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	03/31/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, conducted during a survey, the facility failed to ensure that a resident was free from physical abuse. This was evident for one (1) out of six (6) residents (Resident #1) sampled for abuse. Specifically, Resident #1 has history of aggressive behavior. On 03/16/2026 at approximately 10:15 AM while Resident #1 & 2 was standing in the lobby waiting on the elevator to go upstairs. Resident#1 was observed swinging left wheelchair armrest hitting Resident #2 twice before staff members intervened. Resident #1 was arrested by the Police and taken to the hospital. Resident #2 was also transferred to the hospital on [DATE] for evaluation. Resident #2 did not require any stitches. Resident #1 and Resident #2 returned to the facility on [DATE]. Resident #2 sustained a laceration to mid forehead and was transferred to hospital for treatment. The hospital evaluation did not reveal a serious injury or significant pain.The findings are:The facility's Policy and Procedure titled Abuse Prevention dated 08/27/2025 documented the resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation by anyone in this facility. The policy also documented the facility is to provide a safe environment that protects residents from abuse including but not limited to verbal, mental, or physical abuse. The policy included resident to resident abuse of any type and visitors to resident abuse of any type.Resident #1 was admitted to the facility with diagnoses of Paraplegia, Mood Disorder, Major Depressive Disorder, Anxiety Disorder.The Minimum Data Set (a resident assessment tool) dated 02/12/2026 documented Resident #1 with intact cognition.A review of the facility's video surveillance footage revealed that on 03/16/2026 at 10:15AM Resident #1 and Resident #2 were waiting at the elevator in the front lobby. Other residents were also present. Resident #2 walked over to Resident #1's wheelchair and stood next to Resident #1. Resident #1 was observed making hand gestures while Resident #2 was still standing next to them. Resident #1 was observed taking off their left wheelchair arm rest, then using both hands to swing toward Resident #2. Resident #2 reached over toward Resident #1 to take the wheelchair arm rest away. Resident #1 was observed using the wheelchair armrest to hit Resident #2 on their forehead. Resident #2 started to bleed from their forehead. Staff members arrived immediately and separated both residents. Resident #2 observed going into the elevator.The facility documented the incident in a report dated 03/16/2026. The report documented that an incident of resident abuse did occur on 03/16/2026 at 10:15 AM, as evidenced by video surveillance and witnesses' statements which revealed that Resident #1 struck Resident #2 with the arm rest of their wheelchair. It was documented that the facility contacted local law enforcement at 10:15 AM and arrived at 10:25 AM on 03/16/2026. They responded and arrested Resident #1. In its investigative summary they concluded that Resident #1 was the victim of physical abuse perpetrated by Resident #2. The facility also concluded that staff immediately intervened and separated the residents to prevent further abuse or escalation. The summary noted that the physical assault resulted in Resident #2 sustaining an injury to the forehead, Medical Doctor #1 was notified and ordered the resident transferred the hospital for further evaluation and treatment. The hospital evaluation revealed no major injury to Resident #2. Resident #1 was escorted to the hospital by emergency transport with police escort. The summary (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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