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	09/10/2024

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44843 Based on interviews and record review conducted during the Recertification/Complaint survey (NY00348151) from 09/3/2024 to 09/10/2024, the facility did not ensure all alleged violations involving injuries of unknown source were reported immediately, but not later than 2 hours after the allegations were made, to the State Survey Agency. This was evident for 1 (Resident #105) out of 6 residents reviewed for Abuse. Specifically, the facility did not report that Resident #105 was found with injuries of an unknown source to the New York State Department of Health within 2 hours. The findings are: The facility policy titled Abuse, Neglect, Mistreatment and Misappropriation of Resident Property with effective date 6/2020 and last review date 5/2024 documented that 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 allegation is made. Resident #105 was admitted to the facility with diagnoses which included Vascular Dementia, Cerebral atherosclerosis, and Cerebral Infarction. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #105 had severely impaired cognition and no physical/verbal behavioral symptoms directed toward others. The Nursing note dated 7/12/2024 documented Resident #105 was observed with discoloration on the left upper arm area which was blueish in color and measured 10cm x 5 cm. The Medical note dated 7/15/2024 documented date of service was on 7/12/2024 to assess Resident #105 for complaint of bruise with mild hematoma over the left arm. The Medical note also documented that Certified Nursing Assistant reported to the nurse that Resident #105 had a bruise over the left arm. The Medical Note further documented that Resident #105 was not able to give a proper history due to poor cognitive function. The Medical note documented that the Certified Nursing Assistant and nurses did not see Resident #105 falling from their bed or was there any history of accidents happening while Resident #105 was in their room. The Accident /Incident Occurrence Report/Investigation form documented the occurrence happened at 12:00 PM on 7/12/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Webform submission from Nursing Home Facility Incident Report emailed to the Administrator documented the incident was submitted to New York State Department of Health at 03:46 on 7/13/2024. On 09/05/2024 at 02:17 PM, Registered Nurse #1 was interviewed and stated Resident #105 was found to have a bruise on the left upper arm when the Certified Nurse Assistant provided care to Resident #105 on 7/12/2024. Registered Nurse #1 also stated the cause of the bruise was unknown at that time. Registered Nurse #1 further stated they reported the incident immediately to the Director of Nursing. The Director of Nursing was no longer employed at the facility and could not be reached for interview. On 09/05/2024 at 02:38 PM, the Administrator was interviewed and stated the staff on the floor immediately report all the incidents that occur to the Director of Nursing no matter what time and the Director of Nursing and themselves only were responsible for reporting to Department of Health. The Administrator also stated that the Director of Nursing discussed with them if the incident was reportable to Department of Health, and they knew the facility had to report any allegation of abuse including unknown injury to the state agency immediately within 2 hours of awareness. The Administrator further stated that the bruise on left upper arm for Resident #105 was considered to be an unknown injury and had to be reported to Department of Health within 2 hours of awareness. The Administrator stated that the Director of Nursing had problems logging in the system and the Administrator logged in for the Director of Nursing to submit the report. The Administrator also stated they terminated the Director of Nursing several weeks ago and they had no explanation why the incident which occurred 07/12/2024 was not reported to the Department of Health until 07/13/2024. 10 NYCRR 415.4(b)(2)

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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 - Some	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** 41709 Based on observations, record review and staff interviews conducted during the Recertification survey and Complaint survey (NY00348151) from 09/03/2024 to 09/10/2024, the facility did not ensure that residents comprehensive care plans were reviewed and revised to reflect the resident's status. This was evident for 1 (Resident #91) of 2 residents reviewed for Activities of Daily Living, 1 (Resident #105) of 6 residents reviewed for Abuse and 1 (Resident #7) of 5 residents reviewed for Unnecessary Medication out of 31 sampled residents. Specifically, 1). Resident #91's comprehensive care plan was not reviewed and revised to reflect their preference for wearing hospital-style gowns, and refusal to have their hair care needs addressed, 2). Resident #105's comprehensive care plan related to Victimization was not reviewed and revised after the Minimum Data Set Assessment was completed, and 3). Resident #7's comprehensive care plans related to Pain and Anticoagulant use were not reviewed or revised after the Minimum Data Set Assessment was completed. The finding is: The facility policy titled Care Planning Process last revised 6/24 documented comprehensive, person-centered care plans are based on resident assessments and developed by an interdisciplinary team. The policy further documented care plans must be reviewed and modify as needed by appropriate disciplines prior to scheduled care plan meeting. Each comprehensive care plan problems, goals and interventions should be reviewed for appropriateness to the resident's condition. Each care plan should have a review note completed prior to/during the comprehensive care plan meeting evaluating effectiveness. 1. Resident # 91 had diagnoses which includes Depression, Paranoid Schizophrenia, and Insomnia. The Quarterly Minimum Data Set, dated dated dated [DATE] documented that Resident #91 had severely impaired cognition and required supervision to set up assistance for shower and bath and was independent with personal hygiene. The Quarterly Minimum Data set further documented Resident #91 had physical behavioral symptoms directed toward others, other behavioral symptoms not directed toward others such as pacing, and there was no rejection of care. On 09/03/24 at 12:40 PM, Resident #91 was observed eating lunch in the unit dining area wearing hospital-type gown. Resident #91's hair appeared long on the sides and there was a large, matted clump of hair at the back of Resident #91's head. On 09/04/24 at 09:40 AM, Resident #91 was observed walking in the hallway and entered dining area wearing a hospital-type gown. Hair to the back of Resident #91's head was observed to be in a matted clump. On 09/05/24 at 09:05 AM, and on 09/05/24 at 11:29 AM, Resident #91 was observed walking from the dining area to their room in a hospital-type gown with hair that remained matted to the back of resident's head in long clump. Resident #91 did not answer when greeted. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/09/24 at 09:03 AM, on 09/09/24 at 11:51 AM, and on 09/10/24 at 08:51 AM, Resident #91 was observed walking on unit from dining area to room in a hospital-type gown. Resident #91 continued to have a clump of matted hair to the back of the head. The Comprehensive Care Plan titled Functional Status: Self Care effective 1/17/2024 and last updated documented 7/24/2024 documented Resident #91 required supervision/touching assistance for shower/bathe self and was independent for Personal Hygiene. Interventions included encourage resident to perform self-care as independently as possible, observe for safety, review progress or lack of progress toward discharge goals and update as needed, and continue annual and quarterly assessments to monitor status. The Comprehensive Care Plan titled Behavioral Symptoms Etiology: Resident exhibits behavior problems as evidenced by refusing medications, psychiatric diagnosis of Paranoid Schizophrenia dated effective 4/3/2024 with last evaluation note dated 7/17/2024. Interventions included monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situations, document behavior and potential causes, re-enforce/praise positive behavior and progress, explain to resident the risk of non-adherence and risk of negative outcomes/impact, and refer to physician/psychiatrist as needed. The Certified Nursing Assistant Accountability Record dated January 2024 through September 2024 documented resident received showers and contained no documented evidence that Resident #91 refused care or refused to clean their hair. There was no documentation of Resident #91's preferences for care on the Certified Nursing Assistant Accountability record. The Comprehensive Care Plan meeting dated 10/26/2023, 1/30/2024, 5/2/2024 and 8/1/2024 documented Resident #91 was receiving showers, but there was no documented evidence that Resident #91 Activities of Daily Living, specifically hair grooming and preference for gowns was addressed with Resident #91 and/or representative. The Nursing progress note dated 07/16/2024 at 10:34 AM, documented behavior Note: Even with much encouragement resident refuses to let hair get washed and to put on clothing- prefers to wear the gown. There was no documented evidence that Resident #91's care plan was reviewed or revised to include their preference for hospital-style gowns, or to include interventions and or a plan to address Resident #91's matted and unkempt hair. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 09/06/24 at 10:28 AM, Certified Nursing Assistant #8 stated that they were assigned to care for Resident #91 last month and the only thing Resident #91 allowed Certified Nursing Assistant #8 do for them is provide them with two hospital-style gowns, make their bed, and give them their breakfast and lunch trays. Certified Nursing Assistant #8 also stated that Resident #91 handled all other care by themself and refused to dress in anything other than hospital-style gowns. Certified Nursing Assistant #8 further stated that Resident #91 would only shower when they wanted to shower, despite having designated days to shower on Mondays and Thursdays and they always refused to have their hair washed or cut. Certified Nursing Assistant #8 stated that Resident #91 needed a lot of encouragement to go into the shower, and during shower time the Certified Nursing Assistant stays with Resident #91 but cannot touch their hair. Certified Nursing Assistant #8 stated they were aware of Resident #91's hair needs care, and they did not document that Resident #91 refused to clean their hair because there was no place to document this. Certified Nursing Assistant #8 stated they verbally inform the nurse on the unit that Resident #91 is refusing to wash their hair. During an interview on 09/06/24 at 02:06 PM, Licensed Practical Nurse #2 stated they are aware that Resident #91's hair is matted and cannot be combed out, and they have personally offered Resident #91 a haircut on multiple occasions, but Resident #91 refused. Licensed Practical Nurse #2 also stated that Resident #91 does not like to be touched and walks around in a hospital-style gown all day. Licensed Practical Nurse #2 further stated that Resident #91 is independent with Activities of Daily Living, is compliant with all medications, very engaging, low speech, has no combative behaviors at present. Licensed Practical Nurse #2 stated that they reported the noncompliance with hair care and matted hair to the supervisor and Social Worker, but nothing was done. Licensed Practical Nurse #2 also stated they do not participate in the care planning meetings and did not document the multiple times they offered Resident #91 a haircut. During an interview on 09/06/24 at 02:50 PM, Registered Nurse Supervisor #2 stated that Resident #91 walks up and down in the hallway in a hospital-style gown. Registered Nurse Supervisor #2 also stated that Resident #91 was admitted with matted hair and Resident #91 was encouraged to clean hair during an interdisciplinary team meeting, but they could not recall when this was. Registered Nurse Supervisor #2 further stated that they have approached Resident #91 on several occasions to offer a shower which Resident #91 accepted, but Resident #91 refuses to allow anyone to touch their hair. Registered Nurse Supervisor #2 stated if anyone attempts to touch their hair, Resident #91 turns red, folds arms, and says no, no and walks up and down the hallway. Registered Nurse Supervisor #2 also stated they did not document any of the meetings with Resident #91 or the plan for Resident #91, but there was a note in July 2024 stating that Resident #91 refused to have hair washed, and their preference was to wear hospital-style gowns on the unit. Registered Nurse Supervisor #2 stated they are not responsible for care plans and did not initiate or update the care plan for resident preference of gowns and refusing to wash hair as there was someone specifically assigned to do the care plans, but they are not sure what happened to that. During an interview 09/10/24 at 01:38 PM, the Director of Nursing stated were just told that the Resident #91 had matted hair, was resistive to care, refused activity of daily living care. The Director of Nursing also stated Registered Nurse Supervisors are responsible for creating and revising all care plans and they would instruct them to ensure that the appropriate care plans are in place for Resident #91. 44843 (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #105 (NY00348151) was admitted to the facility with diagnoses which included Vascular Dementia, Cerebral Atherosclerosis, and Cerebral Infarction. The Admission Minimum Data Set 3.0 assessment dated [DATE] documented Resident #105 was had severely impaired cognition and no physical/verbal behavioral symptoms directed toward others. The Nursing note dated 7/12/2024 documented Resident #105 was observed with discoloration on the left upper arm area which was blueish in color and in the size measured 10cm x 5 cm. The Medical note dated 7/15/2024 documented date of service was on 7/12/2024 to assess Resident #105 for complaint of bruise with mild hematoma over the left arm. The Medical note also documented that Certified Nursing Assistant reported to the nurse that Resident #105 had a bruise over the left arm. The Medical Note further documented that Resident #105 was not able to give a proper history due to poor cognitive function. The Medical note documented that the Certified Nursing Assistant and nurses did not see Resident #105 falling from their bed or was there any history of accidents happening while Resident #105 was in their room. The Accident /Incident Occurrence Report/Investigation form documented the occurrence happened at 12:00 PM on 7/12/2024. The Comprehensive Care Plan related to Victimization created 4/16/2024 documented interventions which included to keep Resident #105 separated from other residents possibly disturbed by the behaviors exhibited whenever possible, provide a safe environment, and provide emotional support/reassurance for Resident #105 to express feelings. There was no documented evidence Resident #105's comprehensive care plan related to Victimization was reviewed and/or revised after Resident #105 was observed with an injury of unknown source or after the Admission Minimum Data Set assessment was completed on 4/23/2024 or the Quarterly Minimum Data Set assessment completed on 7/24/2024. 3. Resident #7 had diagnoses of Unspecified Atrial Fibrillation, Unspecified Pain, and Chronic Pain Syndrome. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #7 was cognitively intact. The Minimum Data Set assessment also documented that Resident #7 received anticoagulant and opioid medication. The Physician's order dated 10/21/2023 renewed on 9/3/2024 documented that Resident #7 was to receive Oxycodone-Acetaminophen 10mg-325mg tablet, 1 tablet by mouth every 6 hours for Pain. The Physician's order dated 11/10/2022 renewed on 9/3/2024 documented that Resident #7 was to receive Eliquis 5 mg tablet, give 1 tablet by mouth every 12 hours for Unspecified Atrial Fibrillation. The Medication Administration Record dated August 2024 documented that Oxycodone-Acetaminophen and Eliquis were administered to Resident #7 every day as ordered. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Comprehensive Care Plan with focus on Pain created on 11/10/2022 and last updated 3/29/2024 included interventions of assess for breakthrough pain and need for supplemental doses, assess nature, intensity, location, duration, and frequency of pain, and educate Resident #7 and/or family regarding importance of reporting pain and pain control. The Comprehensive Care Plan with focus on Anticoagulant Use initiated 11/10/2022 and last updated 5/13/2024 documented interventions which included to administer medications as per Medical Doctor orders, avoid bumping and handle resident gently when providing hands on care, and monitor/document/report to Medical Doctor as needed for signs/symptoms of anticoagulant and/or antiplatelet complications. There was no documented evidence that Resident #7's comprehensive care plans related to Pain and Anticoagulant Use were reviewed or revised after the last Minimum Data Set assessment completed on 6/3/2024. On 09/05/2024 at 02:17 PM, Registered Nurse #1 was interviewed and stated they were responsible for reviewing the care plans for residents at least every three months after the Minimum Data Set assessments and as needed. Registered Nurse #1 also stated they were able to check which residents were due for Minimum Data Set assessment in the electronic medical record system and review their care plans accordingly. Registered Nurse #1 further stated they updated or documented to continue the care plan if no change was needed. Registered Nurse #1 stated they updated some care plans for Resident #105 and #7, and it may be an oversight that all care plans were not updated. On 09/09/2024 at 10:17 AM, the Director of Nursing was interviewed and stated the day shift Registered Nurse for the unit was responsible for reviewing and updating the care plans at least every three months after the Minimum Data Set assessment and as needed. The Director of Nursing also stated the Registered Nurse is supposed to document the care plan was reviewed and continue the current care plan if there was no change in the care plan. The Director of Nursing reviewed the medical record and was not able to explain why some care plans were not reviewed or updated in a timely manner for Resident #105 and Resident #7. The Director of Nursing stated the registered nurses were professional and they did not monitor if the Registered Nurse had reviewed and updated the care plans. 10 NYCRR 415.11(c)(2)(iii)