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	05/29/2025

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48876 Based on observation, record review, and interview during the Recertification Survey conducted from 05/21/2025 to 05/29/2025, the facility failed to ensure that notice of availability of the survey results were posted in areas of the facility that are prominent and accessible to the public. Specifically, there were no posted notices throughout the facility of the availability of survey results. The findings are: The facility's policy titled Survey Posting with a reviewed date of 12/04/2024 documented that it is the policy of the facility to comply with all New York State Department of Health and Centers for Medicare & Medicaid Services regulations by ensuring timely and visible posting of all relevant survey results, Plans of Correction, and related public notices in a designated, accessible area within the facility. Documents to be posted in designated posting area of the main lobby include a notice indicating where full reports can be reviewed. Signage will read: Department of Health Survey Results Available for Public Review. The Administrator or designee is responsible for ensuring timely posting and accuracy. During multiple observations on 05/21/2025, there were no notice of availability of survey results posted throughout the facility including the main lobby. During the Resident Council meeting held on 05/21/2025 at 11:53 AM, nineteen (19) residents were in attendance, and all of 19 residents (Residents #3, #18, #32, #35, #36, #45, #49, #53, #69, #87, #109, #135, #142, #147, #150, #152, #160, #187, #206) stated they did not know where to find the survey results and that they have not seen any notice telling them where to find the survey results. The minutes of the Resident Council Meetings held on 02/24/2025, 03/31/2025, and 04/20/2025 had no documentation that information was provided to the residents on where to find the survey results. On 05/22/2025 at 3:07 PM, the Recreation Director was interviewed and stated they had not discussed the locations of survey results or postings of the availability of the survey results during the Resident Council Meeting. The Recreation Director also stated they had not seen any posted signage of the availability of survey results in the facility including the main lobby. (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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	On 05/23/2025 at 8:33 AM, the Administrator was interviewed and stated the last time they observed the signage on the availability of survey reports in the lobby was in 04/2025. They stated they were surprised that the posting was not there. The Administrator further stated that someone must have removed the posting and that they have reposted the signage and will increase their auditing of the location to ensure compliance. 10 NYCRR 415.3 (d)(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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42101 Based on observation, record review, and interviews during the Recertification Survey conducted from [DATE] to [DATE], the facility failed to ensure that parenteral fluids were administered consistent with professional standards of practice. This was evident in 2 of 3 residents reviewed for hydration. Specifically, 1.) On [DATE], Resident #37, who had physician orders for administration of intravenous solution was observed receiving expired intravenous fluids. 2.) On [DATE], Resident #482's peripheral intravenous catheter insertion site dressing was observed undated. Additionally, the physician's order for Resident #482's intravenous hydration did not include the infusion rate, and assessment and maintenance of intravenous site. The findings include: The facility's policy titled Intravenous Therapy with a last reviewed date of [DATE] stated residents receiving intravenous therapy will receive therapies safely, timely, and efficiently in accordance with physician's order. Intravenous lines will be maintained according to evidenced based practices to reduce the risk of infection associated with intravenous catheters. The policy stated the physician's order for the insertion of the intravenous line and the type of access will be ordered under the General Order Group. Orders for intravenous hydration will be placed under medication and include the intravenous formula, rate and duration of infusion. The order for care and management of intravenous catheter site will be placed in the Treatment Order Group. This order will include site inspection and assessment every shift, dressing changes every 3 days and as needed if damaged or soiled for peripherally placed catheters. The nurse is responsible to label the dressing with date and time and sign the electronic Medication Administration Record. 1.) Resident #37 had diagnoses of Dysphagia and Encounter for attention to gastrostomy and Alzheimer's Disease. The quarterly Minimum Data Set assessment dated [DATE] documented Resident #37 was severely cognitively impaired. A nurse's progress note dated [DATE] at 7:50 PM documented they were made aware that Resident #37's percutaneous endoscopic gastrostomy tube was dislodged. The Nurse Practitioner stated they would insert the tube tomorrow. A new order was placed for dextrose 5% ,d+[DATE] normal saline at 45 milliliters per hour for one (1) day. A physician's order dated [DATE] at 7:40 PM documented dextrose 5% and 0.45% sodium chloride intravenous solution, infuse 45 milliliters per hour by intravenous route once daily for 1 day for unspecified hypoglycemia. During observation on [DATE] at 12:59 PM, Resident #37 was observed in a geriatric chair with their back elevated to a semi-sitting position. Resident #37 was receiving 5% dextrose and 0.45 sodium chloride intravenously through a peripheral access to the left hand. The one (1) liter bag of intravenous solution was , d+[DATE] full. The bag had a documented lot number Y383714 and an expiration date of [DATE]. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 3:51 PM, Licensed Practical Nurse #4 stated that Registered Nurse #1 entered the order for intravenous hydration and inserted the peripheral access for Resident #37. They stated they hung the bag of intravenous fluid which they found in a storage drawer in the nurses' station without checking the expiration date. Licensed Practical Nurse #4 stated they are aware they need to check the expiration date on the intravenous solution bag before administering them to the resident. During an interview on [DATE] at 1:43 PM, Registered Nurse #1, who was the Unit Manager was interviewed and stated they did rounds before 8:00 AM this morning and observed Resident #37's intravenous solution was already hanging and running. They stated they were not aware of the expired intravenous solution. During an interview on [DATE] at 1:28 PM, the Director of Nursing stated nurses must check if the intravenous fluids the resident is getting match the doctor's orders and nurses must also check the expiration date. The Director of Nursing stated that nurses must check for signs of infection or infiltration, the intravenous solution bag must have a date when it was started, and the intravenous site and tubing must be dated. 48876 2.) Resident #482 was admitted to the facility with diagnoses that included Diabetes Mellitus, Iron Deficiency Anemia, and Major Depressive Disorder. The admission Minimum Data Set assessment dated [DATE] documented that Resident #482 had intact cognition. On [DATE] at 9:31 AM, Resident #482 was observed with a right upper extremity peripheral intravenous catheter dressing that was undated. A care plan for intravenous therapy was initiated for Resident #482 on [DATE]. The care plan documented Resident #482 has a need for intermittent intravenous therapy due to diarrhea. The facility interventions included monitoring for changes in device insertion site, notify the physician of abnormal findings, giving the intravenous treatment for hydration as per physician's order. A physician's order for Resident #482 dated [DATE] at 2:23 PM documented to give sodium chloride 0.9% by intravenous route for 3 days for diarrhea. The order was discontinued on [DATE] at 4:44 AM. The physician's order did not include the rate of infusion. A nurse's progress note dated [DATE] documented that Resident #482 required intravenous hydration. A 24-gauge angiocatheter was placed in the left hand and the administration of 0.9% sodium chloride solution was started. A physician's order for Resident #482 dated [DATE] at 4:03 PM documented to give sodium chloride 0.9% by intravenous route every shift for 2 days for diarrhea. The physician's order did not include the infusion rate. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A further review of Resident #482's physician's orders from [DATE] through [DATE] revealed there was no physician's order for insertion of peripheral intravenous line. There was no physician's order for dressing changes, and/or care and maintenance of the intravenous site. The Medication Administration Record dated [DATE], [DATE], and [DATE] documented that Resident #482 was administered 0.9% sodium chloride intravenous solution given by intravenous route for 3 days. There was no documented rate of infusion. The [DATE] Treatment Administration Record for Resident #482 was blank. There was no documentation in the Treatment Administration Record that the intravenous insertion site was inspected and assessed every shift or that dressing change every 3 days or as needed was completed. On [DATE] at 10:13 AM, an observation of Resident #482's undated right peripheral intravenous dressing was performed with Registered Nurse #8, who was the nursing supervisor. Registered Nurse #8 was interviewed and stated that a peripheral intravenous line was inserted for Resident #482 on [DATE]. The intravenous access was infiltrated and was discontinued. They stated Registered Nurse #3 inserted a new peripheral intravenous catheter on [DATE]. Registered Nurse #8 stated Registered Nurse #3 should have dated the intravenous access dressing at the time of insertion. On [DATE] at 3:37 PM, Registered Nurse #3 was interviewed and stated that on [DATE], they reinserted Resident #482's peripheral intravenous catheter but did not put a date on the insertion site dressing because another nurse told them they would. Registered Nurse #3 further stated they should have dated the insertion site dressing to ensure that it would be changed every 72 hours. On [DATE] at 11:39 AM, Registered Nurse #7, the licensed nurse who entered Resident #482's physician's order dated [DATE], was interviewed and stated they reviewed the intravenous hydration order for Resident #482 and noted it was missing the dose or frequency of hydration. Registered Nurse #7 stated there were no physician's orders for intravenous insertion, and or dressing changes. They stated the missing and incomplete orders are an oversight. On [DATE] at 8:39 AM, the Director of Nursing was interviewed and stated that according to Registered Nurse #3, they wrapped the insertion site with kerlix gauze after inserting the peripheral intravenous line onto Resident #482 on [DATE], and whoever removed the kerlix gauze must have removed the dated label. The Director of Nursing stated that Registered Nurse #3 should have not wrapped the insertion site with kerlix and should only have added the date on the dressing. During a subsequent interview with the Director of Nursing on [DATE] at 11:15 AM, they stated the physician enters the orders for the residents. They stated that the Registered Nurses who took the verbal order from the physician may also enter the physician's order in the resident's medical record. They stated the unit manager is responsible for ensuring the accuracy of the physician's order every shift. The Director of Nursing stated physician orders for intravenous infusions must contain the medication name, dose, frequency, intravenous insertion, dressing changes, and flushes. On [DATE] at 3:26 PM, Attending Physician #1 stated they had not signed the intravenous orders for Resident #482. They stated they reviewed the orders and noted that they were incomplete. The orders did not contain the frequency or dosage for the intravenous hydration, there was also no physician's order to insert a peripheral venous catheter. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 3:39 PM, the Medical Director was interviewed and stated that the medical providers / attending physicians must review the order for accuracy and completeness on the same day the orders are written and must be signed off. The Medical Director stated if there were inaccuracies in the physician's orders, the Director of Nursing may reach out to them to discuss the issues 10 NYCRR 415.12(k)(2)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42101 Based on observation, record review, and interviews during the Recertification Survey conducted from 05/21/2025 to 05/29/2025, the facility did not ensure that food was handled in accordance with professional standards for food service safety and staff did not ensure that infection control practices were maintained in the kitchen. Specifically, Dietary Staff #1 and #2 were observed with visible facial hair while handling and preparing food. The findings include: The undated facility policy titled Sanitation and Food Safety - Staff Appearance and Hygiene documented hair will be clean and worn pulled back up if longer than shoulder length. Regardless of length, hairnet or approved chef type hat is required in all production and service areas. Facial hair or of any length or design must be covered by a beard guard. During a tray line observation on 05/23/2025 from 11:48 AM- 12:25 PM the following were observed: Dietary Aide #1 was observed with hair restraint and gloves, with a visible mustache and goatee (chin beard) while putting silverwares into a utensil holder opposite the sandwich making station and the cooking area. They were also observed scooping and placing watermelons in plastic cups. Dietary Aide #2 was observed on the tray line with their beard guard below their mustache while handling food side items such as vegetables, fish, white rice, chicken wing, chopped fish, green beans. During an interview on 05/23/2025 at 12:22 PM, Dietary Aide #1 stated they forgot to put their beard cover when they went to the kitchen. Dietary Aide #1 stated they were supposed to wear beard covering when handling food to make sure hair does not drop in food or utensils. During an interview on 05/23/2025 at 12:25 PM, Dietary Aide #2 stated they were instructed by their previous supervisor to only cover the bottom part of their face. During an interview on 05/28/2025 at 11:24 PM, the Food Service Supervisor stated dietary staff with beard and mustache should be wearing beard guards, so hair does not get into residents' food. During an interview on 05/28/2025 at 11:33 AM, the Food Service Director stated that the required uniform in the kitchen includes the use of hair restraint and beard guard for people with mustache and beard. They stated all facial hair must be covered for infection control and to avoid dropping hair in residents' food during preparation. 10 NYCRR 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 40565 Based on observation, record review, and interviews during the Recertification Survey conducted from 05/21/2025 to 05/29/2025, the facility failed to ensure infection control protocol were maintained during medication administration. This was evident in 1 (Licensed Practical Nurse #1) of 5 nurses observed. Specifically, Licensed Practical Nurse #1 failed to perform hand hygiene and did not don appropriate personal protective equipment while administering medications to a resident who had a gastrostomy tube. The findings include: The facility policy and procedure titled Infection Prevention and Control Program - Enhanced Barrier Precautions with a last revised date of 12/12/2023 documented the facility adheres to the Centers for Disease Control and Prevention (CDC) guidelines as related to Enhanced Barrier Precautions in order to prevent the transmission of multidrug-resistant organisms amongst residents and healthcare workers. Staff will perform hand hygiene and don Personal Protective Equipment (PPEs) before entering resident's room. On 05/21/2025 at 9:55 AM, Licensed Practical Nurse #1 was observed administering medications to Resident #121 via gastric tube feeding. Licensed Practical Nurse #1 did not sanitize their hands prior to donning gloves to prepare the medications. Licensed Practical Nurse #1 was observed picking up a medication that dropped on the floor with the same gloved hands and continued to administer medications to Resident #121 without performing hand hygiene and / or changing gloves. Licensed Practical Nurse #1 did not don personal protective equipment prior to entering Resident #21's room to administer medications. There was a signage at the entrance of Resident #121's room that stated staff should observe Enhanced Barrier Precautions when giving care, including administration of medication and wound care treatment. On 05/21/2025 at 12:33 PM, Licensed Practical Nurse #1 was interviewed and stated that Enhanced Barrier Precaution protocol was not observed because they did not notice the signage by the entrance of Resident #121's room. Licensed Practical Nurse stated they did not notice any supplies for enhanced barrier in front or in the resident's room for them to use. Licensed Practical Nurse #1 was not able to explain why they did not perform hand hygiene during medication preparation, after picking up the medication from the floor, and prior to administering medications. On 05/21/2025 at 2:43 PM, Registered Nurse Supervisor #1 was interviewed and stated that in-services on infection prevention protocol are given to staff regularly and during orientation. Registered Nurse Supervisor #1 stated Licensed Practical Nurse #1 was newly hired and was provided education during their orientation program on infection prevention protocol that included handwashing / hand hygiene and Enhanced Barrier Precautions. They stated that enhanced barrier precautions is posted at the entrance of Resident #121's room and needed supplies are positioned strategically on the unit for staff to use when giving care to residents that are on Enhanced Barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/28/2025 at 11:14 AM, the Director of Nursing/Infection Preventionist was interviewed and stated staff received in-service education on infection control and enhanced Barrier Precautions. These in-services are conducted during orientation and annually. The Director of Nursing stated Licensed Practical Nurse #1 is newly hired, still on probation, and was recently given these in-services. The Director of Nursing stated that there are signages posted on the units to let staff know if a resident is on enhanced barrier precautions. They stated they were surprised that Licensed Practical Nurse #1 stated they had not seen it. 10 NYCRR 415.19 (b)(4)