STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335676	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Manor Health Care Center, L L C	1441 Gateway Boulevard Far Rockaway, NY 11691

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interviews conducted during the abbreviated survey (#2650673), the facility did not ensure each resident's right to privacy and confidentiality. This was evident for one (1) of three (3) residents (Resident #1) sampled. Specifically, photographs of Resident #1's body and private space were taken without the resident's or designated representative's written consent. The findings include:The facility policy and procedure titled 'Photographs, video surveillance and audio recordings' dated 01/2022 documented the facility is committed to ensuring that the rights of the residents to safe and secure environment, privacy, confidentiality and dignity are maintained. The policy also stated to support accurate assessment and timely clinical decisions-making, authorized healthcare providers may take photographs or video during emergency situations when necessary to document the condition of a resident. Resident #1 was admitted with diagnosis including Non-Alzheimer's Dementia and Acute kidney failure.The Minimum Data Set (a resident assessment tool) dated 09/17/2025 documented Resident #1 had severely impaired cognition, and they required partial/moderate assistance of staff for most activities of daily living.There was no documentation of resident's photo taken without consent in the medical record. in the resident's chart.On 10/27/2025, at 10:30 AM and at 2:15 PM, attempts to speak with the complainant during the onsite investigation were unsuccessful. On 10/27/2025 at 01:00 PM, the Director of Nursing was interviewed and stated staff are aware that they are not allowed to take any resident's photograph without consent. The Director of Nursing also stated they were notified that Resident #1's photograph was taken by the Medical Doctor #1 during Resident #1 assessment and when having telephone conversation with the family to get their permission to start intravenous fluid for Resident #1 prior to hospital transfer. The Director of Nursing further stated the family was verbally informed by Medical Doctor #1 during the telephone conversation before the photograph was taken and Resident #1's photograph taken was not shared with anyone other than the family just to get their consent for Resident #1's plan of care.On 10/27/2025 at 02:00 PM, Medical Doctor #1 was interviewed and stated when Resident #1 was noted with a large volume of blood-tinged vomit in August 2025, Resident #1 was immediately assessed and evaluated, and they wanted to start Resident #1 on intravenous fluid prior hospital transfer. Resident #1's family was called and notified of the plan of action, but they declined intravenous fluid and hospital transfer. Medical Doctor #1also stated a photo was taken of Resident #1's vomit and was sent to the family to convince them of the urgent need for the treatment intervention in order to get them to agree that Resident #1 be given intravenous fluid immediately and be transferred to the hospital.On 11/25/2025 at 11:50 AM, during a follow-up interview, Medical Doctor #1 stated the picture taken of Resident #1 and shown to the family was to enable them to get consent for emergency care needed by Resident #1. Medical Doctor #1 also stated they did not compromise Resident #1's protective health information, and the photograph was only shared with the resident's health care proxy to enable them to see Resident #1's condition when they were initially refusing urgent interventions needed to be given to Resident #1 to prevent their condition worsening. Medical Doctor #1 further stated the photo of Resident #1's emesis was taken during their conversation, and the family was notified when the photo was being taken, they requested to see the picture before they gave permission for the treatment, and the photograph was never sent to any social media. Medical Doctor #1 further stated they believed they have not violated any regulation by taking and sharing Resident #1's photograph with the person responsible for making decision during an emergency situation for Resident #1, and any further delay in Resident #1's treatment could have been a disaster.On 11/25/2025 at 01:20 PM, during an interview the Medical Director stated the facility is fully aware of resident's protected health information record and their staff have not been violating residents' rights for privacy. The Medical Director stated residents' care is always collaborated with the attending medical doctor every day. Medical Director also stated that the attending doctor was on the phone with Resident #1's family prior taking the photo and the doctor explained to the family on phone that resident's photograph would be taken to show the amount of emesis from Resident #1 before permission was given to provide intravenous fluid and transfer resident out for further urgent care needed. On 11/25/2025 at 02:00 PM, the Administrator was interviewed and stated the facility policy on resident's right for privacy is followed by their physicians. The Administrator also stated if the resident's situation requires emergency attention, the physician would ensure prompt action is taken. The Administrator further stated they have always included Resident #1's representative in the resident's plan of care, and if there is any issue or concern, the staff are readily available to listen to their concern. The Administrator stated they do not