STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335513	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SEAGATE REHABILITATION AND NURSING CENTER	**3015 W 29 ST BROOKLYN, NY 11224**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review conducted during an abbreviated survey (NY 612), the facility did not ensure that each resident receives adequate supervision to prevent accidents. This was evident in 1 out of 3 residents sampled (Resident #1). Specifically, on 07/15/2020, Resident #1 reported that Certified Nursing Assistant #1 (CNA #1) hit his head on the bedrail during care. Resident #1 complained of pain to the left side of his head. Record review revealed that Resident #1 required assistance of two (2) people for bed mobility. On 07/15/2020, CNA #1 did not follow Resident #1's plan of care. The Findings Include: The Facility's Policy and Procedures on Accident/Incidents-Risk Management dated 5/20/2019 documented that an Accident is an unexpected, unintended event that can cause a resident body injury and incident as an unexpected, unintended event that can cause a resident superficial or no injury. Resident #1 was initially admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set, a resident assessment tool, dated 06/26/2020, revealed that Resident #1 had a Brief Interview for Mental Status (BIMS, used to determined attention, orientation and ability to recall information) score of 11/15 (00-7 severe impairment, 08-12 moderate impairment and 12-15 cognitively intact). Review of Resident #1's Activity of Daily Living (ADL) Care Plan dated 06/19/2020, documented that Resident #1 required assistance of 2 people for bed mobility and transfer. Review of the Resident Nursing Instructions dated 06/19/2020, revealed that Resident #1 required 2 persons assistance with bed mobility; turning and positioning when in bed. Review of the Nurse's Progress Note dated 07/15/2020 at 3:19 p.m. documented that Resident #1 reported during morning care, CNA #1 was rude, was rough with him and banged his forehead on the bedrail. Resident #1 stated that he was rude to CNA #1. Resident #1 was assessed, and no visible injury was noted. Resident #1 complained of headache on a scale of 5/10 and pain medication was given. CNA #1 was removed from the assignment. Review of the Facility's Accident and Incident Report dated 07/15/2020 documented that on 07/15/2020 between 8:00 a.m. to 8:30 a.m., Resident #1 reported to staff that CNA #1 was rough during care. Resident #1 stated that CNA #1 banged his forehead on the bedrail and threw a towel over his face. [MEDICATION NAME] was given for pain. Resident #1 and CNA #1 cursed at each other. Review of the Physician's Progress Note dated 07/16/2020 documented that Resident #1 was examined after possibly sustaining an injury. Resident #1 complained of left side headache. No neuro deficit was noted. Review of the Medication Administration Record [REDACTED]#1 reported that while CNA #1 was providing care to him, the CNA banged his head on the bedrail and threw a towel in his face. The RNS stated that she assessed the resident with no visible injury. Upon inquiry, the RNS stated that the Charge Nurse on the unit supervised the CNAs and ensures that the CNAs are following the residents plan of care. During a follow-up interview with the RNS on 09/22/2020 at 1:50 p.m., the RNS stated that the Charge Nurse informed her of Resident #1's allegation. The RNS stated that she spoke with Resident #1 and the resident allegation remained the same. The RNS stated that she assessed Resident #1 with no visible injuries, but that the resident complained of headache. The nurse on the unit administered [MEDICATION NAME] 5mg-325mg tablet. Resident #1 was reassessed, and the pain scale was 0/10. During an interview with CNA #1, who was assigned to Resident #1 on 07/15/2020, on 09/03/2020 at 11:00 a.m., CNA #1 stated that Resident #1 got upset and started cursing and using inappropriate language to her. CNA #1 stated that she provided care to Resident #1 without assistance of another staff member. The CNA stated, she turned Resident #1 and as she was pulling the soiled bedsheet from under the resident, Resident #1's head accidently hit the bedrail. During an interview with the Director of Nursing Service (DNS) on 09/01/2020 at noon, the DNS stated that Resident #1 informed the Social Worker (SW) that during morning activities of daily living (ADL) care, CNA #1 was rude, was rough with him, banged his forehead on the bedrail and threw a towel over his face. The DNS stated that Resident #1 and CNA #1 cursed at each other. The DNS stated that Resident #1 had an order for [REDACTED].#1 complained of headache and pain medication was administered. During a follow-up interview with the DNS on 09/22/2020 at 2:30 p.m., she stated that CNA #1 did not follow Resident #1's plan of care. She stated that the License Practical Nurse (LPN) and the Unit Manager are responsible for supervising the CNAs to ensure that the CNAs follow the residents plan of care. 415.12(h)(1)

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