STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335545	A. Building B. Wing	01/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
King David Center for Nursing and Rehabilitation	2266 Cropsey Avenue Brooklyn, NY 11214

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48931 Based on observations, record review, and staff interviews conducted during the Recertification/Complaint survey conducted from 1/4/24 to 1/10/24, the facility did not ensure that the resident was offered the opportunity to participate in the revision and/or review of the comprehensive care plan. Specifically, resident and resident's representatives were not consistently invited to participate in their care plan meetings. This was evident for 1 resident reviewed for care plans out of 38 residents. (Residents #112). The findings are: The facility policy titled Care Planning-Interdisciplinary Team last revised on 1/2023 documented, the resident, the resident's family and/or the resident legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan. Resident #112 was admitted with diagnoses that included Vascular Dementia, Anxiety, Hemiplegia, and Hemiparesis. The Quarterly Minimum Data Set, dated dated dated [DATE] documented the resident was severely cognitively impaired and was dependent on staff for most Activities of Daily Living. The Annual Minimum Data Set also documented that only the resident participated in the assessment. On 1/4/23 at 11:02 AM, during an interview Resident #112 stated that no one had discussed discharge planning with them and they had not been invited to attend any care plan meetings. The Care Plan Conference Summary dated 11/16/2023 did not document that Resident #112 and/or their representatives participated in the meeting. There was no documented evidence in the electronic medical record that Resident #112 had been invited to or participated in the care plan meetings. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/24 at 3:14 PM, an interview was conducted with Social Worker #2 who stated that Resident #112 was invited to care planning meetings verbally however the invitations and response to the invitations are not documented. Social Worker #2 also stated that residents are invited to the care planning meeting by verbal invitations and resident representatives are mailed or hand delivered letters of invitations. Resident #112 is usually open to attending the meetings and the representative/family sometimes attends. Resident #112 discharge wishes were verbalized during rounds but were not discussed or followed up on during the care plan meetings. On 01/10/24 at 11:13 AM, an interview was conducted with the Director of Social Services who stated that they cover care planning meetings when the assigned Social Worker is not available, along with other members of applicable departments. The Director of Social Services also stated that Resident #112 had not verbalized any concerns regarding discharge to them personally. The Director of Social Services further stated that invitations to the care planning meetings are not documented only attendance to the meetings is documented. 415.13(f)(1)(v)

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48931 Based on observations, record review and interviews conducted during the Recertification survey from 1/4/24 to 1/10/24, the facility did not ensure that the resident received services that accommodated the resident's needs and preferences. Specifically, the call bell in Resident #237's bathroom did not work. The findings are: Resident #237 was admitted to the facility with diagnoses which included Vascular Dementia, Psychotic Disturbance, and Depression. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #237 had moderately impaired cognition, required partial/moderate assistance when performing Activities of Daily Living and supervision for mobility and transfers. The Comprehensive Care Plan for focus resident is at High Risk for Falls last revised on 10/27/23 included interventions of be sure call light is within reach and encourage to use it for assistance as needed, needs prompt response to all requests for assistance, and assist with toileting upon awakening, before/after meals and at bedtime. On 01/04/24 at 10:11 AM and on 01/08/24 at 10:04 AM, an observation was conducted of the resident bathroom. The call device was observed to be in-active, with no observed power to the device. No substitute device or means of emergency communication was observed in the area. On 01/04/24 at 10:11 AM and on 01/08/24 at 10:04 AM, Resident #237 refused to be interviewed. On 01/08/24 at 11:55 AM, an interview was conducted with Registered Nurse #6 who stated that they were not aware that the call system in the shared resident bathroom was not working and had no power. On 01/08/24 at 02:21, an interview was conducted with Certified Nursing Assistant #5 who stated that they were not aware that the call system in the shared resident bathroom was not working and had no power. On 01/08/24 at 02:56 PM, an interview was conducted with Registered Nurse #7 who stated they were not sure about the status of the call device and was not certain if another device was provided for either of the residents to use to call for staff if needed. On 01/08/24 at 03:33 PM, an interview was conducted with the Director of Maintenance who stated that the resident's roommate pulled the call system from the wall on 12/28/23. The area was covered by a metal plate however this would affect the call device in the shared resident bathroom as there was now no power to the device. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/24 at 03:32 PM, a follow-up interview was conducted with the Director of Maintenance who stated that the facility's plan is to rewire the bathroom call device directly to room [ROOM NUMBER]. This is corrective action. Was anything put in place for resident to contact staff until repairs could be made? 415.5 (e)(1)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48931 Based on observations, interviews, and record reviews during a Recertification/Complaint survey from 1/4/23 to 1/10/23, the facility did not ensure that assessments accurately reflected the residents' status. Specifically, the admission assessment did not reflect the presence of a colostomy device that was used for a resident. This was evident for 1 of 1 resident reviewed for Urinary Catheter out of a sample of 38 residents. (Resident #24) The findings are: The facility's policy regarding Minimum Data Set (MDS) Guideline for Completion last reviewed 10/01/23 documented, It is the policy of all Allure Facilities to ensure accurate and timely completion of MDS/Comprehensive Care Plan (CCP) for all residents in accordance with the Federal and State Operation Manual. Resident #24 was admitted to the facility with diagnoses which include Obstructive Uropathy, Unspecified Hydronephrosis, and Chronic Obstructive Pyelonephritis. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented that Resident #24 was moderately cognitively impaired, had no behaviors and did not reject care. Resident required dependent assistance with most Activities of Daily Living, had an indwelling catheter and was frequently incontinent of bowel. On 1/4/23 at 10:32 AM, Resident #24 was interviewed and stated that they had a urinary device in place and experienced pain and discomfort regularly. The Comprehensive Care Plan titled resident has alteration in gastro-intestinal status related to neoplasm of rectum, malignant neoplasm of colon with Colostomy, fistula of intestine was created 10/31/23 and revised 12/27/23. The goal was to not have complications related to ostomy presence through review date. Interventions included: avoid activities that involve bending, discuss concerns with resident/family members, ensure privacy, provide ostomy care as ordered, monitor for complications. The Admission Nursing Summary dated 10/30/23 documented that resident had bilateral nephrostomy tube and colostomy on the right side of the abdomen. The Admission Minimum Data Set assessment did not reflect that Resident #24 had an ostomy in place. On 01/10/24 at 02:12 PM, an interview was conducted the Director of Minimum Data Set assessments who stated that the MDS nurse completes the observations, data collection on entry and is responsible for ensuring the accuracy of the assessment. The Director of Minimum Data Set assessments also stated that the nurse responsible for completing the Admission Minimum Data Set assessment for Resident #24 was no longer an employee of the facility. The Director of Minimum Data Set assessments further stated that they are only responsible to signs off on the assessments and do not check for the accuracy of the document. 415.11 (b)

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 18881 Based on observations and interviews conducted during the Recertification Survey from 01/03/2024 to 01/10/2024, the facility did not ensure that the nurse staffing information was posted appropriately. Specifically, the posting of daily nurse staffing information was not posted in a prominent area which was readily accessible to residents and visitors. The finding is: The facility policy and procedure titled Posting Daily Nurse Staffing Information dated 1/23 documented that it is the policy of our facility to ensure nurse staffing information is readily available in a readable format to residents and visitors at any given time. During observations conducted on 01/03/2024, 01/05/2024 and 01/08/2024, the State Surveyor was unable to locate the postings of the daily nurse staffing levels for each shift or any signage instructing residents or visitors where it was located. On 01/09/2024 at 12:30 PM, the State Surveyor asked the Director of Nursing where the staffing information was located and was shown the posting located in the hallway posted next to the staff bulletin board, near the time clock. This area was not readily accessible to residents or visitors. On 01/10/2024 at 1:30 PM, the Staffing Coordinator was interviewed and stated they were responsible for posting the nursing staffing information daily. The Staffing Coordinator also stated that the information is posted near the employee time clock as this is where the former Staffing Coordinator placed it. The Staffing Coordinator further stated that they were not aware that the notice was to be posted where it is visible for visitors, families, and residents. On 01/10/2024 at 1:35PM, the Director of Nursing was interviewed and stated that as far as they know the staffing information has always been posted in the hallway next to the bulletin board near the time clock. The Director of Nursing further stated the notices would be accessible to residents who go to activities and the rehabilitation center and not all residents and visitors. The Director of Nursing further stated that it did not occur to them that the notice has to be posted in an accessible location for visitors, families, and residents. 415.13

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44864 Based on observations, interviews, and record review conducted during the Recertification and Complaint Survey (NY00297824) from 01/03/2024 to 01/10/2024, the facility did not ensure that menus and dietary preferences were followed. This was evident for 2 (Resident #463 and Resident #125) of 4 residents reviewed for Food out of 38 total sampled residents. Specifically, 1). Resident #125 did not receive food items listed on their tray ticket during mealtime, and 2). Resident #463 did not receive a cheese sandwich as preferred. The findings are: The facility's policy titled Resident food preferences, last revised 1/23, documented that the dietician will visit residents periodically to determine if revisions are needed regarding food preferences. The nursing staff will inform the kitchen about resident requests. 1.Resident #463 was admitted to the facility with diagnoses that include Atrial Fibrillation and Coronary Artery Disease. The 5-day Minimum Data Set 3.0 assessment dated [DATE] documented that resident's cognition as modified independence, Brief Interview for Mental Status score of 12, no swallowing disorder, and on a therapeutic diet. The Minimum Data Set 3.0 assessment also documented that Resident #463 required partial/moderate assistance for eating. The Comprehensive Care Plan for Nutrition created 12/21/23 documented Resident #463 has a therapeutic diet with goals that include Resident will consume more than75% of meals. Interventions include to provide food preferences as desired. The Physician's Orders dated 12/20/23 documented Resident #463's diet as no added salt, regular texture, thin consistency. On 01/10/24 at 12:03 PM, the State Surveyor observed Resident #463 sitting at the nursing station with an escort. While sitting at the nurse's station, the State Surveyor observed Licensed Practical Nurse #1 make a telephone call to the kitchen and inform the Food Service Director that Resident #463 was requesting a cheese sandwich to take to an outside appointment. Licensed Practical Nurse #1 then told Resident #463 that they would not be able to get a cheese sandwich at this time since the kitchen was serving a meat lunch, so they cannot meet that request. The Licensed Practical Nurse #1 then offered Resident #463 a tuna or a peanut butter sandwich, to which Resident #463 replied that they do not like tuna nor peanut butter and insisted that they only want a cheese sandwich. Resident #463 also stated that they will just remain hungry if they cannot get a cheese sandwich. At approximately 12:05 PM, Food Service Director was interviewed via phone and stated that it was not possible for Resident #463 to receive a cheese sandwich even if there were cheese sandwiches available. The Food Services Director stated that since the kitchen was serving a meat lunch according to kosher principles, they are not able to serve a cheese sandwich, which is dairy. The State Surveyor then observed the resident leaving the unit with an escort without any food items. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 1/10/24 documented that resident is alert and verbally responsive no complaints voiced, via wheelchair, accompanied by her escort. Left the unit at 12:15 PM for scheduled Cardiology appointment. On 01/10/24 12:13 PM, a follow-up interview was conducted with the Food Service Director who stated that because the facility is a Kosher facility, they were unable to provide the resident with a cheese sandwich. The Food Service Director also stated that they thought that the resident was going to have the sandwich on a tray on the unit and was not aware that the resident was going to an outside appointment. The Food Service Director further stated that once they realized that the resident was going out, they asked the Rabbi about giving the sandwich in a brown bag, which would have been acceptable, but the resident had already left the facility, without a sandwich. The Food Service Director stated that usually the staff would ask for a bagged lunch, however in this case, they were not made aware that the resident was leaving, and they thought that this request was that the sandwich would have been eaten on the unit. On 01/10/24 at 01:03, Licensed Practical Nurse #1 was interviewed and stated that at 11:30 AM, they asked Resident #243 if they wanted to have a lunch tray, but Resident #243 refused, and stated they wanted a Swiss cheese sandwich. Licensed Practical Nurse #1 also stated that they called downstairs to the kitchen, and spoke with the Food Service Director, who said they would send the sandwich. Licensed Practical Nurse #1 further stated that they called the kitchen again at 12:00 noon, since Resident #463 was about to leave for an outside appointment and had not received the sandwich. Licensed Practical Nurse #1 said that the Food Service Director then told them that they were preparing a meat lunch so they cannot get a cheese sandwich and offered a tuna and or a peanut butter sandwich. The Food Service Director said that the Rabbi said that this is a Kosher facility and that Resident #463 is unable to get a cheese sandwich at this time. Licensed Practical Nurse #1 stated Resident #463 only wants a cheese sandwich, and that they are going out to an appointment. On 01/10/24 01:15 PM, Registered Nurse #1 was interviewed and stated that once the resident has an outside appointment, they get a lunch bag. Registered Nurse #1 also stated that they were not aware that Resident #463 did not have any lunch bag prior since the kitchen would either bring it up or leave it at the front desk. Registered Nurse #1 further stated that Resident #463 did not eat lunch before they left the unit for their appointment and should have gotten something to take on the appointment. Registered Nurse #1 stated that sometimes they would have the sandwich prepared ahead of time. 2. Resident #125 was admitted to the facility with diagnoses that included End Stage Renal Disease, Diabetes Mellitus and Hemiparesis. The Quarterly Minimum Data Set 3.0 assessment dated [DATE], documented resident had intact cognition, was on a therapeutic diet, and participated in goal setting. The Physician's Orders dated 6/19/23 documented Resident #125's diet as no concentrated sweets, renal, no added salt, low potassium diet. The Comprehensive Care Plan for Nutrition created on 5/17/21 documented Resident #125 was on a therapeutic diet. Goals included Resident #125 will maintain adequate nutritional status, and interventions included provide and serve diet as ordered, no concentrated sweets, renal, no added salt, low potassium diet, Regular texture, thin consistency (double vegetable portions). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/03/24 at 12:45 PM during a Dining Observation, Resident #125 was observed lying in bed in their room. The lunch meal ticket documented 1/2 cup peas and carrots, 1 piece banana, 1/2 cup cucumber and onion salad, 1/2 cup penne pasta, 6 oz chicken broth,7 oz sausage and peppers, Resident #125's meal tray did not have a 1/2 cup peas and carrots, 1 piece banana, and the 1/2 cup cucumber and onion salad present on the tray. On 01/03/24 at 12:55 PM, the Registered Dietician was interviewed and stated that Resident #125 did say at times the seltzer and other items were sometimes missing on their tray. The Dietician also stated that when the resident did mention the missing items, they notified dietary staff about the concern. The Dietician further stated that they meet with the Resident #125 often to discuss any concerns. On 01/10/24 at 03:23 PM, the Food Service Director was interviewed and stated that the Kitchen supervisor double checks to ensure accuracy, and staff will notify them if there are any discrepancies. The Food Service Director also stated that they have been working with the dietician to ensure accuracy and that the dietary workers are made aware that they are to check the tickets. On 01/10/24 at 3:03 PM, the Administrator was interviewed and stated that the facility is working to ensure all residents receive the proper meal. The Administrator also stated that the dietary team has to audit trays every meal and that they work hard to ensure all residents receive the correct trays. The Administrator further stated that the staff on the unit also checks the trays. 415.14(c) (1-3)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18881 Based on observation, record review and interview conducted during the Recertification Survey 01/03/2024 to 01/10/2024, the facility did not ensure that the most recent hospice plan of care was provided for a resident. Specifically, the Hospice Assessment, Plan of Care and Hospice team interdisciplinary notes were not provided to the facility and available for review for Resident #87. This was evident for 1 of 1 resident reviewed for Hospice out of 38 sampled residents. The findings are: The facility policy and procedure titled Hospice Program with a revision date of 1/23 documented that King [NAME] Center contracts for hospice services for residents who wish to participate in such programs. The policy also documented that when a resident participates in the hospice program, a coordinated plan of care between King [NAME] Center, Hospice Agency, and resident/family will be developed and shall include directives for managing pain and other uncomfortable symptoms. The care plan shall be revised and updated as necessary to reflect the resident's current status. The Agreement for Hospice Care to Skilled Nursing Facility residents signed between Visiting Nurse Services of New York Hospice and King [NAME] on April 30, 2015, Article 3 Section 2.4 documented that the Hospice shall develop, review, and revise a Hospice Plan of Care for each Hospice resident which reflect the participation of the Hospice, Skilled Nursing Facility and the Hospice resident and family to the extent possible. Hospice will furnish Skilled Nursing Facility with a copy of the Plan of Care and will identify the services to be furnished by Skilled Nursing Facility, and those services to be provided by Hospice. The agreement also documented that would be communication between Hospice and Skilled Nursing Facility to ensure that the needs of Hospice residents are addressed and met 24 hours a day. Resident #87 was admitted with diagnoses that included Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Senile Degeneration of the Brain. The Minimum Data Set 3.0 assessment dated [DATE] documented that the resident was severely cognitively and dependent on staff for all Activities of Daily Living. On 01/08/2024 at 4:26 PM, Resident #87 was observed in their room, in bed asleep, and appeared frail and weak in appearance. On 01/09/2024 at 2:00PM, Home Health Aide #6 (Hospice) sat with Resident #87 in the dining room. The Physician's order dated 12/14/2023 documented renewal of an order for Hospice Care which had been initiated on 08/13/2023. 8an admission assessment, Comprehensive Care Plan, or the Plan of care for the Hospice Home Health Aide. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/09/2024 at 11:30AM, Licensed Practical Nurse #2 was interviewed and stated that they did not know where the Hospice documents for Resident #87 were. During an interview on 01/09/2024 at 11:35AM, Registered Nurse Supervisor #8 stated they did not know where the hospice documents were. Registered Nurse Supervisor #8 also stated that the Hospice Nurse comes in weekly, converses with the staff, but does not give any update on the resident's condition. Registered Nurse Supervisor #8 then reviewed Resident #87's medical record and presented an untitled, handwritten document dated 9/14/23, 9/21/23 and 9/28/23, each note titled RN visit made. There were no other documents from the Registered Nurse or any of the other members of the Hospice interdisciplinary team. On 01/10/2024 at 2:12 PM, a telephone interview was conducted with the Hospice Registered Nurse #9 who stated that Resident #87 was last visited on 12/29/2023. Hospice Registered Nurse #9 also stated that they make weekly visits, coordinate with the nursing home staff, and do Home Health Aide supervision every 2 weeks. Registered Nurse #9 further stated that the Home Health Aide provides companionship, holds the resident's hand, converses, and provides psychosocial-emotional support, makes observation of any changes and reports this to the nurse. Hospice Registered Nurse #9 stated that they are responsible for all transmitting all documents to the facility within 48 hours after each visit. During an interview on 01/09/2024 at 2:22 PM, Home Health Aide #6 stated that they did not receive a copy of Resident #87's Plan of Care, and Hospice Registered Nurse #9 gave them instructions to observe the resident, check their nasal cannula, offer them water or juice, and report any changes to the nursing home staff. 415.12