

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER The Chateau at Brooklyn Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3457 Nostrand Avenue Brooklyn, NY 11229	

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)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709</p> <p>Based on record review and interviews conducted during the Recertification and Complaint (NY00337375) survey from 06/13/2024 to 06/21/2024, the facility did not ensure that residents were free from misappropriation of property. This was evident for 2 (Resident #232 and #334) of 2 residents reviewed for Abuse out of 38 total sampled residents. Specifically, Licensed Practical Nurse #3 diverted narcotic medication ordered and delivered for use with two residents. Licensed Practical Nurse #3 hid the medication in their personal bag and removed it from the facility.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Neglect and Exploitation of resident dated 6/24/2024 documented each resident has the right to free from verbal, sexual, physical, and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect, exploitation, and misappropriation of property. The policy further documented exploitation/misappropriation of resident property is an act or improper course of conduct, including misrepresentation or failure to obtain informed consent which results in monetary, personal, or other benefits, gain or profit for the perpetrator to monetary loss for the resident. This includes deliberate misplacement, exploitation or wrongful (temporary or permanent) use of resident belongings or funds without the resident consent.</p> <p>1. Resident #232 was admitted to facility 2/22/2024 with diagnosis including Malignant Neoplasm of the Bone, Malignant Neoplasm of the Prostate, Pain in Joint, and Low Back Pain.</p> <p>The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #232 was cognitively intact.</p> <p>The Physician Order dated 3/5/2024 documented Percocet Oral Tablet 5-325 mg (Oxycodone with Acetaminophen) give two tablets every six hours as needed for pain.</p> <p>The Pain assessment dated [DATE] documented Resident #232 had occasional pain in last 5 days with a score of 0. Resident #232 received Percocet 5/325 mg every 6 hours as needed, Fentanyl Patch 75mcg every 72 hours, and received pain medication.</p> <p>Review of facility unit assignment documented Licensed Practical Nurse #3 worked on Unit 2 on 3/23/2024 and 3/24/2024.</p> <p>(continued on next page)</p>

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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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone-APAP (Percocet) 5/325 mg tablets were delivered to the unit and was signed and received by Licensed Practical Nurse #3.</p> <p>The Controlled Drug Record Sheet for Resident #232 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Percocet 3/525 mg on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>The facility Investigation Report dated as completed on 4/1/2024 documented that on March 28th, 2024, at 8:50 AM, Licensed Practical Nurse #2 reported to the Nurse Manager that while doing the narcotic count, they noticed that a blister pack containing twenty-six (26) Oxycodone-APAP 5/325 mg tablets were missing for Resident #232. Licensed Practical Nurse #2 also reported that the medication had not been discontinued and that was the number of pills remaining at the end of their shift on the previous day. Licensed Practical Nurse #2 reported they searched the unit, and the medication was not found. The facility Investigation Report also documented as per the 7am- 3 pm nurse, a blister pack of 26 Oxycodone-APAP 5/325 mg tablets which was left upon the completion of the shift, belonging to Resident #232 was now missing. The Director of Nursing was made aware, the medication carts, medication room, and narcotic cabinet on the unit were thoroughly searched by the Director of Nursing and the Administrator. The Controlled Drug Record Sheet for Resident #232 for Oxycodone-APAP 5/325 mg was noted to be absent from the book. The medication cart, the medication room, and narcotic boxes throughout the entire facility were searched. The narcotic sheets were also cross referenced with Resident #232's medication orders, and Medication Administration Record. Footage from facility cameras was reviewed dated back to 3/27/2024, and the Licensed Practical Nurse who worked the 3pm to 11pm shift was observed removing medications from the locked box on the medication cart. The nurse initially denied any knowledge of this medication, but later admitted upon interview that the nurse did in fact take the medication for the nurse's own personal use. Resident #232 was interviewed and denied pain or missing doses of medication. The New York City Police Department was called to the facility and a police report was filed. During interview with the Director of Nursing Services, the Administrator, and the New York City Police Department, the nurse initially denied any knowledge of the medication. The nurse was terminated immediately and taken into custody by the New York City Police Department. An order to replace the missing medication was called in to the Pharmacy and Resident #232 was provided with medication from the emergency box pending delivery of the new order. The result of the investigation revealed that Resident #232's medication were misappropriated; however, Resident #232 endured no physical, emotional, or mental harm as a result. Resident #232 received as needed pain medication as per the Medical Doctor orders. The case was reported to the New York City Police Department, the Department of Health, the Bureau of Narcotics Enforcement, and the Office of the Professions.</p> <p>The Loss of Controlled Substances Report dated 3-28-24 documented that on 3/27/24 at 10:42pm known diversion of 56 tablets Percocet: 5mg-325 mg and 30 Oxycodone 10mg tablets had occurred.</p> <p>Licensed Practical Nurse #3's statement dated 3/28/2024 documented that they administered Percocet 5/325 mg to Resident #232 on the 3pm-11pm shift. Licensed Practical Nurse #3 stated 9 pills were left at the end of the shift. Licensed Practical Nurse #3 then took the blister pack of Percocet and put it with the garbage that night and took the pills home. Licensed Practical Nurse #3 also stated they did not tell the Director of Nursing and Administrator the truth because of fear of losing their job and apologized for lying and taking the pills.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility camera footage of the incident dated 3/27/2024 showed that at 22:42 (10:42pm), Licensed Practical Nurse #3 left the nurse's station, turned off some the lights on the unit and walked toward the medication cart parked just across from the nurse's station. Licensed Practical Nurse #3 opened the narcotic box in the medication cart and removed one blister pack, placed the blister pack in the regular medication cart, and closed the cart. Licensed Practical Nurse #3 then cleaned the top of the medication cart of debris which they placed in the garbage bag and returned to the nurse's station where they removed a small personal bag from the nurse's station and went into a room opposite to the nurse's station. Licensed Practical Nurse #3 left the room at 22:44 (10:44 pm) with no bag in hand and went to the medication cart. Licensed Practical Nurse #3 then took a clear plastic bag containing garbage from the medication cart, opened the medication cart and removed a blister pack which they placed behind the garbage bag. Licensed Practical Nurse #3 then returned to the nurse's station and pick up another bag of garbage and then entered the room opposite the nurse's station. The Licensed Practical Nurse #3 then exited the room at 22:46 (10:46 pm) with the small personal bag which they placed on top of the medication cart, went to another food and discarded the garbage bag. Licensed Practical Nurse #3 then returned to the medication cart, picked up their small personal bag which they then placed in the nurse's station.</p> <p>2. Resident #334 was admitted to the facility on [DATE] with diagnosis including Polyarthritus, Osteoarthritis left knee, and Neuropathy. Resident #334 was discharged to the community on 5/13/2024.</p> <p>The Admission Minimum Data Set, dated dated [DATE] documented Resident #334 was cognitively intact.</p> <p>Physician order dated 3/11/2024 documented order for Oxycodone 10 mg every 6 hours as needed for pain.</p> <p>The PharMerica Pharmacy Electronic Shipping Manifest documented 60 Oxycodone tablets were received by the facility on 3/24/2024 for Resident #334.</p> <p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone 10 mg tablets were delivered to the unit and signed received by Licensed Practical Nurse #3.</p> <p>The Controlled Drug Record Sheet for Resident #334 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Oxycodone 10 mg tablets on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>The facility investigation dated completed 4/1/2024 documented a review of the Narcotic log sheets for Resident #334 revealed that Licensed Practical Nurse #3 documented they received 30 Oxycodone 10 mg tablets, instead of 60 Oxycodone 10 mg tablets that was delivered to Licensed Practical Nurse #3.</p> <p>The New York City Police Department Form for Complaint #2024-061-001871 dated 3/28/2024 documented employee arrested for Petit Larceny, theft from building. The police report narrative also documented that a quantity of 56 Percocet (Oxycodone-APAP 5/325 mg) oral tablets and 30 Oxycodone oral tablets which are controlled substances were removed by the nurse without authority or permission.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/18/2024 at 09:32 AM, an interview was conducted with the Director of Nursing Services who stated they came to work on the morning of 3/28/2024, when Licensed Practical Nurse #2 who worked the day shift on 3/27/2024 reported that they left approximately 26 Percocet 5/325 mg tablets for Resident #232, and when they counted that morning, the Percocet was missing. The Director of Nursing Services also stated the searched the unit, and the entire building wherever narcotics were kept but did not find the missing Percocet tablets. The nurse that worked the night shift and the night Supervisor were called, and they reported no missing narcotics. Licensed Practical Nurse #3 was contacted and denied seeing the missing Percocet. The Director of Nursing Services further stated that they discovered that the narcotic sheets for Resident #232 were also missing and so they decided to view the video footage for the unit which showed Licensed Practical Nurse #3 counting the Percocet with the outgoing day shift nurse. The footage also showed Licensed Practical Nurse #3 removing the Percocet from the narcotic box on the medication cart and placing it among the other medications on the cart before subsequently placing the medication in their personal bag on the unit. The Director of Nursing Services stated the investigation was expanded and missing narcotics for Resident #334 was also identified. The police were called and Licensed Practical Nurse #3 was arrested, reported to the Narcotic Bureau and the Licensing Board, and terminated immediately. The Director of Nursing Services stated no other narcotics was observed missing in the investigation.</p> <p>On 06/18/24 at 02:38 PM, an interview was completed with the facility Administrator who stated the video in the facility is not continuous and can be reviewed by going back and looking at the footage. The Administrator also stated there are no monitors and they only review the cameras if something happens, as in the case of the missing medications. The Administrator provided copy of footage saved to the Surveyor.</p> <p>On 06/19/24 at 09:01 AM, a telephone interview was completed with Licensed Practical Nurse #2, who stated there were only two residents on the unit receiving narcotics at that time. Licensed Practical Nurse #2 stated they left the facility on [DATE] after working the day shift and signed off 26 Percocet tablets to Licensed Practical Nurse #3. They returned to work the next day, and while counting narcotics from the night nurse found that there were no narcotics for Resident #232, and the narcotic log sheet was missing. They looked in the Electronic Medical Record and there was no note or an order that stated that the medication had been discontinued. Licensed Practical Nurse #2 also stated they looked among the regular medications on both carts, in the narcotic box and searched the medication room but did not find the medication so they alerted their supervisor who informed the Director of Nursing. Licensed Practical Nurse #2 stated they have not received narcotics because the medications are always delivered on the evening shift, with duplicate forms which are both given to the nurse when the nurse accepts the narcotics. Licensed Practical Nurse #2 a nurse could possibly throw out or keep one of the forms and document whatever they want on the other form.</p> <p>On 06/20/24 at 08:53 AM, an interview was conducted with the Director of Nursing Services who stated they conducted and reported immediately the investigation missing narcotics for Resident #232, but during the investigation found that there was also missing narcotics for Resident #334.</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/20/24 at 11:20 AM, a telephone interview was conducted with Registered Nursing Supervisor #1 who worked the evening shift on 3/27/2024 who stated that on 3/27/2024 they received narcotics from the pharmacy and gave Licensed Practical Nurse #3 60 Percocet 5/325 mg tablets and 60 Oxycodone 10 mg tablets, two blister packs each for Resident #232 and #334. Registered Nursing Supervisor #1 also stated that after ensuring that the narcotic was locked in the narcotic box, they left Licensed Practical Nurse #3 and did not see what the nurse documented on the resident's narcotic sheets on the unit. Registered Nursing Supervisor #1 further stated they worked with Licensed Practical Nurse #3 before and there were no complaints from staff or residents. Registered Nursing Supervisor #1 stated they are the only supervisor in the building, and they monitor the staff by making rounds on each unit, and staff calls them if there are any issues.</p> <p>On 06/21/24 at 04:34 PM, a telephone interview was completed with Licensed Practical Nurse #3, who stated they are the regular nurse for the evening shift. Licensed Practical Nurse #3 stated they were called downstairs on 3/28/2024 by the Director of Nursing and was shown video footage but they did not take any pills home and the garbage bag was tied and so they may have thrown the blister pack out with the garbage. Licensed Practical Nurse #3 also stated they have never taken the medication home from the facility. Licensed Practical Nurse #3 further stated no one saw Licensed Practical Nurse #3 leave the facility with any blister pack or put a blister pack in Licensed Practical Nurse #3's bag. Licensed Practical Nurse #3 stated may have thrown out the blister pack with the garbage. Licensed Practical Nurse #3 denies in pain and kept repeating I did not take any pills. Licensed Practical Nurse #3 stated they did get arrested and was let go by the facility. Licensed Practical Nurse #3 did not respond when asked why they documented 30 pills were received instead of 60.</p> <p>10 NYCRR 415.4(b)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41709</p> <p>Based on record review and interviews conducted during the Recertification and Complaint (NY00337275) survey from 06/13/2024 to 06/21/2024, the facility did not ensure that misappropriation of property was reported to the Department of Health. This was evident for 1 (Resident # 334) of 2 residents reviewed for abuse out of 38 total investigated sampled residents. Specifically, during another investigation a Licensed Practical Nurse was found to have diverted narcotic medication for Resident #334 and this was not reported to the Department of Health.</p> <p>The findings are:</p> <p>The facility policy titled Abuse Neglect and Exploitation of Resident dated 6/24/2024 documented should the investigation revealed that an abuse occurred the Administrator will report the findings to the local police department, the ombudsman, and state licensing certification agency within such licensing agency within 24 hours of the results of the completion of the investigation, as indicated, and to the state survey and certification agency within five (5) days of the completion of the investigation.</p> <p>Resident #334 was admitted to the facility with diagnosis that included Polyarthritis, Osteoarthritis left knee, and Neuropathy.</p> <p>The Physician's Order dated 3/11/2024 documented order for Oxycodone 10 mg every 6 hours as needed for pain.</p> <p>The Loss of Controlled Substances Report dated 3-28-24 documented that on 3/27/24 at 10:42pm known diversion of 30 Oxycodone 10mg tablets had occurred.</p> <p>The PharMerica Pharmacy Electronic Shipping Manifest documented 60 Oxycodone tablets were received by the facility on 3/24/2024 for Resident #334.</p> <p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone 10 mg tablets were delivered to the unit and signed received by Licensed Practical Nurse #3.</p> <p>The Controlled Drug Record Sheet for Resident #334 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Oxycodone 10 mg tablets on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>The facility investigation dated completed 4/1/2024 documented a review of the Narcotic log sheets for Resident #334 revealed that Licensed Practical Nurse #3 documented they received 30 Oxycodone 10 mg tablets, instead of 60 Oxycodone 10 mg tablets that was delivered to Licensed Practical Nurse #3.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The New York City Police Department Form for Complaint #2024-061-001871 dated 3/28/2024 documented employee arrested for Petit Larceny, theft from building. The police report narrative also documented that a quantity of 56 Percocet (Oxycodone-APAP 5/325 mg) oral tablets and 30 Oxycodone oral tablets which are controlled substances were removed by the nurse without authority or permission.</p> <p>There was no documented evidence that the diversion of 30 tablets of Oxycodone 10 mg tablets had been reported to the Department of Health.</p> <p>On 06/20/24 at 08:53 AM, an interview was conducted with the Director of Nursing Services who stated they conducted and reported immediately the investigation missing narcotics for another resident but during the investigation found that there was also missing narcotics for Resident #334.</p> <p>On 06/21/24 at 03:54 PM, an interview was conducted with the Director of Nursing who stated that the incident report completed on 4/1/24 did not include information regarding Resident #334. The Director of Nursing further stated that this information was included in the Bureau of Narcotic Enforcement and was not provided to the State Surveyor.</p> <p>On 06/21/24 at 03:56 PM, the facility Administrator was interviewed and stated that at the time they submitted the initial report to the Department of Health on 3/27/24 they were only aware of diverted medication for one resident. The Administrator also stated that the information regarding the second resident was not reported because they received notification from the Department of Health stated no additional reporting needed on the initial report. The Administrator further stated that based on that notification they did not think that they needed to report the diversion of medication intended for Resident #334 although it was included in the Bureau of Narcotic Enforcement report.</p> <p>10 NYCRR 415.4(b)(2)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated (NY00337375) survey from 6/13/2024 to 6/21/2024, the facility did not ensure services provided met professional standards. This was evident for 2 (Resident #232 and #334) of 2 residents reviewed for Abuse out of 38 total sampled residents. Specifically, Licensed Practical Nurse #3 diverted narcotics intended for use with two residents. Licensed Practical Nurse #3 documented on 3/24/2024 that 30 Percocet 5/325 mg tablets were received instead of 60 Percocet 5/325 mg tablets for Resident #232 and that 30 Oxycodone 10 mg tablets were received instead of 60 Oxycodone 10 mg tablets for Resident #334. The Registered Nursing Supervisor #1 who delivered the medications to the unit did not monitor the quantity of narcotics the Licensed Practical Nurse #3 documented on the resident's narcotics sheets used on the unit.</p> <p>The findings are:</p> <p>The facility's policy titled Nursing Standards of Care dated 6/24/2024 documented members of the Departments who provide direct care will do so in accordance with professional and legal standards, physicians orders, the Resident/patient's plan of care and the facility policies.</p> <p>The facility policy titled Controlled substances with no initiated, review or revised date documented the facility complies with all laws, regulations, and other requirements to handling, storage disposal and documentation of controlled substances. The policy further documented the nurse receiving the medication and the individual delivering the medication verify the name dose and quantity of each controlled substance record of receipt. Both individuals sign the controlled substance receipt. An individual Resident-controlled substance record is made for each Resident who is receiving controlled substance. The record contains name of the Resident, name and strength of the medication, quantity received, number on hand, name of physician, prescription number name of issuing pharmacy and the date and time received.</p> <p>1. Resident #232 was admitted to facility 2/22/2024 with diagnosis including Malignant Neoplasm of the Bone, Malignant Neoplasm of the Prostate, Pain in Joint, and Low Back Pain.</p> <p>The Physician Order dated 3/5/2024 documented Percocet Oral Tablet 5-325 mg (Oxycodone with Acetaminophen) give two tablets every six hours as needed for pain.</p> <p>The Pain assessment dated [DATE] documented Resident #232 had occasional pain in last 5 days with a score of 0. Resident #232 received Percocet 5/325 mg every 6 hours as needed, Fentanyl Patch 75mcg every 72 hours, and received pain medication.</p> <p>Review of facility unit assignment documented Licensed Practical Nurse #3 worked on Unit 2 on 3/23/2024 and 3/24/2024.</p> <p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone-APAP (Percocet) 5/325 mg tablets were delivered to the unit and was signed and received by Licensed Practical Nurse #3.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Controlled Drug Record Sheet for Resident #232 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Percocet 3/525 mg on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>The facility Investigation Report dated as completed on 4/1/2024 documented that on March 28th, 2024, at 8:50 AM, Licensed Practical Nurse #2 reported to the Nurse Manager that while doing the narcotic count, they noticed that a blister pack containing twenty-six (26) Oxycodone-APAP 5/325 mg tablets were missing for Resident #232. Licensed Practical Nurse #2 also reported that the medication had not been discontinued and that was the number of pills remaining at the end of their shift on the previous day. Licensed Practical Nurse #2 reported they searched the unit, and the medication was not found. The Director of Nursing was made aware, the medication carts, medication room, and narcotic cabinet on the unit were thoroughly searched by the Director of Nursing and the Administrator. The Controlled Drug Record Sheet for Resident #232 for Oxycodone-APAP 5/325 mg was noted to be absent from the book. The medication cart, the medication room, and narcotic boxes throughout the entire facility were searched. The narcotic sheets were also cross referenced with Resident #232's medication orders, and Medication Administration Record. Footage from facility cameras dated back to 3/27/2024 was reviewed and showed the Licensed Practical Nurse who worked the 3pm to 11pm shift removing medications from the locked box on the medication cart. The nurse initially denied any knowledge of this medication, but later admitted upon interview that they did in fact take the medication for the nurse's own personal use. Resident #232 was interviewed and denied pain or missing doses of medication. The New York City Police Department was called to the facility and a police report was filed. During interview with the Director of Nursing Services, the Administrator, and the New York City Police Department, the nurse initially denied any knowledge of the medication. The nurse was terminated immediately and taken into custody by the New York City Police Department. The result of the investigation revealed that Resident #232's medication were misappropriated. The case was reported to the New York City Police Department, the Department of Health, the Bureau of Narcotics Enforcement, and the Office of the Professions.</p> <p>The Loss of Controlled Substances Report dated 3-28-24 documented that on 3/27/24 at 10:42pm known diversion of 56 tablets Percocet 5mg-325 mg and 30 Oxycodone 10mg tablets had occurred.</p> <p>Licensed Practical Nurse #3's statement dated 3/28/2024 documented that they administered Percocet 5/325 mg to Resident #232 on the 3pm-11pm shift. Licensed Practical Nurse #3 stated 9 pills were left at the end of the shift. Licensed Practical Nurse #3 then took the blister pack of Percocet 5/325 mg tablets and put it with the garbage that night and took the pills home. Licensed Practical Nurse #3 also stated they did not tell the Director of Nursing and Administrator the truth because of fear of losing their job and apologized for lying and taking the pills.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Chateau at Brooklyn Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3457 Nostrand Avenue Brooklyn, NY 11229	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility camera footage of the incident dated 3/27/2024 revealed that at 22:42 (10:42pm), Licensed Practical Nurse #3 left the nurse's station, turned off some the lights on the unit and walked toward the medication cart parked just across from the nurse's station. Licensed Practical Nurse #3 opened the narcotic box in the medication cart and removed one blister pack, placed the blister pack in the regular medication cart, and closed the cart. Licensed Practical Nurse #3 then cleaned the top of the medication cart of debris which they placed in the garbage bag and returned to the nurse's station where they removed a small personal bag from the nurse's station and went into a room opposite to the nurse's station. Licensed Practical Nurse #3 left the room at 22:44 (10:44 pm) with no bag in hand and went to the medication cart. Licensed Practical Nurse #3 then took a clear plastic bag containing garbage from the medication cart, opened the medication cart and removed a blister pack which they placed behind the garbage bag. Licensed Practical Nurse #3 then returned to the nurse's station and pick up another bag of garbage and then entered the room opposite the nurse's station. The Licensed Practical Nurse #3 then exited the room at 22:46 (10:46 pm) with the small personal bag which they placed on top of the medication cart, went to another food and discarded the garbage bag. Licensed Practical Nurse #3 then returned to the medication cart, picked up their small personal bag which they then placed in the nurse's station.</p> <p>2. Resident #334 was admitted to the facility on [DATE] with diagnosis including Polyarthritiis, Osteoarthritis left knee, and Neuropathy. Resident #334 was discharged to the community on 5/13/2024.</p> <p>The Admission Minimum Data Set, dated dated [DATE] documented Resident #334 was cognitively intact.</p> <p>Physician order dated 3/11/2024 documented order for Oxycodone 10 mg every 6 hours as needed for pain.</p> <p>The PharMerica Pharmacy Electronic Shipping Manifest documented 60 Oxycodone 10mg tablets were received by the facility on 3/24/2024 for Resident #334.</p> <p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone 10 mg tablets were delivered to the unit and signed as received by Licensed Practical Nurse #3.</p> <p>The Controlled Drug Record Sheet for Resident #334 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Oxycodone 10 mg tablets on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>The facility investigation dated completed on 4/1/2024 documented a review of the Narcotic log sheets for Resident #334 revealed that Licensed Practical Nurse #3 documented they received 30 Oxycodone 10 mg tablets, instead of 60 Oxycodone 10 mg tablets that was delivered to Licensed Practical Nurse #3.</p> <p>The New York City Police Department Form for Complaint #2024-061-001871 dated 3/28/2024 documented employee arrested for Petit Larceny, theft from building. The police report narrative also documented that a quantity of 56 Percocet (Oxycodone-APAP 5/325 mg) oral tablets and 30 Oxycodone oral tablets which are controlled substances were removed by the nurse without authority or permission.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/18/2024 at 09:32 AM, an interview was conducted with the Director of Nursing Services who stated that on the morning of 3/28/2024, Licensed Practical Nurse #2 who worked the day shift on 3/27/2024 reported that they left approximately 26 Percocet 5/325 tablets for Resident #232, and when they counted that morning, the Percocet 5/325 mg tablets were missing. The Director of Nursing Services also stated they searched the unit, and the entire building wherever narcotics were kept but did not find the missing Percocet 5/325 tablets. The nurse that worked the night shift and the night Supervisor were called, and they reported no missing narcotics. Licensed Practical Nurse #3 was contacted and denied seeing the missing Percocet 5/325. The Director of Nursing Services further stated that they discovered that the narcotic sheets for Resident #232 were also missing and so they decided to view the video footage for the unit which showed Licensed Practical Nurse #3 counting the Percocet 5/325 mg tablets with the outgoing day shift nurse. The footage also showed Licensed Practical Nurse #3 remove the Percocet 5/325 mg tablets from the narcotic box on the medication cart and place it among the other medications on the cart before subsequently placing the medication in their personal bag on the unit. The Director of Nursing Services stated the investigation was expanded and missing narcotics for Resident #334 was also identified. The police were called and Licensed Practical Nurse #3 was arrested, reported to the Narcotic Bureau and the Licensing Board, and terminated immediately. The Director of Nursing Services stated no other narcotics was observed missing in the investigation.</p> <p>On 06/18/24 at 02:38 PM, an interview was completed with the facility Administrator who stated the video in the facility is not continuous and can be reviewed by going back and looking at the footage. The Administrator also stated there are no monitors and they only review the cameras if something happens, as in the case of the missing medications.</p> <p>On 06/19/24 at 09:01 AM, a telephone interview was completed with Licensed Practical Nurse #2, who stated there were only two residents on the unit receiving narcotics at that time. Licensed Practical Nurse #2 stated they left the facility on [DATE] after working the day shift and signed off 26 Percocet 5/325 mg tablets to Licensed Practical Nurse #3. They returned to work the next day, and while counting narcotics from the night nurse found that there were no narcotics for Resident #232, and the narcotic log sheet was missing. They looked in the Electronic Medical Record and there was no note or an order that stated that the medication had been discontinued. Licensed Practical Nurse #2 also stated they looked among the regular medications on both carts, in the narcotic box and searched the medication room but did not find the medication so they alerted their supervisor who informed the Director of Nursing. Licensed Practical Nurse #2 stated they have not received narcotics because the medications are always delivered on the evening shift, with duplicate forms which are both given to the nurse when the nurse accepts the narcotics. Licensed Practical Nurse #2 a nurse could possibly throw out or keep one of the forms and document whatever they want on the other form.</p> <p>On 06/20/24 at 08:53 AM, an interview was conducted with the Director of Nursing Services who stated they conducted and reported immediately the investigation missing narcotics for Resident #232, but during the investigation found that there was also missing narcotics for Resident #334.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/20/24 at 11:20 AM, a telephone interview was conducted with Registered Nursing Supervisor #1 who worked the evening shift on 3/27/2024 who stated that they when they receive narcotics from the Pharmacy they count the narcotics, log the date, time medications received, the name and dosage of the medications, the number pills received, and the amount of blister packs received into the narcotic logbook in the nursing office, and then they sign the book. They then take the narcotic book and the narcotics to the nurse on duty on the unit. The nurse on the unit will sign that they received the narcotics in the book and include the amount and the number of blister packs received. After handing over the medications and the book is signed, the Registered Nursing Supervisor #1 stated they will ensure that the nurse places the narcotics into the double locked narcotic box on the unit. Registered Nursing Supervisor #1 stated on 3/27/2024 they received narcotics from the pharmacy and gave Licensed Practical Nurse #3 60 Percocet 5/325 tablets and 60 Oxycodone 10 mg tablets, two blister packs each for Resident #232 and #334. Registered Nursing Supervisor #1 also stated that after ensuring that the narcotic was locked in the narcotic box, they left Licensed Practical Nurse #3 and did not see what the nurse documented on the resident's narcotic sheets on the unit. Registered Nursing Supervisor #1 further stated they worked with Licensed Practical Nurse #3 before and there were no complaints from staff or residents. Registered Nursing Supervisor #1 stated they are the only supervisor in the building and monitors the staff by making rounds on each unit, and staff calls them if there are any issues.</p> <p>On 06/21/24 at 04:34 PM, a telephone interview was completed with Licensed Practical Nurse #3, who stated they are the regular nurse for the evening shift. Licensed Practical Nurse #3 stated they were called downstairs on 3/28/2024 by the Director of Nursing and was shown video footage but they did not take any pills home and the garbage bag was tied and so they may have thrown the blister pack out with the garbage. Licensed Practical Nurse #3 also stated they have never taken the medication home from the facility. Licensed Practical Nurse #3 further stated no one saw Licensed Practical Nurse #3 leave the facility with any blister pack or put a blister pack in Licensed Practical Nurse #3's bag. Licensed Practical Nurse #3 stated may have thrown out the blister pack with the garbage. Licensed Practical Nurse #3 denies in pain and kept repeating I did not take any pills. Licensed Practical Nurse #3 stated they did get arrested and was let go by the facility. Licensed Practical Nurse #3 did not respond when asked why they documented 30 pills were received instead of 60.</p> <p>10 NYCRR 415.11(c)(3)(i)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41709</p> <p>Based on record reviews and interviews conducted during the Recertification and Abbreviated (NY00337375) Survey from 6/13/2024 to 6/21/2024, the facility did not ensure pharmaceutical services was provided to including procedures that assure accurate, receiving of narcotics, establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determine that drug records are in order; and that an account of all controlled drugs is maintained. Specifically, Licensed Practical Nurse #3 diverted narcotics delivered for two residents. Licensed Practical Nurse #3 documented on 3/24/2024 that they received 30 Percocet 5/325 mg tablets instead of 60 Percocet 5/325 mg tablets and 30 Oxycodone 10 mg tablets instead of 60 Oxycodone 10 mg tablets. The Registered Nursing Supervisor#1 who delivered the narcotic medications to Licensed Practical Nurse #3 did not observe the quantity of narcotics Licensed Practical Nurse #3 documented received on the narcotics sheets used on the unit.</p> <p>The findings are:</p> <p>The facility policy titled Controlled Substances with no initiated, review or revised date documented the facility complies with all laws, regulations, and other requirements to handling, storage disposal and documentation of controlled substances. The policy further documented the nurse receiving the medication and the individual delivering the medication verify the name dose and quantity of each controlled substance record of receipt. Both individuals sign the controlled substance receipt. An individual Resident-controlled substance record is made for each Resident who is receiving controlled substance. The record contains name of the Resident, name and strength of the medication, quantity received, number on hand, name of physician, prescription number name of issuing pharmacy and the date and time received.</p> <p>Review of the facility unit assignment documented Licensed Practical Nurse #3 worked on Unit 2 on 3/23/2024 and 3/24/2024.</p> <p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone-APAP (Percocet) 5/325 mg tablets were delivered to the unit and was signed and received by Licensed Practical Nurse #3.</p> <p>The Controlled Drug Record Sheet for Resident #232 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Percocet 3/525 mg on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Investigation Report dated as completed on 4/1/2024 documented that on March 28th, 2024, at 8:50 AM, Licensed Practical Nurse #2 reported to the Nurse Manager that while doing the narcotic count, they noticed that a blister pack containing twenty-six (26) Oxycodone-APAP 5/325 mg tablets were missing for Resident #232. Licensed Practical Nurse #2 also reported that the medication had not been discontinued and that was the number of pills remaining at the end of their shift on the previous day. Licensed Practical Nurse #2 reported they searched the unit, and the medication was not found. The Director of Nursing was made aware, the medication carts, medication room, and narcotic cabinet on the unit were thoroughly searched by the Director of Nursing and the Administrator. The Controlled Drug Record Sheet for Resident #232 for Oxycodone-APAP 5/325 mg was noted to be absent from the book. The medication cart, the medication room, and narcotic boxes throughout the entire facility were searched. The narcotic sheets were also cross referenced with Resident #232's medication orders, and Medication Administration Record. Footage from facility cameras was reviewed dated back to 3/27/2024, and the Licensed Practical Nurse who worked the 3pm to 11pm shift was observed removing medications from the locked box on the medication cart. The nurse initially denied any knowledge of this medication, but later admitted upon interview that the nurse did in fact take the medication for the nurse's own personal use. Resident #232 was interviewed and denied pain or missing doses of medication. The New York City Police Department was called to the facility and a police report was filed. During interview with the Director of Nursing Services, the Administrator, and the New York City Police Department, the nurse initially denied any knowledge of the medication. The nurse was terminated immediately and taken into custody by the New York City Police Department. The result of the investigation revealed that Resident #232's medication were misappropriated. The case was reported to the New York City Police Department, the Department of Health, the Bureau of Narcotics Enforcement, and the Office of the Professions.</p> <p>The Loss of Controlled Substances Report dated 3-28-24 documented that on 3/27/24 at 10:42pm known diversion of 56 tablets Percocet 5mg-325 mg and 30 Oxycodone 10mg tablets had occurred.</p> <p>Review of the facility camera footage of the incident dated 3/27/2024 revealed that at 22:42 (10:42pm), Licensed Practical Nurse #3 left the nurse's station, turned off some the lights on the unit and walked toward the medication cart parked just across from the nurse's station. Licensed Practical Nurse #3 opened the narcotic box in the medication cart and removed one blister pack, placed the blister pack in the regular medication cart, and closed the cart. Licensed Practical Nurse #3 then cleaned the top of the medication cart of debris which they placed in the garbage bag and returned to the nurse's station where they removed a small personal bag from the nurse's station and went into a room opposite to the nurse's station. Licensed Practical Nurse #3 left the room at 22:44 (10:44 pm) with no bag in hand and went to the medication cart. Licensed Practical Nurse #3 then took a clear plastic bag containing garbage from the medication cart, opened the medication cart and removed a blister pack which they placed behind the garbage bag. Licensed Practical Nurse #3 then returned to the nurse's station and pick up another bag of garbage and then entered the room opposite the nurse's station. The Licensed Practical Nurse #3 then exited the room at 22:46 (10:46 pm) with the small personal bag which they placed on top of the medication cart, went to another food and discarded the garbage bag. Licensed Practical Nurse #3 then returned to the medication cart, picked up their small personal bag which they then placed in the nurse's station.</p> <p>The PharMerica Pharmacy Electronic Shipping Manifest documented 60 Oxycodone 10mg tablets were received by the facility on 3/24/2024 for Resident #334.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Narcotic Logbook Sheet dated 3/24/2024 documented 60 Oxycodone 10 mg tablets were delivered to the unit and signed as received by Licensed Practical Nurse #3.</p> <p>The Controlled Drug Record Sheet for Resident #334 revealed Licensed Practical Nurse #3 documented that they received only 30 tablets Oxycodone 10 mg tablets on 3/24/2024 instead of 60 tablets as documented on the Narcotic Logbook Sheet.</p> <p>The facility investigation dated completed on 4/1/2024 documented a review of the Narcotic log sheets for Resident #334 revealed that Licensed Practical Nurse #3 documented they received 30 Oxycodone 10 mg tablets, instead of 60 Oxycodone 10 mg tablets that was delivered to Licensed Practical Nurse #3.</p> <p>The New York City Police Department Form for Complaint #2024-061-001871 dated 3/28/2024 documented employee arrested for Petit Larceny, theft from building. The police report narrative also documented that a quantity of 56 Percocet (Oxycodone-APAP 5/325 mg) oral tablets and 30 Oxycodone oral tablets which are controlled substances were removed by the nurse without authority or permission.</p> <p>There was no documented evidence that the Pharmacy was notified that narcotics had been diverted from the facility.</p> <p>On 06/18/2024 at 09:32 AM, an interview was conducted with the Director of Nursing Services who stated that on the morning of 3/28/2024, Licensed Practical Nurse #2 who worked the day shift on 3/27/2024 reported that they left approximately 26 Percocet 5/325 tablets for Resident #232, and when they counted that morning, the Percocet 5/325 mg tablets were missing. The Director of Nursing Services also stated they searched the unit, and the entire building wherever narcotics were kept but did not find the missing Percocet 5/325 tablets. The nurse that worked the night shift and the night Supervisor were called, and they reported no missing narcotics. Licensed Practical Nurse #3 was contacted and denied seeing the missing Percocet 5/325. The Director of Nursing Services further stated that they discovered that the narcotic sheets for Resident #232 were also missing and so they decided to view the video footage for the unit which showed Licensed Practical Nurse #3 counting the Percocet 5/325 mg tablets with the outgoing day shift nurse. The footage also showed Licensed Practical Nurse #3 remove the Percocet 5/325 mg tablets from the narcotic box on the medication cart and place it among the other medications on the cart before subsequently placing the medication in their personal bag on the unit. The Director of Nursing Services stated the investigation was expanded and missing narcotics for Resident #334 was also identified. The police were called and Licensed Practical Nurse #3 was arrested, reported to the Narcotic Bureau and the Licensing Board, and terminated immediately. The Director of Nursing Services stated no other narcotics was observed missing in the investigation.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/19/24 at 09:01 AM, a telephone interview was completed with Licensed Practical Nurse #2, who stated there were only two residents on the unit receiving narcotics at that time. Licensed Practical Nurse #2 stated they left the facility on [DATE] after working the day shift and signed off 26 Percocet 5/325 mg tablets to Licensed Practical Nurse #3. They returned to work the next day, and while counting narcotics from the night nurse found that there were no narcotics for Resident #232, and the narcotic log sheet was missing. They looked in the Electronic Medical Record and there was no note or an order that stated that the medication had been discontinued. Licensed Practical Nurse #2 also stated they looked among the regular medications on both carts, in the narcotic box and searched the medication room but did not find the medication so they alerted their supervisor who informed the Director of Nursing. Licensed Practical Nurse #2 stated they have not received narcotics because the medications are always delivered on the evening shift, with duplicate forms which are both given to the nurse when the nurse accepts the narcotics. Licensed Practical Nurse #2 a nurse could possibly throw out or keep one of the forms and document whatever they want on the other form.</p> <p>On 06/20/24 at 08:53 AM, an interview was conducted with the Director of Nursing Services who stated they conducted and reported immediately the investigation missing narcotics for Resident #232, but during the investigation found that there was also missing narcotics for Resident #334.</p> <p>On 06/20/24 at 11:20 AM, a telephone interview was conducted with Registered Nursing Supervisor #1 who worked the evening shift on 3/27/2024 who stated that they when they receive narcotics from the Pharmacy they count the narcotics, log the date, time medications received, the name and dosage of the medications, the number pills received, and the amount of blister packs received into the narcotic logbook in the nursing office, and then they sign the book. They then take the narcotic book and the narcotics to the nurse on duty on the unit. The nurse on the unit will sign that they received the narcotics in the book and include the amount and the number of blister packs received. After handing over the medications and the book is signed, the Registered Nursing Supervisor #1 stated they will ensure that the nurse places the narcotics into the double locked narcotic box on the unit. Registered Nursing Supervisor #1 stated on 3/27/2024 they received narcotics from the pharmacy and gave Licensed Practical Nurse #3 60 Percocet 5/325 tablets and 60 Oxycodone 10 mg tablets, two blister packs each for Resident #232 and #334. Registered Nursing Supervisor #1 also stated that after ensuring that the narcotic was locked in the narcotic box, they left Licensed Practical Nurse #3 and did not see what the nurse documented on the resident's narcotic sheets on the unit. Registered Nursing Supervisor #1 further stated they worked with Licensed Practical Nurse #3 before and there were no complaints from staff or residents. Registered Nursing Supervisor #1 stated they are the only supervisor in the building and monitors the staff by making rounds on each unit, and staff calls them if there are any issues.</p> <p>On 06/20/24 at 11:54 AM, a telephone interview was completed with The Director of PharMerica Pharmacy, who provides medication for the facility. The Director of Pharmacy stated once the facility placed an order for prescription, example a narcotic, it is received by the Pharmacy electronically. the Pharmacist will look at the order and then fill the order. The Director of Pharmacy stated then the medication is picked up by the courier, and the courier will deliver the medication to the facility. The courier is instructed to look for the Nursing Supervisor, who will count the medication and signed that they received the medications as ordered. The Director of Pharmacy stated that once the medication delivered to the facility and the signature is received, the courier's job is completed. The Director of Pharmacy stated they were not made aware of any diversion of narcotics or missing narcotics from this facility and the State Surveyor's call is the first time they are hearing about any diversion from the facility.</p> <p>(continued on next page)</p>		

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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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/21/24 at 04:34 PM, a telephone interview was completed with Licensed Practical Nurse #3, who stated they are the regular nurse for the evening shift. Licensed Practical Nurse #3 stated they were called downstairs on 3/28/2024 by the Director of Nursing and was shown video footage but they did not take any pills home and the garbage bag was tied and so they may have thrown the blister pack out with the garbage. Licensed Practical Nurse #3 also stated they have never taken the medication home from the facility. Licensed Practical Nurse #3 further stated no one saw Licensed Practical Nurse #3 leave the facility with any blister pack or put a blister pack in Licensed Practical Nurse #3's bag. Licensed Practical Nurse #3 stated may have thrown out the blister pack with the garbage. Licensed Practical Nurse #3 denies in pain and kept repeating I did not take any pills. Licensed Practical Nurse #3 stated they did get arrested and was let go by the facility. Licensed Practical Nurse #3 did not respond when asked why they documented 30 pills were received instead of 60.</p> <p>10 NYCRR 415.18(b)(1)</p>