

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335560	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2025
NAME OF PROVIDER OR SUPPLIER The Monarch at Brooklyn Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 135 Linden Boulevard Brooklyn, NY 11226	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated survey (incident 673540), the facility failed to ensure that an alleged violation involving abuse, neglect, exploitation or mistreatment are reported immediately but not later than two hours after the allegation is made, if the events that cause the allegation involved abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident for one (1) out of five (5) residents (Resident #3) sampled for abuse. Specifically, on 07/10/2024 at 9:00 PM, Resident #3's family reported to Registered Nurse Supervisor #2 that on 07/10/2024 at around 5:45 PM, Resident #3 reported to them that they were hit on the left side of their head and upper back. Registered Nurse Supervisor #2 assessed Resident #3. Resident #3 had no bruises, scratches, lacerations, or discoloration. The facility investigated the alleged allegation and concluded that it was inconclusive. The facility did not report the alleged allegation of abuse to New York State Department of Health or law enforcement within two hours. The facility reported the allegation on 07/11/2024 at 8:15 PM. The findings are: The facility's Policy and Procedure titled Freedom from Abuse, Neglect, and Exploitation, dated 04/05/2021 documented all alleged violations involving mistreatment, neglect, abuse, care plan violations, including injuries of unknown origin, are reported immediately to the Administrator/designee and the Director of Nursing. When there is reasonable cause to believe abuse has occurred, a report is also made to the State Certification agency and all other agencies as required, immediately. Resident #3 was admitted to the facility with diagnoses including Alzheimer's Disease, Depression, and Hypertension. The Minimum Data Set, dated [DATE] documented that Resident #3 had severely impaired cognition. A statement by Registered Nurse Supervisor #2 dated 07/10/2024 documented that they received a call from Resident #3's family reporting that Resident #3 informed them that they were hit on the left side of their head and upper back. Resident #3 was assessed and had no bruises, scratches, lacerations, discoloration, or bleeding. Resident #3 also denied pain on assessment. A Webform Submission from: Nursing Home Facility Incident Report dated 07/11/2024 showed the facility submitted the report to the New York State Department of Health on 07/11/2024 at 8:15 PM. During a telephone interview on 07/10/2025 at 10:11 AM, Registered Nurse Supervisor #2 stated they were informed by Resident #3's family at approximately 9:00 PM via telephone that Resident #3 alleged they were hit in the head by Certified Nursing Assistant #3. Registered Nurse Supervisor #2 stated they called the Director of Nursing and reported the allegation to them on 07/10/2024 after 9:00 PM. During a telephone interview on 07/10/2025 at 12:56 PM, Director of Nursing #1 stated they could not recall the incident or Resident #2. They stated they are no longer working at the facility; however, if an abuse allegation is made, Registered Nurse Supervisor #2 should have informed them immediately so they could gather all information and report it to the Department of Health within the two-hour timeframe. They stated they do not know why the incident was not reported timely and if Resident #3 felt safe and did not want law enforcement to be contacted, they would not inform law enforcement. During a telephone interview on 07/29/2025 at 3:22 PM, the Administrator stated they were not working at the facility during that incident; however, any allegation of abuse should be reported to the Department of Health and law enforcement within two hours. 10 NYCRR 415.4(b)(2)</p>		