STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335666	A. Building B. Wing	03/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bezalel Rehabilitation and Nursing Center	29 38 Far Rockaway Blvd Far Rockaway, NY 11691

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review and interviews the facility failed to ensure that they employed a qualified staff member to serve as the Director of Food and Nutrition. This was identified during the kitchen task. Specifically, the current Director of Food Service did not meet the minimum qualifications of being a certified dietary manager or similar national certification for food service management and safety.The finding is: A review of the Facility Assessment documented the services of a Registered Dietitian as part-time, three days per week. The facility appointed Employee #11 as the Food Service Director. During the initial tour of the kitchen on 03/18/2026 at 09:45 AM, Employee #11 stated that they were the Acting Food Service Director as the previous Food Service Director had resigned a few months earlier and they were just temporarily supervising the kitchen. The Acting Food Service Director provided a Dietary Managers Program Certificate dated 12/21/1999. Certified Dietary Manager (CDM), one must meet specific educational and experience requirements, including a minimum of one course in nutrition and two courses in foodservice management from an accredited post-secondary education institution; a comprehensive, minimum 90-hour foodservice course curriculum or by completing the classroom portion of an approved foodservice manager training program, and pass a certification exam which measures their knowledge and abilities in managing and directing foodservice operations. To maintain the Certified Dietary Manager credential, continuing education is required. There was no documented evidence the Acting Food Service Director met these requirements. During an interview on 03/23/2026 at 10:50 AM, the Administrator stated that the previous Food Service Director left approximately two months ago and did not anticipate being without a new director for this long. The Administrator was not able to provide any current certifications or registrations for the Acting Food Service Director. 415.14(a)(1)(2)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that each resident with pressure ulcers received care, consistent with professional standards of practice, promote healing, prevent infection, and prevent new ulcers from developing for three (Resident #34, #1, and #79) of three (3) residents reviewed for Pressure Ulcers. Specifically, 1) Resident #34 had an air mattress to help heal pressure ulcers. The resident weighed 201 pounds; however, the air mattress weight setting was set at 450 pounds; 2) Resident #1 utilized an air mattress due to pressure ulcer to the sacrum. The air mattress weight setting for Resident #1was not set consistent with the resident's actual weight. The resident weighed 146.8 pounds, and the air mattress weight setting was set at 400 pounds 3) Resident #79 was at risk for pressure ulcer development and had a physician's order for a low air loss mattress (air mattress). The air mattress weight setting for Resident #79 was not set consistent with the resident's actual weight. Resident #79 weighed 129.2 pounds, and the air mattress weight setting was set at 340 pounds. The findings are: The facility policy titled Air Mattress, reviewed 03/2026, documented air mattresses must be set, adjusted, and monitored according to the resident current weight, body type, and clinical needs in accordance with the manufacture guidelines and the facility protocol. The air mattress is intended to reduce incidence of pressure ulcers and promote healing. For the Initial set up: obtain accurate resident weights, set mattress according to resident weight and manufacture guideline. For weight-based adjustment: input and adjust weight setting based on most recent documented weight. For weekly/change in condition review: re-assess mattress settings after significant weight change. The policy documented that the nursing staff was responsible to set and adjust mattress and check setting and function every shift; perform and document the assessments. 1). Resident #34 was admitted with diagnoses including fractures of left tibia (bone in calf) and left femur (bone in thigh), morbid obesity, and Stage 4 pressure ulcers (full-thickness wound extending to exposed muscle, tendon, or bone). The 03/02/2026 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact, and that the resident was admitted with four (4) Stage 4 pressure ulcers. A Comprehensive Care Plan for one of the stage 4 pressure ulcers, titled coccyx (a small, triangular bone at the base of the spine), actual pressure ulcer, stage 4, effective 02/26/2026, had an intervention to provide pressure reducing low air loss mattress. The most recent update dated 03/12/2026 documented, coccyx stage 4, the site was evaluated during weekly wound rounds with the wound Physician—size 2.5 centimeters in length, 0.9 centimeters in width, and 1.6 centimeters in depth. Recommendations were to continue to offload the site. A physician's order dated 03/12/2026 documented silver alginate (highly absorbent, sterile, antimicrobial wound dressings derived from seaweed) 4-inch by 4-inch bandage to the coccyx; cleanse with Dakin's (antiseptic) solution, pat dry and cover with calcium alginate gauze daily and when needed. Resident #34's weight documented in the medical record dated 03/10/2026 was 201.8 pounds. During an observation on 03/18/2026 at 11:00 AM, Resident #34 was in bed. The air mattress weigh wetting was set at 450 pounds. The resident stated they had a wound on the tail bone and left leg that they acquired at home after a leg fracture from a fall. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed no documentation that the air mattress weight setting was being monitored. During an interview on 03/20/2026 at 8:15 AM, Licensed Practical Nurse #1 (4th floor charge nurse/medication nurse) stated, they are not responsible for checking the weight setting or documenting about the mattress. Normally the Assistant Director of Nursing Services or the Maintenance Director checked the air mattress weight settings. Licensed Practical Nurse #1 stated if a resident complains about the mattress or if the mattress is deflated, they would let the maintenance department know. During an interview on 03/20/2026 at 10:00 AM, Licensed Practical Nurse #2 (treatment nurse) stated they would call the Assistant Director of Nursing Services or the Maintenance Director for any issues related to the air mattress. The floor nurses are supposed to check the air mattress weight setting during rounds on each shift. Any nurse can change the weight setting. The monitoring of the weight setting is not documented. Licensed Practical Nurse #2 stated there should be an order for the air mattress, but after searching Resident #34's electronic medical record orders, they could not find the order. A physician's order dated 03/20/2026 at 10:43 AM documented low air loss mattress, check function and setting daily. During an interview on 03/23/2026 at 12:45 PM, Registered Nurse #1 (4th floor supervisor) stated they were not sure who was responsible to monitor the air mattress weight settings on a daily basis. During an interview on 03/23/2026 at 1:20 PM, the Maintenance Director stated the maintenance department is responsible for setting up the air mattress. The maintenance staff enters the initial weight on the air mattress weight setting after conferring with nursing staff. On a daily basis, the nurses and the certified nursing assistants are responsible for monitoring the air mattress weight setting. The nursing staff knows how to adjust the weight setting on the air mattress. During an interview on 03/23/2026 at 2:20 PM, the Assistant Director of Nursing Services #1 stated the maintenance department is responsible for installing the air mattress and do the initial set-up. On a daily basis, the unit charge nurse and/or the unit nurse manager should be looking at the mattress setting including the weight setting, every shift. Assistant Director of Nursing Services #1 stated that if the mattress weight setting is set too high, this may cause the mattress to be too firm and increase the risk for wound development or deterioration of the existing wounds. During an interview on 03/24/2026 at 10:42 AM, Wound Care Physician #1 stated the weight setting on the air mattress should be consistent with the resident's weight. If the mattress is overinflated, this is a concern 2) The operation manual for the low-air-loss alternating-pressure air mattress used by Resident #1 documented instructions, including pressing the up/down buttons on the panel to adjust the weight/ pressure level to the patient's specific requirements. Users can adjust air mattress to a desired firmness according to patient's weight or the suggestion from a health care professional Resident #1 was readmitted with a diagnosis of a stage 2 pressure ulcer to the sacrum. An admission Minimum Data Set Assessment with an assessment reference date of 02/17/2026, documented a Brief Interview for Mental Status of nine (9), indicating moderately impaired cognition. Resident #1 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	required set-up assistance for eating, substantial/maximal assistance for bed mobility and toilet hygiene and was dependent on staff for transfer. The resident was at risk of developing a pressure ulcer and was admitted with a Stage II pressure ulcer to their sacrum. A comprehensive care plan dated 02/12/2026 documented Resident #1 had an actual pressure ulcer, stage 2, to the sacrum. Interventions included provide treatment as ordered and provide pressure reducing low air loss mattress. A Physician order dated 03/05/2026 documented a low air loss mattress. A review of Resident #1's weight record documented a weight of 146.8 pounds on 03/05/2026. During an observation on 03/18/2026 at 10:50 AM, the weight setting for the air mattress was set at 400 pounds. During an observation on 03/19/2026 at 9:48 AM and 03/23/2026 at 9:27 pounds, the air mattress weight setting was set at 180 pounds. During an interview on 03/23/2026 at 9:57 AM, Licensed Practical Nurse #3 stated that Resident #1 has an air mattress because of the pressure ulcer to their sacrum. Licensed Practical Nurse #3 stated that when they go into the room to administer medications, they check the mattress to ensure it is sufficiently inflated. If they find a concern with the mattress, they will notify the Nursing Supervisor. Licensed Practical Nurse #3 stated that they did not notice the mattress weight setting was set at the 400-pound. During an interview on 03/23/2026 at 10:15 AM, Registered Nurse Supervisor #2 stated that maintenance department is responsible to install the air mattress as well as set the initial weight setting based on information (the resident's weight) provided to them by the nursing staff. Registered Nurse Supervisor #2 stated that if there is an issue with the air mattress, they call the Director of Maintenance or the Assistant Director of Nursing to make any adjustments. Registered Nurse Supervisor #2 stated they and the other nurses on the unit are supposed to check the mattress weight settings for accuracy; however, they had not been checking the weight setting in the prior week and were not aware Resident #1's air mattress weight setting was set at 400-pound setting. During an interview on 03/23/2026 at 2:20 PM, the Assistant Director of Nursing stated that once an order for a low air loss mattress is placed, the maintenance department is responsible for installing the air mattress and completing the initial set-up including inputting the weight setting. After the air mattress is installed, the nursing staff is responsible for monitoring the weight settings on a daily basis. If there are any issues with the mattress, such as it is alarming, is deflated, has become unplugged, maintenance department should be notified. The Assistant Director of Nursing stated that if the weight setting on the mattress is set too high, it may be too hard and might increase the risk for wound development or deterioration. 3) Resident # 79 was admitted with diagnoses, including, pressure ulcer of right hip, stage 4, chronic multifocal osteomyelitis (bone infection), and adult failure to thrive. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a brief interview for mental status score of 13, which indicated the resident was cognitively intact. The resident had upper and lower extremity impairments to both sides and required total staff assistance. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations on 03/18/2026, at 11:09 AM, the resident was observed in bed, atop a low air loss mattress. The weight setting on the mattress was set to 340 pounds. The physician's order dated 02/19/2026 documented, Low Air Mattress, The medical record documented Resident #79 weighed 129.2 pounds on 03/16/2026. The Comprehensive Care Plan dated 02/24/26, under Pressure Ulcer/Injury, documented, at risk for break in the skin, with interventions that included, pressure relieving air mattress. During an interview on 03/24/2026 at 10:53 AM, the Director of Nursing Services stated when a resident requires an air mattress, the maintenance department and the Assistant Director of Nursing Services set up the air mattress, based upon the resident weight. On a daily basis, the charge nurse should monitor the weight setting of the mattress. On 03/24/2026 at 11:51 AM Registered Nurse #3 was interviewed and stated that they worked the 7:00 AM-3:00 PM shift on 03/18/2026 and were responsible for checking the low air loss mattress setting. They could not recall if it was checked on that day but stated that the mattress should have been set to the setting closest to the resident's weight of 129 pounds which was the 160-pound setting.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure each resident received preadmission screening for individuals with a mental disorder and individuals with intellectual disability. This was identified for one (1) (Resident #21) of 23 residents reviewed for Preadmission Screening and Resident Review. Specifically, Resident #21 was admitted to the facility on [DATE] with an incomplete Preadmission Screening and Resident Review form. Items 22 through 26 of the Preadmission Screening and Resident Review form dated were not completed prior to admission. Response to Items 22 through 26 would determine if a Level II evaluation was required.The finding is:A facility policy titled Pre-admission Screening (PASRR) Requirements dated 07/30/2025 documented all individuals applying for new admission to the facility must be screened to identify serious mental illness or mental retardation/developmental disability. Prior to admitting an applicant to the facility, the admissions department will review the screen form completed by the referring entity to determine if the Level I review reflects a need for a Level II referral. The Social Worker will receive the admission documents for all new admissions and will review them to determine if a Level II assessment is required and if so ensure that it was obtained by the admission Department.Resident #21 was admitted with diagnoses including anxiety disorder, sequelae of cerebral infarction (long-term effects caused by a stroke), and ulcerative colitis (a chronic inflammatory bowel disease). The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of seven (7), indicating the resident had severe cognitive impairment. A review of Resident #21's electronic medical record indicated the resident was initially admitted to the facility on [DATE].A Preadmission Screening and Resident Review form dated 03/07/2025 for Resident #21 documented items 22 through 26 were not answered. Items 22 through 26 of the Preadmission Screening and Resident Review form include the following: dementia diagnosis, Level I Review for Possible Mental Illness, and Level I Review for Possible Mental Retardation/Developmental Disability. Guideline on the form indicated If item 23 or any of items 24-26 are marked YES, proceed to Categorical Determinations (items 27-30). If item 23 and all of items 24-26 are marked NO, proceed to Patient/Resident/Person Disposition (item 36).A Comprehensive Care Plan titled Mood State/Depression initiated 03/10/2025 and last reviewed on 03/22/2026 documented interventions including evaluation by a psychiatric consult as needed, monitor for changes in behavior and mood, and monitor for changes in mental and cognitive status.A Physician's order dated 9/26/2025 and renewed on 03/01/2026 documented to administer Clonazepam (an antianxiety medication) 0.25 milligrams disintegrating tablet, one (1) tablet by oral route two (2) times per day for anxiety disorder.During an interview on 03/24/2026 at 11:40 AM the Director of Admissions stated part of their responsibilities include ensuring a completed and signed Preadmission Screening and Resident Review is obtained prior to the resident's admission to the facility. The Director of Admissions stated Resident #21's Preadmission Screening and Resident Review was not completed as items 22 through 26 on the screen were not answered and they (the Director of Admissions) could not recall why the resident was admitted with an incomplete screen. The Director of Admissions stated the Preadmission Screening and Resident Review for Resident #21 should have been completed prior to the resident's admission to the facility.During an interview on 03/24/2026 at 12:08 PM, the Director of Social Services stated the Director of Admissions was responsible for ensuring residents are admitted with a completed Preadmission Screening and Resident Review. They stated they review Preadmission Screening and Resident Review for new admissions The Director of Social Services stated they review Preadmission Screening and Resident Review for new admissions and stated if a resident was somehow admitted with an incomplete or inaccurate Preadmission Screening and Resident Review, then they would refer to a qualified consultant to initiate and complete a new Preadmission Screening and Resident Review. The Director of Social Services stated Resident #21's (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preadmission Screening and Resident Review was not complete as items 22 through 26 were not answered. The Director of Social Services did not know why they were admitted with an incomplete screen.During an interview on 03/24/2026 at 12:39 PM, the Administrator stated Resident #21's Preadmission Screening and Resident Review were not completed prior to admission because items 22 through 26 were not answered. The Preadmission Screening and Resident Review should have been completed prior to admission to ensure if a resident is appropriately placed and if a Level II screen is warranted.10 NYCRR 415.11(e)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interviews the facility failed to ensure that for each pharmacist medication regimen review, the Physician documented in the medical record that the identified irregularity has been reviewed, and what, if any, action has been taken to address it; and if there is to be no change in medication, the Physician documented regarding the rationale for not changing the medication. This was identified for one (1) (Resident #10) of five (5) residents reviewed for unnecessary medications. Specifically, a pharmacy medication regimen review for Resident #10 dated 01/29/2026 recommended changing the medication oxybutynin (treats overactive bladder) to a different medication that causes less side effects. The disagree box was checked on the medication regimen review form; however, there was no documentation in the medical record from the Physician documenting the rationale for the disagreement.The finding is:The facility policy titled Medication Regimen Reviews, dated 08/2023, documented once a month the consultant pharmacist will review the medication profile and other clinical parameters for all residents. The pharmacist will either select the recommendation or no recommendation in the progress note section of the electronic medical record. All recommendations will be sent to the Director of Nursing Services or designee for review and response in the form of a separate electronic report. The Director of Nursing Services will review the recommendations and discuss them with the primary care physician/nurse practitioner. The primary care physician/nurse practitioner can either agree or disagree with the recommendations; the responses will be noted in the response section of the separate electronic report; the responses may be obtained from the physician/nurse practitioner, the Director of Nursing Services or their designee. The policy did not document the Physician's responsibility to document in the medical record the rationale for disagreeing with the recommendation provided on the pharmacy medication regimen review and/or actions taken to address those irregularities.Resident #10 was admitted with diagnoses including diabetes mellitus, non-Alzheimer's dementia, and depression. The 03/02/2026 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 9, indicating the resident had moderate cognitive impairment. The resident was frequently incontinent of urine. The resident also had a diagnosis of repeated falls.A physician's order dated 11/28/2025 and renewed on 03/19/2026 documented oxybutynin chloride 5 milligram tablet, give one tablet by oral route every 12 hours at 9:00 AM and 9:00 PM for overactive bladder.A pharmacy medication regimen review dated 01/29/2026 for Resident #10 documented in the Recommendation column: the resident is receiving oxybutynin 5 milligram every 12 hours for overactive bladder control. This is a highly anticholinergic medication (medications that reduce muscle contractions and muscle spasms, but can cause side effects such as dry mouth, constipation, urinary retention, blurred vision, and confusion), should be avoided in the elderly, and can lead to falls. The Pharmacist suggested to re-evaluate the use of oxybutynin and to consider alternative instead, such as myrbetriq (25 milligram/50 milligram) daily. The disagree box was checked in the Prescriber Response column with a comment: MD disagree, continue same. The response was undated with no indication as to who documented the comment. The Medical Director and Director of Nursing Services signature boxes were not signed or dated.A progress note, in the electronic medical record dated 01/29/2026, written by the consultant Pharmacist documented medication regimen review, recommendations noted - prescriber notified.Review of the medical record revealed no documentation from the Physician or other medical provider regarding the 01/29/2026 medication regimen review.During an interview on 03/20/2026 at 1:20 PM, the Director of Nursing Services stated they wrote the comment on the medication regimen review regarding the Physician's disagreement and for continuing the oxybutynin medication for Resident #10 after they spoke to Physician #1.During an interview on 03/23/2026 at 8:40 AM, Physician #1 (who is also the Medical Director) stated the Director of Nursing Services did call them regarding the 01/29/2026 medication regimen review and their decision was to maintain the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication as is. The Medical Director stated that oxybutynin medication is the standard of care, and the resident was doing well on this medication. That is what they would have documented on the medication regimen review recommendation, but this one fell through the cracks.10 NYCRR 415.18(c)(2)