STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335328	A. Building B. Wing	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palm Gardens Center for Nursing and Rehabilitation	615 Avenue C Brooklyn, NY 11218

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 43285 Based on interviews and record review conducted during an abbreviated survey (NY00320077), the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Social Security Act. Additionally, the facility failed to ensure that a reasonable suspicion of a crime against a resident or an individual receiving care from the facility was reported not later than 24 hours to the State Survey Agency, New York State Department of Health (NYSDOH). This was evident in 15 of 18 sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15). Specifically, on 07/10/2023, the Administrator and the Director of Nursing received a report stating that Certified Nursing Assistant #1 (CNA #1) administered medications to 15 residents without a nursing license. The facility reported the incident to the NYSDOH on 07/14/2023, 4 days after the incident occurred. The facility did not report the incident to local law enforcement. The findings are: The NY State Education Law Section 6512 Unauthorized Practice a Crime states that it is a felony for anyone who practices or offers to practice or holds themselves out as being able to practice any profession in which a license is a prerequisite to the practice of the acts. The facility's Policy and Procedure titled Reporting Abuse to State Agencies and Other Entities/Individuals with a revised date of 10/2022 documented that all alleged/suspected violations or crimes and all substantiated incidents of abuse will be promptly reported to appropriate state agencies and other entities, or individuals as required by law. Resident #1 was admitted to the facility on [DATE] with diagnoses of Respiratory Failure, Tracheostomy, and Diabetes. The Minimum Data Set, (MDS, a resident assessment tool) dated 06/12/2023 documented that Resident is severely impaired in cognition. Resident #2 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Cerebral Infarction. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #3 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Chronic Atrial Fibrillation, and Seizure. The MDS dated [DATE] documented that Resident is moderately impaired in cognition. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #4 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Respiratory Failure. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #5 was initially admitted to the facility on [DATE] with diagnoses of Tracheostomy, Myocardial Infarction and Diabetes. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #6 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Chronic Obstructive Pulmonary Disease (COPD), and Parkinson's Disease. The MDS dated [DATE] documented that Resident is cognitively intact. Resident #7 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes and Seizure. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #8 was admitted to the facility on [DATE] with diagnoses of Tracheostomy and Anoxic Brain Damage. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #9 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Bipolar Disorder, and Major Depressive Disorder. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #10 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Cerebral Infarction and COPD. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #11 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Alzheimer's Disease. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident#12 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Anoxic Brain Damage. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #13 was initially admitted to the facility on [DATE] with diagnoses of Tracheostomy, Cardiac Arrest, and Diabetes. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Resident #14 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, COPD, and Schizophrenia. The MDS dated [DATE] documented resident is severely impaired in cognition. Resident #15 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Anxiety Disorder, and Diabetes. The MDS dated [DATE] documented that Resident is severely impaired in cognition. Review of the electronic Medication Administration Record (eMAR) for 07/10/2023 revealed that CNA #1 administered medications to 15 residents, a total of 106 medications. CNA #1 used their username and password to log in to CNA kiosk to access the eMAR. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility summary of investigation dated 07/22/2023 documented that on 07/10/2023 around 10:00pm, the DON were notified by RNS #1 that CNA #1 was performing duties as a licensed nurse on the 2nd floor 3:00pm-11:00 pm shift on the low side. The facility investigated the incident and concluded that CNA #1 posed as a Nurse and proceeded to give care to residents. CNA #1 was terminated. Residents had no evidence of abuse, neglect, or mistreatment. There was no documented evidence that the facility reported the allegation to local law enforcement. During an interview on 07/25/2023 at 10:00AM, the Director of Nursing (DON) stated that the incident was not reported to the local law enforcement. The DON stated that they never knew that they were supposed to report the incident to local law enforcement. The DON stated that they were of the impression that they have five days to report the incident to the NYSDOH not 24 hours. During an interview on 07/24/2023 at 3:32PM, the Administrator stated that they did not report the incident to the local law enforcement. The Administrator stated that CNA #1 was an Agency staff. Therefore, they reported the incident to the agency with the assumption that the agency would report the incident to local law enforcement and other agencies. The Administrator stated that they thought the incident falls under reported accident in which they have 5 days to do the initial report. 10NYCRR 415.4(b)

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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 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43285 Based on interviews and record review conducted during an abbreviated survey (NY00320077), the facility failed to provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This was evident in 15 of 18 sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15). Specifically, the facility was not in compliance with the New York (NY) Education Law Section 6512 Unauthorized Practice of a Profession and NY Education Law 6509 Professional Misconduct. On 07/10/2023, Certified Nursing Assistant #1 (CNA #1) identified themself as a Licensed Practical Nurse (LPN). Registered Nurse Supervisor #1 (RNS #1) did not verify CNA #1's job title and did not check the staffing schedule. RNS #1 permitted CNA #1 to perform licensed nurse activities. The electronic Medication Administration Record (eMAR) for Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15 documented that CNA #1 administered their medications for the evening shift on 07/10/2023. CNA #1 used their username and password to log-in to the CNA kiosk to access the eMAR. The findings are: The NY State Education Law Section 6512 states that it is a felony for anyone who practices or offers to practice or holds themselves out as being able to practice any profession in which a license is a prerequisite to the practice of the acts. The NY State Education Law Section 6509 states that permitting an unlicensed person to perform activities requiring a license is professional misconduct. The facility policy titled Medication Administration with review date of 08/2022 stated that only licensed Registered Nurse (RN) and Licensed Practical Nurse (LPN) are assigned responsibility for preparing, administering, and recording of medications. Only RN and LPN are permitted access to the drug storage at each nursing station. Only RN and LPN shall be permitted to administer medications to residents. A Nursing Schedule dated 07/10/2023 documented that CNA #1 was scheduled for the day shift (7:00 AM - 3:00 PM) and evening shift (3:00 PM - 11:00 PM) to work as a CNA. A review of CNA #1's personnel file and the Office of Professions (OP) License Verification Search revealed that CNA #1 did not possess a nursing license. Resident #1 was admitted to the facility on [DATE] with diagnoses of Respiratory Failure, Tracheostomy, and Diabetes. The Minimum Data Set, (MDS, a resident assessment tool) dated 06/12/2023 documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 8 medications to Resident #1 including Heparin 5000-unit injection, Humalog U-100 Insulin Subcutaneous (SQ) solution, Levemir U-100 Insulin SQ, Keppra 100 mg/ml oral solution, and Metoprolol Tartrate 50 mg tablet via Gastric tube (GT). (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Cerebral Infarction. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 8 medications to Resident #2 including NovoLog U-100 Insulin SQ, and Levetiracetam oral solution, Valproic Acid 500mg/10ml oral solution, and Vimpat 100 mg tablet via GT. Resident #3 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Chronic Atrial Fibrillation, and Seizure. The MDS dated [DATE] documented that Resident is moderately impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 6 medications to Resident #3 including and Humalog U-100 insulin SQ and Clonazepam 0.25 mg tablet via GT. Resident #4 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Respiratory Failure. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 8 medications to Resident #4 including Heparin 5000 injection and Novolin U-100 Insulin, and Metoprolol Tartrate 25 mg, Clonazepam 0.5 mg tablet via GT. Resident #5 was initially admitted to the facility on [DATE] with diagnoses of Tracheostomy, Myocardial Infarction and Diabetes. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 5 medications to Resident #5 including Admelog and Basaglar Kwik Pen Insulin SQ, and Ferrous Sulfate 220 mg via GT. Resident #6 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Chronic Obstructive Pulmonary Disease (COPD), and Parkinson's Disease. The MDS dated [DATE] documented that Resident is cognitively intact. The eMAR dated 07/10/2023 documented that CNA #1 administered 9 medications to Resident #6 including Alprazolam 0.5 mg and Midodrine 10 tablet via GT. Resident #7 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes and Seizure. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 8 medications to Resident #7 including Carbidopa 25 mg-levodopa 100 mg tablet, Eliquis 2.5 mg, Levetiracetam 100 mg/ml oral solution, and Metoprolol Tartrate 25 mg tablet via GT. Resident #8 was admitted to the facility on [DATE] with diagnoses of Tracheostomy and Anoxic Brain Damage. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 9 medications to Resident #8 including Synthroid 88 mcg tablet, and Keppra 100mg/ml solution via GT. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Bipolar Disorder, and Major Depressive Disorder. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 5 medications to Resident #9 including Heparin 5,000 unit/ml subcutaneously and Clonazepam 2 mg tablet, Quetiapine 100 mg tablet, Valproic acid 250 mg/5ml oral solution via GT. Resident #10 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Cerebral Infarction and COPD. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 6 medications to Resident #10 including Levothyroxine 500 mcg tablet and Metoprolol Tartrate 50 mg tablet via GT. Resident #11 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Alzheimer's Disease. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 6 medications to Resident #11 including Carvedilol 3.125 mg tablet and Eliquis 5 mg tablet via GT. Resident#12 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Diabetes, and Anoxic Brain Damage. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 7 medications to Resident #12 including Admelog U-100 Insulin, Desmopressin 4 mcg/ml injections and Latanoprost 0.005% eye drops. Resident #13 was initially admitted to the facility on [DATE] with diagnoses of Tracheostomy, Cardiac Arrest, and Diabetes. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 4 medications to Resident #13 including Carbidopa 25 mg-levodopa 2100 mg tablet via GT. Resident #14 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, COPD, and Schizophrenia. The MDS dated [DATE] documented resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 10 medications to Resident #14 including Humalog U-100 Insulin SQ, Clonazepam 1 mg tablet, and Levetiracetam 100 mg/ml SQ solution via GT. Resident #15 was admitted to the facility on [DATE] with diagnoses of Tracheostomy, Anxiety Disorder, and Diabetes. The MDS dated [DATE] documented that Resident is severely impaired in cognition. The eMAR dated 07/10/2023 documented that CNA #1 administered 4 medications to Resident #15 including Novolin U-100 insulin SQ, Metoprolol Tartrate 50 mg tablet and Levetiracetam 500 mg/5ml via GT. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 07/23/2023 at 7:00 PM, RNS #1 stated that on 07/10/2023 at approximately 3:20 pm, while they were doing their rounds, CNA #1 approached them and identified themself as a nurse who was scheduled to work on the 2nd floor. RNS #1 stated that they did not observe CNA #1 wearing their ID, they did not ask CNA #1 to show their identification (ID) badge, and did not check the staffing book to verify CNA #1. RNS #1 stated that they instructed CNA #1 to administer medication on the low side of the unit. During a telephone interview on 07/23/2023 at 6:29 PM, CNA #1 stated that they worked the morning shift on 07/10/2023 on the 2nd floor and that they agreed to stay for the 3:00 pm - 11:00 pm shift on the same unit. CNA #1 stated that RNS #1 came to the unit and told them that they will be assisting LPN #1 in administering medication on the lower side. CNA #1 stated that they informed RNS #1 that they are a CNA and that RNS #1 walked away and left them with LPN #1. CNA #1 stated that they were wearing an ID badge while speaking with RNS #1. CNA #1 denied telling LPN #1 that they were a nurse. CNA #1 stated that LPN #1 showed them how to hang the feedings and that they hang 5 tube feedings by themself. CNA #1 stated that LPN #1 showed them how to locate residents' medications on the medication cart and that they administered narcotics to the residents. CNA #1 stated that they do not recall how many residents they administered medications to. CNA #1 stated that they agreed to work as a nurse knowing that they do not have the license. During a follow-up interview with CNA #1 on 07/24/2023 at 4:11 PM, CNA #1 stated that they logged in the eMAR with the same username and password they use to access the CNA kiosk. CNA #1 stated that when they logged in, they were able to see all residents' medications. CNA #1 stated that LPN #1 showed them how to navigate the eMAR, how to sign for the medications, and how to open and take medications from the medication cart. During a telephone interview on 07/23/2023 at 8:30 PM, RN #1 stated that on 07/10/2023 at approximately 3:25 PM, CNA #1 came to the unit and introduced themself as a nurse and that they were sent by RNS #1 to work on the unit. RN #1 stated that CNA #1 was not wearing an ID badge and that they asked CNA #1 if they were a nurse and CNA #1 replied yes. During an interview on 07/24/2023 at 10:47 AM, LPN #1 stated that on 07/10/2023 (could not recall time), RNS #1 came to inform them that another nurse is coming to administer medications and that they will be covering the desk. LPN #1 stated that CNA #1 arrived in the unit and introduced themself as a nurse and that they received their LPN license in July 2023. LPN #1 stated that they gave CNA #1 the keys and directed CNA #1 how to administer medications including narcotic. During a follow-up interview on 07/25/2023 at 3:21 PM, LPN #1 stated that CNA #1 took out the medications from the medication cart, narcotic box, and from the blister packs, and administered them to the residents. LPN #1 stated that CNA #1 administered the medications that they signed for on the eMAR. During an interview on 07/24/2023 at 12:30 PM, the Assistant Director of Nursing (ADON) stated that all RNS's must check the staff members' names against the nursing schedule to ensure who the staff are and what unit they are assigned to. During an interview on 08/31/2023 at 12:30PM, the Director of Nursing (DON) stated that all nursing staff must check with the RNS prior to going to their assigned unit. RNS must look at the schedule to verify the staff name, job title, and their assigned floor. (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/24/2023 at 3:32 PM, the Administrator stated that all staff members who are doing double shifts are supposed to go the nursing office and check with the RNS on duty. The RNS must verify the staff name, job title, and to know which floor they are working on. 10NYCRR 400.2