

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East Bay Drive Long Beach, NY 11561	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record review, the facility failed to ensure that each resident received adequate supervision and assistance devices to prevent accidents. This was identified for one (Resident #10) of three residents reviewed for Accident. Specifically, Resident #10 required a Hoyer (mechanical) lift and two persons assistance for chair/bed-to-chair transfer and a toilet transfer was not attempted due to medical condition or safety concerns as per the resident's plan of care. On 05/15/2026 Registered Nurse #9 placed Resident #10 on the toilet and then instructed Certified Nursing Assistant #9 to transfer Resident #10 back to their wheelchair. Certified Nursing Assistant #9 and Certified Nursing Assistant #6 manually transferred Resident #10 back to the wheelchair resulting in skin tears on the resident's left arm and left leg. Complaint # 2806371 The findings include: The facility's policy titled, Activities of Daily Living dated 11/2018 documented the facility will provide the necessary care and services based on the comprehensive assessment of a resident and consistent with the resident's needs. Individualized care plans are based on accurate assessment of the resident's self-performance and the amount and type of support being provided to the resident. Resident #10 had diagnoses that included dementia (a condition that affects memory, thinking and the ability to perform daily activities), difficulty in walking, and muscle weakness. A Quarterly Minimum Data Set (an assessment tool) dated 3/6/2026 documented a Brief Interview of Mental Score of 12, indicating the resident had intact cognition. Resident #10 was dependent on staff for toileting hygiene and toileting transfer care. Resident #10 was frequently incontinent of bowel and bladder and was not on a toileting program. A Comprehensive Care Plan for Bowel Incontinence dated 11/20/2025 documented to provide bedpan/bedside commode [to the resident]. A Comprehensive Care Plan for Activities of Daily Living dated initiated on 11/20/2025, documented Resident #10 had activities of daily living self-care performance deficit. Intervention was updated on 05/25/2026 to indicate resident required two-person assistance for toileting transfer. Resident #10's Kardex (a nursing instruction tool) dated 05/15/2026 documented Resident required a Hoyer (mechanical left) and two-person assistance for chair/bed-to-chair transfer. The toilet transfer was not attempted due to medical condition or safety concerns. Bedpan/bedside commode was provided for toileting needs. The Certified Nursing Assistant Accountability record for May 2026 documented the resident required mechanical lift with two-person assistance for chair/bed-to-chair transfer. The Certified Nursing Assistant Accountability Record from 05/01/2026 through 05/25/2026 documented Resident #10's toilet transfer was not attempted due to medical condition or safety concerns. An Accident and Incident Report dated 05/15/2026 documented that at approximately 7:25 PM the resident was transferred from the toilet to the wheelchair by two staff members. During the transfer, the resident sustained skin tears to the left arm and left leg. A written statement by Certified Nursing Assistant #9 documented that Registered Nurse # 9 told Certified Nursing Assistant #9 to transfer Resident #10 (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 335432
		If continuation sheet Page 1 of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East Bay Drive Long Beach, NY 11561	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the toilet to the wheelchair. Certified Nursing Assistant #9 requested Certified Nursing Assistant #6 for assistance with the transfer. A statement by Certified Nursing Assistant #6 documented they assisted Certified Nursing Assistant #9 in transferring [Resident #10] from the toilet to the wheelchair. During an interview on 07/07/2026 at 3:20 PM, Certified Nursing Assistant #6 stated they manually assisted Certified Nursing Assistant #9 to transfer Resident #10 from the toilet to the wheelchair on 05/15/2026. Certified Nursing Assistant #6 stated Resident #10 was sitting on the toilet when they entered the room. During the transfer they had to support the resident's weight while balancing and lowering the resident to the wheelchair. Certified Nursing Assistant #6 stated Resident #10 sustained left arm and left leg skin tears. During an interview on 07/08/2026 at 10:10 AM, Certified Nursing Assistant #9 stated Resident #10 did not use the toilet and the toileting needs including brief changes were completed while the resident was in bed. Certified Nursing Assistant #9 stated that on 05/15/2026 Registered Nurse # 9 transferred the resident to the bathroom alone and informed them to transfer the resident back to the wheelchair after the resident finished toileting. Certified Nursing Assistant #9 stated Resident #10 should not have been placed on the toilet. During an interview on 07/09/2026 at 5:44 PM, Registered Nurse # 8, who was the 7:00 PM to 7:00 AM shift unit nurse on 05/15/2026, stated Resident #10 should have been provided a bedpan for toileting needs and was not supposed to be placed on the toilet, for safety reasons. Registered Nurse # 8 stated that Registered Nurse #9, who was the 7:00 AM to 7:00 PM nurse, transferred Resident #10 to the toilet; however, they (Registered #9) were no longer on the unit when the accident took place. Registered Nurse # 8 stated they had to initiate an accident report after the incident occurred. During a telephone interview on 07/13/2026 at 11:47AM, Registered Nurse #9 stated Resident #10's brief was usually changed while the resident was in bed. Registered Nurse #9 stated they was unsure if the resident required two people or a mechanical lift for transfers. Registered Nurse # 9 did not recall transferring the resident to the toilet on 05/15/2026. During an interview on 7/16/2026 at 10:18AM, the Director of Nursing Services stated that staff must check the residents' Kardex and care plans for the level of assistance and devices needed to provide care activities including toileting care. The Director of Nursing Services stated Resident #10 should not have been transferred to the toilet for safety reasons. The Director of Nursing Services stated the incident related to Resident #10 on 05/15/2026 was avoidable. During an interview on 7/29/2026 at 10:44 AM, Physical Therapist #1 stated that Resident #10 required a mechanical (Hoyer) lift and was dependent on two staff members for transfers. Physical Therapist #1 stated Resident #10 did not have the ability to hold themselves on their own while sitting in a toilet due to poor trunk control and required staff assistance. Physical Therapist #1 stated Resident #10 should not be toileted in the bathroom because it is difficult to transfer the resident on to the toilet with a mechanical lift. Physical Therapist #1 stated that resident's toileting care should be provided while the resident is in bed. 10 New York Code Rules and Regulations 415.12(h)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East Bay Drive Long Beach, NY 11561	
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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the medical care of each resident was supervised by a physician and that orders for each resident's immediate care and needs were provided throughout the resident's stay. This was identified for one (Resident #2) of two residents reviewed for Quality of Care/Treatment-Drugs and Medication. Specifically, Resident #2 had ongoing physician orders for Morphine Sulfate Oral Solution (a narcotic drug used for pain control), ordered for a 30-day interval each time. A 30-day order that ended [DATE] was re-ordered on [DATE] for another 30 days, but the prescription was not signed by the physician and therefore, the medication could not be delivered by the pharmacy and the resident did not receive the morphine for four days ([DATE]-[DATE] (four doses were missed); the morphine was re-ordered on [DATE] after the resident's family complaints of the missed morphine doses. Complaint 2591591The findings include:The facility policy titled Medical Services, dated 11/2017, documented that each resident shall receive the best quality medical care to ensure maximal functional ability, physical and mental well-being. The Medical Director shall be responsible for: implementation of resident medical care policies; coordination of physician services and medical care in the facility; assure that each resident's responsible physician attends to the resident's medical care. Each resident shall have an attending physician who is a member of the interdisciplinary care team.Resident #2 was admitted with diagnoses including Alzheimer's disease, Stage 4 pressure ulcer (full-thickness skin and tissue loss exposing muscle, tendon, or bone) to sacrum (triangular bone at lower back), and closed fracture of the left femur (large bone in thigh). The [DATE] quarterly Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident was rarely understood and had memory problems. The Minimum Data Set assessment documented that the resident had received scheduled opioid medications in the last five days. The staff assessment of resident pain indicated the resident did not have pain during the lookback period.A physician's order dated [DATE] documented palliative care (specialized medical care focused on providing relief from the symptoms of an illness and to improve quality of life).A physician's order dated [DATE] documented morphine sulfate (concentrate) oral solution 100 milligrams per five milliliters, give 0.125 milliliters by mouth at bedtime for pain for 30 days, with an end date of [DATE].A physician monthly note dated [DATE] written by Nurse Practitioner #1 documented the resident was on palliative care for pain management and the treatment plan was to continue with Tylenol, lidocaine patch, and morphine. The case was reviewed with Physician #1.A physician progress note dated [DATE] written by Physician #3 documented medications were reviewed and no side effects were noted. The resident was stable and they will continue all medications as prescribed and monitor the resident closely.A physician progress note dated [DATE] written by Nurse Practitioner #1 documented pain management: continue with Tylenol, lidocaine patch, and morphine; continue with current medications and treatment as ordered. Monitor resident closely. Case was reviewed with physician (#1).Review of the April and [DATE] medication administration records revealed that the morphine doses from the [DATE] standing order were administered every night at 9:00 PM from [DATE] until [DATE].A physician's order dated [DATE] documented morphine sulfate (concentrate) oral solution 100 milligrams per five milliliters, give 0.125 milliliters by mouth at bedtime for pain for 30 days, to start [DATE] with and end date of [DATE].The morphine was not administered from [DATE] to [DATE] (four days). There were no refusals documented in the medical record and the morphine is omitted from the record for those four days.A physician's order dated [DATE] documented morphine sulfate (concentrate) oral solution 100 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East Bay Drive Long Beach, NY 11561	
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 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	milligram per five milliliters, give 0.125 milliliter by mouth at bedtime for pain for 30 days. During an interview on [DATE] at 11:42 AM, Nurse Practitioner #1 stated they are not associated with facility anymore and did not recall the resident. During an interview on [DATE] at 2:10 PM, Physician #1 stated when the [DATE] morphine order expired on [DATE], the nurses should have let the physician know so that the medication could be re-ordered. Physician #1 stated the physicians do not remember to re-order the medication. The medication was not re-ordered until [DATE] because nursing did not let the physicians know in time. The physicians do not receive notification when the medication prescription expires, and they are dependent on nurses to be notified. During an interview on [DATE] at 8:54 AM, the Medical Director stated the electronic medical record highlights the orders that have to be reviewed or renewed in red. The physicians write monthly notes as they review orders and should make sure all orders are renewed. The lapses in morphine orders from [DATE] to [DATE] should not have happened. The Medical Director stated the nurses need to call the physician to get the medication re-ordered if a medication is running out. During an interview on [DATE] at 9:15 AM, Registered Nurse #3 stated they had administered the last morphine dose of morphine from the [DATE] standing order on [DATE]. Registered Nurse #3 stated that morphine is a narcotic medication, so the physician must provide a signature in the electronic medical record before the pharmacy could fulfill the order. Registered Nurse #3 stated the morphine was most likely re-ordered on [DATE] but the pharmacy was waiting for the physician's signature before the order could be fulfilled. During an interview on [DATE] at 10:05 AM, the Director of Nursing Services stated there is a narcotic sheet that the nurses document on and count out each day; this sheet would show the quantity of the medication is getting less and less; the nurses should ensure the re-ordering process is initiated early enough to make sure the medication is re-ordered several days before the last dose because there may be a delay in getting the physician signature. The physician should also ensure the medication is re-ordered with the monthly renewal/review of medications. During an interview on [DATE] at 9:05 AM, Pharmacist #1 stated they reviewed the morphine orders from [DATE] and had no explanation on the pharmacy side as to why the order for morphine was not re-ordered until [DATE], after the order expired on [DATE]. During an interview on [DATE] at 2:39 PM, Licensed Practical Nurse #4 stated on [DATE] Resident #2's family member approached them during the day shift and complained that the resident did not receive the evening dose of morphine for four days. Licensed Practical Nurse #4 stated they checked an internal communication system that the facility uses to communicate with physicians and identified that prior to [DATE], for multiple evenings, the night shift staff were reaching out to Physician #1 to sign the prescription for an order that was placed [DATE]. Licensed Practical Nurse #4 stated on [DATE] they reached out to Nurse Practitioner #1 and asked them to sign the morphine prescription. Nurse Practitioner #1 agreed. Licensed Practical Nurse #4 stated they had to delete the previous order that was originally placed on [DATE] and re-entered a new order dated [DATE]. The nurse practitioner signed the prescription for the [DATE] order. New York Code Rules and Regulations 415.15(b)(1)(i)(ii)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East Bay Drive Long Beach, NY 11561	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on record reviews, and interviews, the facility failed to ensure each resident received food prepared in a form designed to meet individual needs. This was identified for one (Resident #10) of three residents reviewed for Nutrition. Specifically, on 07/06/2026, Resident #10 was not served chopped textured consistency diet as ordered by the physician. Complaint # 2806371 The findings include The facility's Diet Manual dated March 2026 documented that the chopped diet is based on the regular diet, but all hard-to-chew foods are eliminated. All foods that require more than minimal chewing or are not soft are chopped into pieces. The diet is prescribed for residents with difficulty chewing due to weakness or poor dentition. Resident #10 was admitted with diagnoses including dementia (a condition that affects memory, thinking and the ability to perform daily activities), dysphagia (difficulty swallowing) and muscle weakness. A Quarterly Minimum Data Set (an assessment tool) dated 03/06/2026 documented a Brief Interview of Mental Score of 12, indicating Resident #10 had intact cognition. Resident #10 required supervision for eating, had swallowing problems related to holding food in mouth, coughing or choking during meals, complaints of difficulty or pain with swallowing, and required a mechanically altered diet. A Quarterly Minimum Data Set (an assessment tool) dated 06/03/2026 documented a Brief Interview for Mental Status Score of 8, indicating Resident #10 had moderately impaired cognition. Resident #10 required supervision for eating. Resident #10 presented with no swallowing problems and required a mechanically altered diet. A Comprehensive Care Plan for Choking Potential dated 11/20/2025 documented interventions including diet and food consistency as per physician's order and provide assistance and monitoring during meals. A Comprehensive Care Plan for Aspiration Risk dated 11/21/2025 documented interventions to ensure appropriate diet/liquid consistency. A Physician's Order dated 02/16/2026 documented diet order: no concentrated sweets, chopped texture, and thin liquid (regular) consistency. A speech language pathologist progress note dated 06/03/2026 documented Resident #10 continued to tolerate chopped diet with thin liquid consistency with no overt sign and symptoms of aspiration. A review of facility's resident menu documented the menu items for dinner on 07/06/2026 were as follows: -Fish nuggets or an alternate entree of broccoli cheddar quiche, the sides were mashed potatoes, broccoli Normandy, matzoh ball soup, ice cream, bread, whole milk and coffee. During an interview on 07/06/2026 at 12:45 PM, Resident #10 stated their appetite was all right and they can feed themselves using their left hand. During an interview on 07/08/2026 at 8:38 AM, Resident #10's family member stated Resident #10 often received food that was not chopped. Resident #10's family member stated they often had to chop the resident's food themselves. Resident #10's family member stated they were with Resident #10 during the dinner meal on 07/06/2026 when Resident #10 was served a whole piece of quiche and the matzoh ball soup. Both the quiche slice and the matzoh balls were not chopped. Resident #10's family member stated they showed the un chopped meal that was served to the resident to Licensed Practical Nurse #3. Resident #10's family member stated had they not been in the room with the resident, the resident would have consumed the wrong consistency food. During an interview on 07/08/2026 at 11:25 AM, the Director of Food Services stated quiche was served on 07/06/2026 as an alternate dinner meal. The Director of Food Service confirmed that Resident #10 was on a chopped texture diet and received a slice of quiche and the matzoh balls (in soup) that were not chopped. The Director of Food Services stated that to maintain the structure, integrity, and the presentation of the food items such as quiche, matzoh balls, lasagna, and chicken pot pie, the kitchen staff did not chop these food items prior to delivery to the (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335432	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 375 East Bay Drive Long Beach, NY 11561	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	units. These food items should be chopped by dietary staff or nursing staff on the unit prior to serving the residents. During an interview on 07/08/2026 at 11:50 AM, Speech Language Pathologist #1 stated they assessed Resident #10 in June 2026 and determined Resident #10 continued to require a chopped texture consistency diet due to partial dentition. During an interview on 07/08/2026 at 2:26PM, the Director of Nursing Services stated that nursing staff must ensure residents on mechanically altered diet received the appropriate textured food. During an interview on 07/09/2026 at 2:51PM, Licensed Practical Nurse # 3 stated Resident #10 usually enjoyed their meal in their room with their family members. Resident #10 was able to feed themselves but was unable to cut their food due to impaired cognition. Licensed Practical Nurse # 3 stated they provided setup assistance and would chop the resident's food upon request. Licensed Practical Nurse # 3 stated a slice of quiche was served on 07/06/2026 night, however they could not recall if they assisted in chopping the resident's meal. 10 New York Code Rules and Regulations 415.14(d)(3)		