

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335625	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/27/2025
NAME OF PROVIDER OR SUPPLIER Downtown Brooklyn Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 520 Prospect Place Brooklyn, NY 11238	
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)		
<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the onsite visit for Complaint NY00384702, it was determined that the facility failed to maintain safe and comfortable temperature levels. This was evident on four (4) of four (4) resident floors, where 55 out of 55 rooms sampled had temperatures above the Federal and State requirements in accordance with 42 CFR Part 483 and 10 NYCRR: 415.29. Specifically, room [ROOM NUMBER] was 105 degrees Fahrenheit, room [ROOM NUMBER] was 102 degrees Fahrenheit, and Resident #1 room [ROOM NUMBER] temperature reading was 96 degrees Fahrenheit. Three (3) complaints were submitted to the State Agency regarding high temperatures throughout the facility from 06/24/2025 through 06/25/2025, stating all residents were affected. The facility temperature log on 06/24/2025 at approximately 4:00 PM documented high temperatures above the regulatory range in 29 of the 36 resident rooms sampled. This resulted in Immediate Jeopardy to all resident's health and safety.</p> <p>The findings are:</p> <p>Observations during the initial tour of the facility on 06/25/2025, from 11:10 AM to 12:15 PM, included temperatures in resident rooms and corridors measuring above Federal and State required ranges of 71 to 81 degrees Fahrenheit. Temperatures were observed between 84 and 105 degrees Fahrenheit. On 06/26/2025 between 10:15 AM and 12:15 PM, 61 resident rooms were sampled with 27 resident rooms having temperatures above the regulation. Residents and staff were seen complaining to the Director of Maintenance and maintenance staff regarding the heat in their various units.</p> <p>On 06/25/2025 at approximately 12:14 PM, the Corporate Regional Administrator was interviewed and stated they were not aware of any complaints about malfunctioning Packaged Terminal Air Conditioner (PTAC) units or high temperatures in resident rooms until the evening of 06/24/2025. They stated that all Packaged Terminal Air Conditioner units in resident rooms were serviced on 04/29/2025, including Heating, Ventilation, and Air Conditioning (HVAC) which was serviced on 05/23/2025 in preparation for summer.</p> <p>A review of the facility's policy on Heat Precaution dated 07/2016 revealed that the facility shall provide information to staff, resident and family to identify and reduce adverse effects of increased heat and humidity and to prevent heat related illnesses. The policy is to ensure the safety of residents during high heat alert and to assist preventing heat illness among residents during the hot and humid weather.</p> <p>(continued on next page)</p>		

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 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>A review of the Maintenance Logbooks on the 2nd to 5th floors revealed that on four (4) of four (4) resident floors, there were maintenance entries indicating the air conditioning was not working, residents requested fans, rooms were reported to be hot, circuit breaker tripped off or portable air conditioners were installed in rooms. These entries were made from 06/06/2025 through 06/25/2025 and more than 36 resident rooms were affected by faulty air conditioner or hot air complaints.</p> <p>A review of the facility Daily Room Temperature Log Readings for 06/24/2025 and 06/25/2025 revealed that hallway and resident room temperatures on resident floors ranged from 74 to 90 degrees Fahrenheit.</p> <p>During an interview on 06/26/2025 at 11:06 AM, Resident #1 stated they had been in the facility for six (6) years, and had been telling the facility management, specifically the previous Administrator and maintenance staff, about the preparation for heatwaves because their experience during summer periods in the facility has not been pleasant. They stated that although the facility performed maintenance activities such as fixing the Packaged Terminal Air Conditioner units, and checking the circuit breakers, those maintenance methods did not always yield desired results. They stated that in their own opinion, centralized Heating, Ventilation, and Air Conditioning may be the solution to the high temperatures in the facility during the summer.</p> <p>During an interview on 06/26/2025 at 4:12 PM, in Resident #1's room, with their Family Member #1 they stated they have complained to facility staff about the high temperature in the resident's room. They stated that on one occasion, Resident #1 had a severe headache due to the high temperature in their room. Nursing Supervisor #1 was informed, and Resident #1's vital signs were taken and recorded as normal. They stated that on more than one occasion they requested a fan for the room. They further stated that on 06/18/2025 they complained to the Admissions Director, who was in the reception area at the time, and on 06/23/2025 they complained to Registered Nurse Supervisor # 1. On 6/18/2025, The admission Director called the maintenance department because the room thermostat was reading 86 degrees Fahrenheit. On 06/21/2025 and 06/22/2025, the maintenance log documented the resident's room was very hot and a fan was requested.</p> <p>During a telephone interview on 06/26/2025 at 4:30 PM with Resident #1's Family Member #2, they corroborated Family Member #1's statement regarding the high temperature in the resident's room, as they had visited Resident #1 on 06/25/2025.</p> <p>During an interview on 06/26/2025 at 4:52 PM with Certified Nurse Aide #5, they stated residents had been complaining about their air conditioners not working for the past three (3) days. They said they usually take residents to a cooler place, give them water, and check their vitals. They stated that they will call the nurse if they observe anything strange with the weather or temperature.</p> <p>During an interview on 06/27/2025 at 12:42PM with Maintenance Staff #1, they stated their department was getting calls from nursing stations and resident family members to inform them of air conditioners malfunctioning and they were attending to the issues. They stated they were hired about three (3) weeks ago.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>During an interview on 06/27/2025 at 3:50 PM, the Director of Maintenance stated all Heating, Ventilation, and Air Conditioning systems in the facility were serviced and circuit breakers were checked. They stated that the maintenance of this equipment was completed on 04/29/2025 in preparation for summer. They stated their department receives calls occasionally to attend to some malfunctioned units, but they noticed an increase in calls around 06/23/2025. They stated they mobilized their staff to attend to the issues; they take the system out, wash, flush and change the filters, after which they bring the unit in and reinstall. They do Packaged Terminal Air Conditioner replacement where necessary, change parts as needed, and put portable air conditioning units where the Packaged Terminal Air Conditioner units could not be fixed.</p> <p>During an interview on 06/27/2025 at approximately 11:16 AM, the admission Director stated they received multiple calls on 06/23/2025 from residents newly admitted reporting that their rooms were extremely hot, with most calls coming from the 3rd floor. The admission Director stated they called Maintenance and the Nurse Supervisor to offer a room change. The admission Director stated that they sent Maintenance staff to resident rooms, to check and work on the issues raised.</p> <p>During an interview on 06/27/2025 at approximately 3:13 PM, the Administrator stated they are the chairman of the Quality Assurance Performance Improvement committee and are responsible for all department performance, including the Maintenance Department. The Administrator stated that on 06/19/2025, they received an email from the New York State Department of Health with a heat advisory memo. Maintenance was immediately deployed to re-check the air conditioning units in the resident's rooms, Packaged Terminal Air Conditioner and Heating, Ventilation, and Air Conditioning to ensure proper operation. The Administrator stated that no issues were reported on 06/21/2025 and 06/22/2025.</p> <p>The Administrator stated they contacted an electrician due to the breaker tripping. The electrician came on site on 06/24/2025 and assessed the electrical grid and contacted Con [NAME] (the energy company) and discovered that Con [NAME] had cut the voltage to the facility by 8%. They also contacted the air conditioning company on 06/24/2025 due to an abnormal number of overheated air conditioning units. The air conditioning company came to the facility on the same day and evaluated the air conditioning units and there were no significant issues, but some units failed and were replaced immediately. The Administrator stated that on 06/24/2025 at 7:58 PM, they received a phone call from the New York State Department of Health stating there is a complaint of heat in the building and requested the temperature log to be sent the following day (06/25/2025). The log was sent at 2:00 PM on 06/25/2025. The Administrator stated they were not in the facility on 06/25/2025 due to a medical appointment, but a Quality Assurance Performance Improvement meeting was held on 06/26/2025 to discuss a heat problem in the facility.</p> <p>Immediate Jeopardy was identified, and the Administrator was notified on 06/25/2025 at approximately 5:22 PM.</p> <p>An acceptable immediate corrective action plan from the facility was received on 06/25/2025 at approximately 6:12 PM.</p> <p>Immediate Jeopardy was removed on 06/27/2025 at 5:00 PM based on the following corrective actions taken by the facility:</p> <p>Observation of all units was done by the State Surveyor on 06/27/2025 between 12:15 PM and 1:02 PM. 70 resident rooms were sampled and temperatures ranged between 65 to 79 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Surveyors interviewed two families and five (5) alert and oriented residents who were satisfied with room temperatures.</p> <p>The facility held a Quality meeting on 06/26/2025 to discuss the deficiency cited for Immediate Jeopardy F584.</p> <p>30 Industrial sized 'Spot Coolers' were observed in operation in the facility. They were situated in the hallways throughout the eight (8) units in the facility. They were used to offset any extreme temperatures that occurred due to the heat wave. Two (2) Spot Coolers were in reserve. The Surveyor also observed 100 portable air conditioners in reserve.</p> <p>Invoice dated 06/25/2025, delivery date 06/26/2025, documented 100 Portable Air Conditioners were purchased.</p> <p>On 06/26/2025, facility staff assessed all residents for vital signs.</p> <p>Temperature Entry dated 06/26/2025 was reviewed and revealed that vital signs for 307 residents were taken, and no abnormal temperature was documented except Resident #7, who had 102.8 F, BP 194/106 and was taken to the hospital with suspected Sepsis. Dx Heart Failure, Obesity, Pulmonary Hypertension. Resident #7 room was not on the pool of the temperature. Their room has portable A/C, and the current room temperature was 81F.</p> <p>Six (6) residents were sampled for body temperature and vitals, no abnormality was reported. As per the Medical Director, all four (4) physicians were in-serviced over the phone to do more frequent rounds.</p> <p>Observation on 06/27/2025 on all units revealed Hydration Stations were seen on all resident units, to ensure residents remain hydrated and safe.</p> <p>Cooling Areas are on all units including the dining rooms, lounges and at the end of the hallways to maintain resident comfort.</p> <p>The maintenance staff checked for open windows and made sure blinds were drawn to prevent excessive heat from the sun.</p> <p>The facility changed parts and made any necessary repairs to Packaged Terminal Air Conditioners and some units were replaced.</p> <p>Temperatures have continuously been taken on all units, at 2-hour intervals.</p> <p>All staff were in-serviced on heat precautions during extreme heat events as per the Director of Nursing. The facility utilized online, phone and classroom delivery methods. This was documented with lesson plans and attendance sheets.</p> <p>Employees not physically present in the building for an in-person re-education were provided with an in-service module via Relias for their immediate compliance.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Many</p>	<p>Seven (7) employees, six (6) Certified Nursing Assistants and one (1) Nurse, who are on leave, will be re-educated on the first day that they report back to work.</p> <p>During an interview with interdisciplinary staff, they verbalized knowledge of heat advisory policy.</p> <p>Transfer agreements were reviewed and are ready to be implemented if the need should arise.</p> <p>The facility provided a heat wave notification advisory to the resident contacts and the Ombudsman to notify them of current conditions and what the facility is currently doing to rectify the condition.</p> <p>The Heat Precaution Policy dated 6/2025, was revised to include Supplemental Actions to be taken due to extreme weather .</p> <p>10 NYCRR: 415.5(h)(4)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during an abbreviated and partial extended survey, complaint # NY00384702, it was determined that administration failed to ensure that the facility was administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was evident on four (4) of four (4) residents floors, where 55 out of 55 rooms sampled had temperatures above the Federal and State requirements. Specifically, on 06/25/2025 at 11:10 AM the temperature in room [ROOM NUMBER] was 105 degrees Fahrenheit, room [ROOM NUMBER] was 102 degrees Fahrenheit, and Resident #1 room [ROOM NUMBER] temperature reading was 96 degrees Fahrenheit. Three (3) complaints were submitted to the State Agency regarding high temperature throughout the facility from 06/24/2025 through 06/25/2025, stating all residents were affected. The facility did not an effective system in place to monitor and maintained the temperature of the facility within an acceptable range of 71 degrees Fahrenheit to 81 degrees Fahrenheit.</p> <p>Findings are:</p> <p>The facility's policy and procedure on the Quality Management Program dated 04/28/2025, documented the Quality Assurance and Performance Improvement Program of the facility supported the mission by establishing a formal, facility-wide system that strives to improve care for residents, service, and facility operations on a continuous basis. The Quality Management Program relied on a systematic, comprehensive, data-driven, proactive approach to performance management and improvement that focuses on indicators of the outcomes of care and quality of life. The program evaluates residents' and other customers' needs and expectations and involves coordination within and between the facility departments and services. The leadership team of the facility maintains overall responsibility for the implementation of the quality management program. The facility's leadership focuses on the identification and prevention of risk exposures, include the safety and security of the environment.</p> <p>In a temperature log dated 06/25/2025 at 11:10 AM, documented the temperature in the sampled 55 residents' rooms on all eight units, which ranged from 83 degrees Fahrenheit to 105 degrees Fahrenheit. Seven rooms were over 100 degrees Fahrenheit.</p> <p>In a temperature log dated 06/26/2025 at 10:15 AM, the documented temperature in the 61 sampled residents' rooms on all eight units, which ranged from 71 degrees Fahrenheit to 89 degrees Fahrenheit.</p> <p>During an interview on 06/27/2025 at approximately 11:16 AM, the admission Director stated they received multiple calls on 06/23/2025 from residents who were newly admitted reporting that their rooms were extremely hot, with most calls coming from the 3rd floor. The admission Director stated they called Maintenance and the Nurse Supervisor to get the residents room changed. The admission Director stated Maintenance staff went to the resident rooms to correct the air conditioning issue.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 06/27/2025 at approximately 3:13 PM, the Administrator stated they are the chairman of the Quality Assurance Performance Improvement committee and are responsible for all department performance, including the Maintenance Department. The Administrator stated that on 06/19/2025, they received an email from the New York State Department of Health with a heat advisory memo. Maintenance was immediately deployed to re-check the air conditioning units in the resident's rooms, the Packaged Terminal Air Conditioner and the Heating, Ventilation, and Air Conditioning to ensure proper operation. The Administrator stated there were no issues reported on 06/21/2025 and 06/22/2025.</p> <p>The Administrator stated they contacted an electrician due to the breaker tripping. The electrician came on site on 06/24/2025 and assessed the electrical grid and contacted Con [NAME] (the energy company) and discovered the energy company had cut the voltage to the facility by 8% (eight percent). They also contacted the air conditioning company on 06/24/2025 due to an abnormal number of overheated air conditioning units. The air conditioning company came on the same day and evaluated the air conditioning units and there were no significant issues, but some units failed and were replaced immediately. The Administrator stated that on 06/24/2025 at 7:58 PM, they received a phone call from the New York State Department of Health stating there is a complaint of heat in the building and requested the temperature log to be sent the following day (06/25/2025). The log was sent at 2:00 PM on 05/25/2025. The Administrator stated they were not in the facility on 06/25/2025 due to a medical appointment, but a Quality Assurance Performance Improvement meeting was held on 06/26/2025 to discuss a heat problem in the facility.</p> <p>During an interview on 06/27/2025 at 11:55 AM, the Assistant Director of Nursing /Staff Educator stated no family or residents complained to them on 06/23/2025, 06/24/2025, or 06/25/2025. The Assistant Director of Nursing /Staff Educator stated on 06/23/2025, during rounds, some areas of the hallway felt warm, and they called maintenance staff, who responded. The Assistant Director of Nursing/Staff Educator stated they notified the Director of Maintenance that it was warm. The Assistant Director of Nursing /Staff Educator stated that they did not notify the Director of Nursing or Administrator, and they did not check the residents' rooms.</p> <p>During an interview on 06/27/2025 at 12:34 PM, the Director of Nursing stated that they first became aware that someone had made a complaint of being uncomfortable with the room temperature on 06/25/2025 from the State Surveyor at 5:00 PM. The Director of Nursing stated that the State Surveyor told them that the room temperature was above the acceptable range. The Director of Nursing stated they did rounds after that, and it was warm in the units and rooms.</p> <p>During an interview on 06/27/2025 at 3:34 PM, the Medical Director stated they are aware of the elevated temperatures in the facility and will monitor the medical status of residents.</p> <p>10 NYCRR 415.26</p>		