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	06/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooklyn-Queens Nursing Home	2749 Linden Boulevard 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 - Some	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** Based on observation, record review and interviews, the facility failed to ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury to the State Survey Agency. This was evident in three (Residents #144, #135, and #68) of seven residents reviewed for accidents and abuse. Specifically, the facility failed to timely report the following incidents to the New York State Department of Health: 1.) On 03/12/2026, Resident #144 intentionally punched a window in their room, shattering the glass and sustaining multiple lacerations to the right hand from broken glass shards; 2.) On 09/22/2025, Resident #135 was found on the floor with a large hematoma on the left orbital area, stated they were pushed; 3) On 03/30/2026, Resident #68 sustained a bruise of unknown origin on the left thigh that was not reported to the New York State Department of Health. The findings include: The facility policy titled Prevention of Abuse, Neglect, Misappropriation of Resident Property and Exploitation, reviewed on 02/2026, required that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source be reported immediately , but not later than 2 hours after the allegation was made, to the Administrator and State Survey Agency. 1) Resident #144 had diagnoses that included Unspecified dementia, adjustment disorder, and peripheral vascular disease. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment and physical behavioral symptoms. A nursing note dated 03/12/2026 at 9:23 AM documented that Resident #144 punched and shattered a bedroom window resulting in bleeding lacerations to the right hand. A nursing note dated 03/13/2026 at 10:37 PM documented that Resident #144 returned from the hospital emergency department. X-ray of the right hand showed fracture on the fourth finger. The Nursing Home Facility Incident Report documented the Administrator became aware of the incident on 03/12/2026 at 6:45 PM. However, the incident was not reported to the New York State Department of Health until 03/13/2026 at 1:32 PM, more than two hours after the facility became aware of the event and 2) Resident #135 had diagnoses that included dementia, Alzheimer's disease, and history of falls. (continued on next page)

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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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment and history of falls with no injury since admission. The facility's accident report dated 09/22/2025 documented that Resident #135 was found on the floor at 12:00 PM with a large hematoma on the left orbital area. The report documented that they had been pushed and subsequently fell. The Nursing Home Facility Incident Report documented the Administrator became aware of the incident on 09/22/2025 at 1:00 PM. However, the incident was not reported to the New York State Department of Health until on 09/23/2025 at 10:49 AM, exceeding the required two-hour time frame. During an interview on 05/29/2026 at 11:44 AM, the Director of Nursing stated that allegations involving injuries of unknown source and resident self-harm are required to be reported to the New York State Department of Health immediately but no later than two hours after the facility becomes aware of the allegation. The Director of Nursing confirmed that the incidents involving Residents #135 and #144 were not reported within the required timeframe and attributed the failures to the former Assistant Director of Nursing , who was responsible for investigations and reporting. During an interview on 05/29/2026 at 2:45 PM, the Administrator confirmed the facility failed to comply with reporting requirements for allegations involving injuries of unknown source and resident self-harm, and stated the former Assistant Director of Nursing's employment was terminated due to these failures. 3. Resident #68 had diagnoses that included Alzheimer's disease, dementia, and seizure disorder. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment and wandering. A nurse's note dated 03/30/2026 documented that at 8:23 AM, a palm sized discoloration to Resident #68's left dorsal thigh area. The physician was notified and ordered monitoring. The facility's accident/ incident report documented a purple discoloration, however, the facility investigation did not contain conclusion sufficient to rule out abuse, neglect, or mistreatment. During an interview on 06/02/2026 at 1:00 PM, Certified Nursing Assistant #13, the aide assigned to Resident #68, stated the bruise was discovered during morning care. During an interview on 06/02/2026 at 1:04 PM, Registered Nurse #2 stated an incident report was completed and forwarded to the Assistant Director of Nursing but was unaware whether the incident had been reported to the New York State Department of Health. During an interview on 06/02/2026 at 2:11 PM, the Director of Nursing stated the Assistant Director of Nursing was responsible for investigations and State reporting and failed to complete the investigation or submit the required report to the State. The Director of Nursing acknowledged the incident should have been reported to the New York State Department of Health. During an interview on 06/02/2026 at 2:27 PM, the Administrator stated they were unaware of the incident until 06/02/2026 and confirmed the incident would have been reported had they been informed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 New York Codes, Rules and Regulations 415.4

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure all alleged violations were thoroughly investigated. This was evident in three (Residents #144, #135, and #68) of seven residents reviewed for accidents and abuse. Specifically, the facility failed to conduct thorough investigations regarding: 1.) Resident #144, who intentionally punched a window, causing it to shatter and resulting in multiple lacerations and a fractured finger; 2.) Resident #135, who was found on the floor with left orbital swelling and pain and subsequently alleged being pushed; and 3.) Resident #68, who was observed with bruise of unknown origin to the left thigh. The findings include: The facility's policy titled Accidents and Incidents – Investigating and Reporting, reviewed 08/2025, stated that all accidents and incidents involving residents shall be investigated and reported to the Administrator. The policy further stated that the Director of Nursing is responsible for ensuring the Administrator receives a copy of each accident/incident report. 1. Resident #144 had diagnoses that included Unspecified dementia, adjustment disorder, and peripheral vascular disease. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment and physical behavioral symptoms. A nursing note dated 03/12/2026 at 9:23 AM documented that Resident #144 punched and shattered a bedroom window resulting in bleeding lacerations to the right hand. A nursing note dated 03/13/2026 at 10:37 PM documented that Resident #144 returned from the hospital emergency department. X-ray of the right hand showed fracture on the fourth finger. The facility investigation summary dated 03/18/2026 documented that Resident #144 intentionally struck the window with the right hand, causing the glass to shatter and resulting in multiple lacerations. The summary further documented that interviews were conducted with residents in adjacent rooms and others who may have had contact with the resident prior to the incident. However, review of the investigation revealed no documented statements from residents reportedly interviewed. The investigation contained statements from the assigned Certified Nursing Assistant, Licensed Practical Nurse, and Registered Nurse, but did not include statements from all staff assigned to or present on the unit at the time of the incident. 2. Resident #135 had diagnoses that included dementia, Alzheimer's disease, and history of falls. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment and history of falls with no injury since admission. The facility accident/incident report dated 09/22/2025 documented that Resident #135 stated they had been pushed and fell. The facility's five-day investigation summary documented that Resident #135 described the alleged perpetrator as a female wearing red. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the investigation revealed statements were obtained from nursing personnel assigned to the unit; however, no statements were obtained from recreation staff who were the only employees who routinely wore red coats, matching the resident's description of the alleged perpetrator. During an interview on 05/29/2026 at 11:44 AM, the Director of Nursing stated that facility protocol required obtaining statements from all staff who may have had knowledge of an allegation or incident. The Director of Nursing further stated that recreation staff wore red coats and should have been interviewed based on the resident's description and acknowledged the investigation was not thorough as they failed to obtain statement from the recreation staff. They stated that the Assistant Director of Nursing was primarily responsible for conducting investigations and failed to obtain statements from all relevant staff and residents. They stated the assistant director's employment was terminated in April 2026 due to deficiencies in conducting investigations. During an interview on 05/29/2026 at 2:45 PM, the Administrator acknowledged that investigations involving Residents #135 and #144 were not completed thoroughly because statements were not obtained from all relevant staff and residents and stated the former Assistant Director of Nursing's employment was terminated due to these failures. 3. Resident #68 had diagnoses that included Alzheimer's disease, dementia, and seizure disorder. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment and wandering. A nurse's note dated 03/30/2026 documented that at 8:23 AM, a palm sized discoloration to Resident #68's left dorsal thigh area. The physician was notified and ordered monitoring. The facility accident/incident report dated 03/30/2026 documented that a Certified Nursing Assistant observed a five by three-centimeter purple discoloration to the resident's left posterior thigh during morning care. The report documented that Resident #68 was unable to state how the injury occurred. Review of the facility's investigation revealed no investigation summary, conclusion, or findings sufficient to determine the cause of the injury or rule out abuse, neglect, or mistreatment. During an interview on 06/02/2026 at 2:11 PM, the Director of Nursing stated the Assistant Director of Nursing, who was responsible for investigations, failed to complete the investigation and that several incomplete investigations were later discovered. During an interview on 06/02/2026 at 2:27 PM, the Administrator stated they were unaware of the incident until 06/02/2026 and stated that the Director of Nursing is trying to put information together to complete the investigation. 10 New York Codes, Rules and Regulations 415.4