STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility did not ensure that a resident's right to a safe, clean, comfortable, and homelike environment was maintained. This was evident on all resident units (Unit 2, 3 and 4). Specifically, rooms were not cleaned, hallways and day rooms were observed discolored with dark-brown color stains, days rooms and hallways were observed with cracked floor tiles, and days rooms also were observed with greasy dark stains in the corners. Findings are The facility policy titled, Maintenance Services, with a current effective date of 05/28/2025, documented that the facility provides maintenance services to the facility, grounds, and equipment in accordance with current standards of practice and State and Federal regulations. Functions of maintenance personnel may include, but are not limited to, maintaining the building in good repair and free from hazards. The facility policy titled, Cleaning and Disinfection of Environmental Surfaces, last revised on 04/16/2025, documented that the facility will clean and disinfect environmental surfaces according to the current Center for Disease Control recommendations for disinfection of healthcare facilities and the Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standard. Horizontal housekeeping surfaces (e.g., floors, tabletops) will be cleaned and disinfected on a regular basis, when spills occur, when these surfaces are visibly soiled, when the room/area is terminally cleaned/disinfected, and/or following the direction of the Department of Health. Vertical housekeeping surfaces (e.g., walls, windows) in resident areas will be cleaned and disinfected when these surfaces are visibly contaminated, soiled, when the room/area is terminally cleaned/disinfected, and/or following the direction of the Department of Health. On 03/08/2026 at 09:30AM, upon entering the 2nd floor, the odor of urine was noted. room [ROOM NUMBER] was observed to have a door frame tarnished with brown staining/marking and brown substance on the wall. The bathroom was found with brown stains on the toilet. The tiles behind the toilet appeared dirty and brown. The hand towels on the rack smelled foul. The sink had a dripping faucet. On 03/08/2026 at 09:42AM, observations made of the 2nd floor resident shower room and dirty linen cart room include brown substance on the wall and floors, a dirty linen bag on the floor, a hairbrush and comb on the shower floor, and underwear lying on a wheelchair. On 03/08/2026 at 09:44AM, in room [ROOM NUMBER] the oxygen concentrator was noted to be dusty with a white residue on knobs and on top of the machine. The concentrator was in use, with undated (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
	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tubing attached to the resident's tracheostomy. The GT pole was noted with brown residue on the pole as well as an accumulation at the base. In room [ROOM NUMBER] the entrance was noted with blackened areas on the flooring and in the corner of the room. Blackened areas of flooring were also noted around furniture and under the sink. The bottom of the wall facing the bed was noted with white splash marks on the wall. In room [ROOM NUMBER] the entrance was noted with dirty baseboards with blackened tiles. On 03/10/2026 at 11:05AM, upon getting off the elevator on the 2nd floor, a strong urine odor was noted. On 03/11/2026 at 9:51AM, the 2nd floor nurses' station floor tiles were noted to be black, and the equipment at the nurses' station were in disrepair including a dirty and rusted oxygen tank holder. Under the desk at the nurses' station a build up of dirty and dusty was noted around the wires. On 3/12/2026 at 10:40AM, observations on the 2nd Floor Vent Unit include, but are not limited to tiles in the hallway with visible brown stains, areas of brown and white discoloration on the hallway wallpaper between the guardrails, white splatter on hallway wallpaper, and peeling wallpaper in the hallway. Additionally, the white fire extinguisher case was noted with brown discolorations and the sign that points to the fire extinguisher was noted to be peeling off. On 03/08/2026 at 10:06AM, the 3rd Floor nurses station was noted with 1 black chair covered with paper as a barrier from dirt or residue on the chair and 1 black chair missing an arm rest. Under the nurses' station desk was old food as well as dirty and dark stained floor tiles. The wall behind the nurses' station was stained. The cabinet door was noted to be missing handles and appeared broken. The resident refrigerator had brown colored rusted stains on the outside. On 03/08/2026 at 10:20AM the 3rd Floor Unit resident shower room was noted to have a musty, stale odor. The entrance of the shower room was observed to have black-stained floor tiles. The shower room was noted with brown stains on the ceiling tiles and stained flooring. The shower floor of Shower Stall #2 was noted to have white and brown substances present. On 03/08/2026 at 10:31AM, in room [ROOM NUMBER] the sink had brown substance on the edges, and the floor was sticky with areas of dirt. On 03/08/2026 at 10:35AM, peeling wallpaper was noted on the wall near room [ROOM NUMBER]. In room [ROOM NUMBER] there was a ripped chair and a dirty bedside table tray. On 03/08/2026 at 10:52AM both radiators in the 3rd Floor Shower Room located in the rear of the unit were observed to have rust. Floor tiles leading to the shower stall had brown-colored substance around the edges. On 03/08/2026 at 11:20AM an observation of the 3rd Floor Unit noted dark brown stains in the hallway and dining room, dark greasy stains around the corners and on baseboards of the dining area and hallways, and multiple cracked tiles in the hallway and dining room. On 03/08/2026 at 11:30AM, Shower Stalls #1 and #2 were toured with Maintenance Staff #1. The hot water in Shower Stall #1 ran from 11:38AM to 11:41 AM. The water was cool to touch using the back of the hand and the thermometer read between 78-79 degrees F and 25.7 degrees C. The shower head was noted to be leaking. Maintenance Staff #1 stated the 3rd floor is their responsibility but was (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unable to explain why the shower did not feel hot. Maintenance Staff #1 also stated they make daily rounds on the unit for any repairs and there is someone who tests the water. The hot water in Shower Stall #2 ran from 11:41AM to 11:44AM. The thermometer read between 78-81 degrees F and 28 degrees C. The water was warmer than Shower Stall #1, but was still cool. On 03/08/2026 at 11:51AM a tour of the 4th Floor Unit noted the following observations: brown stains on the floor, yellow stains in the dining room and hallway floors, dark, greasy and dirt-filled stains in the corners of the hallway and day room, and brown stains on the floor of the entrance to the garbage holding station. On 3/11/2026 at 10:25AM, Housekeeper #1 was interviewed and stated they are responsible for doing specific things in the facility when the regular housekeeper is off. Housekeeper #1 was observed in room [ROOM NUMBER] and had stated they were told to clean the concentrator and the GT pole. Housekeeper #1 stated the pole needed to be cleaned because there was dirt stuck on the pole and at the bottom of the pole stand, and the concentrator needed to be cleaned because it was dirty as well. Housekeeper #1 stated they are assigned different duties especially when the regular housekeeper is off. They stated there is not a schedule of when to clean certain items such as concentrators, but that the housekeepers carry out tasks per the Director's instructions. On 03/11/2026 at 10:12AM, Housekeeper #2 was interviewed and stated they handle cleaning all offices and the activity room every other Monday and Wednesday. They are also responsible for three floors, and they go from floor to floor to pick up all garbage in contact rooms, wipe down the units and nurses' stations. Housekeeper #2 stated they use odor neutralizer to mop and wipe the building. They agreed that the floors are dirty despite using a regular mop. Housekeeper #2 suggested the floors needed stripping. Housekeeper #2 stated they are only the fill-in Housekeeper for the regular housekeeper who was off. On 03/12/2026 at 09:15AM, Maintenance Staff #1 was interviewed and stated that they have been working at the facility for years and they oversee the 3rd floor and the vent unit on the 2nd floor. Their job duties are to make daily rounds of the unit to see if any repairs are needed and to fix them. They stock the Personal Protective Equipment (PPE) carts on the wall. They also stated that the molded ceiling tile was caused by a leak on the 4th floor, and they were waiting for the leak to be cleared to fix the tile. They also stated that they are not responsible for the unit tiles or the walls, and that is the responsibility of the housekeeping department. They also stated that they fix the radiators, and broken wheelchairs brought to them by the nursing staff. On 03/12/2026 at 09:30AM, Maintenance Staff #3 was interviewed and stated they are responsible for only cleaning the floors and the hallway. They mop, sweep, and sometimes buff the floors. They admitted the floors, tiles, and walls need replacement and did not want to elaborate if administration was aware of the problem. Maintenance Staff #3 also stated that the urine odor on the unit is more evident in the morning when care is being performed. Maintenance Staff #3 stated housekeeping staff come and pick up the dirty linen 4 times a day. They also stated that the building needs repairs. On 03/12/2026 at 10:00AM Maintenance Staff #2 was interviewed and stated that since they have been working at the facility the number of housekeeping staff had significantly decreased. They listed their responsibilities on the 3rd floor: cleaning all 26 rooms, cleaning bathrooms, ensuring furniture and beds are cleaned, dumping garbage, cleaning toilets, mopping and sweeping. Maintenance Staff #2 also admitted reparations were needed for the facility including replacing the flooring. Additionally, Maintenance Staff #2 mentioned that resident shower rooms are cleaned by separate housekeeping (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff, but if extra staff were available, they would be assigned to clean it. On 03/13/26 at 11:39 AM, an interview was conducted with Maintenance Staff #4 who stated that they were stationed on Unit 3 only, and they are responsible for cleaning all the rooms, and the other staff who was not present on the floor today would buff the hallway. They concluded that the unit was dirty because they have not been cleaning the unit every day as the unit might get dirty again due to the snow. On 03/16/2025 at 11:00 AM, an interview was conducted with Maintenance Staff #5 who stated that they have been assigned to the 4th floor for several years. Maintenance Staff #5 also stated they would not usually clean the hallway and dining areas unless they were instructed by the supervisor. Maintenance Staff #5 further stated they could not recall the last time they saw the person responsible for cleaning the hallway. On 03/13/2026 at 12:15PM, the Director of Housekeeping/Maintenance was interviewed and stated it is their responsibility to oversee the housekeeping/maintenance staff. The maintenance staff on the floor are to do daily rounds of the unit to see if any repairs are needed and the housekeeping staff are there to perform the cleaning aspect of the units and report any issues that arise so that they can be taken care of. The Director of Housekeeping/Maintenance stated that they try to get to the items that need repairing and sometimes they do not know what needs to be repaired because they are not told. The Director of Housekeeping/Maintenance stated that the repairs are starting off with the elevators. On 3/13/2026 at 12:27PM, the Administrator was interviewed and admitted to the poor condition of the facility but failed to provide an explanation for its status. The Administrator stated that renovations for the facility are underway and are to include replacing the elevator, roof, floors, walls and repairing the interior of all the units. 10 NYCRR 415.5(h)(2) 10 NYCRR 415.5(h)(4)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure sufficient nursing staff were available to provide nursing and related services to assure resident safety to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. Specifically, review of the weekend staffing and the Payroll Based Journal Staffing Data Report dated [NAME] 1st, 2025 to September 30th, 2025, was evident for low weekend staffing. The findings include, but are not limited to: The Payroll Based Journal Staffing Data Report for Quarter four (4) of 2025 dated July 1st to September 30th documented that submitted weekend staffing data was excessively low. The Facility assessment dated [DATE] documented the following Units' levels/capacity: fourth (4th) floor: 45 residents, third (3rd) floor: 45 residents, second (2nd) floor: 33 residents, and the ventilator unit: 17 residents. The Facility's undated document titled, Concord Nursing and Rehabilitation Center, documented PAR levels of Certified Nursing Assistants and Licensed Practical Nurses as follows: Certified Nursing Assistants: Day shift (7:00 AM -3:00PM): Fourth Floor: Six (6), Third Floor: Six (6), Second Floor: Four (4), Ventilator Unit: Three (3) Evening shift (3:00pm -11:00PM): Fourth floor: Four (4), Third Floor: Four (4), Second Floor: Three (3), Ventilator Unit: Three (3) Night Shift (11:00pm - 7:00PM): Fourth Floor: Two (2), Third Floor: Three (3), Second Floor: Two (2), Ventilator Unit: Two (2) Note: As of 1/2026: PAR level for Certified Nursing Assistants on the Night shift on Third Floor changed from three (3) Certified Nursing Assistants to Two (2) Certified Nursing Assistants. Licensed Practical Nurses: Day Shift (7:00 AM - 3:00PM): Fourth floor: Two (2), Third Floor: Two (2), Second floor: One (1), Ventilator Unit One (1) Evening shift (3:00PM - 11:00 pm): Fourth floor: Two (2), Third floor: Two (2), Second floor: One (1), Ventilator Unit: One (1) Night Shit (11:00PM - 7:00AM): Fourth floor: One (1), Third floor: One (1), Second floor: One (1), Ventilator Unit: One (1) Licensed Practical Nurse. Review of the actual weekend staffing schedule from 07/05/2025 through 09/28/2025 documented the following missing staff: Saturday July 5th, 2025: Day shift (7:00 AM -3:00 PM): Ventilator unit, and fourth floor: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM- 11:00 PM): Ventilator unit and Second floor: One (1) Certified Nursing Assistant; Third and fourth floors: One (1) Licensed Practical Nurse. Sunday July 6, 2025: Day Shift (7:00AM- 3:00PM): Fourth floor: One (1) Certified Nursing Assistant; Third floor: One (1) Licensed Nurse. Evening shift (3:00PM - 11:00 PM): Second floor: One Certified Nursing Assistant; third and fourth floor: One (1) Licensed Practical Nurse. Saturday July 12, 2025: Evening shift (3:00 PM -11:00 PM): Second floor; One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Night shift (11:00 PM - 7:00 AM) Third floor: One (1) Certified Nursing Assistant. Sunday July 13, 2025: Day shift (7:00 AM- 3:00 PM): Third and fourth floors: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second floor; one (1) Certified Nursing Assistant; Third and fourth floors: One (1) Certified Nursing Assistant and one (1) Licensed Practical Nurse. Night shift (11:00 PM - 7:00 AM): Third and Fourth floors: One (1) Certified Nursing Assistant. Saturday July 19, 2025: Day shift (7:00 AM- 3:00pm): Second and third floors: One (1) Certified Nursing Assistant Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Night shift (11:00 PM - 7:00 AM): Third floor: One (1) Certified Nursing Assistant. Sunday July 20, 2025: Day shift (7:00 AM - 3:00 PM): Ventilator unit, third and fourth floors: One (1) Certified Nursing Assistant; fourth floor: Two (2) Certified Nursing Assistants; third floor: One (1) Licensed Practical Nurse. Evening shift (3:00PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant. Third floor: One (1) Licensed Practical Nurse. Saturday July 26, 2025: Day shift (7:00 AM - 3:00 PM): Third and fourth floors: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): second and fourth floors: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Practical Nurse. Sunday July 27, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): second floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Saturday August 2, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floors: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Second and fourth floors: One (1) Certified Nursing Assistant. Sunday August 3, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floor: Two (2) Certified Nursing Assistant; third floor: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second and fourth floor: One (1) Certified Nursing Assistant. Saturday August 9, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floor: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant, third and fourth floors: One (1) Licensed Practical Nurse. Sunday August 10, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floor: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Saturday August 16, 2025: Day shift (7:00 AM - 3:00 PM): Ventilator unit: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second and third floors: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Sunday August 17, 2025: Day shift (7:00 AM - 3:00 PM): Second and fourth floors: One (1) Certified Nursing Assistant; third floor: Two (2) Certified Nursing Assistants, fourth floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Ventilator unit and Second floor: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Saturday August 2, 2025: Day shift (7:00 AM - 3:00 PM): Third and fourth floors: One (1) Certified Nursing Assistant and one (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Ventilator and second floors: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Night Shift (11:00 PM - 7:00 AM): Third floor: One (1) Certified Nursing Assistant. Sunday August 24, 2025: Evening shift (3:00 PM - 11:00 PM): Second and third floors: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Night shift (11:00PM - 07:00 AM): Second and fourth floors: One (1) Certified Nursing Assistant Saturday August 30, 2025: Day shift (7:00 AM - 3:00 PM): Second floor: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Sunday August 31, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floor: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second and fourth floors: One (1) Certified Nursing Assistant and one (1) Licensed Practical Nurse. Night Shift (11:00 PM - 7:00 AM): Third floor: One (1) Certified Nursing Assistant. Saturday September 6, 2025: Day shift (7:00 AM - 3:00 PM): Fourth floor: One (1) Certified Nursing Assistant and One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant; fourth floor: One (1) Licensed Practical Nurse. Sunday September 7, 2025: Day shift (7:00 AM - 3:00 PM): Third floor: One (1) Certified Nursing Assistant, and One (1) Licensed Practical Nurse; fourth floor: Two (2) Certified Nursing Assistants and one (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Second, third, and fourth floors: One (1) Licensed Practical Nurse. Saturday September 13, 2025: Day shift (7:00 AM - 3:00 PM): Third and fourth floors: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant; third floor: One (1) Licensed Practical Nurse. Sunday September 14th , 2025, short/missing staff: Day shift (7:00 AM - 3:00 PM): Third floor; One (1) Licensed Practical Nurse; Fourth floor: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): third and fourth floors: One (1) Licensed Practical Nurse. Saturday September 20, 2025: Day shift (7:00 AM - 3:00 PM): Second floor: One (1) Certified Nursing Assistant; Third floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Second floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Night Shift (11:00 PM - 7:00 AM): Third floor: One (1) Certified Nursing Assistant. Sunday September 21, 2025: Day shift (7:00 AM - 3:00 PM): Third and fourth floors: One (1) (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse; Fourth floor: One (1) Certified Nursing Assistant. Evening shift (3:00 PM - 11:00 PM): Second and third floors: One (1) Certified Nursing Assistant Saturday September 27, 2025: Day shift (7:00 AM - 3:00 PM): Second and third floors: One (1) Certified Nursing Assistant; Fourth floor: Two (2) Certified Nursing Assistants; Third (3rd) floor: One (1) Licensed Practical Nurse. Evening shift (3:00 PM - 11:00 PM): Fourth floor: One (1) Certified Nursing Assistant; third and fourth floors: One (1) Licensed Practical Nurse. Sunday September 28, 2025: Day shift (7:00 AM - 3:00 PM): Second and third floors: One (1) Certified Nursing Assistant; Fourth floor: Two (2) Certified Nursing Assistants On 03/09/2026 at 9:47 AM, Certified Nursing Assistant #7 was interviewed and disapproved of the staffing for the facility. Certified Nursing Assistant #7 stated they were working on the unit yesterday and today with three (3) Certified Nursing Assistants for 32 residents; each Certified Nursing Assistant has eleven (11) residents to care for, each requires varied degrees of help. Certified Nursing Assistant #7 stated no residents came out of bed today because most require Hoyer lifts and need two (2) staff to get them out of bed. Certified Nursing Assistant #7 expressed difficulty in managing the workload including feedings, activities of daily living, 2 (two) staff assists when working with 2 (two) other certified nursing assistants on the unit. Certified Nursing Assistant #7 stated they cannot take a break because of the workload, but the facility refuses to pay for missed break. Certified Nursing Assistant #7 stated the second floor needs more staffing as they had been running around today trying to get the work done. Certified Nursing Assistant #7 expressed disappointment in that the facility did not staff the second floor with four (4) certified nursing assistants despite the presence of the Department of Health. On 03/09/2026 at 10:28 AM Certified Nursing Assistant #7 was observed and interviewed in room [ROOM NUMBER] assisting with Hoyer lift transfer. They expressed feeling overwhelmed, rushed and stressed by working. On 03/09/2026 at 10:02AM, Certified Nursing Assistant #12 was interviewed and stated the assignment is very heavy, and work gets backed up as residents require 2-staff assists. Certified Nursing Assistant #12 stated the unit only has three (3) Certified Nursing Assistants, so two (2) will work together on residents requiring 2(two)-staff assist while the other will go to the residents who only needs one (1) assist, and any Hoyer Lift on assignment will wait for care. Certified Nursing Assistant #12 stated it is impossible to take a break and ensure care is being given, despite the facility stating Certified Nursing Assistants must take break. On 03/09/2026 at 10:07AM, Licensed Practical Nurse #2 was interviewed and stated they are doing the best they can with the staff the facility provides. Licensed Practical Nurse #2 stated the unit only had three (3) Certified Nursing Assistants and they work together to get the residents cleaned up and out of bed as soon as possible. On 03/11/2026 at 4:11 PM, Licensed Practical Nurse #2 was observed sitting at nurses' station; they stated they were attempting to document in the medical record before going home. Licensed Practical Nurse #2 stated one (1) Certified Nursing Assistant was with the evening nurse giving care to a new admission, one (1) Certified Nursing Assistant working on the unit, and the unit was waiting for another Certified Nursing Assistant to return from clinic. On 03/10/26 at 11:36 AM during the Resident Council meeting, Resident #65 stated that staffing is poor at night and weekends reporting that staff do not respond to call bell for over two (2) hours. Resident #65 also stated that although they are self-sufficient in many things, there are some residents who need help but are not getting help on time. Resident #65 added that call bells are not answered by staff at times because only two (2) Certified Nursing Assistants work on the unit. On 03/10/26 at 11:49 AM during the Resident Council meeting, Resident #54 stated that staffing had been cut on weekends and overnight shifts for multiple units to the extent that there is only one (1) Certified Nursing Assistant providing care for approximately forty (40) residents on each floor. Resident #54 stated that this creates an unsafe environment for the residents because the existing staff frequently get called to other floors. Resident #54 also stated it is impossible to provide care and answer call lights in a timely manner. Resident #54 added the risk of residents' falls/accidents are greatly increased, especially if they attempt to toilet themselves because there are no staff to assist them. On 03/11/2026 at 4:00 PM, Licensed Practical Nurse #3 was interviewed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and stated staffing could be better, but they work with the staff facility provided. Licensed Practical Nurse #3 refused to make any other statement regarding staffing. On 03/11/2026 at 4:04 PM, Certified Nursing Assistant #6 was interviewed and stated they work with staff the facility provides. Certified Nursing Assistant #6 also stated staff communicate and help each other to get the work done. Certified Nursing Assistant #6 refused to make other comments regarding staffing. On 03/11/2026 at 4:16 PM, Certified Nursing Assistant #11 was interviewed and stated staffing is hard at times, and they must work with what staff the facility has given. Certified Nursing Assistant #11 stated on this evening shift there are only two (2) Certified Nursing Assistants with one (1) Licensed Practical Nurse on the unit. Certified Nursing Assistant #11 stated there is a new admission and a resident who is a risk for elopement that needs monitoring and constant redirection. Certified Nursing Assistant #11 stated another staff went to an appointment and had not returned at the time of the interview. Certified Nursing Assistant #11 added they were doing the best they can with what they were given. On 03/11/2026 at 12:47 PM, Registered Nurse Supervisor #4 was interviewed and stated the weekend staffing has changed over the last month. Registered Nurse Supervisor #4 stated there used to be three (3) Certified Nursing Assistants on the third floor, but this was changed one month ago to two (2) Certified Nursing Assistants. Registered Nurse Supervisor #4 had no other comment about the staffing. On 03/11/2026 at 1:02 PM, The Staffing Coordinator was interviewed and stated the current PAR levels for the facility are the same from July to present except there used to be three (3) Certified Nursing Assistant on the night shift on the third floor, and this was changed one month ago to two (2) Certified Nursing Assistants. The Staffing Coordinator stated the Director of Nursing provided the par levels when they first started working in the facility. The Staffing Coordinator believes the staffing for the facility is adequate. The Staffing Coordinator stated the facility has one (1) agency Certified Nursing Assistant working in the facility, and they will soon become a regular facility staff. The facility does not use agencies but utilizes per diem staff and overtime to cover gaps in staffing. The Staffing Coordinator stated when staff call out, the Supervisor will call the following shift to come in early or ask the staff already working in the facility to stay. If coverage is not found, the unit will work with what they have. The Staffing Coordinator stated sometimes the staff call out on the weekends, and a good effort is made to replace the staff. The Staffing Coordinator stated believes staffing is stable. On 3/12/2026 at 12:13 PM, the Director of Nursing was interviewed and stated finding coverage for callouts on the weekends is very difficult. The Director of Nursing stated they always try to get the staff replaced by calling part-timers, asking staff already in the facility to stay, and calling the future shift to come in early. The Director of Nursing stated the Supervisor must write on the staffing sheet who called out on the bottom of the page for Director to follow up. The Director of Nursing stated staffing is a constant work in progress and they have postage next to the clock for the hiring of four (4) full-time Certified Nursing Assistant for the day shift. The Director of Nursing stated they can also hire Per Diems who want to work full-time before they open the positions to outside applicants. The Director of Nursing is involved in the staffing and works with the Staffing Coordinator and Supervisor to replace staff who call out on the weekend. On 03/12/2026 at 3:20 PM, the Administrator was interviewed and stated that staffing is a challenge, and the facility does not have contracts with staffing agencies due to a contract with 1199. The Administrator stated that the facility participates in job fairs, posts vacancies online (ex. Indeed) and they also offer bonuses, higher salaries and provide uniforms as an incentive to get staffing. The Administrator stated that the facility has been offering overtime pay for extra shifts, and they ensure that there are additional staff to available to call in case there are callouts during the weekends. The Administrator stated that the staff call out a lot on the weekend. The Administrator also stated the from July to September, the summer months specifically, staffing is always a challenge, but currently staffing is stable. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

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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 observations, record review and staff interview, the facility failed to ensure that food was stored, prepared, and distributed, and that expired food in the walk-in freezer/refrigerator and the unit pantry were discarded in accordance with professional standards for food service safety. This was evident during the kitchen and unit pantry observation tasks. Specifically, food items were observed in the refrigerators with green, grey, black, and white fuzzy substances on them and expired food items were observed in the unit pantry resident refrigerator. The findings are: A facility policy and procedure titled, Food Storage, last revised 05/10/2024, documented that sufficient storage facilities will be provided to keep foods safe, wholesome, and appetizing. Food will be stored in an area that is clean, dry, and free from contamination. Food will be stored, at appropriate temperatures and by methods designed to prevent contamination or cross contamination. On 03/10/2026 at 10:00 AM, a tour of the facility kitchen was conducted with the Food Service Director. As per the Food Service Director, the food storage room gets circulated and checked daily for cleanliness and expiration dates by themself once a week on Thursdays, when the food is delivered. In the dry storage room, the following was observed: 1 gallon bottle of Worcestershire sauce with a date of 11/23/2023 with no expiration date on the bottle. 1 gallon bottle of Soy Sauce with a receive date of 06/14/2025 and expiration date on the bottle. The bottles of Worcestershire sauce and Soy Sauce were observed to be stained with dark brown colored debris. Food storage in the freezer/refrigerator was observed to include: More than 30 onions were observed in a clear container sitting in the refrigerator/freezer on the shelf, not covered or dated. 9 onions out of the counted 30 onions were observed to have some white fuzzy, grey, green, and black colored contents on the outside of the onions. The floor underneath the food rack where the meat thaws out is observed to have dried, red-colored stains. On 03/11/2026 at 09:51 AM, the refrigerator labeled Resident Refrigerator in the Resident Dining/Day Room on the second floor Ventilator Unit was observed to contain multiple expired items including: one (1) open salad dressing bottle with a use by date of 07/04/2025; one (1) open salad dressing bottle with a use by date of 10/28/2025; one (1) open salad dressing bottle with a use by date of 12/26/2025; one (1) half pint carton of Reduced Fat Milk with a best by date of 03/01/2026; one (1) half pint carton of Chocolate Fat Free Milk with a best by date of 03/06/2026; and two (2) facility-prepared applesauce cups labeled 03/08. A sign located on the exterior of the fridge documented that the food products should be discarded 48 hours after the date labeled on the item. Additionally, the Refrigerator/Freezer Temperature Log dated March 2026 did not document temperature checks on the refrigerator from 03/04/2026 through 03/11/2026. (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/10/2026 at 10:30 AM, Food Service Director was interviewed and stated that they do not even use Worcestershire sauce or soy sauce, and it should have been discarded. They further stated that the sauces should have only been kept for 6 months. As per the Food Service Director, the dates on the bottle of the Worcestershire sauce (11/23/2023) and on the soy sauce (06/14/2025) are the dates the facility received them. The Food Service Director also stated that the onions were received last Thursday on 03/05/2026 and they did not check the onions to see if they were good. The Food Service Director stated they are the only person who checks the food. On 03/10/2026 at 10:45 AM, Dietary Aide #2 was interviewed and stated that they are the morning cook, and they prepare breakfast and lunch. They did not look at the onions because the previous cook had already cut up the onions, they were used onions to prepare the beef stroganoff. On 03/10/2026 at10:46 AM, Registered Dietitian was interviewed and stated that they are to check the food and get rid of it and stop the cooking and redo the cooking. On 03/11/2026 at 12:43 PM, Certified Nursing Assistant #2 was interviewed and stated that the Resident Refrigerator is managed by the kitchen staff, and that every 48-72 hours someone from the kitchen department comes to the unit and removes all expired or outdated items. Certified Nursing Assistant #2 stated that they believed the kitchen was also responsible for completing daily temperature checks on the refrigerator. On 03/11/2026 at 12:44 PM, Licensed Practical Nurse #4 was interviewed and stated that they access the Resident Refrigerator daily to get supplement shakes for residents. Licensed Practical Nurse #4 stated that the milk that was observed to be past their best by dates were intended for residents, and that the expired salad dressings were staff-owned items. Licensed Practical Nurse #4 stated that the kitchen department is responsible for cleaning out the Resident Refrigerator every two (2) days, and for checking and logging the temperature on the temperature log. On 03/11/2026 at 12:49 PM, Registered Nurse #2 was interviewed and stated that the kitchen staff are responsible for cleaning out the Resident Refrigerator every 2 days and for completing the temperature log. Registered Nurse #2 stated that they did not know why there were expired items in the Resident Refrigerator. On 03/12/2026 at 09:44 AM, the Director of Nursing was interviewed and stated that the kitchen department is responsible for inspecting the Resident Refrigerators, removing expired items every two (2) days, and for monitoring and logging the temperatures. The Director of Nursing stated that if a nursing staff member observed an expired item in the refrigerator, they are expected to dispose of it, but the ultimate responsibility falls on the kitchen department. On 03/12/2026 at 10:17 AM, the Food Service Director was interviewed and stated that they are responsible for cleaning out the Resident Refrigerators, including the one on the second floor Ventilator Unit, and for completing the daily temperature checks on the refrigerators. The Food Service Director stated that they did not do it consistently on the ventilator unit because only a few residents on that unit received trays from the kitchen. The Food Service Director stated that they believed that most of the expired items in that refrigerator were staff items but stated that no expired items should have been in the refrigerator. On 03/12/2026 at 12:11 PM, Food Service Director was interviewed and stated that they have been the Food Service Director since 2020 and that they are responsible for managing the whole kitchen (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and nine (9) staff members; that includes payroll, scheduling, ticketing, serving, bringing the food trucks to the floor, doing daily inventory of the supply of food, and checking for the expiration dates. The Food Service Director also stated that they have only nine (9) staff and need ten (10) staff for the kitchen to carry out the activities. Since the elevator has been broken for more than one month, it has been challenging. The Food Service Director admitted they have noted the trucks on the unit stand and wait for a long time before they are distributed out to the residents. The staff can use the microwave to heat up the food. The Food Service Director also stated that food gets delivered every Thursday and that is when the food gets inspected and rotated. When the onions came in, they were put into a container. The onions were supposed to be inspected prior to being put into the container. The Food Service Director stated the kitchen staff who put the onions into the container last Thursday stated to them that they did see a few bad onions in the bag and removed them. On 03/12/2026 at 12:30 PM, Dietary Aide #1 was interviewed and stated that the onions came in last Thursday 03/05/2026, and when they took the onions out of the mesh bag it came in there were about 2-4 onions that were soft and discolored. They had gotten rid of the bad onions and put the rest in the refrigerator. They stated that they do not do daily inspection of the food. 10 New York Code Rules and Regulations 415.14

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	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility did not ensure building elevators were maintained in safe working conditions. This was evident for (2) of three (3) elevators (Elevator #2 and #3) observed. Specifically, Elevators #2 and #3 were observed broken and was reported to be out of services for over several months, causing delays and restricting residents' movement around the facility, including delay of food services to the units.ˆ The findings include: Observations conducted from 03/08/2026 to 03/13/2026 between the hours of 10:00AM and 3:00PM included attention to the 2 passenger elevators (Elevator #1 and #2) and 1 service elevator (Elevator #3). Not Working signage had been posted on elevators #2 and #3. Despite the signage, Elevator #2 was observed being used. It was noted that Elevator #2 would skip Floor #3. On 03/10/26 at 11: 19 AM, during the resident council meeting, Resident #65 stated that the two elevators, #2 and #3 have been broken down for several months and that they have mentioned it on several occasions at several previous resident council meetings, but the facility has not done anything about it. Resident #65 also stated as elevator #3 is used mainly to transport food to all the units, the food has been arriving cold since the elevator has been broken. On 03/10/26 at 11: 25, Resident #54 also verbalized concern about the broken elevators. They stated that food gets cold before it gets to their unit because it must be transported using an alternate elevator. They also stated that they often cannot leave the unit due to broken elevators. On 03/12/26 at 12:10 PM, an interview was conducted with the Director of Recreation who stated they were aware of the broken elevator; however, residents or family had not complained to them. The Director of Recreation also stated they experience delays moving residents around in the facility and they have had to wait or page for the elevator where and when they need it. On 03/12/26 at 01:49 PM, an interview was conducted with the Director of Maintenance who stated that the facility has 3 elevators, 2 for passengers and the other for moving things around. The Director of Maintenance also stated that elevators #2 and #3 are currently undergoing refurbishment and they would probably be replacing them. The Director of Maintenance further stated that they have been constantly replacing parts and fixing the broken elevators to ensure they are in good working condition, and they will continue to do so to meet residents' needs. On 03/12/2026 at 2:55 PM, an interview was conducted with the Administrator who confirmed Elevators #2 and # 3 were broken and out of service for a few months. Administrator also stated the facility has been constantly fixing and repairing elevators, and the facility has not ignored resident concerns regarding broken elevators. The Administrator stated they have been receiving complaints about the elevators, and they try to accommodate residents and family members as much as possible by having someone operate Elevator #3 for passengers and residents to cover all the units. The Administrator concluded that the facility is in the process of replacing the elevators to maintain them in good working condition. 10 NYCRR 415.29

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	335538	A. Building B. Wing	03/13/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not ensure that a resident was free from physical restraints for purposes of discipline or convenience that are not required to treat the resident's medical symptoms, and did not ensure the evaluation of the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This was evident for one (1) of three (3) residents investigated for Restraints out of 27 total sampled residents. Specifically, Resident #117 was observed wearing a hand mitten restraint on multiple occasions without a physician's order, resident or representative consent, or documentation reflecting ongoing re-evaluation for the need of the hand mitten restraint. ^ The findings are: The facility policy titled, Physical Restraint Use, last revised 12/02/2024, documented that the facility promotes a restraint free environment and supports the resident's right to be free from physical restraints imposed for the purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Physical Restraints shall be utilized in accordance with current standards of practice and State and Federal regulations. Examples of devices that may be considered a physical restraint include but are not limited to mittens. Prior to the initiation of a physical restraint, a comprehensive assessment will be completed to determine the need for the restraint and identify alternative less restrictive interventions. Alternate interventions should be attempted and the effectiveness of the interventions documented by the Interdisciplinary Team as part of the resident's Comprehensive Care Plan. A physical restraint shall only be used upon the written order of the healthcare provider and will include type of restraint, reason for application/use (medical reason), specific schedule for its use, frequency of release and type of activity during release, frequency of observation. A physical restraint shall only be used upon consent of the resident and/or resident representative. The use of a physical restraint shall be documented in the clinical record. Resident #117 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Seizure Disorder, and Respiratory Failure. The admission Minimum Data Set assessment dated [DATE] documented that as a resident in the facility, Resident #117 received respiratory treatments including oxygen therapy, suctioning, tracheostomy care, and invasive mechanical ventilator treatment. The admission Minimum Data Set assessment dated also documented that Resident #117 did not use physical restraints. On 03/08/2026 at 11:17 AM, 03/10/2026 at 02:16 PM, and 03/11/2026 at 09:59 AM, Resident #117 was observed with a teal hand mitten restraint on their left hand. The Speech Therapy progress note dated 03/05/2026 documented that Resident #117 was observed with a left-hand mitten secondary to tracheostomy removal. Review of Resident #117's electronic medical record failed to evidence documentation of a physician's order for the use of the hand mitten restraint, a baseline or comprehensive care plan that referenced the use of the hand mitten restraint, a consent related to the use of the hand mitten restraint, or documentation related to the implementation date and ongoing evaluation of the hand mitten restraint. On 03/11/2026 at 02:29 PM, Certified Nursing Assistant #3 was interviewed and stated that Resident #117 used a hand mitten restraint because they had a history of trying to pull out their tracheostomy and gastrostomy devices. On 03/11/2026 at 02:35 PM, Registered Nurse #2, who is a Unit Manager for Resident #117's unit, was interviewed and stated that prior to implementing a hand mitten restraint, observations are made of resident behaviors that indicate a hand mitten restraint would provide safety benefits for the resident. The Medical Doctor would be notified and if they agreed that the restraint may be beneficial to the resident's safety, the Interdisciplinary Team and the resident's family or representative would be consulted. Registered Nurse #2 stated that an order would be entered into the electronic medical system by the Registered Nurse as per the discussion with the Interdisciplinary Team, and the Medical Doctor would sign off on it in the electronic medical record. After the order is signed, the restraint is implemented by the nurse. (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #2 further stated that a Restraint Assessment and Restraint Comprehensive Care Plan are completed at the time of implementation, quarterly, and as needed, and that the Unit Manager is responsible for completing this. Registered Nurse #2 was unable to provide an explanation for why Resident #117 had a hand mitten restraint in use without an order, documentation in the electronic medical record related to the necessity of the restraint, or documentation of discussions with the resident's representative or interdisciplinary team related to the hand mitten restraint use. On 03/11/2026 at 02:52 PM, the Director of Nursing was interviewed and stated that a hand mitten restraint was implemented for Resident #117 after the resident attempted to remove their tracheostomy and gastrostomy devices. The Director of Nursing stated that the Registered Nurse Unit Manager should have created an order for the physician to sign in the electronic medical record, created a comprehensive care plan related to the restraint use, completed the initial restraint assessment, and included progress note documentation related to the restraint use. The Director of Nursing stated that they could not speak on behalf of the Registered Nurse Unit Manager but believed that the lack of documentation related to Resident #117's restraint may have been a result of Resident #117 being transferred to the hospital multiple times since their admission to the facility. The Director of Nursing stated that they oversee the Registered Nurse Unit Managers and that restraint use is discussed with them during their daily morning meetings but that they were not aware that Resident #117 lacked documentation related to the restraint. On 03/13/2026 at 09:40 AM, the Assistant Director of Nursing was interviewed and stated that the Registered Nurse Unit Manager is responsible for initiating orders for restraints in the electronic medical record and that the Medical Doctor will then be prompted to sign-off on it. The Assistant Director of Nursing stated that they will then also review the order after the Medical Doctor signs it to ensure it is implemented correctly. The Assistant Director of Nursing stated that Resident #117 should not have had the hand mitten restraint placed by the Nurse until the order was in the electronic medical record. On 03/13/2026 at 11:54 AM, Physician #2 was interviewed and stated that they are the Physician that is responsible for Resident #117's care. Physician #2 stated that they were aware that Resident #117 was using a hand mitten restraint but was unable to confirm the indication for use or the initiation date of the restraint because they were unable to access Resident #117's medical record at the time of the telephone interview. Physician #2 stated that they could not recall if the hand mitten restraint was in use the last time they assessed the resident. Physician #2 stated that an order for the hand mitten restraint should have been signed in the electronic medical record, a restraint assessment should have been completed, a consent should have been obtained, a Comprehensive Care Plan should have been completed, and regular documentation of the restraint should have been completed. Physician #2 stated that they believed that the lack of required documentation related to the restraint occurred due to a lack of adequate communication and documentation from the Interdisciplinary Team. Physician #2 stated that they take responsibility for the issue because they should have ensured there were procedures in place that could have prevented the restraint from being implemented without the required documentation in place from occurring. On 03/12/2026 at 12:05 PM, the Medical Director was interviewed and stated that if the Interdisciplinary Team believes a resident may benefit from a restraint, the Medical Doctor will determine if there is an indication for use that demonstrates that the resident presents a danger to themselves without the restraint to ensure it is necessary, such as a confused resident who cannot be redirected from potentially harmful behavior. A consent is obtained from the family. An order for the restraint is entered into the electronic medical record by the Nurse or the Medical Doctor and then is signed by the Medical Doctor. The Medical Director stated that the Nurse then completes the initial Restraint Assessment and applies the restraint and creates a Comprehensive Care Plan for the restraint. After reviewing Resident #117's electronic medical record, the Medical Director stated that they were unable to locate an order, initial assessment, documentation demonstrating the indication of use for the restraint, consent, or any other documentation related to the hand mitten restraint. The Medical Director stated that the Nurse should (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

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Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not have applied the restraint device without a signed order in the electronic medical record and that the Medical Doctor should have ensured the order was entered and signed after the discussion with the Interdisciplinary Team. The Medical Director further stated that this was a deviation from the facility's policy and procedure. On 03/13/2026 at 12:27 PM, the Administrator was interviewed and stated that they had not been aware of any concerns related to restraint use until the surveyor brought it to the facility's attention. The Administrator stated that they believed a lack of documentation related to the restraint use may have contributed to the issue. 10 New York Code Rules and Regulations 415.4(a)(2-7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility did not ensure that a comprehensive person-centered care plan that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs was completed and implemented for each resident. This was evident in 1 of 3 residents reviewed for Restraints out of 27 total sampled residents. Specifically, Resident #102 was observed to utilize a Wander Guard elopement prevention device without a corresponding Comprehensive Care Plan in place. The findings are: The facility policy titled, Care Plans - Comprehensive, last reviewed 08/02/2024, documented that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment, and the interdisciplinary team reviews and updates the care plan at least quarterly with scheduled quarterly assessments. Resident #102 has diagnoses that include Alzheimer's Disease, Diabetes Mellitus, and Heart Failure. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #102 used a wander/elopement alarm daily. On 03/08/2026 at 10:02 AM, on 03/11/2026 at 12:55 PM, and on 03/12/2026 at 09:21 AM, Resident #102 was observed with a wander/elopement device on their right hand. The Physician's Order dated 07/22/2025 and renewed on 10/01/2025 documented Resident #102 was ordered to wear a wander/elopement alarm for wandering and exit seeking behavior. The Elopement Risk Evaluation dated 11/27/2025 documented that Resident #102 utilized a Wander Management Device. A review of the electronic medical record did not indicate that a Comprehensive Care Plan had been created and implemented to address Resident #102's use of the wander/elopement alarm. On 03/12/2026 at 09:23 AM, Certified Nursing Assistant #9 was interviewed and stated that Resident #102 used a wander/elopement alarm due to having a history of exit seeking behavior. On 03/12/2026 at 09:32 AM, Registered Nurse #1 who is a Unit Manager on Resident #102's unit was interviewed and stated that Resident #102 used a wander/elopement alarm due to his risk of wandering. Registered Nurse #1 stated that they were responsible for creating and updating the Comprehensive Care Plan to address Resident #102's wander/elopement alarm use. Registered Nurse #1 reviewed Resident #102's electronic medical record with the surveyor and stated that Resident #102 did not have a wander/elopement alarm use care plan in place and that it must have been overlooked. ˆ On 03/12/2026 at 09:58 AM, the Director of Nursing was interviewed and stated that the Registered Nurse Unit Manager was responsible for creating the Comprehensive Care Plan for Resident #102's wander/elopement device and that they did not know why Registered Nurse #1 did not complete the care plan as they should have. 10 New York Code Rules and Regulations 415.11(c)(1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and staff interviews, the facility did not ensure that the resident Comprehensive Care Plan was reviewed and revised for one (1) (Resident #6) of eight (8) residents reviewed for Accidents out of 27 sampled residents. Specifically, there was no documented evidence that the Comprehensive Care Plan for Falls was reviewed and revised after the last quarterly Minimum Data Set assessment was completed and after the resident had a fall with injury.ˆ The findings are: The facility policy and procedure titled, Care Plans Comprehensive, last reviewed 8/2/2024, states that a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functionable needs is developed for each resident. The policy also stated that the Care Planning Interdisciplinary team is responsible for reviewing and updating the care plan during significant change, readmission, and at least quarterly with the scheduled Minimum Data Set.ˆ ˆ Resident #6 was admitted with diagnoses which include, but are not limited to Progressive neurological condition, Anemia, Hypertension, Perivascular Disease, Renal Insufficiency, Parkinson's Disease, and Depression. The Quarterly Minimum Date Set Assessments dated 12/8/2025 and 03/09/2026 both documented resident has short-term and long-term memory problems, no Memory recall, and is severely cognitively impaired with no signs and symptoms of delirium.ˆ The assessments additionally documented the resident required dependent care for all activities of daily living.ˆ On 03/11/2026 at 12:12 PM, Resident #6 was observed lying in low bed turned to left side.ˆ Resident #6 appeared well groomed. On 03/13/2026 at 10:00 AM, Resident #6 was observed lying in bed with two (2) staff at bedside administering activity of daily living care.ˆ Nursing progress notes dated 2/18/2026 at 07:18 AM, documented resident status as post-incident and that as per Certified Nursing Assistant resident slipped off the bed while giving care.ˆ Resident with small skin breaks to right side of mouth, no swelling, no bruising noted. Resident had no signs or symptoms of discomfort.ˆ Resident care completed and vital signs taken, neuro checks in place.ˆ Medical progress note dated 2/18/2026 06:12PM, documented follow up after fall on February 18th, 2026.ˆ As per staff, the resident slipped off the bed while Certified Nursing Assistant was providing care. Initially noted with small skin break to lower lip.ˆ On exam today right lower lip with abrasion measuring approximately 1.0 centimeters x 0.5 centimeters, mild swelling and ecchymosis present.ˆ Resident had no active bleeding, and the resident denied pain, headache, dizziness, nausea or vomiting.ˆ The resident had no change in mental status from baseline. The resident is cognitively impaired with Dementia present. Oriented two times (2) and pain score of zero over ten (10).ˆ The plan continues with neuro checks, monitor vital signs for seven (7) days, reinforce fall precautions, staff education on safe transfer, monitor for changes in mental status, right lower lip with ecchymosis cleanse with normal saline apply topical protective barrier as needed.ˆ Monitor for signs of infection. Acetaminophen 650mg every six hours as needed for pain, cold compress to lip.ˆ Comprehensive Care Plan titled Residentˆis at risk for falls related to Dementia, Parkinson's disease Hypothyroidism, Nephrolithiasis and altered mental status with goals, last dated with revision and effective 11/30/2025, documented interventions implemented 11/30/2025 included anticipating needs, be sure resident call light is within reach and encourage to use for assistance as needed, clutter free environment, enhanced monitoring for safety. There was no documented evidence that the Comprehensive Care Plans for Risk for falls was reviewed and or revised after the last two (2) quarterly Minimum Data Set assessments of 12/8/2025 and 3/9/2026, and after the resident had a fall on 2/18/2026.ˆ On 03/12/2026 at 10:57 AM Registered Nurse Supervisor #2 was interviewed and stated that Registered Nurse Supervisors are responsible for updating, and initiating care plans, as needed.ˆRegistered Nurse Supervisor #2 stated care plans are updated quarterly, annually, with significant changes, and as needed.ˆ Registered Nurse Supervisorˆ#2 stated they were familiar with Resident #6 but could not recall the incident of fall on (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/18/2026.ˆ Registered Nurse Supervisor #2 stated the resident fall care plan should be updated for this fall. Registered Nurse Supervisor #2 reviewed the electronic medical record and stated they did not see any updated Care Plan for this incident.ˆRegistered Nurse Supervisor #2 stated the care plan was not updated because the Supervisor on duty at the time of incident did not update the care plan after the fall.ˆ ˆˆˆ On 03/12/2026 at 12:08 PM, the Director of Nursing was interviewed and stated that the resident care plan is updated if something happened. The Supervisor or manager should address the care plans based on the shift of the episodic event. The Director of Nursing stated Care Plans are updated quarterly, with significant change, annually, and as needed.ˆ The Director of Nursing verified that falls would be considered an episodic event where a supervisor or manager should update or revise the care plan. The Director of Nursing stated if the supervisor did not update the care plan the Nurse Manger is responsible for updating the care plan.ˆ The Director of Nursing was not sure how the supervisor missed updating the care plan for Resident #6 after the fall as the supervisor usually handles care plan updates promptly.ˆ ˆˆ 10 New York Code Rules and Regulations 415.11(c)(2)(i-iii)

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	335538	A. Building B. Wing	03/13/2026

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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 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** Based on observation, record review, and interviews, the facility did not ensure a resident who needed respiratory care was provided with such care, consistent with professional standards of practice. This was evident for 1 (Resident #23) out of 8 residents reviewed for Respiratory Care out of 27 sampled residents. Specifically, Resident #23 was observed using oxygen via undated nasal cannula at a rate of 4 liters per minute when the Physician's Order was written for oxygen to be received at a rate of 2 liters per minute. The findings are: The facility's policy titled, Oxygen Therapy Administration, last reviewed 09/17/2025, documented to initiate flow of oxygen following manufacturer instructions for use, based on the type of device, and at the prescribed flow rate. Resident #23 had diagnoses that included Congestive Heart Failure, Sepsis, Cardiogenic Shock The AnnualˆMinimum Data Set assessment dated [DATE] documented that Resident #23 has severe cognitive impairment and received oxygen therapy while residing in the facility. The Interdisciplinary Care Plan titled, At Risk for/has an alteration in respiratory system related to cardiac disease created 02/9/2026, documented that Resident #23 will receive adequate oxygenation as evidenced by resident's acceptable pulse oximetry level.ˆ The Physician's Orderˆdated 02/09/2026 documented that Resident #23 was to receive Supplemental Oxygen via nasal cannula at a rate of two (2) liters per minute. The Nurse Practitioner progress note dated 03/03/2026 documented to continue oxygen 2 liters via nasal cannula as needed. On 03/08/2026 at 11:46 AM, Resident #23 was observed in their room wearing an undated nasal cannula attached to the oxygen concentrator located at bedside next to the resident. Resident #23 was noted to be receiving oxygen at a rate of 3-4 liters per minute. Resident #23 was interviewed and was unable to recall the ordered amount of oxygen for the resident. On 03/09/2026 at 10:57 AM, Resident #23 was observed in their room wearing an undated nasal cannula attached to the oxygen concentrator located at bedside next to the resident. The oxygen was noted to be given at a rate of 4 liters per minute. ˆOn 03/12/2026 at 10:58 AM, the Nurse Practitioner was interviewed and stated that the order is for supplemental oxygen which means as needed. The pulse oxygen is taken as part of the vital signs. The Nurse Practitioner also stated that there are no orders for the pulse oxygen parameters to indicate when to give or not to give oxygen but that there should be parameters for Resident #23 to receive oxygen. The Nurse Practitioner reviewed their progress note dated 03/03/2026 which states to continue with oxygen due to heart failure with 2 liters of nasal cannula as needed. The Nurse Practitioner stated there should be parameters to address the as needed basis. The Nurse Practitioner was unsure of the proper dating and labeling of the tubing and was unable to recall the corresponding facility policy.ˆAs per the Nurse Practitioner, who also observed the oxygen tank at 4 liters, the resident should be receiving 2 liters. The Nurse Practitioner stated they would change the order to provide more clarification.ˆ On 03/12/2026 at 11:12 AM Registered Nurse #3 was interviewed and stated that the oxygen tubing is supposed to be labeled, dated, and changed every three (3) days. It is the responsibility of the nurses to check the oxygen tank to make sure the ordered number of liters is being administered correctly. Registered Nurse #3 stated Resident #23 is supposed to be on two (2) liters per minute as needed. They also stated although Resident #23's pulse oxygen saturation level has been running between 97%-99%, Resident #23 will become short of breath if taken off oxygen. On 3/12/2026 at 2:45 PM, the Director of Nursing was interviewed and stated that if a resident requires any oxygen, there needs to be a documented reason for the oxygen, assessment validating its need, order, and care plan. It is the staff nurse's responsibility to monitor the oxygen administration and pulse oxygen saturation.ˆ It is standard facility policy to date the oxygen tubing and change it weekly.ˆThe nursing staff is supposed to check the oxygen concentrator on each shift to make sure that the right amount of oxygen liters is being administered as per the doctor orders because they have to document administration. There needs to be an order to monitor the pulse oxygen saturation along with the parameters for oxygen (continued on next page)

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	335538	A. Building B. Wing	03/13/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration.ˆThe director of nursing admitted that had they been aware, they would have fixed the issue. 10 NYCRR 415.12(k)(6)

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	335538	A. Building B. Wing	03/13/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals were stored in locked compartments consistent with state or federal requirements and professional standards of practice. This was evident for 1 (4th Floor) of 4 units. Specifically, a large bag containing discontinued medications with multiple blister packs was observed on top of a desk at the 4th floor nurses' station. Additionally, stock medications were stored on the 4th floor nurses' station cabinet and were not locked. The findings are: A facility policy titled, Medication Storage, dated 05/2025, documented that it is the policy of the facility that all medications delivered to the facility are stored according to the federal and state guidelines. The policy documented that over-the-counter medications may be stored in the medication carts or a locked cabinet within the nursing station. On 03/13/26 at 12:01 PM, on unit 4, a large clear plastic bag was observed on top of a desk at the 4th floor nurses' station. The clear plastic bag had several blisters containing residents' medications. There was no nursing staff present at the nurses' station at the time of this observation. On 03/13/26 at 12:10 PM on unit 4, the medication cabinet was observed open at the 4th floor nursing station. There were multiple stock medications inside the cabinet, these include, but are not limited to, Calcium/Vitamin D Plus, Melatonin, Aspirin, Acetaminophen, Vitamin C, Ferrous Sulfate. There was no nursing staff present at the nurses' station at the time of this observation. On 03/13/26 12:36 PM, an interview was conducted with Registered Nurse #5 who stated there is no specific medication room on the unit. They stated that all medications are stored at the nursing station. Registered Nurse #5 also stated that there was no key for the medication cabinet and it has always been like that. On 03/13/2026 at 12:44 PM an interview was conducted with Registered Nurse #6 who stated that the unit does not have a medication room. They stated that all medications are kept at the nursing station inside the cabinet. Registered Nurse #6 also stated that they were not aware that the medication cabinet needs to be locked up, and that it has always been like that. Registered Nurse #6 concluded that the bag of blister packs was waiting to be picked up by pharmacy as return medication. On 03/13/26 1:10 PM, an interview was conducted with the unit manager, Registered Nurse #1, who also confirmed that the unit does not have a medication room and all medications are kept inside the cabinet at the back of the nursing station. The unit manager also stated that the medication cabinet has been broken for a few months and was reported to the maintenance staff but never been fixed. Registered Nurse #7 further stated that the bag of blister packs is return medication and will be picked up by the pharmacy probably before the end of the day. Registered Nurse #7 concluded that the bag of medications was supposed to be locked up but could not explain why it was kept there on the table. On 03/13/26 at 01:45 PM, an interview was conducted with the Director of Nursing who stated that the facility does not have medication rooms, and that all medications are in the nursing station. They stated that medications were supposed to always be locked. The Director of Nursing stated they were not aware that the medication cabinet was broken. They also confirmed that all returning medications are also to be locked up. 10 NYCRR 415.18(e)(1-4)

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	335538	A. Building B. Wing	03/13/2026

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on the observations and interviews, the facility did not ensure garbage was disposed of and refused properly.ˆ Specifically, waste, debris, and trash were not properly contained in closed dumpsters, and the garbage dumpster area was not maintained to prevent potential feeding and harborage for pests. This was observed during the Kitchen facility task. The findings are: The facility's policy and procedure titled, Garbage-Food and Refuse Disposal, last revised 12/2020, documents food-related garbage and refuse are disposed of in accordance with current state laws. All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. Storage areas will be kept clean at all times and shall not constitute a nuisance. Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. Housekeeping personnel will empty garbage and refuse containers daily and will clean the containers daily on the outside. On 03/10/2026 at 11:40 AM, an observation was made with the Director of Housekeeping/Maintenance of the garbage and refuse area outside the facility located near the trash compactor. Items observed included debris scattered outside along the fence line and a receptacle lid left open, exposing brown colored boxes. The debris included dusty chairs with brown rust, ripped chairs, multiple bags of recyclable water bottles, juice bottles, and cans, an old wheelchair, wood pallets, walkers, televisions, equipment parts, a washing machine, and open bags of cement. The facility had two (2) separate large blue colored dumpsters. 1 of the large blue colored dumpsters was left uncovered and overflowing with cardboard boxes along. Multiple clear trash bags containing brown colored boxes were observed lying on the ground next to the blue dumpsters. Additional observations included one (1) large green colored compactor and its surrounding area containing black colored debris, plastic containers and water bottles. On 03/10/2026 at 11:45 AM, Director of Housekeeping/Maintenance was interviewed and stated that they have a staff of 14 workers (2 maintenance workers and 12 housekeepers) that work under them. They also stated that the garbage area is cleaned once a week and the recycled garbage is supposed to be picked up on Mondays and Thursdays. The Director of housekeeping/Maintenance was not sure why garbage had not been picked up. The garbage area is hosed down once a week on Friday or Monday morning. They are responsible for making sure that the staff does their job and keeps the area clean.ˆ They also stated that they have told the employees not to put the collected recycled bottles in the garbage area. They also stated that the debris has only been there for about a month, and they are waiting for an additional dumpster to collect the debris. The Director of Housekeeping/Maintenance also then heard making a telephone call to the trash compactor company requesting a dumpster to remove the excessive debris from around the trash compactor area. 10 NYCRR 415.14(h)

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F 0636 Level of Harm - Potential for minimal harm Residents Affected - Many	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. Based on record reviews and interviews, the facility did not ensure that a comprehensive assessment of a resident was conducted in accordance with the required timeframes. This was evident for 15 (Resident #s 94, 17, 11, 41,ˆ64, 140, 13, 17, 26, 37, 92, 46, 122, 103, 75) of 16 residents reviewed during the Resident Assessment Facility Task. Specifically, the admission and Annual assessments were not completed within 14 days of the Assessment Reference Date. The findings include but are not limited to: The facility policy titled, Minimum Data Set 3.0, last reviewed 01/2019, documented it is the policy of the facility to follow the guidelines of the most current State specific Resident Assessment Instrument manual correctly and effectively according to the Centers for Medicare and Medicare Services.ˆ The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented the Minimum Data Set assessment with a target date of 11/01/2025 for Resident #94 was completed late, more than 14 days after the Assessment Reference Date. The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented the Minimum Data Set assessment with a target date of 11/4/2025 for Resident #17 was completed late, more than 14 days after the Assessment Reference Date. The Centers for Medicare and Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented the Minimum Data Set assessment with a target date of 10/11/2025 for Resident #37 was completed late, more than 14 days after the Assessment Reference Date. On 03/13/2026ˆ at 12:27 PM, the Administrator was interviewed and stated Minimum Data Set Assessments should be submitted on time per regulation, but they did not have an explanation for why the Minimum Data Set Assessments were submitted or completed late. The Administrator was aware that there was a backlog of Minimum Data Set Assessments and that they were being submitted and completed late. The Administrator stated the Minimum Data Set Coordinator does the Minimum Data Set submission and assessments, and the Regional Minimum Data Set Coordinator oversees the Minimum Data Set Coordinator for the facility, andˆ jointly, they submit them. The Administrator stated the Minimum Data Set Coordinator for the facility is unavailable at that time. The Administrator stated that they have additional remote Minimum Data Set employees hired to try to catch up on the backlog and prevent it from happening in the future. On 03/12/2026 at 2:39 PM, The Director of Nursing was interviewed and stated that the Minimum Data Set Coordinator is currently on vacation and they were not aware that any of the Minimum Data Set Assessments were submitted or completed late.ˆ The Director of Nursing stated there is a full-time Minimum Data Set Coordinator and two (2) other staff that are not full-time workers but work remotely reviewing charts. They do not submit the Minimum Data Set Assessments. The Director of Nursing stated there is a regional director that oversees the Minimum Data Set Coordinator. On 03/12/2026 12:46 PM, The Regional Minimum Data Set Coordinator for the facility was interviewed and stated they are aware that the facility has a completion and submission issue for the Minimum Data Sets.ˆ The Regional Minimum Data Set Coordinator stated there are two coordinators assigned to the facility, one is full time, and the other oneˆis part time.ˆ The Regional Minimum Data Set Coordinator stated the facility also has an additional twenty (20) hour assessor remotely as well.ˆ The Regional Minimum Data Set Coordinator statedˆthey live in upstate New York and rarely come to the facility, but they speak to the assessors multiple times a week and they try to schedule additional hours when help is available.ˆ The Regional Minimum Data Set Coordinator stated scheduling is limited by the hours budgeted by the facility.ˆ The Regional Minimum Data Set Coordinatorˆstated there is a staffing issue,ˆand there are not enough hours for the staff to complete the complete the assessments, and as a result they are submitted and completed late.ˆ The Regional Minimum Data Set Coordinator will talk to the speak with the Administrator to see what could be done, as the current Minimum Data Set Coordinator for the facility is unavailable at present.ˆˆˆ ˆ 10 New York Code Rules and Regulations 415.11(a)(3)(i)

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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 0638 Level of Harm - Potential for minimal harm Residents Affected - Many	Assure that each resident?s assessment is updated at least once every 3 months. Based on record reviews and interviews, the facility did not ensure timely completion of each resident's quarterly review assessments. This was evident for 16 (Residents 140, 143, 64, 13, 17, 26, 37,46, 94, 41, 92,122,11,103, 93, and 75) of 16 residents reviewed during the Resident Assessment Facility Task. Specifically, the residents' Quarterly Minimum Data Set assessments were not completed within 14 days of the Assessment Reference Date. The findings include, but are not limited to: The facility policy titled, Minimum Data Set Assessment 3.0, last reviewed 08/2019, documented it is the policy of this facility to follow the guidelines of the State specific Resident Assessment Instrument manual correctly and effectively according to centers for Medicare and Medicaid Services.^^^ The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented Resident #140's Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 02/03/2026 was completed with an assessment date more than 14 days after the reference date.^ The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented resident #143's Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 11/01/2025 was completed with an assessment date more than 14 days after the reference date.^ The Centers for Medicare & Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report documented resident # 41's Quarterly Minimum Data Set Assessment with an Assessment Reference Date of 02/03/2026 was completed with an assessment date more than 14 days after the reference date.^ On 03/13/2026^ at 12:27 PM, the Administrator was interviewed and did not have an explanation for why the Minimum Data Set Assessments were submitted or completed late, but stated they were aware the assessments should be submitted on time per regulation. Additionally, the Administrator admitted they were aware that there was a backlog of Minimum Data Set assessments and that they were being completed and submitted late. The Administrator stated the Minimum Data Set Coordinator does the Minimum Data Set submission and assessments. According to the Administrator, the Regional Minimum Data Set Coordinator oversees the facility's Minimum Data Set Coordinator, and^ jointly, they submit them. The Administrator stated the Minimum Data Set Coordinator for the facility is unavailable at present. The Administrator stated that they have hired additional remote Minimum Data Set employees to try to catch up on the backlog and to prevent it from happening in the future. On 03/12/2026 at 2:39 PM, the Director of Nursing was interviewed and stated that the Minimum Data Set Coordinator was currently on vacation; The Director of Nursing was not aware that any of the Minimum Data Set Assessments were completed and submitted late.^ The Director of Nursing stated there is a full-time Minimum Data Set coordinator and two (2) other staff that are not full-time workers but work remotely reviewing charts and they do not submit the Minimum Data Set Assessments. The Director of Nursing stated there is a regional director that oversees the Minimum Data Set Coordinator. On 03/12/2026 12:46 PM, the Regional Minimum Data Set Coordinator for the facility was interviewed and stated they are aware that the facility has an issue with on time completion and submission of Minimum Data Set Assessments.^ The Regional Minimum Data Set Coordinator stated there are two coordinators assigned to the facility, one is full time and the other one^is part-time.^ The Regional Minimum Data Set Coordinator stated the facility also has an additional twenty (20) hour assessor working remotely as well.^ The Regional Minimum Data Set Coordinator stated^they live in upstate New York and rarely come to the facility. However, they speak to the assessors multiple times a week, and they stated they try to schedule additional hours when help is available.^ The Regional Minimum Data Set Coordinator stated the facility has budgeted for a certain number of hours. The Regional Minimum Data Set Coordinator^stated there is a staffing issue,^and there are not enough hours for the staff to complete the complete the assessments, and as a result they are submitted and completed late.^ The Regional Minimum Data Set Coordinator will talk to the speak with the Administrator to see what could be done, as the current Minimum Data Set Coordinator for the facility is unavailable at present.^^^ ^ 10 New York Code Rules and Regulations 415.11(a)(3)(ii)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335538	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Concord Nursing and Rehabilitation Center	300 Madison Street Brooklyn, NY 11216

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 0640 Level of Harm - Potential for minimal harm Residents Affected - Many	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on record review and interviews, the facility did not ensure Minimum Data Set Assessments were electronically transmitted to the Centers for Medicare and Medicaid Services Data System within 14 days after assessments were completed. This was evident for 16 (Residents #s 92, 37, 93, 17, 143, 13, 94, 26, 46, 64, 122, 11, 103, 75, 140, and 41) out of 16 residents reviewed for Resident Assessment Facility Task Specifically, Minimum Data Set assessments were not transmitted within 14 days after the assessments were completed. The findings include, but are not limited to: The facility policy titled, Minimum Data Set 3.0, last reviewed 8/2019, documented it is the policy of the facility to follow the guidelines of the most current State specific Resident Assessment Instrument manual correctly and effectively according to the Centers for Medicare and Medicaid Services.ˆ The Quarterly Minimum Data Set assessment for Resident #92 with an Assessment Reference target date of 11/01/2025ˆwas submitted to the Centers for Medicare and Medicaid on 11/24/2025 as evidenced on the Centers for Medicare and Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report.ˆ ˆˆˆ The Quarterly Minimum Data Set assessment for Resident #37 with an Assessment Reference target date of 02/02/2026 was submitted to the Centers for Medicare and Medicaid on 03/09/2026 as evidenced on the Centers for Medicare and Medicaid Services Minimum Data Set 3.0 Nursing Home Final Validation Report. ˆˆ On 03/13/2026ˆ at 12:27 PM, the Administrator was interviewed and stated Minimum Data Set Assessments should be submitted on time per regulation, but they did not have an explanation for why the Minimum Data Set Assessments were submitted or completed late. The Administrator was aware that there was a backlog of Minimum Data Set Assessments and that they were being submitted and completed late. The Administrator stated the Minimum Data Set Coordinator does the Minimum Data Set submission and assessments, and the Regional Minimum Data Set Coordinator oversees the Minimum Data Set Coordinator for the facility, andˆ jointly, they submit them. The Administrator stated the Minimum Data Set Coordinator for the facility is unavailable at that time. The Administrator stated that they have additional remote Minimum Data Set employees hired to try to catch up on the backlog and prevent it from happening in the future. On 03/12/2026 at 2:39 PM, The Director of Nursing was interviewed and stated that the Minimum Data Set Coordinator is currently on vacation and they were not aware that any of the Minimum Data Set Assessments were submitted or completed late.ˆ The Director of Nursing stated there is a full-time Minimum Data Set Coordinator and two (2) other staff that are not full-time workers but work remotely reviewing charts. They do not submit the Minimum Data Set Assessments. The Director of Nursing stated there is a regional director that oversees the Minimum Data Set Coordinator. On 03/12/2026 12:46 PM, The Regional Minimum Data Set Coordinator for the facility was interviewed and stated they are aware that the facility has a completion and submission issue for the Minimum Data Sets.ˆ The Regional Minimum Data Set Coordinator stated there are two coordinators assigned to the facility, one is full time, and the other oneˆis part time.ˆ The Regional Minimum Data Set Coordinator stated the facility also has an additional twenty (20) hour assessor remotely as well.ˆ The Regional Minimum Data Set Coordinator statedˆthey live in upstate New York and rarely come to the facility, but they speak to the assessors multiple times a week and they try to schedule additional hours when help is available.ˆ The Regional Minimum Data Set Coordinator stated scheduling is limited by the hours budgeted by the facility.ˆ The Regional Minimum Data Set Coordinatorˆstated there is a staffing issue,ˆand there are not enough hours for the staff to complete the complete the assessments, and as a result they are submitted and completed late.ˆ The Regional Minimum Data Set Coordinator will talk to the speak with the Administrator to see what could be done, as the current Minimum Data Set Coordinator for the facility is unavailable at present.ˆˆˆ ˆ 10 New York Code Rules and Regulations 415.11