STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335560	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Monarch at Brooklyn Rehab and Nursing Center	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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interview during the Recertification and Abbreviated Survey (Incident 673700) the facility failed to ensure each resident received adequate supervision to prevent elopement. This was evident for one (1) (Resident #203) of two (2) residents reviewed for wandering and elopement out of 35 total sampled residents. Specifically, on 09/01/2024, Resident #203, who was severely impaired in cognition and had a wander alert device (a device that alerts staff when the resident is exiting the building), left the building undetected through the front door at 11:25 AM. Resident #203 was located by the facility staff approximately 300 feet from the facility and returned to the facility at 1:11 PM. The findings include:The policy and procedure titled Wandering and Elopement Risk with a last revised date of 05/20/2025 defined elopement as an occurrence when a resident leaves the premises or safe area without authorization and/or any necessary supervision to do so. The policy documented if a resident is identified as at risk for wandering, elopement, or other safety issue, the resident's care plan will include strategies and interventions to maintain the resident's safety. Residents identified as having an elopement risk will have a wander alert device applied. The wander alert device will be checked daily and as needed for placement and functioning. A photograph will be placed in the elopement binders on the units and at the front desk. Resident #203 had diagnoses of Cerebrovascular Accident, Non-Alzheimer's Dementia, and Parkinson's Disease. The Minimum Data Set (a resident assessment tool) dated 08/08/2024 documented Resident #203 had severely impaired cognition and exhibited wandering behavior. A comprehensive care plan for Unsafe Wandering at Moderate/High Risk was initiated for Resident #203 on 08/29/2024. The care plan documented that resident was walking off unit and had verbal threats to leave or escape. The facility interventions include use of wander alert device; check wander alert device for placement and functioning every shift; replace the wander alert device per manufacturer's recommendation; ascertain the resident's whereabouts during each shift; maintain the resident's photo on the unit and at the receptionist's desk; and alarmed doors on either end of the hallway on the unit.A behavior note dated 08/29/2024 at 9:57 PM documented Resident #203 was wandering and seeking to exit the floor by attempting to press the elevator. A wander alert device was placed on the left wrist. A nurse's note dated 08/29/2024 at 10:16 PM documented that Resident #203 was wandering in the hallway at around 9:00 PM, and at about 9:09 PM rushed to the elevator when they saw a family member leaving the unit. A physician's order dated 08/29/2024 included wander alert device to left wrist, check placement every shift. An order to check wander alert device function every night shift was entered on 09/18/2024. The Treatment Administration Records from 08/29/2024 to 02/11/2025 documented the wander alert device was in place every shift.A physician's order dated 07/10/2024 documented every 30-minute safety visual check. The Medication Administration Record documented that 30-minute checks were completed on 09/01/2024 for the 7:00 AM to 3:00 PM shift. A nurse's notes dated 09/03/2024 at 6:41 PM documented 09/01/2024 at 12:27 phone call received that resident was missing from unit. Resident returned to the facility at 1:11 after elopement procedure was initiated.Review of the staff written statements dated 09/01/2025 revealed that on 09/01/2024, Resident #203 was in the dining room at 8:00 AM for breakfast. The resident was administered medications at 9:30 AM and received their 10:00 AM Ensure supplement. At about 10:30 AM, the resident went to the bathroom and refused to go back to the dining room and was walking up and down the hallway. Certified Nursing Assistant #6 documented in their written statement that the last time they saw Resident #203 was at 11:00. The Resident Incident/Investigation Report dated 09/01/2024 documented that based on review of camera footage, Resident #203 left the unit at approximately 11:20 AM on 09/01/2024. The resident was observed in the lobby area and exited the building at 11:25 AM. The front desk security guard was interacting with two (2) visitors who needed assistance with entering information on the kiosk when the resident walked by him and exited through the front entrance. The facility investigation documented all wander alert mechanisms were checked and working, however, Resident #203's wander alert device was not working at the time. On 08/11/2025 at 2:23 PM an interview was conducted with Certified Nursing Assistant #6 who was on the unit at the time Resident #203 eloped. They stated the resident was on 30-minute checks and that the resident was a wanderer. They stated on the day of the incident; they found out that Resident #203 was missing when they cannot find the resident during lunch time. They stated they immediately started searching for the resident. On 08/12/2025 at 12:37 PM, an interview was conducted with the Receptionist, who stated that the front desk has one receptionist during the day and a security guard at nighttime. They stated they are responsible for screening visitors and making