STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335070	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn Gardens Nursing & Rehabilitation Center	835 Herkimer Street Brooklyn, NY 11233

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey (Incident #711926), the facility failed to ensure that residents are free from resident-to-resident abuse. This was evident in two (2) of seven (7) residents (Resident #5 and Resident #7) sampled. Specifically, Resident #5, a known wanderer, wandered into Resident #7's room from a shared bathroom on 01/14/2025 at 8:10 AM. As a result, Resident #5 and Resident #7 were engaged in a resident-to-resident altercation, and Resident #5 sustained an abrasion and swelling to their upper lip. The findings are: The facility's Policy and Procedure titled Abuse Prevention dated 12/29/2023, documented that the intent of the policy was to prevent/prohibit resident abuse. The facility provides a safe resident environment that protects residents from abuse, including verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This includes staff to resident abuse of any type, resident to resident abuse of any type and visitor to resident abuse of any type. Resident #5 was admitted to the facility with diagnoses including Alzheimer's Dementia, Psychotic Behavior, and anxiety disorder.The Minimum Data Set (an assessment tool) dated 12/18/2024, documented Resident #5 had severe cognitive impairment. A Behavioral/ at Risk for Abuse Care Plan dated 11/25/2024 documented interventions for staff to observe the resident during rounds and care, monitor for changes in mood, and keep the resident away from other peers whenever possible. A review of the Resident Nursing Instructions dated 01/10/2025 documented Resident #5 had behaviors of wandering, kicking/hitting, using abusive language, threatening, and resisting care.A review of a nursing note by Registered Nurse Supervisor #3 dated 01/14/2025 documented Resident #5 was found on the floor with their buttocks positioned near the bedside of Resident #7's room. Upon assessment, Resident #5 was observed to have a small cut to the inner part of the upper lip, swelling noted in the area, and bleeding. The bleeding was controlled upon immediate intervention, and cold compression was applied. Resident #5 was alert and oriented with no acute distress but noted with confusion. The [NAME] pain scale assessment was completed; Tylenol 650 milligram tablets were administered. A review of a Medical Progress Note by Medical Doctor #2 dated 01/14/2025 documented Resident #5 had an altercation with Resident #7, and they were punched. Resident #5 had a mild swelling of the upper lip, especially on the left side. Resident #5 also had a small wound like to the right angle 0.5 cm in the upper inner left lip in the mucous membrane, not open. The resident denies any complaint except mild pain in the upper lip and no other signs of injury. A review of the 'Nursing Rounds' sheet dated 01/14/2025 documented Resident #5 was last seen in their room sitting on the bed at 8:00 AM by Certified Nursing Assistant #4, as evidenced by their initials. Resident #7 was admitted to the facility with diagnoses including Alzheimer's Dementia, Schizophrenia, and Legal Blindness.The Minimum Data Set, dated [DATE], documented Resident #7 had intact cognition. The Resident Nursing Instructions dated 10/29/2024 documented Resident #7 had behaviors of yelling and screaming. A Risk for Abuse Care Plan, due to diagnoses of weakness, paranoid schizophrenia, movement disorder, and anxiety disorder, dated 11/27/2024 documented interventions including staff to continue monitoring and redirect as needed. A review of the facility's Accident/Incident Report Form dated 01/14/2025 documented at 8:10 AM, Resident #5 was found in Resident #7's room, sitting on the floor. Resident #5 was observed with bleeding and swelling to their upper lip. Resident #7 admitted to punching Resident #5 when Resident #5 refused to leave their room. The facility's Summary of Investigation documented that on 01/14/2024 at around 8:10 AM, Resident #5 entered Resident #7's room (next door) thinking it was their room and was assaulted by Resident #7. The facility concluded that there was no credible evidence to believe that neglect, abuse, and mistreatment occurred. During a telephone interview on 10/03/2025 at 1:50 PM, Certified Nursing Assistant #4 stated that Resident #5 and Resident #7 resided in separate private rooms but shared a bathroom. Certified Nursing Assistant #4 stated they responded to the call bell from Resident #7's room and observed Resident #5 sitting on the floor on 01/14/2025 (unsure of time), and they immediately notified the nurse on the unit. Certified Nursing Assistant #4 stated Resident #7 is verbally aggressive and does not want people coming into their room. Certified Nursing Assistant #4 stated they performed hourly rounding to ensure residents are safety. Certified Nursing Assistant #4 stated they redirected Resident #5 whenever they observe them wandering in the hallway. Certified Nursing Assistant #4 stated Resident #5 usually stays in the dining room and participates in activities. Certified Nursing Assistant #4 stated they were assigned to Resident #5 and Resident #7 on 01/14/2025 on the 7:00 AM - 3:00 PM shift. Certified Nursing Assistant #4 stated Resident #5

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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 conducted during an Abbreviated Survey (Incident # 2616975), the facility did not ensure that the results of all investigations pertaining to alleged violations involving abuse, neglect, exploitation or mistreatment, were reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within five (5) working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident for three (3) of seven (7) residents (Resident #1, #2, #3) sampled for abuse. Specifically, on 09/14/2025 at 12:40 AM, Resident #3 hit Resident #1 and Resident #2 with a footrest from a wheelchair. Resident #1 sustained injury above their right eyebrow, and Resident #2 sustained a large swelling to their right arm. The facility investigated the incident, but did not submit the results of the findings within five (5) days to the New York State Department of Health. The facility submitted the results of the findings on 09/22/2025 at 10:59 AM. The findings are:The facility's Policy and Procedure titled Abuse Prevention dated 12/29/2023, documented that the results of all investigations must be completed, and available to the New York State Department of Health within five (5) working days of the alleged violations is verified appropriate corrective action must be taken.Resident #1 was admitted to the facility with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Depression. The Minimum Data Set (an assessment tool) dated 06/13/2025 documented Resident #1 had moderately impaired cognition.Resident #2 was admitted to the facility with diagnoses including Depression, Hypertension, and Cerebrovascular Disease. The Minimum Data Set, dated [DATE] documented Resident #2 had intact cognition.Resident #3 was admitted to the facility with diagnoses including Depression and Pain.The Minimum Data Set, dated [DATE] documented Resident #3 had intact cognition.A facility's Investigation Summary dated 09/19/2025 documented, without provocation, Resident #3 hit Resident #1 with a footrest of Resident #1's wheelchair on 09/14/2025 at 12: 40 AM. Resident #1 sustained injury above their right eyebrow. Resident #3 also chased Resident #2, who was responding to the noise in the hallway, into their room and hit them with the footrest on their right forearm which resulted in a large swelling. The facility concluded that the incident did not meet definition of abuse as there was no prior pattern of aggression, no clear malice or intent to inflict harm. A review of Nursing Home Investigative Report revealed the facility submitted result of the investigation to New York Department of Health on 09/22/2025 at 10:59 AM.During an interview on 09/24/2025 at 2:12 PM, the Director of Nursing stated they were informed about the incident by Registered Nurse Supervisor #1 on 09/14/2025 at 1:06 AM. The Director of Nursing stated that the Administrator is responsible for reporting the initial and submitting of the five (5) day report to the New York State Department of Health. The Director of Nursing stated they are responsible for reporting all the reportable accident/incidents to the New York State Department of Health, when the Administrator is absence. The Director of Nursing stated the five (5) day submissions are due within five (5) days after the initial submission of the reportable to the New York State Department of Health. During an interview on 09/25/2025 at 4:24 PM, the Administrator stated they were informed about the alleged incident by Registered Nurse Supervisor #1 on 09/14/2025 at 1:15 AM. The Administrator stated that they are responsible for reporting the initials and the five (5) day to the New York State Department of Health. The Administrator stated the facility has five (5) business calendar days from the date that the incident was reported to the New York State Department of Health, to submit the five (5) day report to the New York State Department of Health. The Administrator stated they submitted the five (5) day to the New York State Department on 09/22/2025 and that it should have been submitted 09/19/2025. The Administrator stated they do not know why the five (5) day report was submitted late. 10 NYCRR 415.4(b)(2)