from side to side in bed, and that that was also supposed to mean that Resident #56 had a behavior of banging their head against the headboard. 3. Resident #203 was re-admitted to the facility with diagnoses that included Acute Respiratory Failure and Pneumonia. The Quarterly Minimum Data Set (a resident assessment tool) dated 05/12/2026 documented Resident #203 was cognitively intact and required assistance of staff to complete Activities of Daily Living. The Quarterly Minimum Data Set also documented that Resident #203 received continuous oxygen therapy. The Physician orders dated 05/08/2026 documented an order for oxygen continuously at 2 liters per minute via nasal canula for shortness of breath. There was no documented evidence that a care plan for oxygen via nasal cannula had been initiated. On 6/11/2026 at 2:24 PM, Registered nurse #3 was interviewed and stated that the admission nurse (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	initiates the care plan based on the resident's diagnoses, medications and needs. Registered Nurse #3 also stated Resident #203 was sent to the hospital for acute respiratory distress and was re-admitted to the facility with an order for oxygen. Registered Nurse #3 further stated that a care plan for oxygen treatment should have been initiated on the day of readmission to the facility. On 6/11/2026 at 5:04 PM, the Director of Nursing was interviewed and stated that the facility has been having a lot of changes in the staffing pattern, especially among the Registered Nurses. The Director of Nursing also stated they have lost six Registered Nurses from the schedule, and the remaining nurses cannot find the time to initiate and update care plans. The Director of Nursing further stated they are aware of the problem, and the shortage of nurses greatly impacts their documentation compliance. 10 New York Code, Rules and Regulations 415.11(c)(1)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:38Number of residents cited: 4Based on record review and interview, the facility failed to ensure that a resident's comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This was evident for one of five residents (Resident #8) reviewed for Unnecessary Medications, one of five residents (Resident #191) reviewed for Respiratory Care, one of one resident (Resident #56) reviewed for Abuse, and one of one resident (Resident #29) reviewed for Advance Directives out of a sample of 38 residents. Specifically, 1). The care plan related to Depression for Resident #8, 2). The Respiratory care plan for Resident #191, 3). The Abuse Care Plan for Resident #56, and 4). The Advance Directive care plan for Resident #29 was not reviewed and revised after each assessment. The findings include but are not limited to: The facility policy titled Comprehensive Care Plan dated last reviewed 06/2025 documented the care plans are revised as changes in the resident's condition dictate. Care plans are reviewed at least quarterly. 1. Resident #8 was admitted with diagnosis that included Anxiety Disorder and Depression. The Quarterly Minimum Data Set (a resident assessment tool) dated 01/22/2026 and the Significant Change Minimum Data Set, dated [DATE] documented Resident #8 was cognitively intact and received an antidepressant. The Physician orders last reviewed 6/9/2026 documented an order for Sertraline (Zoloft) 75 milligrams once a day for Depression. Review of Medication Administration record dated March 2026, April 2026, May 2026 and June 2026 documented Resident #8 received medication as ordered. The care plan titled the resident used antidepressant related to Depression created 5/29/2024 and last reviewed 2/28/2026 had interventions which included administer antidepressant medications as ordered by physician, monitor side effects and effectiveness every shift, and monitor document adverse reactions to antidepressants. A Nursing weekly behavior note dated 6/3/2026 documented resident receiving psychotropic medication with no adverse side effects from psychotropic mediations. A Psychology progress note dated 6/1/2026 documented resident missing sibling who died. The goals to improve and adjust to difficult loss. Resident will continue to explore feelings and grief and loss. There was no documented evidence that the Resident #8's care plan for Depression was reviewed or revised after completion of the Significant Minimum Data Set assessment dated [DATE]. 2. Resident #191 had diagnoses that included Coronary Artery Disease (is a common type of heart disease which affects the main blood vessels that supply blood to the heart, called the coronary (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	arteries), Alzheimer's Disease, and Respiratory Failure (serious condition in which the lungs cannot provide enough oxygen to the blood or remove enough carbon dioxide from it). The Annual Minimum Data set (a resident assessment tool) dated 1/21/2026, and the Quarterly Minimum Data Set, dated [DATE] documented Resident #191 had severely cognitive impairment and never/rarely made decisions. The Minimum Data Set assessments further documented Resident #191 was receiving Oxygen therapy. The Physician's orders dated last reviewed 6/6/20206 documented order for Oxygen continuously two (2) liters via nasal canula humified for shortness of breath. Review of Respiratory Administration record dated June 2026, May 2026, April 2026, documented resident receiving Oxygen treatments as ordered. The care plan titled The resident has Oxygen therapy related to Congestive Heart failure, resident is on nebulizer treatments created 5/28/2025 and last reviewed 7/19/2025 included Interventions of changing residents' positions every two hours to facilitate lung secretions, movement and drainage, monitor for signs/symptoms of respiratory distress and report to Medical Doctor as needed. There was no documented evidence that Resident #191's oxygen therapy care plan had been reviewed or revised after the completion of Minimum Data Set assessments on 01/21/2026 and 04/07/2026 and updated to reflect the resident is no longer on nebulizers treatments. On 06/11/2026 at 5:04 PM, during an interview the Director of Nursing stated there were a lot of changes in facility staffing, especially for Registered Nurses. The Director of Nursing also stated the changes included changes in unit assignment, and the facility used to have a Registered Nurse in charge for each floor. The Director of Nursing further stated this change greatly impacted facility documentation compliance. The Director of Nursing stated one year ago, the facility had one unit Manager, one Registered Nurse Charge Nurse, and one Licensed Practical Nurse who gave medication for each floor. The Director of Nursing stated the facility lost six Registered Nurse positions, and the facility cannot get the time to complete care plans. On 06/11/2026 at 2:17 PM, during an interview, Registered Nurse #1 stated care plans are updated quarterly, annually, after a significant change and as needed in the care planning meeting. Registered Nurse #1 also stated during the care planning meeting, if there were no changes then no editing is needed in the care plan. Registered Nurse #1 further stated if there are no changes in the resident care, they will not put in a note or document the care plan was reviewed as there is an assumption that the care plan is still in effect, and there is general signing off by the different departments, but no updating of the individual care plan itself. Registered Nurse #1 someone looking at the care plan would not know if the care plan had been updated by looking at the care plan. Registered Nurse #1 stated the care plans in the facility are updated by discussing the resident during the care planning meetings, and the Social Worker enters a note that the care plan meeting was done. Registered Nurse #1 reviewed the notes in the residents' medical record and were unable to identify any written documentation that showed the care plans were reviewed or revised after each assessment. 3. Resident #56 had diagnoses including Alzheimer's Disease, Psychotic Disorder, Depression, and Anxiety Disorder. The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 03/17/2026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335826	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Buena Vida Rehab and Nursing Center	48 Cedar Street Brooklyn, NY 11221

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented that Resident #56 had severe cognitive impairments, was rarely/never understood, and was rarely/never able to understand others. The Quarterly Minimum Data Set assessment also documented that Resident #56 was dependent on others for all areas of care. The Comprehensive Care Plan titled Potential Abuse documented that Resident #56 was at risk of abuse due to re-admission and their Dementia diagnosis. The goals documented that Resident #56's safety would be maintained, and that they would verbalize feeling safe in their environment. The Comprehensive Care Plan for Potential Abuse was last revised on 10/17/2025 and there was no documented evidence that it was reviewed after Resident #56's Minimum Data Set assessment on 03/17/2026. On 06/11/2026 at 01:37 PM, the Director of Social Services was interviewed and stated that they were responsible for updating the Potential Abuse Comprehensive Care Plan for Resident #56 on a quarterly basis within a few days of each Minimum Data Set assessment being completed. The Director of Social Services confirmed that the Potential Abuse care plan had not been updated since 10/17/2025 and that it should have been updated after Resident #56's Minimum Data Set assessment on 03/17/2026. The Director of Social Services stated that they did not know how they had missed updating the care plan. 4. Resident #29 had diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that causes airflow blockage and makes breathing difficult), malnutrition (poor nutrition from not getting enough food or the right nutrients), and hypertension (high blood pressure). The Quarterly Minimum Data Set assessment (a resident assessment tool) dated 04/12/2026 documented Resident #29 had severely impaired cognition and a feeding tube. A comprehensive care plan for Advance Directives with a last reviewed date of 04/11/2026 documented no feeding tube for Resident #29. The physician's orders dated 09/22/2025 with a revision date of 04/10/2026 documented an order for a long-term feeding tube. The April 11, 2026, Medical Orders for Life-Sustaining Treatment form documented long-term feeding tube. On 06/11/2026 at 3:45 PM, the Director of Social Service was interviewed and stated their department reviews care plans during initial assessments, comprehensive assessments, annual assessments, quarterly assessments, and readmissions from hospitals. The Director of Social Service further stated Social Worker #1 reviewed but forgot to update Resident #29's advance directive care plan after the physician placed an order for a long-term feeding tube. On 06/12/2026 at 11:23 AM, Social Worker #1 was interviewed and stated they overlooked updating Resident #29's advanced directives care plan to reflect their changed status to long term feeding tube because they were busy documenting notes in records and visiting people. 10 New York Codes, Rules and Regulations 415.11(c)(2) (i-iii)