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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review, and interviews, the facility failed to maintain a resident's right to a safe, clean, comfortable homelike environment. This was evident in one (1) (Unit 4) of 5 units observed. Specifically, the unit hallway, dayroom, and pantry room were observed with dark, brown-colored stains on the floor. The floor edges were observed with old, yellow-colored grease-like stains. A heavy strong old odor was also noted. The findings include: The facility was not able to present a policy related to the deficiency. On 08/07/2025 at 10:15 AM, during observation in Unit 4, the floors in the hallway in front of the nursing station and in front of the elevator, entrance by the dayroom, and the pantry were observed with dirt, dark stains, and with old, yellow-colored grease-like stain. A heavy strong odor was also noted. There were 26 residents in the day room at the time of this observation. On 08/07/2025 10:59 AM, an interview was conducted with Licensed Practical Nurse #3. They stated that the hallway, at the front of the elevator, and towards the day room have always been dirty. They stated that this unit is a dementia floor, and that residents throw food all over and spit liquids on the floor. Licensed Practical Nurse #3 stated they informed the housekeeping staff about this concern, and nothing was done about it. On 08/07/2025 at 11:20 AM, an interview was conducted with Registered Nurse #2, who was the nursing supervisor, who stated that they were aware of the dirty floor and that the management is aware of this environment issues and is being currently worked on. On 08/07/2025 at 10:40 AM, an interview was conducted with Housekeeping Staff #1 who stated their duty is to ensure that the floor is clean and that garbage is removed. They stated that the evening housekeeping staff is responsible for scrubbing the floor. On 08/07/2025 at 11:30 AM, an interview was conducted with Housekeeping Staff #2 and stated they are assigned in Unit 4 and that the evening staff are responsible for mopping the floor. On 08/12/2025 at 11:00 AM, an interview was conducted with the Director of Housekeeping. They stated that they have at least one housekeeper on each unit. They stated they have two (2) porters who work in the evening shift and they pick-up the garbage and dirty linen and buff the hallway. The Director of Housekeeping stated they were aware of the dirty floor in Unit 4; however, the floor has residents with dementia and takes more time to clean.10 NYCRR 415.5(h)(2)

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews conducted during the Recertification survey from 08/07/2025 to 08/14/2025, the facility did not ensure that residents' Comprehensive Care Plans were reviewed and revised after each assessment. This was evident for one (1) (Resident #8) of five (5) residents reviewed for Unnecessary Medications. Specifically, there was no documented evidence that the Comprehensive Care Plans for Anticoagulation Therapy and Psychoactive Drug Use were reviewed and revised after the last quarterly Minimum Data Set assessment was completed.The findings include: The facility policy and procedure titled Comprehensive Care Plans dated 05/25/2025 stated 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 interdisciplinary team reviews and updates the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set assessment. Resident #8 had diagnoses including Acute Embolism, Diabetes Mellitus, and Non-Alzheimer's Dementia. The Quarterly Minimum Data Set assessment dated [DATE] documented that Resident #8 had severe cognitive impairments and was prescribed an anticoagulant. The Physician's Order dated 03/20/2025 and renewed on 08/04/2025 documented that Resident #8 was prescribed Xarelto 20 mg daily for Acute Embolism and Thrombus of the Lower Right Extremity. The Physician's Order dated 10/01/2024 documented that Resident #8 was prescribed Quetiapine 50 mg daily for Bipolar Disorder. The Physician's Order dated 04/14/2025 documented that Quetiapine was decreased to 25 mg daily, and then discontinued entirely on 04/27/2025. The Anticoagulation Therapy Comprehensive Care Plan dated 03/20/2025 documented that Resident #8 was on an anticoagulant related to a history of Deep Venous Thrombosis. On 03/31/2025, the Comprehensive Care Plan was updated to document that the plan of care was reviewed and would continue for the next 90 days. There was no documented evidence that the facility reviewed the Anticoagulation Therapy Comprehensive Care Plan following Resident #8's Quarterly Minimum Data Set Assessment on 06/13/2025. The Psychoactive Drug Use Comprehensive Care Plan dated 10/01/2024 documented that Resident #8 was prescribed psychoactive medication to treat Bipolar Disorder. On 04/17/2025, the Comprehensive Care Plan was updated to document that Resident #8 was seen by the psychiatrist who had decreased their Quetiapine dose from 50 mg daily to 25 mg daily, with plans to discontinue the medication entirely two weeks later. There was no documented evidence that the facility reviewed the Psychoactive Drug Use Comprehensive Care Plan following Resident #8's Quarterly Minimum Data Set Assessment on 06/13/2025, or after Quetiapine was discontinued on 04/27/2025. On 08/13/2025 at 11:58 AM, Registered Nurse #2, who is a Registered Nurse Supervisor, was interviewed and stated that Resident #8 takes an anticoagulant for Deep Venous Thrombosis prevention and had previously taken an antipsychotic medication which has since been discontinued. Registered Nurse #2 stated that Comprehensive Care Plans are updated quarterly, typically before the Minimum Data Set assessment is completed. They further stated that the Minimum Data Set department sends out a schedule of care plans that are due to be updated, and that nurses can also see which care plans need to be updated in the electronic medical record. Registered Nurse #2 stated that they were not aware that Resident #8's Comprehensive Care Plans were overdue for a review, and that they should have been reviewed before the Quarterly Minimum Data Set assessment dated [DATE] was completed. On 08/14/2025 at 10:20 AM, the Director of Nursing was interviewed and stated that Comprehensive Care Plans are updated quarterly when the Minimum Data Set assessments are conducted. The Director of Nursing stated that the nurse manager on the unit is responsible for updating the Anticoagulant Therapy and Psychoactive Drug Use Comprehensive Care Plans, and that they did not know why they were not updated when the Quarterly Minimum Data Set assessment dated [DATE] was completed. On 08/14/2025 at 12:15 PM, the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator was interviewed and stated that Comprehensive Care Plans are updated quarterly when the Minimum Data Set assessments are conducted. The Administrator stated that they were unaware that Resident #8's Comprehensive Care Plans had not been reviewed and would investigate why that occurred in conjunction with the nursing department. NYCRR 415.11(c)(2)(i-iii)

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that the Minimum Data Set assessment accurately reflected a resident's status. This was evident for 2 (Resident #12 and #188) of 35 total sampled residents. Specifically, 1.) Resident #188's Minimum Data Set assessment did not accurately reflect their fall history; 2.) Resident #12's Minimum Data Set assessment documented they had diagnosis of Post Traumatic Stress Disorder. There was no documented evidence that the resident had this diagnosis. The findings include: The facility policy and procedure titled Minimum Data Set Accuracy dated 5/20/2025 documented that it is the policy of the facility that any person completing a portion of the Minimum Data Set (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. 1.) Resident #188 had diagnoses of Anoxic Brain Injury, Seizure, Depression and Asthma. A comprehensive care plan for falls was initiated for Resident #188 on 07/09/2024 and was last reviewed on 04/29/2025. The care plan documented that Resident #188 had actual fall occurrences on: 09/18/2024, 12/14/2024, 02/01/2025, 03/07/2025, 04/02/2025, and 04/27/2025. The Annual Minimum Data Set assessment dated [DATE] did not document any fall occurrence for Resident #188. On 08/14/2025 at 12:22 PM, the Minimum Data Set Coordinator was interviewed and stated they are responsible for scheduling the Minimum Data Set assessments and monitoring the assessments for completion. The Minimum Data Set Coordinator stated Resident #188 had fall occurrences after the last assessment and it should have been coded on the annual Minimum Data Set. 2.) Resident #12 had diagnoses of Unspecified dementia, Schizophrenia, and Major depressive disorder. The Annual Minimum Data Set assessment dated [DATE] documented Resident #12 had severely impaired cognition, had no behavior symptoms, and had diagnosis of Post Traumatic Stress Disorder. A review of Resident #12's medical record did not reveal a diagnosis of Post Traumatic Stress Disorder. On 08/12/2025 at 10:59 AM, the Minimum Data Set Coordinator was interviewed and stated their main responsibilities include scheduling the Minimum Data Set assessment and care plan meetings, monitoring them for completion, and submission of Minimum Data Sets. They stated they did not check Resident #12's assessment for accuracy since the assessors who completed the assessment were professionals. They stated that they reviewed the resident's medical record and spoke with the assessor; and they confirmed that Resident #12 had no diagnosis of Post Traumatic Stress Disorder. 10 NYCRR 415.11(b)