STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335637	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn-Queens Nursing Home	2749 Linden Blvd 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907 Based on observations, record review, and interviews conducted during an abbreviated survey (NY00340994), the facility did not ensure a resident's designated representative was notified of changes in condition. This was evident in 1 out of 5 residents (Resident #1) sampled. Specifically, the Nurse's Progress Note dated 04/29/2024 documented that Resident #1 sustained an excoriation to the right elbow because of friction (the action of one surface or object rubbing against another). The Medical Doctor was notified, and Bacitracin Ointment was ordered. Record review revealed that Resident #1's designated representative was not notified. The findings are: The facility policy titled Change in Resident's Condition or Status dated 06/2024 documented the facility promptly notifies the resident, attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia (memory loss), Hypertension, and Diabetes Mellitus. The Minimum Data Set, dated dated dated [DATE] documented that Resident #1 had a Brief Interview of Mental Status score of 9 out of 15, indicating moderately impaired cognition. A Nurse's Progress Note dated 04/29/2024 documented Resident #1 was observed twitching (jerking or convulsive movement) in bed. Not new, right elbow noted with adhesion from body rubbing on the bed sheets (friction). The Medical Doctor and wound care nurse were notified. A Wound Care Note, by wound care nurse, dated 05/03/2024 documented that Resident #1 was seen by the Wound Care Medical Doctor during rounds. The excoriation to Resident #1's right elbow measured 2centimeter x 2centermeter x 0.1centimeter with 100 percent epithelial tissue. The wound must be cleansed with Normal Saline, pat dry, and apply Xeroform (occlusive dressing) daily and as needed. A Medical Doctor's Note dated 05/05/2024 documented clean wound and peri-wound (the area around the wound) with Normal Saline prior to applying primary dressing. Peri wound should be treated with routine cleaning protocol. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order's dated 04/29/2024 with revised date of 05/08/2024 documented clean right elbow with Normal Saline, pat dry, and apply Xeroform and cover with dry dressing daily and as needed. There was no documented evidence that Resident #1's representative was notified. During a telephone interview on 07/11/2024 at 9:46 am, the Wound Care Nurse stated that they did not inform or have any conversation with Resident #1's representative regarding the skin impairment to Resident #1's right elbow. During an interview on 07/11/2024 at 11:40 am, Director of Nursing #2 stated that they could not locate any documentation of Resident #1's representative being notified of the right elbow excoriation. 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 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 (NY00324097), the facility failed to report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This was evident in 1 out of 3 residents sampled (Residents #3). Specifically, on 09/16/2023 at approximately 6:00 pm, Resident #3 was observed on the floor mat in their room. The facility completed their investigation on 10/17/2023 and submitted the findings to New York State Department of Health on 10/17/2023. The facility did not complete and submit the investigation report within 5 working days to New York State Department of Health. The findings include: The Facility's Policy and Procedure on Abuse and Neglect, revised 05/2024, states on page 11 report the results of all investigations to the Administrator or his or her designated representative and to the officials in accordance with State Law, including immediate or 24-hour reporting to the State Survey Agency, law enforcement and the follow-up report to the State Agency, within 5 working days of the incident. Resident #3 was admitted to the facility with diagnoses including Traumatic Brain Injury, Hemiplegia and Seizure Disorder. The Minimum Data Set (an assessment tool) dated 09/18/2023 documented that Resident #3 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 3 associated with severely impaired cognition. The facility's Investigation Summary dated 09/16/2023 with completion date of 10/17/2023, documented that Resident #3 had an unwitnessed fall and was observed lying on their left side on the floor mat. Resident #3 was alert and confused. The investigation concluded that the fall was an accident. Staff were educated on fall safety and prevention, hourly rounding protocol, anticipating resident's needs, and resident teaching was provided. A Webform Submission from Nursing Home Facility Incident Report showed that the facility submitted their completed investigation to New York State Department Of Health on 10/17/2023 at 6:21 pm. During a telephone interview on 06/17/2024 at 11:00 am, the Director of Nursing stated that the investigation summary was supposed to be reported to the Department of Health within 5 days. The Director of Nursing stated that the investigation was not reported because they thought that further actions was not needed. During a telephone interview on 06/17/2024 at 12:21 pm, the Administrator stated that the completed investigation should have been submitted to the Department of Health within 5 business days. The Administrator went on to say that they do not know why the investigation was submitted so late; and that it must have been an oversight. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.4 (b)(1)(ii)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 48907 Based on observations, record review, and interviews during an abbreviated survey (NY00340994), the facility did not develop and implement a comprehensive person-centered care plan with measurable objectives and time frames to meet a resident's status. This was evident in 1 out of 5 residents (Resident #1) sampled. Specifically, on 04/29/2024 at 3:41 pm, Resident #1 was observed with an excoriation to their right elbow due to friction (the action of one surface or object rubbing against another). A care plan was not developed with interventions to prevent friction. The findings include: The facility's Policy and Procedure titled Care Planning, Comprehensive with a revised date of 06/01/2023, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs are developed and implemented for each resident. The policy further documents that a comprehensive care plan is revised as needed based on changes in the resident's condition, order changes or any change in status. Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia (memory loss), Hypertension, and Diabetes Mellitus. The Minimum Data Set (an assessment tool) dated 05/01/2024 documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 9 out of 15, indicating moderately impaired cognition. There was no care plan developed for the skin impairment to Resident #1's right elbow. A Nurse's Progress Note dated 04/29/2024 documented that Resident #1 was observed twitching (jerking or convulsive movement) in bed. Not new, right elbow noted with adhesion from body rubbing to bed sheets (friction). The Medical Doctor and wound care nurse informed. During a telephone interview on 07/11/2024 at 9:24 am, the Wound Care Nurse stated that Resident #1 developed an excoriation from rubbing their right elbow on the bed sheet. The Wound Care Nurse stated that they assessed Resident #1's elbow and there was no bleeding. The Wound Care Nurse stated that an order was obtained to apply Bacitracin Ointment to the areas and to cover with dry dressing. The Wound Care Nurse went on to say that Resident #1 has uncontrollable movements and monitoring was ordered. The Wound Care Nurse stated that Resident #1 was being followed by the wound team and the area was in healing process. The Wound Nurse stated that Resident #1 did not have a bruise on their right foot. The Wound Care Nurse stated that a skin impairment care plan was not initiated, and that one should have been implemented. Several attempts were made to contact Registered Nurse Supervisor #3 but was unsuccessful. Registered Nurse Supervisor #3 is no longer working at the facility. 10 NYCRR 415.11(c)(1)

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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. 48907 Based on observations, record review, and interviews during an abbreviated survey (NY00340994), the facility did not ensure that a resident care plan was reviewed and revised by the interdisciplinary team. This was evident in 1 out of 5 residents (Resident #1) sampled. Specifically, the facility's Accident/Incident Report dated 05/02/2024 documented at 6:05 pm, Resident #9's visitor reported that Resident #2 walked over to Resident #1 with a knife (black handle stainless steel knife) in their hand on 05/02/2024. The staff were alerted by Resident #9's visitor who took the knife from Resident #2. The facility investigated the incident but did not review and revised Resident #1's care plan. The findings include: The facility's Policy and Procedure titled Care Planning, Comprehensive with a revised date of 06/01/2023, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs are developed and implemented for each resident. The policy further documents that a comprehensive care plan is revised as needed based on changes in the resident's condition, order changes or any change in status. Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia (memory loss), Hypertension, and Diabetes Mellitus. Minimum Data Set (a resident assessment tool) dated 05/01/2024 documented Resident #1 had a Brief Interview of Mental Status score of 9 out of 15, indicating moderately impaired cognition. A Comprehensive Care Plan for Victimization dated 04/19/2024, documented interventions to provide emotional support and reassurance for resident to express feelings. The care plan was not updated to reflect on the knife incident of 05/02/2024. The facility's Accident/Incident Report dated 05/02/2024 at 6:05 pm documented Resident #2's family visited and left food with utensils for Resident #2. Resident #2 walked over to Resident #1's bedside with a knife. The facility investigation concluded that abuse did not occur. Resident #2 was in possession of a knife because their family brought them food. During an interview on 06/03/2024 at 2:36 pm, Registered Nurse Supervisor #2 stated that the supervisors are responsible for initiating the care plans and updating them as needed. 10 NYCRR 415.11(c)(1)