STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335682	A. Building B. Wing	08/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beach Gardens Rehab and Nursing Center	17 11 Brookhaven Avenue 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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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(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 - Few	Based on observation, interviews, and record review conducted during an Abbreviated Survey (NY00374237), the facility failed to ensure that all alleged violations are thoroughly investigated in response to allegations of abuse, neglect, exploitation, or mistreatment, and that the results of all investigations are reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency. This was evident for one out of six residents (Resident #1) reviewed for abuse. Specifically, during an interview on 07/30/2025 at 11:30 AM, Licensed Practical Nurse #1 stated that on 03/01/2025 or 03/02/2025, Resident #1's family complained to them that Certified Nursing Assistant #1 was verbally rough with Resident #1. Licensed Practical Nurse #1 stated that they called and notified Registered Nurse Supervisor #2. Registered Nurse Supervisor #2 did not initiate an investigation, did not remove Certified Nursing Assistant #1 from the schedule pending investigation, and did not inform the Director of Nursing or the Administrator.The findings are: The facility's Policy and Procedure entitled Abuse Prevention with last review date of 12/29/2023 documented it is the policy of this facility that if any staff is made aware of any alleged violation of abuse, neglect or mistreatment the facility will thoroughly investigate the alleged violation, attempt to prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress, and take appropriate corrective action as a result of investigation findings. The facility's Policy and Procedure entitled Accident and Incident Investigation and Reporting, last review date of 12/29/2023, documented that the Registered Nurse Supervisor is responsible for initiating the Accident and Incident form by ensuring that all required investigation statements are completed in a timely manner. Resident #1 was admitted to the facility with diagnoses including Hemiplegia, Hemiparesis, and Cerebral Infarction.The Minimum Data Set (a resident assessment tool), dated 03/05/2025, identified that Resident #1 had intact cognition. A Care Plan Behaviors: Risk for Abuse, effective date 02/26/2025, documented interventions include assisting the resident with concerns as they arise. A review of the Accident/Incident Log dated from 03/01/2025 to 03/31/2025 revealed that no incident for Resident #1 was registered in the log A review of the Grievance Log dated from 03/01/2025 to 03/31/2025, no grievance was documented regarding Resident #1's family complaint.A review of the Nursing Notes dated 03/01/2025-03/05/2025 revealed no documented evidence that Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 spoke with Resident #1's family. During an interview on 7/30/2025 at 11:06 AM, the assigned Certified Nursing Assistant #1, who worked on the 7-3 shift on 03/01/2025 and 03/02/2025, stated that they remember Resident #1. Certified Nursing Assistant #1 stated they don't remember the exact day they observed Resident #1 ambulate to the bathroom with no assistance. Certified Nursing Assistant #1 stated they got a wheelchair that was close and placed it behind the resident to prevent a fall. A day or two after, the family came, and they spoke with Licensed Practical Nurse #1. Certified Nursing Assistant #1 stated that after Licensed Practical Nurse #1 talked with the family, Licensed Practical Nurse #1 told them that they could not go to Resident #1's room, and no one explained why. Certified Nursing Assistant #1 stated they were not asked to write a statement. During an interview on 07/30/2025 at 11:30 AM, Licensed Practical Nurse #1 stated that they worked on 03/01/2025 and 03/02/2025, 7-3 shifts. Licensed Practical Nurse #1 stated on 03/01/2025 or 03/02/2025 that they went to the room and the family member was there, who said they don't want Certified Nursing Assistant #1 to provide care for Resident #1. Licensed Practical Nurse #1 stated that a family member told them that Certified Nursing Assistant #1 spoke in the manner that Resident #1 did not like, and that Certified Nursing Assistant #1 was not nice to Resident #1 and was rough verbally. Licensed Practical Nurse #1 stated that they asked Resident #1, but they did not say anything except that they don't want Certified Nursing Assistant #1 providing care. Licensed Practical Nurse #1 stated that it was a form of abuse to be verbally rough with Resident #1. Licensed Practical Nurse #1 stated that they removed Certified Nursing Assistant #1 from Resident #1's care assignment, but they continued with the rest of their resident care assignments. Licensed Practical Nurse #1 stated that they had notified the Registered Nurse Supervisor #1, who came and spoke with the family member. Licensed Practical Nurse #1 stated that they were not asked to write a statement. During an interview on 07/30/2025 at 12:46 PM, Registered Nurse Supervisor #1, who worked on 03/02/2025 7-3 shift, stated Licensed Practical Nurse #1 informed them that the family doesn't want Certified Nursing Assistant #1 to take care of Resident #1. Registered Nurse Supervisor #1 stated they spoke with a family member who said that Resident #1 doesn't like Certified Nursing Assistant #1 because the tone of their voice was not nice when Resident #1 was

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interviews, and record review conducted during an Abbreviated Survey (NY00374494), the facility failed to ensure a resident's medical record contained complete nursing notes in accordance with professional standards of practice. This was evident in one out of six residents (Resident #2) reviewed for Abuse. Specifically, on 03/08/2025, at 2:30 PM, Resident #2 complained to Registered Nurse Supervisor #2 that Certified Nursing Assistant #2 had hit them on the arm. Registered Nurse Supervisor #1 performed a body assessment but did not document it in Resident #2's Electronic Medical Records. There were also no nursing notes in Resident #2's Electronic Medical Record addressing Resident #2's behavior witnessed by Licensed Practical Nurse #2. The findings are: The facility Policy and Procedure entitled Accident and Incident Investigation and Reporting, last review date of 12/29/2023, documented that the Unit Nurse will be responsible for documenting his/her observations with regard to the Accident/Incident in the medical record. The documentation should include a detailed account of the occurrence, description of any injuries, first aid administered, the resident‘s condition, and the time when the Registered Nurse Supervisor was notified. The Registered Nurse Supervisor RNS is responsible for documenting in the medical record his/her assessment findings, the time the Medical Doctor was notified, the Medical Doctor's response/instructions, the resident's response to any treatment/interventions, and the time the family member was notified. Resident #1 was admitted to the facility with diagnoses including Hemiplegia, Hemiparesis, and Cerebral Infarction.The Minimum Data Set (a resident assessment tool), dated 03/05/2025, identified that Resident #1 had intact cognition. A review of the facility's investigation dated 03/08/2025 documented that Resident #2 called police and accused Certified Nursing Assistant #2 of hitting them on their arm at approximately 2:30 PM. Registered Nurse Supervisor completed body assessment with no visible injury noted. The facility concluded that the abuse accusation was not substantiated. Review of the nursing progress notes from 03/08/2025 to 03/10/2025 revealed no documented evidence that the resident was assessed by a Registered Nurse. There was also no documented evidence of Resident #2 exhibiting behavior on 03/08/2025 During an interview on 07/31/2025 at 10:35 AM, Licensed Practical Nurse #2 stated that they were the charge nurse on the 7-3 shift on 03/08/2025. Licensed Practical Nurse #2 stated that they were by the pantry, which is opposite from the Resident #2 room, and they heard Resident #2 was talking loudly. Licensed Practical Nurse #2 stated that they went to see what happened and observed Certified Nursing Assistant #2 serving coffee. Certified Nursing Assistant #2 was approximately four feet away and had an overbed table between them and Resident #2. Resident #2 was sitting on their bed and yelling. Licensed Practical Nurse #2 stated that they asked Certified Nursing Assistant #2 what was happening, and Certified Nursing Assistant #2 said they were picking up the cups from the overbed table, and Resident #2 became upset, started throwing stuff from their table to the floor, and yelling. Licensed Practical Nurse #2 stated that they told Certified Nursing Assistant #2 to leave the room and let the resident calm down. Licensed Practical Nurse #2 stated that they provided emotional support and called Registered Nurse Supervisor #2. Licensed Practical Nurse #2 stated that they don't recall why they did not document Resident #2's behavior in the resident's medical chart, and they should have documented. During an interview on 07/31/2025 at 11:07 AM, Registered Nurse Supervisor #2 who worked on 03/08/2025 7-3 shift, stated that on 03/08/2025 around 2:30 PM, Resident #2 came to the office and reported Certified Nursing Assistant #2 hit their shoulder, took their coffee, threw coffee on the bed, and all staff from the overbed table to the floor. Registered Nurse Supervisor #2 stated that they went immediately to the unit with Resident #2 and assessed their skin. Registered Nurse Supervisor #2 stated that no injury or redness was noted. Registered Nurse Supervisor #2 was not able to recall which arm Resident #2 was complaining about. Registered Nurse Supervisor #2 stated they don't remember why they did not document the body assessment in Resident #1's Electronical Medical Record. Registered Nurse Supervisor #2 stated that they are responsible and should have documented the body assessment, that they called the Medical Doctor and Psychiatry and Psychology consults orders were taken and that the police came. Registered Nurse Supervisor #2 stated they notified the Director of Nursing right away and initiated the incident report. Registered Nurse Supervisor #2 also stated that they are responsible for monitoring if Licensed Practical Nurses are writing behavior notes. Registered Nurse Supervisor #2 stated that Licensed Practical Nurse#2 should have documented Resident #2's behavior on 03/08/2025 in the progress note, the resident's Electronic Medical Record, and the intervention that was implemented. During an interview on 07/31/2025 at 12:05 PM, Registered Nurse