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	12/09/2025

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 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 during the Complaint Survey (iQIES 711881), the facility failed to notify the designated representative of Resident #4's significant weight loss. The findings are: The facility's policy titled Notification of Changes with effective date 12/22/2020 and last reviewed date 12/22/2024 documented the facility was to inform resident and resident's representative when there was a significant change in the resident's physical, mental, or psychosocial status. It also documented the family/representative would be notified of the change by either nurse or social worker. It further documented the date and time of the notification would be documented in the medical record.Resident #4 had diagnoses which included End stage renal disease; Pressure ulcer of unspecified site, stage 3; and Pressure ulcer of unspecified site, stage 2.The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #4 had weight loss of 5% or more in the last month or loss of 10% or more in last 6 months and was not on physician-prescribed weight-loss regimen. The Weight monitor record documented Resident #4 had 5.79% weight loss from 207 lbs on 12/6/2023 to 195 lbs on 1/8/2024. The Dietary note dated 01/10/2024 documented Resident #4 had 6% weight loss in 1 month. There was no documented evidence in medical record that Resident #4's representative was notified of Resident #4's weight loss of more than 5% in one month. On 10/10/2025 at 11:08 AM, Registered Nurse #2 was interviewed and stated they did not notify Resident #4's representative of the weight change. The Registered Nurse also stated the dietitian was responsible to notify the representative if there was any concern for nutrition. On 10/10/2025 at 2:59 PM, Social Worker #1 was interviewed and stated the dietitian was responsible to notify the representative of a resident's weight change. On 10/10/2025 at 10:05 AM, Dietitian #1 was interviewed and stated Resident #4 was on dialysis and was transferred to the hospital on [DATE] and 12/26/2023. The Dietitian stated Resident #4 lost weight during their hospitalization and that the resident had more than 5% weight loss after re-admitted to the facility on [DATE]. Dietitian #1 also stated it was considered a significant weight loss for more than 5% in a month. Dietitian further stated they should notify the representative of the significant weight loss and documented the notification in the dietary note. Dietitian #1 reviewed the dietary notes from December 2023 to January 2024. Dietitian #1 stated they were not able to find any documented evidence that the representative was notified of the significant weight loss. On 10/10/2025 at 12:37 PM, the Administrator was interviewed and stated the facility had to notify the representative if a resident had a significant weight. The Administrator also stated 5% weight loss in 1 month was considered significant weight change. The Administrator further stated the dietitian should notify the representative and document the communication of significant weight change in the dietary note. 10 NYCRR 415.3(f)(2)(ii)(c)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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	335070	A. Building B. Wing	12/09/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the Complaint Survey (Complaint 711914), the facility did not ensure medical records were complete and accurately documented in accordance with accepted professional standards and practices. This was evident for 1 of 3 Residents (Resident #2). Specifically, Resident #2 had physician's order for the treatment of the right medial bunion. A review of the treatment administration record revealed that the treatments were not documented on several occasions.The findings are:The facility's policy and procedure titled Documentation in the Medical Record which was last reviewed on 04/13/2022 documented that progress notes must document all events pertaining to the residents stay in the facility. The Licensed Professional must maintain medical records on each resident in accordance with acceptable professional standards and practices that are complete and accurately documented.Resident #2 was admitted with diagnoses that included Non-Alzheimer's Dementia, Congestive Heart Failure and Peripheral Arterial Disease. The Comprehensive Minimum Data Set assessment dated [DATE] documented that Resident #2 was cognitively impaired and had two unstageable deep tissue injuries. The Care Plan Titled Pressure Injury to the Right Medial Bunion with an effective date of 02/10/2024 documented that it was a hospital acquired Deep Tissue injury with risk factors of decreased mobility present. The interventions included to administer treatment as ordered, wound care consult, and offload pressure ulcer site.The physician's order dated 02/09/2024 documented to cleanse right medial bunion wound with normal saline, pat dry, then clean with skin prep and leave open to air, once daily and as needed. The order was transcribed in the Treatment Administration Record to document completion during 7:00 AM to 3:00 PM shift.The Treatment Administration Record from 04/01/2024 to 05/31/2024 revealed that wound treatment were left blank on 04/03/2024, 04/05/2024,04/09/2024, 04/13/2024, 04/14/2024, 04/15/2024,04/19/2024, 04/20/2024, 04/21/2024, 04/27/2024, 05/01/2024, 05/04/2024, 05/11/2024, 05/12/2024, 05/14/2024, 05/15/2024, 05/19/2024, 05/25/2024 and 05/26/2024The Nursing Progress Notes from 04/01/2024 to 05/31/2024 did not contain any documentation related to wound treatment on 04/03/2024, 04/05/2024,04/09/2024, 04/13/2024, 04/14/2024, 04/15/2024,04/19/2024, 04/20/2024, 04/21/2024, 04/27/2024, 05/01/2024, 05/04/2024, 05/11/2024, 05/12/2024, 05/14/2024, 05/15/2024, 05/19/2024, 05/25/2024 and 05/26/2024.On 10/14/2025 at 10:22AM, Licensed Practical Nurse #2 was interviewed and stated that they do not recall Resident #2. They stated they worked on 04/09/2024 but was not sure why the treatment was not documented for that date. They stated it was the wound care team who often did the wound care for the residents at that time and that could be the reason why they had not signed off on the treatment administration record. On 10/14/2025 at 11:12 PM, Licensed Practical Nurse #1 was interviewed and stated they do not recall the resident. The Licensed Practical Nurse stated if they did not sign on the administration record, it is either the resident was not in the unit or they refused. The Licensed Practical Nurse #1 further stated that if they had rendered wound treatments, they would have documented it in the treatment administration record because that is proof it has been done. On 10/10/2025 at 1:02 PM, the Wound Care Doctor was interviewed and stated that they had been following the Resident #2 wounds since admission. The order in place for April 2024 and May 2024 was to cleanse the right medial bunion with skin prep and leave it open to air daily. Nursing staff are supposed to document in the system once treatment is done. If it is not documented, either the nurse may have forgotten to do it or did not do it at all. The goal of skin prep is to protect the skin and if it is not administered properly, the skin can open. The wound care doctor further stated that if a wound care treatment is not done properly, the wound can deteriorate.On 10/10/2025 at 12:53PM, The Assistant Director of Nursing was interviewed and stated that despite looking in the resident's chart they could not find any other documentation in regard to why the treatment was not signed off. The Assistant Director of Nursing stated that they are not sure if the treatment was rendered, and the staff may have forgotten to sign off on the treatment administration record. However, there is no documentation in the treatment administration record regarding why the treatments on those dates were left blank. The Assistant Director of Nursing further stated that if the treatment administration record is not signed off for, that means that care was not rendered.On 10/10/25 at 1:28 PM, the Director of Nursing Services was interviewed and stated they had not received any complaints about Resident #2 wound treatments not being given, therefore wound treatments were most likely administered on those dates. They stated that nurses and nursing supervisors are responsible for ensuring that treatments are properly documented. 10 NYCRR