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	06/03/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during survey, the facility failed to ensure pharmaceutical services was provided (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident; establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, and that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This was evident for one of five residents (Resident #3) reviewed. Specifically, Resident #3's blister pack with Oxycodone 10 milligrams (30 tablets) and reconciliation (counting) sheet were observed missing on [DATE] at 9:00 PM from a lock narcotic box and has not been located. The facility failed to ensure Resident #3's Oxycodone was accounted for and reconciled to prevent diversion.The findings are:The facility policy titled Controlled Substances revised date 04/2025 documented it is the policy of the facility to prescribe, administer, store and destroy all controlled substances withing the accepted regulations of the responsible governing body. In the event the controlled substance order has been changed, discontinued, contaminated or expired, the controlled blister pack complete with the count sheet must be submitted to the Director of Nursing or designee. All narcotics will be counted and reconciled at the beginning of every shift with outgoing and oncoming nurses. Both must sign the controlled substance count sheets attesting to the presence of the narcotic as stated from the previous shift. Any discrepancies in the count must be reported to the nursing supervisor immediately.Resident #3 was admitted to the facility with diagnosis of dementia, nasal bones fracture and cirrhosis of liver.The Minimum Data Set (a resident assessment tool) dated [DATE] documented Resident #3 had severely impaired cognition.A Pharmacy Log (dispensed from pharmacy) dated [DATE] documented Oxycodone 10 milligram 42 tablets.A Manifest/Order document dated [DATE], signed for by Registered Nurse Supervisor #1 (signature indicates medication was received), documented Oxycodone 10 milligram, amount 42 tablets for Resident #3.A Physician's Order dated [DATE] at 6:33 PM revealed that Oxycodone 10 milligrams (standing order) was discontinued and reordered at 6:35 PM to be given as needed.A review of the Medication Administration Record dated from [DATE] to [DATE] revealed Oxycodone 10 milligrams was last administered to Resident #3 on [DATE] at 1:00 PM. The Oxycodone was then placed on hold at 5:00 PM on [DATE].There was no documented evidence Resident #3 received any Oxycodone from [DATE] to [DATE].A facility Investigation Summary dated [DATE] documented that on [DATE] (no time documented) Licensed Practical Nurse #1 reported Resident #3's Oxycodone blister pack with 30 tablets and the corresponding count sheet was missing. The Nursing Supervisors searched the units, including medications carts, medication rooms, and controlled substance storage areas, to no avail. On [DATE], pharmacy delivered the Oxycodone, and it was signed for by Registered Nurse Supervisor #1 who also delivered the Oxycodone to the unit Licensed Practical Nurse #1. Oxycodone was held on [DATE] due to Resident #3's lethargy. On [DATE] Oxycodone 10 milligrams three times a day (standing) was discontinued and re-ordered to be given as needed. On [DATE] Resident #3 was transferred from the 2nd floor to the 5th floor. Registered Nurse #1 who (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received Resident #3 reported that they did not receive Oxycodone. Licensed Practical Nurse #5 who transferred Resident #3 to the fifth floor stated they did not transfer the Oxycodone to the fifth floor. The list of controlled substances /count sheets scheduled to be returned for destruction was reviewed and Oxycodone was not removed from the unit for destruction. The pharmacy was contacted and asked to review the returned drug list. Oxycodone had not been returned with non-controlled substances. To date, the missing blister pack and count sheet have not been located.A Loss of Controlled Substances Report (to Bureau of Narcotics) dated [DATE] documented suspected diversion on 2nd and 5th floor. Oxycodone 10 milligrams 30 tablets. Police were notified. During an interview on [DATE] at 1:21 PM, the Complainant stated they worked in the facility as an Assistant Director of Nursing until 04/2026 (unsure of date). The Complainant stated that on [DATE], on the evening shift, they received a message (a group chat that includes Director of Nursing) from Registered Nurse Supervisor #6 stating that Licensed Practical Nurse #1 told them that Resident #3 was asking for pain medication and they were unable to locate Resident #3's Oxycodone. The Complainant stated that the Director of Nursing told them to check the 2nd floor where Resident #3 was residing prior to being transferred to the 5th floor. The Complainant stated that on [DATE], they were told by the Director of Nursing that the Oxycodone was not located. The Complainant stated they were not instructed to report the missing narcotics to law enforcement, Bureau of Narcotics and Department of Health.Licensed Practical Nurse #1 was not interviewed as they are no longer employed by the facility and their whereabouts are unknown. During an interview on [DATE] at 3:27 PM, Licensed Practical Nurse #2, who worked on [DATE] and [DATE] on the 3:00 PM-11:00 PM shift, stated they counted Oxycodone 10 milligram with outgoing nurse (Licensed Practical Nurse #4) at the beginning of the evening shift around 3:00 PM on [DATE]. They stated they did not administer any Oxycodone at 5:00 PM due to Resident #3 being lethargic. Licensed Practical Nurse #2 stated they notified Registered Nurse Supervisor #1 who instructed them to hold the Oxycodone. Licensed Practical Nurse #2 stated that Registered Nurse Supervisor #1 did not notify them that the Oxycodone was changed from a standing order to an as needed order. Licensed Practical Nurse #2 stated that they informed the incoming night nurse (Licensed Practical Nurse #3) that Resident #3's Oxycodone was put on hold due to lethargy. Licensed Practical Nurse #2 stated they counted all the narcotics at around 11:00 PM, including Resident #3's Oxycodone 10 milligrams, with incoming Licensed Practical Nurse #3, then they left work as their shift ended. Licensed Practical Nurse #2 stated that the evening shift Registered Nurse Supervisor #1 did not remove any narcotic blister pack from the medication room during their shift. Licensed Practical Nurse #2 stated that they are supposed to be notified of any medication changes so they can handover the information to the incoming nurse. Licensed Practical Nurse #2 stated the administration called them into the office 10 days after the medication was missing to ask them about the missing Oxycodone and they wrote a statement.During an interview on [DATE] at 4:06 PM, Licensed Practical Nurse #3, who worked on the 11:00 PM-7:00 AM shift on [DATE], [DATE], [DATE], [DATE], and [DATE], stated they counted narcotics on [DATE] at around 11:00 PM with Licensed Practical Nurse #2, but do not recall counting Oxycodone 10 milligram for Resident #3. Licensed Practical Nurse #3 stated they were aware Resident #3 was on Oxycodone, but thought the Oxycodone was discontinued and a nursing supervisor removed it from the unit. Licensed Practical Nurse #3 stated they don't check the electronic Medication Administration record for as needed medications unless a resident requests the medication.During an interview on [DATE] at 7:10 PM, Licensed Practical Nurse #4 who worked on [DATE] and [DATE] on the 7:00 AM- 3:00 PM shift, stated that they administered Oxycodone 10 milligrams to Resident #3 at 9:00 AM and 1:00 PM on [DATE] on the 7:00 AM - 3:00 PM shift. Licensed Practical Nurse #4 stated that they counted the narcotics on [DATE] on the 7:00 AM - 3:00 PM shift with the outgoing Licensed Practical Nurse #3, who worked the night shift from 11:00 PM - 7:00 AM on [DATE], and Resident #3's Oxycodone blister pack and counting sheet was not in the locked cabinet in the medication room. Licensed Practical Nurse #4 stated that Licensed Practical Nurse #3 told them that (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3's Oxycodone was discontinued, so they assumed Registered Nurse Supervisor #1 removed the blister pack and counting log for destruction. Licensed Practical Nurse #4 stated they checked the orders and Oxycodone 10 milligrams was discontinued as a standing order, but they did not check the as needed orders. During an interview on [DATE] at 3:31 PM, Registered Nurse Supervisor #1 stated they were called to Resident #3's unit on [DATE] during the evening (3:00 PM - 11:00 PM) (does not recall exact time) because Resident #3 was lethargic. Registered Nurse Supervisor #1 stated they assessed Resident #3 and notified medical doctor and family. Registered Nurse Supervisor #1 gave a telephone order to discontinue the standing order for Oxycodone 10 milligrams and ordered Oxycodone 10 milligrams as needed. Registered Nurse Supervisor #1 stated they notified Licensed Practical Nurse #2 who worked on the evening shift and Registered Nurse Supervisor #2 who worked on the night shift (11:00 PM - 7:00 AM, of the changes in doctor's order. Registered Nurse Supervisor #1 stated they did not remove Oxycodone blister pack and corresponding count sheet from the medication room because the day shift (7:00 AM - 3:00 PM) supervisors are responsible for removing the discontinued medications from the narcotic box. Registered Nurse Supervisor #1 added that Medical Doctor #1 should have sent a new script or called the pharmacy with the changes in Oxycodone. Registered Nurse Supervisor #1 stated that Licensed Practical Nurse #1 (on the 3:00 PM - 11:00 PM shift) informed them on [DATE] that Resident #3 asked for pain medication, but they could not locate the Oxycodone blister pack. Registered Nurse Supervisor #1 stated they notified the Director of Nursing, Assistant Director of Nursing and Medical Doctor #1 (unsure of time). Registered Nurse Supervisor #1 stated they conducted a search, but the Oxycodone blister pack and corresponding count sheet was not located. During an interview on [DATE] at 1:06 PM Registered Nurse Supervisor #2 who worked on [DATE] at 11:00 PM -7:00 AM shift, stated they did not remove Resident #3's discontinued Oxycodone from the narcotic box. They stated that the day shift supervisor is responsible for removing the discontinued narcotics for destruction. Registered Nurse Supervisor #2 stated they were notified of the changes in Oxycodone, but no one asked them to remove the Oxycodone blister pack and counting sheet from the unit.During interview on [DATE] at 5:30 PM Registered Nurse Supervisor #3, who worked [DATE] 7:00 AM - 3:00 PM shift and covered 2nd floor, stated they were not notified, and they did not remove Resident #3's Oxycodone from the unit on [DATE]. Registered Nurse Supervisor #3 stated that when narcotics are removed from the unit, the supervisor puts them in a lock narcotic box in the nursing office, then count the narcotics with the incoming supervisor, then Director of Nursing signs off on the count for destruction. During telephone interview on [DATE] at 6:19 PM, Registered Nurse Supervisor #4 who worked [DATE] on 7:00 AM - 3:00 PM shift, stated they did not collect any control medications from Resident #3's unit on [DATE] on 7:00 AM - 3:00 PM shift. They stated that the Oxycodone blister pack and corresponding count sheet was not logged in by previous shift (11:00 PM - 7:00 AM). Registered Nurse Supervisor #4 stated the discontinued Oxycodone should have been removed from the unit on [DATE] when the medication was discontinued and brought to the nursing office.During an interview on [DATE] at 3:13 PM, Pharmacy Consultant stated they were notified about the medication diversion issue on [DATE] by Director of Nursing. Pharmacy Consultant stated that former Assistant Director of Nursing (complainant) was the Risk Manager at the time the Oxycodone was missing, and they should have immediately reported the missing Oxycodone to the Director of Nursing, Bureau of Narcotics and to them. Pharmacy Consultant stated they were not involved in any corrective actions and didn't recall the outcome of investigation. Pharmacy Consultant stated if the order was discontinued, blister pack with remaining Oxycodone should have been removed from the narcotic box and new order/script should have been sent to the pharmacy. Pharmacy Consultant stated they don't know if a new script was sent.During an interview [DATE] at 11:03 AM, the Director of Nursing stated that the missing Oxycodone should have been investigated, and the outcome reported to them. They stated that the Assistant Director of Nursing should have also reported the missing narcotic to the Bureau of Narcotics and the police. However, the former Assistant Director of Nursing give them an incomplete (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation on [DATE] (unsure of time). The Director of Nursing stated during completion of the investigation, they discovered that the order for Oxycodone was changed from a standing order to as needed, but the blister pack with Oxycodone and counting sheet could not be located. The Director of Nursing stated they checked the narcotics destruction log in the nursing office and Oxycodone 10 milligrams were not on the list for destruction. They stated the incoming nurse should have counted all controlled medications with outgoing nurses and ensure all controlled medications are accounted for. The Director of Nursing stated they completed the investigation and concluded that Resident #3's blister pack with Oxycodone and corresponding counting sheet could not be located. They stated they did not report the incident to the New York State Department of Health. They stated they notified the Administrator, Pharmacist and Medical Director on [DATE].During a follow up interview on [DATE] at 1:31 PM, the Director of Nursing stated the pharmacy consultants perform medication audits and conduct monthly medication regime reviews, but do not conduct narcotic reconciliation. The Director of Nursing stated Licensed Practical Nurse #1 was terminated (unsure of date). During an interview on [DATE] at 4:10 PM, the Administrator stated they were not notified of the missing Oxycodone on [DATE]. The Administrator stated they heard rumors from staff (unsure of date) regarding the missing Oxycodone, and they asked the Director of Nursing about the rumors, and they were told that former Assistant Director of Nursing was investigating the missing Oxycodone. The Administrator stated the Director of Nursing should have informed them withing 24 hours. The Administrator stated the former Assistant Director of Nursing was responsible for investigating and reporting the findings to the Director of Nursing. The Administrator stated that no-one followed up with the investigation to ensure timely completion and the appropriate agencies notified. The Administrator stated that the former Assistant Director of Nursing submitted an incomplete incident report to the consultant on [DATE] (who handed it over to the Director of Nursing). 10 New York Codes, Rules, and Regulations 415.18(a)