STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335604	A. Building B. Wing	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn United Methodist Church Home	1485 Dumont Avenue Brooklyn, NY 11208

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 48907 Based on observations, record review, and interviews conducted during an abbreviated survey (NY00360005), the facility did not ensure a resident's designated representative was notified of changes in condition. This was evident in one out of three residents (Resident #2) sampled. Specifically, a Health Status Note dated 11/05/2024 documented Resident #2 complained of left eye pain. An assessment was done and revealed mild swelling to the left eye. The Medical Doctor was informed and an ordered for Diclofenac eye drops. There is no documented evidence that Resident #2's designated representative was notified of the changes in condition. The findings are: The facility policy titled: Family Notification revised 01/2025 documented it is the facility's policy to notify the resident, the representative/designee or guardian whenever there is a transfer, room change and change in the resident's condition. Resident #2 was admitted to the facility with diagnoses including Hypertension and Cerebrovascular Accident (a medical term for a stroke). The Minimum Data Set (an assessment tool), dated 09/26/2024, documented Resident #2 had moderate cognitive impairment. A Health Status note dated 11/05/2024 documented Resident #2 complained of left eye pain, an assessment revealed no eye redness or discharge. Pain at the edge of the left upper eyelid when touched and mild swelling observed. The Medical Doctor was informed and ordered Diclofenac eye drops to the left eye three times daily for seven days. An Attending Physician/Provider note dated 11/06/2024 documented Resident #2 was assessed and observed with mild swelling around their left eye. No evidence of acute infection. Plan was to start eye drops to reduce inflammation and any discomfort. If no improvement in the next twenty-hour to thirty -six hours, oral antibiotics will be started. A Physician's Order dated 11/05/2024 documented instill one drop pf Diclofenac Sodium Ophthalmic Solution 0.1 % in the left eye three times a day for left eye pain for seven days. There was no documented evidence that Resident #2's representative was notified. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Service note dated 11/07/2024 documented Resident #2's representative visited and observed that Resident #2's left eye was slightly puffy. The representative stated they were not informed of the resident's condition. During an interview on 03/05/25 at 9:49 AM, Social Worker #2 stated that on 11/07/2024 at 4:43 PM Resident #2's representative approached them into their office and reported that they were not informed about Resident #2's left eye. Social Worker #2 stated the policy is to call the resident's family if there is a change in condition or if the resident is being discharged to the hospital. The Social Worker stated that the policy states that nurse is supposed to call the family if there is a change in condition. During an interview on 03/05/2025 at 3:38 PM, Registered Nurse Supervisor #2 stated they assessed Resident #2 on 11/05/2024 and Resident #2 complained of pain while pointing to their left lower eye. The Medical Doctor was notified and assessed Resident #2. The Registered Nurse Supervisor #2 stated that the Medical Doctor ordered eye drops. Registered Nurse Supervisor #2 stated they do not recall notifying Resident #2's representative, however, Resident #2 was alert and oriented and able to understand their plan of care. Registered Nurse Supervisor #2 stated that the Medical Doctor discussed the plan of care with Resident #2. During a telephone interview on 03/11/2025 at 1:00 PM, the Director of Nursing stated the protocol is to always inform the family of any change in the resident condition, incident, physician's orders, and anything pertaining the resident. The Director of Nursing stated Resident #2 was alert, oriented and the Medical Doctor discussed with them about ordering eye drops to treat the discomfort and swelling and Resident #2 agreed with the Medical Doctor's plan of care. During a telephone interview on 03/11/2025 at 2:38 PM, that Administrator stated it is the facility's protocol to notify the family of resident's change in condition, fall, incident, hospital transfer, etc. the Administrator stated that Resident #2's representative should have been notified of Resident #2's eye condition. 10 NYCRR 415.3(f)(2)(ii)(c)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48907 Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00372860), the facility did not ensure that a resident was free from abuse. This was evident for one (1) out of nine (9) residents (Resident #1) sampled. Specifically, the facility's dining room surveillance video recording dated 02/22/2025 showed at 9:05 AM Certified Nursing Assistant #1 hit Resident #1 on their left upper shoulder (once) with the back of their left hand, then walked out of the dining room, after Resident #1 threw liquid on Certified Nursing Assistant #1 who was standing behind them. Housekeeper #1, who was in the dining room, then walked over to Resident #1 and wheeled the Resident out of the dining room at 9:08 AM. Resident #1 was assessed by Registered Nurse Supervisor #1 with no visible injury, pain, or discomfort. The findings are: The facility's Policy and Procedure titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property was revised on 08/2024. The policy states that each resident will be free from Abuse and will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for protection. The facility will strive to educate staff and other applicable individuals in techniques to protect all parties. Resident #1 was admitted to the facility with diagnoses including Hypertension (high blood pressure) and Schizophrenia (a chronic mental illness characterized by disruptions in thought processes, perceptions, emotions, and social interactions). The Minimum Data Set (an assessment tool) dated 01/09/2025 documented Resident #1 had severe cognitive impairment. The Comprehensive Care Plan titled: At Risk for Victimization dated 02/01/2024 documented Resident #1 was at risk for victimization due to observed verbal aggression and socially inappropriate behavior. The interventions documented to encourage verbalization of feelings and to observe for changes in mood, behavior, and affect. The dining room surveillance video (#1) recording dated 02/22/2025 showed at 9:05AM Certified Nursing Assistant #1 picked up Resident #1's meal tray and exited the dining room. Certified Nursing Assistant #1 returned to the dining room and went up behind Resident #1, used their right hand to tap the right side of Resident #1's wheelchair three times. Resident #1 in turn, picked up a cup and without looking tossed the content (liquid) of the cup behind them. The liquid spilled onto Certified Nursing Assistant #1 and onto the floor. Certified Nursing Assistant #1 hit Resident #1 on their left shoulder (once) with the back of their left hand and walked out of the dining room. Housekeeper #1 who was in the dining room rearranging the dining tables, turned around and saw Resident #1 throw the liquid and Certified Nursing Assistant #1 hit Resident #1 on their left shoulder with the back of their hand. Housekeeper #1 then walked over to Resident #1 and was talking to Resident #1 before escorting the resident out of the dining room. Camera view of the dining room ended. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The unit hallway surveillance video (#2) recording dated 02/22/2025 showed at 9:08 AM on 02/22/2025, Housekeeper #1 escorted Resident #1 from the dining room to the nursing station and was observed having a conversation with Licensed Practical #1 (Housekeeper #1 was reporting the incident). Resident #1 was observed at the nursing station and a staff providing supervision. Licensed Practical Nurse #1 observed preparing/administering medication. Licensed Practical Nurse #1 observed having a conversation with Certified Nursing Assistant #1 (Licensed Practical Nurse stated they told Certified Nursing Assistant #1 to stop caring for residents). Certified Nursing Assistant #1 walked away from Licensed Practical Nurse #1 and could be seen on camera carrying linens into a resident room, then went into another resident's room (resident alert and oriented times three) with linens after Licensed Practical Nurse #1 spoke with them. Registered Nurse Supervisor #1 arrived on the unit at 10:14 AM. Certified Nursing Assistant #1 left the unit at 10:25 AM. An Incident Note dated 02/22/2025 by Registered Nurse Supervisor #1 documented at approximately 9:35 AM, Housekeeper #1 reported they witnessed Resident #1 tossed apple juice at Certified Nursing Assistant #1, and Certified Nursing Assistant #1 hit Resident #1 on their left should with the back of their hand. Resident #1 was assessed for any physical or emotional trauma. There were no physical injury or pain reported. The dining room camera was reviewed and showed at approximately 9:05 AM Certified Nursing Assistant #1 hit Resident #1. The facility's investigation dated 02/22/2025 documented at approximately 9:35 AM, Housekeeper #1 reported to Registered Nurse Supervisor #1 that they witnessed Resident #1 tossed back liquid at Certified Nursing Assistant #1. Certified Nursing Assistant #1 then hit Resident #1 on their left shoulder with the back of their hand. Resident #1 was assessed and there was no injury or complaints of pain. The facility concluded that abuse had occurred. Certified Nursing Assistant #1 was suspended and subsequently terminated. Staff were re-in serviced on abuse, neglect, mistreatment, and reporting. During a telephone interview on 03/03/2025 at 11:01 AM, Certified Nursing Assistant #1 stated on 02/22/2025 between 10:15 AM and 10:30 AM (not sure of the time), Resident #1 had completed their breakfast in the dining room. Certified Nursing Assistant #1 stated they were attempting to remove Resident #1's meal tray and the resident became excited and threw water at them. Certified Nursing Assistant #1 stated they did not hit Resident #1, but they rubbed Resident #1 on their back and told the resident not to throw anything at them. Certified Nursing Assistant #1 stated Housekeeper #1 was in the dining room and thought they had hit Resident #1. Certified Nursing Assistant #1 stated they did not react to Resident #1's behavior and walked away to care for another resident. Certified Nursing Assistant #1 stated while they were providing incontinent care to a resident (identified as alert and oriented times three) Licensed Practical Nurse #1 approached them and they showed Licensed Practical Nurse #1 their uniform and explained what Resident #1 had done. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 9:22 AM Housekeeper #1 stated that on 02/22/2025 between 9:00 AM and 9:15 AM (not sure of the time) they observed Certified Nursing Assistant #1 walked up behind Resident #1 and Resident #1 threw juice at Certified Nursing Assistant #1. Certified Nursing Assistant #1 punched Resident #1 on their back with a closed fist. Housekeeper #1 stated they were standing at approximately 10-15 feet away from Resident #1 and Certified Nursing Assistant #1 when they heard a popping sound. Housekeeper #1 stated Resident #1 reported to them that Certified Nursing Assistant #1 punched them in their back. Housekeeper #1 stated they wheeled Resident #1 to the nurse and informed Licensed Practical Nurse #1. Housekeeper #1 stated they are aware that they should not have wheeled Resident #1 out of the dining room and that they could have used the phone in the dining room to call the nurse. Housekeeper #1 stated they were in-serviced on calling the nurse immediately and provide supervision to protect the resident. During a telephone interview on 03/06/2025 at 12:51 PM, Licensed Practical Nurse #1 stated at approximately 9:15 AM Housekeeper #1 informed them that they witnessed Certified Nursing Assistant #1 hit Resident #1 on their back. Licensed Practical Nurse #1 stated they did not report the incident immediately to Registered Nurse Supervisor #1 because they were in the middle of distributing medication. However, Registered Nurse Supervisor #1 arrived on the unit and was asking for Certified Nursing Assistant #1, as they were getting ready to inform Registered Nurse Supervisor #1 of the incident. Licensed Practical Nurse #1 stated Resident #1 was unable to explain what happened. Licensed Practical Nurse #1 stated they had instructed Certified Nursing Assistant #1 to stop working. Licensed Practical Nurse #1 they received in-service to report any incident t their supervisor immediately, stop the perpetrator from completing their assignment and monitor the resident or victim. During an interview on 03/03/2025 at 4:09 PM Registered Nurse Supervisor #1 stated at 9:30 AM Housekeeper #1 approached them with the Administrator on Duty and reported that they witnessed Certified Nursing Assistant #1 punch Resident #1. Registered Nurse Supervisor #1 stated they joined the Administrator on Duty between 9:45 AM and 9:50 AM and reviewed the surveillance video recording before going to the unit at approximately 10:10 AM because they did not receive a call from Licensed Practical Nurse #1. Registered Nurse Supervisor #1 stated the surveillance video recording showed Certified Nursing Assistant #1 hit Resident #1 on their left upper shoulder with an open hand (palm hitting the shoulder). Registered Nurse Supervisor #1 stated they assessed Resident #1 and there were no injuries and Resident #1 denied pain. Registered Nurse Supervisor #1 stated at approximately 10:20 AM they were on the unit looking for Certified Nursing Assistant #1 and saw them in a room and told them to stop what they were doing and report to the nurse's office. Registered Nurse Supervisor #1 stated they should have gone to the unit before watching the video. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/2025 at 8:54 AM Acting Administrator stated on 02/22/2025 at 10:25 AM Registered Nurse Supervisor #1 informed them that they removed Certified Nursing Assistant #1 from the unit. Acting Administrator stated after reviewing the surveillance video recording it was determined that abuse had occurred. Acting Administrator stated the surveillance video recording showed Certified Nursing Assistant #1 hit Resident #1 on the left upper shoulder with the back of their hand. Acting Administrator stated Resident #1 was assessed by Registered Nurse Supervisor #1 and Resident #1 did not complain of discomfort and there were no injuries. Acting Administrator stated that the Social Workers were called into the facility to conduct interviews with all residents on the unit. Acting Administrator stated that the Administrator was notified of the incident at 10:30 AM on 02/22/2025 and an ad hoc meeting was held via phone conference. Acting Administrator stated the Abuse policy was reviewed, and no changes were made. Acting Administrator stated that Certified Nursing Assistant #1 was suspended and later terminated. Acting Administrator stated all staff were reeducated on abuse and reporting and they also had discussions with the staff on how to protect residents from further abuse. During an interview on 03/04/2025 at 11:00 AM, Administrator stated Director of Nursing informed them on 02/22/2025 at 10:30 AM that Certified Nursing Assistant #1 hit Resident #1. Administrator stated they instructed Director of Nursing to remove Certified Nursing Assistant #1 off the unit and start an investigation. Administrator stated a conference was held on 02/22/2025 and in attendance was the Medical Director, Director of Nursing, Acting Administrator and the Administrator on Duty. Administrator stated they discussed the incident, reviewed the Abuse policy and instructed the Social Workers to go to the facility to interview all the residents on the unit. Administrator stated to prevent reoccurrence, all staff were reeducated on abuse and an audit tool was initiated to reinforce reporting. During a telephone interview on 03/11/2025 at 12:47 PM, the Director of Nursing stated they were informed of the incident by Registered Nurse Supervisor #1 on 02/22/2025 at approximately 10:19 AM. The Director of Nursing stated they notified the Administrator, and a meeting was held with the administrative team to discuss the incident. The Director of Nursing stated they instructed Registered Nurse Supervisor #1 to remove Certified Nursing Assistant #1 off the unit. The Director of Nursing stated they watched the surveillance video recording and had concluded that abuse did occur. The Director of Nursing stated they conducted in-services on abuse and reporting to all staff. The Director of Nursing stated that the staff were instructed to report any incident timely and not wait. The Director of Nursing stated to prevent reoccurrence, Certified Nursing Assistant #1 was suspended, abuse police was reviewed, and all staff were re in serviced on abuse and reporting. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the non-compliance and was in substantial compliance for this specific regulatory requirement prior to and during the time of this survey. A Plan of Correction is not required for this citation. The facility took immediate corrective actions and was found to incompliance on 02/24/2025, prior to Surveyors' onsite visit on 03/03/2025. On 02/22/2025, Policy and Procedure on Abuse was reviewed. No revisions were done. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/22/2025, facility re-in-serviced all staff members (nursing staff, housekeeping, administrative staff, Occupational/Physical Therapy staff, Security, Activity staff, Dietary staff etc.) on the following: Verbal Abuse, Sexual Abuse, Mental Abuse, Involuntary Seclusion, Mistreatment, Neglect, Misappropriation of Property, Screening, Training, Prevention, Identification, Investigation, Reporting/Response, and Protection. The facility took immediate corrective actions. On 02/22/2025 at 10:25 AM Certified Nursing Assistant #1 was removed from the schedule immediately and subsequently terminated. On 02/22/2025 Resident #1 was assessed with no visible injuries or complaints of pain. On 02/22/2025 - Psychiatrist conducted a virtual evaluation of Resident #1. On 02/22/2025 - Abuse policy reviewed with no changes made. On 02/22/2025 a Quality Assurance and Performance Improvement meeting was held on. Topic: Resident #1 being hit on the back of their left shoulder by Certified Nursing Assistant #1. Attendance sheet with names of attendees obtained. On 02/22/2025 - assessment done on all cognitively impaired residents on the unit. On 02/22/2025 an audit done to identified residents with potential for abuse. On 02/22/2025 - all residents on the unit were interviewed to determine if they had experienced any abuse. 02/22/2025 all residents on CNA #1's assignment was interviewed to ascertain if abuse had occurred. On 02/22/2025 an in-service on Abuse, Mistreatment, Neglect and Misappropriation of Property, Protecting, and Reporting was completed. Target audience: All staff. Certified Nursing Assistants 33/33 in-serviced =100% Licensed Practical Nurses 15/15 in-serviced =100% Registered Nurses 15/15 in-serviced = 100% Dietary, Housekeeping, Rehab, Security, and Administrative staff 100% in-serviced. 10 NYCRR 415.4(b)(1)(i)

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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. 48907 Based on record review and interviews conducted during an Abbreviated Survey (NY00372860), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, were reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involved abuse or resulted 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 in one out of nine (9) residents (Resident #1) reviewed. Specifically, the facility's dining room surveillance video recording dated 02/22/2025 showed at 9:05AM Certified Nursing Assistant #1 hit Resident #1 on their left shoulder after Resident #1 picked up a cup and without looking tossed the content (liquid) of the cup behind them (wetting Certified Nursing Assistant #1.) Housekeeper #1 who was in the dining room at the time stated that they heard a popping sound after Certified Nursing Assistant #1 hit Resident #1 on their shoulder. The facility did not report the allegation of abuse within 2 hours to law enforcement. The facility notified law enforcement at 12:08 PM. The findings are: The facility's Policy and Procedure titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property was revised on 08/2024. The policy states the facility will ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse 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. In addition, local law enforcement will be notified of any reasonable suspicion of a crime against a resident in the facility. Resident #1 was admitted to the facility with diagnoses including Hypertension (high blood pressure) and Schizophrenia (a chronic mental illness characterized by disruptions in thought processes, perceptions, emotions, and social interactions). The Minimum Data Set (an assessment tool) dated 01/09/2025 documented Resident #1 had severe cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The dining room surveillance video (#1) recording dated 02/22/2025 showed at 9:05AM Certified Nursing Assistant #1 picked up Resident #1's meal tray and exited the dining room. Certified Nursing Assistant #1 returned to the dining room and went up behind Resident #1, used their right hand to tap the right side of Resident #1's wheelchair three times. Resident #1 in turn, picked up a cup and without looking tossed the content (liquid) of the cup behind them. The liquid spilled onto Certified Nursing Assistant #1 and onto the floor. Certified Nursing Assistant #1 hit Resident #1 on their left shoulder (once) with the back of their left hand and walked out of the dining room. Housekeeper #1 who was in the dining room rearranging the dining tables, turned around and saw Resident #1 throw the liquid and Certified Nursing Assistant #1 hit Resident #1 on their left shoulder with the back of their hand. Housekeeper #1 then walked over to Resident #1 and was talking to Resident #1 before escorting the resident out of the dining room. Camera view of the dining room ended. The facility's investigation dated 02/22/2025 documented at approximately 9:35 AM, Housekeeper #1 reported to Registered Nurse Supervisor #1 that they witnessed Resident #1 tossed back liquid at Certified Nursing Assistant #1. Certified Nursing Assistant #1 then hit Resident #1 on their left shoulder with the back of their hand. Resident #1 was assessed and there was no injury or complaints of pain. The facility concluded that abuse had occurred. Certified Nursing Assistant #1 was suspended and subsequently terminated. During a telephone interview on 03/14/2025 at 9:40 AM the Director of Nursing stated it is the policy of the facility to report abuse within two hours to the law enforcement. The Director of Nursing stated they notified the Department of Health, then the Attorney General, and then law enforcement. The Director of Nursing stated that the report to law enforcement was late. During a telephone interview on 03/14/2025 at 10:48 AM the Administrator stated that the policy states law enforcement should be notified within two hours of being aware of an incident. The Administrator stated that law enforcement was notified at around 12:00 PM because they were gathering information. 10 NYCRR 415.4 (b)(1)(ii)