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	12/03/2025

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

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record review and interviews conducted during the Recertification survey, the facility did not ensure there was sufficient nursing staff to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the Payroll Based Journal Staffing Data report for 3rd Quarter 2025 triggered for low weekend staffing and review of staffing indicated that actual staffing levels were not maintained at par levels indicated in the Facility Assessment.The findings are:The facility policy titled Staffing Levels with review date of 08/2025 stated it is the policy of the facility that staffing levels in Palm Gardens will be adequate to provide nursing care to our residents 24/7.The Payroll Based Journal (PBJ) Staffing Data Report dated Fiscal Year (FY) Quarter 3 2025 (April 1- June 30) documented the facility triggered for the metric of excessively low weekend staffing.The facility document titled Facility Assessment Tool, dated 09/2025, documented a staff to resident ratio with the number of staff required to work on each unit. The Facility Assessment Tool also documented the par level of staffing to ensure a sufficient number of qualified staff are available to meet each resident's needs and the Unit Staffing as follows: 7:00 AM to 3:00 PM shift:2nd floor unit staffing: 2 Registered Nurses, 2 Licensed Practical Nurses, and 6 Certified Nursing Assistants3rd floor unit staffing: 1-2 Registered Nurses, 2 Licensed Practical Nurses, and 6 Certified Nursing Assistants4th floor unit staffing: 1 Registered Nurse, 2 Licensed Practical Nurses, and 5-6 Certified Nursing Assistants5th floor unit staffing: 1 Registered Nurse, 1 Licensed Practical Nurse, and 5-6 Certified Nursing Assistants 6th floor unit staffing: 1 Registered Nurse, 1 Licensed Practical Nurse, and 5-6 Certified Nursing Assistants7th floor unit staffing: 1 Registered Nurse, 2 Licensed Practical Nurses, and 5-6 Certified Nursing Assistants. 3:00 PM to 11:00 PM shift:2nd floor unit staffing: 1 Registered Nurse, 2 Licensed Practical Nurses and 6 Certified Nursing Assistants3rd floor unit staffing: 1 Registered Nurse, 2 Licensed Practical Nurses, 5 Certified Nursing Assistants4th floor unit staffing: 2 Registered Nurses or 2 Licensed Practical Nurses and 5-6 Certified Nursing Assistants5th floor unit staffing: 1 Registered Nurse or 1 Licensed Practical Nurses and 5 Certified Nursing Assistants6th floor unit staffing: 1 Registered Nurse or 1 Licensed Practical Nurse and 5 Certified Nursing Assistants7th floor unit staffing: 2 Registered Nurses or 2 Licensed Practical Nurses and 5 Certified Nursing Assistants. 11:00 PM to 7:00 AM shift:2nd floor unit staffing: 1 Registered Nurse, 2 Licensed Practical Nurses, and 4 Certified Nursing Assistants3rd floor unit staffing: 1 Registered Nurse, 2 Licensed Practical Nurses and 4 Certified Nursing Assistants4th floor unit staffing: 2 Registered Nurses or 2 Licensed Practical Nurses, and 4 Certified Nursing Assistants5th floor unit staffing: 1 Registered Nurse or 1 Licensed Practical Nurse and 3 Certified Nursing Assistants6th floor unit staffing: 1 Registered Nurse or 1 Licensed Practical Nurse and 3 Certified Nursing Assistants7th floor unit staffing: 1 Registered Nurse or 1 Licensed Practical Nurse and 3 Certified Nursing Assistants Review of staffing information dated 04/05/2025 to 04/27/2025 documented the following: On 04/05/2025 on the 7:00 AM to 3:00 PM, shift the 2nd Floor and 4th floor were short 1 Licensed Practical Nurse. On 04/06/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Registered Nurse.On 04/06/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse.On 04/06/2025 on the 11:00 PM to 7:00 AM shift, the 2nd (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	floor and 3rd floor were short 1 Licensed Practical Nurse.On 04/12/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Registered Nurse, and the 3rd floor was short 1 Licensed Practical Nurse.On 04/12/2025 on the 3:00 PM to 11:00 PM shift, the 3rd floor was short 1 Licensed Practical Nurse.On 04/13/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Registered Nurse.On 04/13/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 04/13/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 04/19/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Registered Nurse, the 3rd floor was short 2 Registered Nurses, and the 4th floor was short 1 Licensed Practical Nurse.On 04/19/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse, and the 3rd floor was short 1 Registered Nurse.On 04/19/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 04/20/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Registered Nurse, the 3rd floor and 6th floor were short 1 Certified Nursing Assistant, and the 7th floor was short 2 Certified Nursing Assistants. On 04/20/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse, and the 3rd and 4th floor were short 1 Certified Nursing Assistant. On 04/20/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor 3rd floor were short 1 Licensed Practical Nurses, and the 5th floor and 6th floor were short 1 Certified Nursing Assistant. On 04/26/2025 on the 3:00 PM to 11:00 PM shift, the 3rd floor was short 1 Licensed Practical Nurse.On 04/26/2025 on the 11:00 PM to 7:00 AM shift, the 3rd floor was short 1 Licensed Practical Nurse, and the 4th floor was short 1 Certified Nursing Assistant.On 04/27/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse.On 04/27/2025 on the 11 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse, and the 3rd floor was short 1 Registered Nurse. Review of staffing information dated 05/03/2025 to 05/31/2025 documented the following: On 05/03/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse and 1 Registered Nurse, and the 5th floor was short 1 Certified Nursing Assistant.On 05/03/2025 on the 3:00 PM to 11:00 PM shift, the 5th floor was short 1 Certified Nursing Assistant. On 05/04/2025 on the 7:00 AM to 3:00 PM shift, the 3rd floor was short 1 Certified Nursing Assistant. On 05/04/2025 on the 3:00 PM to 11:00 PM shift, the 3rd floor was short 1 Registered Nurse.On 05/04/2025 on the 11:00 PM to 7:00 AM shift, the 3rd floor was short 1 Registered Nurses, and the 4th floor was short 1 Certified Nursing Assistant. On 05/10/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 05/10/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Registered Nurse, and the 3rd floor was short 1 Licensed Practical Nurse.On 05/10/2025 on the 11:00 PM to 7:00 AM shift, the 4th floor was short 1 Certified Nursing Assistant. On 05/11/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurses, and the 7th floor was short 1 Certified Nursing Assistant. On 05/11/2025 on the 11:00 PM to 7:00 AM shift, the 3rd floor was short 1 Registered Nurse, 2 Licensed Practical Nurses, and 1 Certified Nursing Assistant. On 05/12/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 05/12/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse. On 05/17/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse. On 05/18/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse, and the 3rd floor was short 1 Registered Nurse. On 05/18/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse, and the 7th floor was short 1 Certified Nursing Assistant. On 05/11/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse, and the 4th floor, 5th floor, 6th floor were short 1 Certified Nursing Assistant. On 05/24/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 4th floor were short 1 Certified Nursing Assistant. On 05/25/2025 on the 11:00 PM to 7:00 AM shift, the 3rd floor was short 1 Licensed Practical Nurse.On 05/31/2025 on the 7:00 AM to 3:00 PM shift, the 2nd and 4th floor were short 1 Licensed Practical Nurse.On 05/31/2025 on the 3:00 PM to 11:00 PM shift, the 7th floor was short 1 Certified Nursing Assistant.On 05/31/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	short 1 Licensed Practical Nurses, and the 4th floor and 6th floor were short 1 Certified Nursing Assistant. Review of staffing information dated 06/01/2025 to 06/29/2025 documented the following: On 06/01/2025 on the 3:00 PM to 11:00 PM shift, the 7th floor was short 1 Certified Nursing Assistant. On 06/01/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse, and the 3rd floor was short 1 Registered Nurse.On 06/07/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor, 3rd floor, and 4th floor were short 1 Licensed Practical Nurses, and the 3rd floor was short 1 Certified Nursing Assistant.On 06/07/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor and 3rd floor were short 1 Licensed Practical Nurse.On 06/07/2025 on the 11 PM to 7:00 AM shift, the 4th floor and 7th floor were short 1 Certified Nursing Assistant. On 06/08/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Registered Nurse.On 06/08/2025 on the 3:00 PM to 11:00 PM shift, the 3rd floor was short 1 Certified Nursing Assistants, and 1 Licensed Practical Nurse.On 06/08/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse, the 3rd floor was short 1 Registered Nurse, and the 4th floor was short 1 Certified Nursing Assistant. On 06/14/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse. On 06/14/2025 on the 11:00 PM to 7:00 AM shift, the 4th floor was short 1 Certified Nursing Assistant.On 06/15/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 06/22/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 06/22/2025 on the 11:00 PM to 7:00 AM shift, the 3rd floor was short 1 Licensed Practical Nurse.On 06/28/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse, and the 3rd floor was short 1 Registered Nurse.On 06/28/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse and the 3rd floor was short 1 Registered Nurse.On 06/28/2025 on the 11:00 PM to 7:00 AM shift, the 2nd floor was short 1 Licensed Practical Nurse.On 06/29/2025 on the 7:00 AM to 3:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse, and the 3rd floor was short 2 Registered Nurses. On 06/29/2025 on the 3:00 PM to 11:00 PM shift, the 2nd floor was short 1 Licensed Practical Nurse. On 09/16/2025 at 9:59 AM, the Staffing Coordinator was interviewed and stated in the morning they check to see if there were any sick calls and work on the monthly schedule and find replacement if there are call outs. The Staffing Coordinator also stated if there is a shortage of nursing staff, the certified nurse assistants will get moved around from different floors depending on the census; a replacement cannot be found every time so we sometimes will work short. The Staffing Coordinator further stated sick calls happen mostly on the weekends and they have been trying to schedule extra people, so the weekend shortage is better now than it was before. The Staffing Coordinator stated between April and June of 2025, the facility had been working short of staff as the registered nurses and certified nurse assistants were leaving or resigning and going to other places. Facility staff was doing double shifts, and more agency staff were used and this worked for a little bit, but then sometimes the staff would call out at the last minute. The Staffing Coordinator also stated they work with the administrator and the Director of Nursing to look for agency staff to accommodate the shortage. On 09/18/2025 at 12:31 PM, the Director of Nursing was interviewed and stated the facility has the same amount of staffing on weekends as during the week, and the only thing they can think of is that there were call outs and staff taking off for vacation, but they tried to replace the staff. The Director of Nursing also stated on the weekend the supervisors try to replace the call outs but if it is more than 3 call outs, it may be difficult to replace all 3 of the call outs. The Director of Nursing further stated they have some nursing staff that work only on the weekends, and some staff do double shifts, and the facility is always trying to recruit staff but when they are trained and put on the floor, they will leave and never come back. The Director of Nursing stated the facility works with 11 different contracted agencies, and they have daily interviews, and the Staffing Coordinator works very hard to make sure that the facility is fully staffed. 10 NYCRR 415.13(a)(1)(i-iii)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interviews conducted during the Recertification survey, the facility did not ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety. This was evident during the Kitchen task. Specifically, Dietary staff were observed not wearing hair restraint appropriately while performing tasks in the kitchen. The findings include:The facility policy on Dietary Uniform Code with a revised date of 06/15/2025 stated all employees when working in the dietary department will wear a hairnet/hair restraint as per policy. This hairnet/hair restraint will cover all hair. [NAME] and facial hair should be contained. On 09/14/2025 at 09:23 AM, the Food Service Director was observed wearing a baseball cap with some hair sticking out of the baseball cap. On 09/14/2025 at 09:25 AM, [NAME] #1, was near the kitchen table assisting in wrapping tuna sandwiches. [NAME] #1 was observed wearing a baseball hat that ended above both ears and all of their hair was not restrained and was sticking out under the baseball cap. On 09/14/2025 at 09: 35 AM, Dietary Aide #1 was standing adjacent to the kitchen table assisting in wrapping sandwiches. Dietary Aide #1 was observed wearing a baseball cap and all of their hair was not restrained and was sticking out under the baseball cap.On 09/14/2025 at 09:37 AM, Dietary Aide #2 was standing near an open pot on the stove. Dietary Aide #2 was observed wearing a baseball cap and all of their hair was not restrained and was sticking out under the baseball cap.On 09/14/2025 at 09:44 AM, Dietary Aides #3 and #4 were observed near the kitchen door carrying food containers. Neither dietary aide was wearing a hair restraint. A box of hair nets was observed on a wall at the entrance to the Kitchen.On 09/15/2025 at 10:55 AM, the Food Service Director was interviewed and stated they always wear a baseball hat and did not realize some hair was not covered, however they will use the hair net to completely cover their hair. The Food Service Director also stated to ensure compliance they randomly check their staff to ensure correct application of hair nets or hair coverings that must fully cover the entire hair. On 09/16/2025 at 11:45 AM, [NAME] #1 was interviewed and stated they thought a baseball cap was acceptable to wear in the kitchen since they see the Food Service Director wear a baseball cap.On 09/16/2025 at 12:04 PM, Dietary Aide #1 was interviewed and stated they thought the baseball hat is acceptable to wear while helping in the kitchen and did not realize some of their hair was sticking out of the baseball hat. On 09/16/2025 at 12:10 PM, Dietary Aide #2 was interviewed and stated they were wearing baseball cap but when they saw the surveyor they changed it immediately to a hairnet.On 09/19/2025 at 01:24 PM, the Administrator was interviewed stated they were made aware that some kitchen staff were not wearing appropriate hair covering while preparing food for the residents which is not acceptable. The Administrator further stated the Food Service Director must ensure kitchen staff wears appropriate and complete hair covering at all times while in the kitchen for safety and to avoid hair accidentally falling while preparing food. 10 NYCRR 415.14 (h)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews conducted during the Recertification survey, the facility did not ensure that each resident was treated with respect, dignity and care in a manner that promotes maintenance or enhancement of their quality of life and recognizes each resident's individuality. This was evident for one (1) out of six (6) units (Unit 7) observed. Specifically, 6 (six) out of 38 residents (Resident #64, #85, #38, #245, #248 and #11) on the 7th floor, were served meals in a disposable 3 (three) compartment white colored foam containers with disposable plastic cutlery. The findings are:The facility policy titled Resident Rights, with review date of 08/2025, stated the resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. The admission Minimum Data Set 3.0 assessment for Resident #64 dated 07/21/2025 documented Resident #64 had moderate cognitive impairment and required dependent assistance with eating. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #85 had severe cognitive impairment and required dependent assistance with eating. The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #38 had severe cognitive impairment and required supervision or touching assistance with eating.The Quarterly Minimum Data Set 3.0 assessment dated [DATE] documented Resident #248 had severe cognitive impairment and required supervision or touching assistance with eating.The admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #113 had intact cognition and required set up assistance with eating. There was no documented evidence Residents #64, #85, #38, #248 or #11 required the use of plastic or disposable dinnerware for medical or behavioral reasons. On 09/14/2025 at 12:12 PM, during an observation of the lunch meal on the 7th floor, 1 (one) meal truck with 11(eleven) lunch trays arrived on the unit. 4 (four) of the 11 (eleven) meal trays had a white foam 3 (three) compartment disposable container, white colored plastic utensils in a plastic seal, cold liquids that were poured into white foam disposable cups, and white foam disposable bowls that contained soup. On 9/15/2025 at 12:20 PM, during another observation of the lunch meal on the 7th floor, the meal truck was observed to have 4 (four) white foam containers that contained pureed/chopped food, along with plastic eating utensils (spoon, fork, knife, and napkin) and white foam cups and bowls that had hot and cold liquids inside.On 09/15/2025 at 12:30 PM, the 2nd food truck arrived on the 7th floor and was observed to have 3 (three) white foam 3 (three) compartment containers that had pureed/chopped food. Residents were observed using white plastic utensils and drinking liquids out of a white foam cups and white foam bowls holding soup.On 09/17/2025 at 10:16 AM, in the hallway near the kitchen 10 (ten) brown cardboard boxes that contained multiple 3-part compartment Styrofoam containers were observed.On 09/17/2025 at 11:30 AM, the lunch meal tray line was observed in the kitchen and some meals were plated in a white foam 3 (three) compartment disposable containers, other meals were plated on ceramic plates, and hot soup was placed in white foam containers and covered with a plastic lid. In addition, 4 in 1 plastic disposable utensil kits that contained a spoon, knife, fork, and napkin were placed on all meal trays. On 09/17/2025 at 09:52 AM, Certified Nursing Assistant #2 was interviewed and stated residents always use plastic forks and eat out of the plastic containers. Certified Nursing Assistant #2 also stated the residents who require chopped and puree food receive their meals in plastic containers. Certified Nursing Assistant #2 further stated they had worked at the facility for 10 years, and meals had always been served this way. On 09/17/2025 at 10:02 AM, Registered Nurse #2 was interviewed and stated residents have always received soup and hot cereal in plastic bowls, water in plastic cups and meals in white foam compartment containers. Registered Nurse #2 also stated meals have always been served this way and it may be for safety reasons. The Significant Change in Status Minimum Data Set 3.0 assessment dated [DATE] documented Resident #245 was cognitively intact and (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required partial/moderate assistance with eating.On 09/17/2025 at 12:30 PM, Resident #245 was interviewed and stated that this is the way meals are served at the facility. On 09/17/2025 at 11:45 AM, the Food Service Director was interviewed and stated that the facility has been using the plastic disposable cutlery and dishware since the COVID-19 pandemic. The Food Service Director also stated the 3-compartment food container is used for pureed food because the food runs into each other when on a regular plate. The Food Service Director further stated this item is also used for residents on contact isolation and for visitors. On 09/17/2025 at 2:07 PM, the Director of Nursing was interviewed and stated during the COVID-19 pandemic the facility was using the disposable dishware and utensils. The Director of Nursing also stated they were not sure why they continued to use disposable food items. On 09/18/2025 at 10:45 AM, the Registered Dietitian was interviewed and stated residents have not complained about using the disposable utensils/dishware during Resident Council meetings. The Registered Dietitian also stated disposable utensils have been in use for the eight years they have been at the facility. The Registered Dietitian further stated most residents receive their food on a ceramic plate with the dome covering, and resident's receiving a pureed diet get the three (3) compartment disposable containers and disposable utensils.On 09/18/2025 at 11:54 AM, the Administrator was interviewed and stated the residents complained the pureed foods were getting mixed up/running into each other when on a regular plate, so they tried to purchase plates that had sections, but they did not fit under the dome to keep the food hot. The Administrator also stated the residents requested this and they had not complained about using disposable dishware/utensils. 10 NYCRR 415.3 (d)(1)(i)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 4Number of residents cited: 1 Based on observation, record review, and interviews conducted during the Recertification survey, the facility did not ensure a resident who needed respiratory care was provided such care, consistent with professional standards of practice. This was evident for one (1) out of four (4) residents (Resident #33) reviewed for Respiratory Care out of 38 sampled residents. Specifically, Resident #33 was observed on multiple occasions using oxygen with an undated nasal cannula. The findings are: The facility's policy titled Oxygen Administration last reviewed 08/2025 stated oxygen tubing is changed weekly. The policy also stated the facility will provide the means to safely administer oxygen therapy to those residents requiring it.Resident #33 had diagnoses which included Heart failure and Essential Hypertension. The admission Minimum Data Set, dated [DATE] documented Resident #33 was cognitively intact and received oxygen therapy while residing at the facility. The Interdisciplinary Care Plan titled 'Alteration in Cardiovascular Function or Decrease in Cardiac Output' with effective date 06/25/2025 documented to provide oxygen as ordered by medical doctor and teach oxygen conservation techniques. The Physician's Order dated 06/24/2025 documented Resident #33 was to receive oxygen via nasal cannula at a rate of 2 liters per minute continuously. On 09/14/2025 at 10:46 AM, Resident #33 was observed resting in bed and wearing an undated nasal cannula attached to the concentrator next to the right side of bed while receiving oxygen at a rate of 2 liters per minute. Resident #33 was interviewed and stated that they could not recall the last time their nasal cannula was changed. During multiple observations from 09/14/2025 at 10:46 AM to 09/15/2025 at 12:14 PM, Resident #33 was observed resting in their bed and wearing an undated nasal cannula attached to the concentrator on the right side of their bed.On 09/15/2025 at 12:15 PM, Licensed Practical Nurse #1 was interviewed and stated Resident #33 received oxygen therapy due to heart failure. Licensed Practical Nurse #1 also stated the nasal cannula tubing had to be changed every three (3) days, and they were not aware the nasal cannula tubing had to be dated. Licensed Practical Nurse #1 further stated they did not know when the nasal cannula tubing was last changed. Licensed Practical Nurse #1 stated they worked on the unit yesterday 09/14/2025 and today 09/15/2025 and would change the nasal cannula tubing by the end of the shift.On 09/15/2025 at 12:39 PM, Registered Nurse #1 was interviewed and stated Resident #33 had an order to receive continuous oxygen at a rate of 2 liters per minute. Registered Nurse #1 also stated the night shift nurse was responsible to change and date the nasal cannula tubing once a week on Sunday night or as per doctor's order for infection control purposes. Registered Nurse #1 further stated any nurse who observed undated nasal cannula tubing or soiled tubing was to change the tubing as needed, and it should be dated every time the tubing was changed. Registered Nurse #1 went to Resident #33's room with surveyor and observed the nasal cannula tubing was undated. Registered Nurse #1 was unable to provide an explanation for why Resident #33's nasal cannula tubing was undated. 09/17/2025 at 12:14 PM, the Director of Nursing was interviewed and stated the nasal cannula tubing is to be dated when it was changed so staff were aware when it needed to be changed next. The Director of Nursing also stated they made round on the units once a day and looked for resident care and safety, cleanliness of medication cart, and environment. The Director of Nursing further stated they did not look at the nasal cannula tubing when making rounds at the units. 10 NYCRR 415.12(k)(6)

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	12/03/2025

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

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 5Number of residents cited: 1 Based on record review and interviews conducted during the Recertification survey the facility did not ensure that the drug regimen of each resident was reviewed at least once a month by a Licensed Pharmacist. This was evident for 1 of 5 residents (Resident #14) reviewed for Unnecessary Meds, Chemical Restraints/Psychotropic Meds, and Med Regimen Review out of an investigative sample of 38 residents. Specifically, there was no documented evidence the Medication Regimen Review for Resident #14 was completed in August 2025.The findings are:The facility's policy entitled Medication Regimen Review last reviewed 8/2025 stated the drug regimen of each resident must be reviewed at least once a month by a Licensed Pharmacist. The policy further stated the review must include a review of the resident's chart, including residents on psychotropic medications. Resident #14 was admitted to the facility with diagnosis including Larynx Cancer, Heart Failure, Seizure Disorder Depression, and Schizophrenia. The Significant Change in Status Minimum Data Set assessment dated [DATE] documented Resident #14 was moderately impaired and was receiving antipsychotic, antianxiety, antidepressant, antiplatelet, hypoglycemic, and anticonvulsant medication. The Physician orders last reviewed 08/27/2025 documented orders for Risperidone 1 mg tablet give two tablets (2 mg) by oral route every 12 hour for Schizophrenia, Lantus Solostar U-100 Insulin 100 unit/mL (3 mL) subcutaneous pen inject 20 units by subcutaneous route once daily at bedtime, and Venlafaxine 100 mg tablet give 1 tablet (100 mg) by oral route 2 times per day. The Pharmacy progress notes dated 3/22/2025, 4/28/2025, 05/26/2025, 06/19/2025, 7/31/2025, and 9/16/2025 documented based upon the information available at the time of the review, and assuming the accuracy and completeness of such information it is my professional judgment that at such time, the resident's medication regimen contained no new irregularities. There was no documented evidence a pharmacy review had been completed for Resident #14 in August 2025. During a telephone interview on 09/17/2025 at 10:18 AM, the Consultant Pharmacist stated they are responsible for doing monthly, admission, and readmission medication reviews for the facility. The Consultant Pharmacist also stated they usually check the medical records, and when reviewing for Resident #14 they noticed the review was not documented in the medical record. The Consultant Pharmacist further stated they recall looking at Resident #14's chart and there were no irregularities, but they forgot to document in the medical record. The Consultant Pharmacist stated this was just a human error. During an interview on 09/16/2025 at 10:15 AM, the Director of Nursing stated the Pharmacy Consultant comes every month and reviews the charts of the residents. The Director of Nursing also stated the Pharmacist was in the building, and they are not sure what happened with the review of Resident #14's and why it was missed. The Director of Nursing further stated the Consultant Pharmacist comes every month and they did not know the review was missed until the surveyor brought this issue to their attention. 10 NYCRR 415.18(c)(2)

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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. Based on observations and interviews conducted during the Recertification survey, the facility did not ensure notice of the availability of the survey results were posted in areas of the facility that are prominent and accessible to the residents and the public. Specifically, there were no posted notices throughout the six (6) resident floors of the facility about the availability of survey results.The findings are:The facility's policy titled Residents' Rights with a reviewed date 08/2025 stated the resident has a right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. During multiple building observations conducted between 09/14/2025 at 09:18 AM and 09/16/2025 at 09:41 AM, survey results were observed in a binder at the security station in the lobby area. There were no notices posted to inform the residents and the public on any of six (6) resident units about where the survey results could be located. During the Resident Council meeting held on 09/16/2025 at 10:32 AM, ten (10) residents were in attendance, and nine (9) out of ten (10) residents (Residents #20, #44, #62, #159, #163, #183, #195, #233, and #235) 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 06/26/2025, 07/31/2025, and 08/28/2025 had no documentation that information was provided to the residents on where to locate survey results. On 09/17/2025 at 12:19 PM, the Administrator was interviewed and stated they posted signage where to find state survey results by elevators on all six (6) resident floors. The Administrator also stated they had wall painting on the resident floors recently and the signage about where to find the survey results might have dropped off. The Administrator further stated they made rounds to all six (6) resident floors every day, and they did not pay attention to the signage about where to find the survey results. The Administrator made rounds with the surveyor to all six (6) resident units and was not able to locate any signage indicating where the survey results were located on any of the six (6) resident floors. 10 NYCRR 415.3 (d)(1)(v)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review, and interviews conducted during the Recertification survey, the facility failed to ensure the nursing staff information was posted as required. Specifically, the daily nurse staffing information posting did not include the resident census, total number and actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift and was not maintained for a minimum of 18 months. The findings include:The facility policy titled Staffing Level with review date of 08/2025 stated it is the policy of the facility that the daily schedule will be posted before the beginning of each shift to guide the staff members on their assignments for the day. The policy also stated Nurse staffing information will be posted detailing the number of licensed nursing staff including registered nurses, licensed practical nurses, and nurses' aides on duty for every shift every day.On 09/14/2025 at 09:06 AM, upon entrance into the facility a Daily Staffing sheet dated 09/12/2025 was posted which documented the number of registered nurses, licensed practical nurses and certified nurse aides, but did not include the resident census, the total number and actual hours worked by the staff.On 09/14/2025 at 2:20 PM, the Director of Nursing was interviewed and stated they are aware the Daily Staffing posting was dated 09/12/2025, and this is because the Staffing Coordinator is not in the building on the weekends. The Director of Nursing also stated they are aware the Daily Staffing information had not been posted since 09/12/2025. On 09/16/2025 at 09:59 AM, the Staffing Coordinator was interviewed and stated they are responsible for posting the Daily Staffing information in the morning which includes the projected hours, projected staff numbers and the par level needed on the unit. The Staffing Coordinator also stated if they are not in the facility, the Human Resources Assistant will write out the Daily Staffing information that is prepared for the weekend and post it. The Staffing Coordinator further stated the nursing supervisor is supposed to put up the posting on the weekends once in the morning during the day shift. The Staffing Coordinator also stated they include the current date, do not include the census, and enters the projected hours and not the actual hours worked. The Staffing Coordinator also stated they did not know they were supposed to store the staffing posting information for at least 18 months and they had been discarding the staffing posting information. On 09/16/2025 at 10:47 AM, the Director of Nursing was re-interviewed and stated the posting of the staffing which consists of the registered nurses, licensed practical nurses, and certified nurse aides is posted daily for each shift on the wall in the lobby and includes the census and the hours and numbers on the Daily Staff information posting are projected numbers and hours and not the actual numbers and hours worked. The Director of Nursing also stated they were not aware the daily staffing posting was being posted inaccurately and did not pay attention. On 09/16/2025 at 10:58 AM, the Human Resources Assistant was interviewed and stated they were told to place registered nurses, licensed practical nurses and certified nurse aides on the sheet along with the number working on each shift and the hours they would be working. The Human Resources Assistant also stated they do not have access to the electronic medical record, so they are not able to retrieve the census. The Human Resources Assistant further stated when the Staffing Coordinator is off on the weekends, they do not post the Daily Staff information. 10 NYCRR 415.13