STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335174	A. Building B. Wing	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobble Hill Health Center Inc	380 Henry Street Brooklyn, NY 11201

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interviews conducted during the Abbreviated survey (NY00307820), the facility failed to ensure that the services provided or arranged by the facility meets professional standards of quality. This was evident in 1 out of 3 residents (Resident #1) sampled. Specifically, on 12/27/22 at approximately 06:30am on the night shift (11:00pm-07:00am), Resident #1 was observed on the floormat in their room and was picked up and put back into their bed by Registered Nurse #1. An x-ray result dated 12/28/22 documented that Resident #1 sustained an acute nondisplaced right femur intertrochanteric fracture. The facility's Investigation Summary dated 12/29/22, revealed that Registered Nurse #1 did not report the fall. There was no documented evidence that Resident #1 was assessed by Registered Nurse #1. The facility became aware of Resident #1's fall on 12/29/22 during an interview with Registered Nurse #1. The findings are: The facility Policy and Procedure titled Reporting and Documenting Resident Accident/Incident with reviewed date 11/2023 documented that All residents involved in accident/incidents are assessed by the nurse and the physician. The Registered Nurse assesses all resident's condition when an accident/incident occurs or when resident is eased to the floor. Notifies the physician if the resident's condition requires immediate medical attention or transfer to the hospital. If transfer to the hospital is indicated, notify the designated representative immediately. The facility Policy and Procedure on Prevention of Resident Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property dated 11/2023 documented that the facility is committed to providing residents with an environment that is free from abuse, neglect, or mistreatment. Resident #1 was admitted to the facility with diagnoses including Osteoarthritis, Osteoporosis, and Dementia. The Minimum Data Set 3.0 dated 12/02/22 documented that Resident #1 was moderately impaired in cognition and required extensive assistance of one-person in transfer, and ambulation and extensive assistance of two persons in bed mobility. A nursing progress note dated 12/27/22 at 3:07pm, by Licensed Practical Nurse #1 who worked on the 07:00am - 03:00pm, documented that Resident #1 had a right hip pain and that bruising was observed on Resident #1's right lower extremity with some scratches. Nursing Supervisor #2 and Nurse Practitioner #1 were notified. (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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NAME OF PROVIDER OR SUPPLIER Cobble Hill Health Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 380 Henry Street Brooklyn, NY 11201	

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note, by Licensed Practical Nurse #2 who worked on the 03:00pm - 11:00pm, dated 12/27/22 at 04:21pm documented Resident #1 observed with two reddened circular areas to the left lateral aspect of Resident #1's left lower extremity. A liner reddened area appeared to be a scratch was observed at Resident #1's inner right lower extremity, and Resident #1 had facial grimacing when Resident #1 was turned. A Physician's Order dated 12/27/22 at 05:06pm documented a bilateral hip x-ray. A late note dated 12/28/22 at 09:22am, by Nurse Practitioner #1, documented that Resident #1 was evaluated on 12/27/22 (no time identified) with facial grimacing and occasional moaning. No falls reported. A Radiology Report dated 12/28/22 documented that a service was provided on 12/28/22 and that the results revealed an Acute nondisplaced, right femur intertrochanteric fracture. A nursing progress note, by Licensed Practical Nurse #3, dated 12/28/22 at 11:22pm documented that Resident #1 was transferred to the hospital for evaluation at 11:20pm. A Hospital After Visit Summary dated 01/04/23 documented that Resident #1 was status post intramedullary nail of the right femur on 12/30/22 without complication. A Facility Investigation Summary dated 12/29/22, documented there was evidence of neglect. Registered Nurse #1 failed to report an incident that led to injury. Initially, Registered Nurse #1 reported that nothing unusual happened on 12/27/22. However, on 12/29/22 Registered Nurse #1 was informed that Resident #1 had sustained an acute right femur intertrochanteric fracture and Registered Nurse #1 sighed and stated that Resident #1 fell on the ground and that they picked up Resident #1, assessed Resident #1, but did not report the fall. During a telephone interview on 02/13/24 at 03:34pm, Certified Nursing Assistant #1 stated that they worked on 12/26/22 on the 11:00pm - 07:00am shift. Certified Nursing Assistant #1 stated that they heard shouting coming from Resident #1's room and asked Registered Nurse #1 to check Resident #1's room. Certified Nursing Assistant #1 stated that they also went to Resident #1's room and observed Registered Nurse #1 in the process of transferring Resident #1 from the floormat to the bed. Certified Nursing Assistant #1 stated that they assisted with putting Resident #1 back in bed. Certified Nursing Assistant #1 stated that they did not observe Registered Nurse #1 assess Resident #1. Certified Nursing Assistant #1 stated that after Registered Nurse #1 put Resident #1 back in bed, Registered Nurse #1 left the room. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 02/14/24 at 9:10am, Registered Nurse #1, who worked on 12/26/22 on the 11:00pm - 07:00am shift, and that they were at the nursing station when they were asked to go to Resident #1's room. Registered Nurse #1 stated that they went to Resident #1's room and observed Resident #1 on the floormat. Registered Nurse #1 affirmed that they picked up Resident #1 from the floormat and Certified Nursing Assistant #1 assisted them. Registered Nurse #1 stated that they assessed Resident #1's body for bruising and that range of motion was done and that Resident #1 was not in pain. Registered Nurse #1 stated that Resident #1 was observed on the floormat around 06:30am (close to end of shift) and that they did not report the fall. Registered Nurse #1 stated that that were not sure that they wrote about the fall. A subsequent telephone interview on 02/28/24 at 03:27pm, Registered Nurse #1 said that they were aware of the Policy and Procedure on Incident/Accident and that they should have notified their nursing supervisor and medical doctor. Registered Nurse #1 also stated that they should have documented their assessment of Resident #1. Registered Nurse #1 stated that they did not report the fall because it was close to the end of their shift. During a telephone interview on 02/15/24 at 9:47am, Nursing Supervisor #2 stated that Licensed Practical Nurse #1 notified them on 12/27/23 at approximately 08:00am that Certified Nursing Assistant #2 reported to Licensed Practical Nurse #1 that Resident #1 was not themself. Nursing Supervisor #2 stated that they assessed Resident #1 together with Licensed Practical Nurse #1 and Certified Nursing Assistant #2. Nursing Supervisor #2 stated that Resident #1 had a small scratch on their right hip and pushed Nursing Supervisor #2's hand when Resident #1's right hip was touched. There was no swelling or discoloration to bilateral hip and Nurse Practitioner #1 was notified. Nurse Practitioner ordered an x-ray of bilateral hip, Diclofenac gel to apply to right hip and to continue with Acetaminophen for pain. There was no documentation of Nursing Supervisor #2's assessment and findings. During a telephone interview on 02/14/24 at 1:37pm, Nurse Practitioner #1 stated that they were informed on 12/27/22 (can't remember the time and who informed them) that Resident #1 seemed to be in pain when moving their right leg. Nurse Practitioner #1 stated that they were in the building and immediately examined Resident #1. Nurse Practitioner #1 stated that Resident #1 had occasional moaning and facial grimacing when Resident #1 moved their right hip. Nurse Practitioner #1 stated that the x-ray result revealed an acute non-displaced right femur intertrochanteric fracture. Nurse Practitioner #1 stated that they did not order a STAT x-ray because there were no reported falls or trauma. During an interview on 02/06/24 at 3:00pm, the Director of Nursing stated that they conducted the investigation and that Registered Nurse #1 initially stated that nothing unusual happened to Resident #1. The Director of Nursing stated that when they informed Registered Nurse #1 that Resident #1 sustained a right hip fracture, Registered Nurse #1 stated that Resident #1 fell on their shift. The Director of Nursing stated that Registered Nurse #1 stated that they did not report the incident to Nursing Supervisor #1 because they were tired and wanted to go home. The Director of Nursing stated that Registered Nurse #1 failed to report the fall and there was evidenced of neglect. 10 NYCRR 415.11(C)(3)(i)