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	08/14/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to provide a safe, clean, comfortable, and homelike environment to the residents. This was evident in three (3) (2nd, 3rd, and 4th Floors) of 4 units observed. Specifically, residents' closets were in disrepair; resident wheelchairs were dirty; feeding pumps and poles were observed with feeding stains; curtains had dirt; walls had missing paint; and floors were stained and dirty. The findings include but is not limited to: The facility's policy titled Environment Services with a last reviewed date of 04/25/2025 stated it is the policy of the facility to ensure that all residents' rooms are comfortable, cleaned, and sanitized according to set standards to maintain a safe sanitary and comfortable homelike environment. 1. From 08/07/2025 – 08/13/2025, the following were observed on the 3rd Floor: The dining room had dusty ceiling tile; the window blinds had black colored debris. A green chair was observed with ripped cushion. The floor had brown stains, and the tables had chipped and brown stain edges. The dry wall was chipped. The communal shower room had cracked tiles behind the door; the bottom of the door was missing a metal frame; and the ledge on the wall had brown colored stains. The following rooms had damaged or cracked closet veneers: Rooms 302, 303, 304, 305, 306, 307, 315, 317, 318, 320, and 322. In room [ROOM NUMBER], the curtain had brown stains, and the air-conditioning unit was leaking. In room [ROOM NUMBER], the window curtain was ripped, and the bathroom had missing tile and had dirty edges. In room [ROOM NUMBER], the curtains had brown stains, and the window mesh was ripped; the enteral feeding pump had feeding stains, and the ceiling tiles were stained. In room [ROOM NUMBER], the enteral feeding pole, feeding pump, and the floor had cream colored stains. The pillowcase had brown stains. In room [ROOM NUMBER], the dry wall was scraped. In room [ROOM NUMBER], the window screen was torn and the window blinds had brown stain. (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In room [ROOM NUMBER], the window screen was torn, the window blinds had brown stain and frayed edges. In room [ROOM NUMBER], the edge of the bathroom door had brown colored chipped metal and the corners were dirty. The dry wall was damaged; the window curtain had frayed edges, and the curtains had hole in mesh and stained. In room [ROOM NUMBER], the curtain hook was hanging, the dry wall above the baseboard was damaged, the blue privacy curtain had brow stains. In room [ROOM NUMBER], the window screen and curtain were ripped. In room [ROOM NUMBER], there was a blues stain on the window. In room [ROOM NUMBER], the curtains had frayed edges and black debris. In room [ROOM NUMBER], the wall had missing paint behind the television. In room [ROOM NUMBER], there was dried enteral feeding on the floor and feeding pump; and the curtain had black stain. Resident #58's wheelchair had ripped arm rest. Resident #74's wheelchair was noted with dust and debris. The wheels had white colored stains. During an interview on 08/13/2025 at 12:06 PM, Housekeeper #4 stated the rooms are cleaned when dirty, the baseboards are cleaned monthly, and that they wipe and clean 17 rooms every day. They stated they change the privacy curtains when necessary. During an interview on 08/14/2025 at 3:48 PM, the Maintenance Director stated they are aware of the torn window screen and that the residents' closet needs to be replaced. They stated some of the curtains are ripped and some hooks were stuck. The Director stated they made a list of issues that need to be addressed and provided it to the Administrator. They stated the facility should be homelike because if your family or loved ones are here, you want them to be comfortable and decent. During an interview on 08/14/2025 at 3:33 PM, the Administrator stated they walk around the facility daily and weekly and had no issues with the cleanliness of the resident units. They stated they do a quick check of the dining rooms and the cleanliness of the curtains. The Administrator stated when doing rounds, they do not look at the door structure, but they look to see if the floor and counters are clean. 2. On 08/08/2025 at 9:22 AM the following observations were made: Several residents' closets were in disrepair. room [ROOM NUMBER] was observed with stained walls, chipped painting, and the baseboard was falling off. room [ROOM NUMBER] was observed with dirt stains in the corner of the room. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room [ROOM NUMBER] was observed with a wet towel under the air conditioner. room [ROOM NUMBER] had a broken bed side table and there were scuff marks on the floor. room [ROOM NUMBER] had a broken bed side table, and the floor was dirty around bedside table. room [ROOM NUMBER] had an unpainted area on the wall facing the resident's bed. A lot of dirt and dust was observed under the ice machine and the suction machine. On 08/13/2025 at 11:37 AM, Housekeeper #2 was interviewed and stated they are the regular Housekeeper on the 2nd Floor, and they are responsible to clean all the rooms every day. Housekeeper #2 stated they also clean the dining room and that sometimes if anything is broken, then they call maintenance. Housekeeper #2 stated that they are only responsible for mopping the floor and there is a separate person who does the buffing. On 08/13/2025 at 12:00 PM, the Maintenance and Housekeeping Director was interviewed and stated 2nd Floor is in need of cleaning and that the buffing machine was broken, so they borrowed from the other facility. They stated they are aware of the closets that are in disrepair and that these were reported to the Administrator. 3. During multiple observations from 08/07/2025 at 10:55 AM to 08/14/2025 at 11:00 AM the following were observed in 4th Floor: On 08/07/2025 at 10:55 AM, in room [ROOM NUMBER], observed with unpainted wall besides residents' bed. room [ROOM NUMBER] was observed with scraped paints on the lower wall. room [ROOM NUMBER] had a full garbage container. room [ROOM NUMBER]-bathroom door had rusty chopped paint. The shower room had whitish sticky dry stains in the floor On 08/08/2025 at 11:45 AM, Resident #2 was interviewed and stated their garbage bin is not emptied regularly. On 08/14/2025 at 12:07 PM, Resident #15 was interviewed and stated they noticed the unpainted wall, but nobody came to fix it. On 08/14/2025 at 12:14 PM, the Director of Maintenance and Housekeeping was interviewed and stated the unpainted walls were assigned to the maintenance staff but do not know why they were not done. They stated housekeepers are assigned to each floor and does not know why the floor is still dirty. On 08/14/2025 at 1:14 PM, the Administrator was interviewed and stated they are aware that some residents room needs to be repainted and that some rooms need to be cleaned but they do not know why those things were not done. They stated now that they know the problem, they will do an audit of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what needs to be done and repaired. 10 NYCRR 415.5(h)(2)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to report all alleged violations involving neglect, abuse, and/or including injuries of unknown source to the State Survey Agency. This was evident in two (2) (Residents #154 & #46) of five (5) residents reviewed for Abuse out of 35 total sampled residents. Specifically, 1.) on 07/09/2025, Resident #154 was observed with a black and blue discoloration on their right eye. The resident was cognitively impaired and could not explain how the injury occurred. There was no witness to how the resident sustained the injury. This incident was not reported to the New York State Department of Health. 2.) On 05/30/2025, Resident #46 had a fall occurrence and sustained laceration on the forehead and cut on the bridge of the nose while being provided care by Certified Nursing Assistant #3. This incident was not reported to the New York State Department of Health.The findings include: The facility's policy titled Abuse Prevention with a last reviewed date of 12/29/2023 documented that the facility staff must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property immediately to the Administrator and or Director of Nursing , who in turn must report to the New York State Department of Health and or Police Department within the prescribed time frames as stipulated by Centers for Medicare and Medicaid Services.1. Resident #154 was admitted to the facility with diagnoses that included Non-Traumatic Brain Dysfunction and Non-Alzheimer's Dementia.The quarterly Minimum Data Set, dated [DATE] documented resident's cognition as severely impaired, no behavior symptoms and no wandering.A nurse's note by Registered Nurse #1 dated 07/09/2025 at1:30 PM documented they were informed by the Certified Nursing Assistant that Resident#154 was noted with bruise around their eye. A black and blue discoloration observed around Resident's #154 right eye and right side of their forehead. The nurse's note further documented that Resident #154 was unable to state what happened. The facility's Accident/Incident Report dated 07/09/2025 at 7:10 AM documented that the nature of the occurrence was an unknown injury. The report further documented a black and blue discoloration around right eye, and a small discoloration on the right side of forehead. The investigation documented that Resident #154 was interviewed and had no recollection of the event. The resident was unable to explain how they sustained the injury due to confusion secondary to dementia. On 08/12/2025 at 4:38 PM, the Assistant Director of Nursing was interviewed and stated they review all resident incidents. They stated Resident #154 could not remember what occurred due to their cognition and resident has memory loss. They stated that this incident was an injury of unknown origin, but they do not believe it has to be reported to the Department of Health. On 08/14/2025 at 3:21 PM, the Director of Nursing was interviewed and stated that the Assistant Director of Nursing is responsible for reviewing all incidents, and that the supervisors notify them if there is an allegation of abuse or neglect. The Director of Nursing stated that the incident/accidents are discussed as a team, and they take each situation personally. They stated for this incident, it was not reported to the Department of Health because by the time the nursing supervisor came to relay the information, the team did not feel there was any suspicion of abuse. 2. Resident #46 was admitted to the facility with diagnoses that included Coronary Artery Disease, Diabetes Mellitus and Non-Alzheimer's Dementia. The Quarterly Minimum Data Set, dated [DATE] documented Resident #46's cognition as severely impaired, no behaviors, moderate assistance for eating, supervision for bed mobility, dependent on staff for transfer and impairment on both sides to lower extremity.A nurse's note dated 05/30/2025 documented writer responded to a loud noise from the room, observed resident lying face down on floor on the right side of the bed, with the Certified Nursing Assistant at the bedside. Resident was alert and verbally responsive. Registered Nurse supervisor called to unit. Resident noted with skin tear to forehead and nose.The Director of Nursing Summary dated 06/05/2025 documented Resident #46 had an accidental (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fall during care on 05/30/2025 at around 7:51 AM. The summary documented that Resident #46 was receiving care when the Certified Nursing Assistant turned the resident to their side and fell out of bed. The resident sustained laceration on their nose and forehead and was transferred to the hospital for evaluation. A nurse's note dated 05/30/2025 documented Resident#46 returned from the emergency room at 2.05 PM, status post fall with laceration to forehead and nose bridge, resident had sutures done, dressing in place, blood smear to nose bridge dressing seen and evaluated by the medical doctor with no new orders, denies pain at this time. Swelling to forehead and nose bridge noted. On 08/14/2025 at 3:32 PM, the Director of Nursing was interviewed and stated that the reason the incident was not reported to the New York State Department of Health was because it was a minor laceration and from nursing assessment, it was not deemed to be major. The Director of Nursing also stated that the incidents are all discussed with the team, and the decision is made to report or not.10 NYCRR 415.4(b)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interviews, the facility failed to ensure that food was stored, prepared, distributed and served in accordance with professional standards for food service safety. This was evident during the kitchen and food service observations. This was evident during the kitchen and food service observation. Specifically, 1.) Dietary staff were observed not properly wearing hair restraint while in the kitchen; 2.) Expired enteral feedings were stored on the unit and by the security area; and 3.) Cold sandwiches were not stored at a safe temperature. The findings include: The facility policy on Dress Code with a revised date of 08/11/2025 documented all employees when working in the dietary department will wear a hairnet / hair restraint as per policy. This hairnet/hair restraint will cover all hair. [NAME] and facial hair should be contained. The undated facility policy on Temperature Controlled for Safety Food documented that egg and tuna salad must be kept in the refrigerator in 3-4 days, temperature of 40 Fahrenheit or below. 1. During kitchen observation on 08/12/2025 between 2:33 PM through 2:44 PM, Dietary Aide #3 was observed in the kitchen, without a beard net while washing the food cart and taking clean dishes from the dish machine. Dietary Aide #4 was in the kitchen, without a beard net while rinsing the dishes. Dietary Aide #5 was observed with beard not fully covered, and with hair net above their ears, not fully covering their hair, while they were putting relish into plastic cups. On 8/12/2025 at 2:44PM, a maintenance staff and outside vendor doing water sampling in the kitchen not wearing hair restraints or beard nets.On 08/13/2025 between 2:48 PM to 3:00 PM, Dietary Aide #5 was observed with their beard not fully covered, while opening preparing packets of thawed raw fish. During an interview on 08/12/2025 at 2:59 PM, Dietary Aide #3 stated they thought that only their beard had to be covered and not their mustache. They stated that they sometimes forget to grab a beard net when in the kitchen.During an interview on 08/12/2025 at 3:08 PM, Dietary Aide #4 stated they normally wear a mask because of their mustache. They stated they know they need to cover their facial hair, so it does not fall into the food. During an interview on 08/12/2025 at 3:02 PM, the Assistant food Service director stated all facial hair must be covered when in the kitchen. 2. On 08/12/2025 at 12:57 PM, a 1-liter bottle of Jevity 1.5 Cal was observed in the 5th floor pantry labeled with use before date of July 2025. On 08/12/2025 between 3:23 PM to 3:30 PM, boxes of 24 - eight (8) ounces Jevity 1.2 with use by date of 08/01/2025 and one (1) liter bottle of Jevity 1.5 with use by date of 07/01/2025 were stored in the visitor room by the security area. During an interview on 08/13/2025 at 10:30 AM, the Central Supply Aide stated the expired enteral feeding found in 5th Floor belongs to a resident who was in the hospital. The feeding was removed from the unit yesterday. They stated that the kitchen used to be in charge of the enteral feedings, and they took over four (4) months ago. During an interview on 08/14/2025 at 4:32PM, the Director of Nursing stated that the facility has a contract for enteral feeding and liquid nutritional supplements. They stated that dates are checked by the delivery person, and that supply is checked daily. They stated that if enteral feeding and liquid nutritional supplements are expired it is unsafe and would not provide proper nutrition. 3. On 08/12/2025 between 2:45 PM - 2:51 PM, the kitchen refrigerator was observed at 34 Fahrenheit. A tuna sandwich labeled with discard date of 08/14/2025 had a temperature of 68.8 Fahrenheit; and egg salad sandwich with a temperature of 51.2 Fahrenheit. During an interview on 8/12/2025 at 2:55PM, Dietary Aide #2 stated that the sandwiches were made at 11:30AM. They stated they did not put the ingredients on ice when they were making the sandwiches which they should have done to maintain the temperature. During an interview on 08/13/2025 at 2:59 PM, the Assistant Food Service Director stated the sandwiches should be between 35 to 40 Fahrenheit so no one can get sick with food poisoning. 10 NYCRR 415.14 (h)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interviews, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This was evident during environmental observation. Specifically, the visitor's waiting area by the security desk had a hole on the baseboard, had cobwebs, debris on top of the air-conditioning unit; staff bathrooms had a hole in the wall and black colored stain on the floor; and resident's bathroom was out of order. The findings include but is not limited to: The facility's policy titled Preventive Maintenance with a last reviewed date of 04/11/2024 stated that all broken equipment that affect resident or staff safety must be reported immediately to the Building Service Director or Administrator for immediate plan of action. The following were observed from 08/08/2025 through 08/13/2025:The visitor's waiting area by the security desk was noted with cobwebs in the right lower edge of the window; there was a hole on the baseboard on the right of the air conditioning unit. The air conditioning unit had a clear tape on top with black debris under the tape. The 3rd Floor staff bathroom had dirty corners and had corroded metal door frame. The staff bathroom in the Rehabilitation Department had holes in the wall under the soap dispenser, the floor had black colored debris, and the toilet handle was difficult to flush. The resident's bathroom in the Rehabilitation Department had an out of order sign and was noted with stained tile ceiling; had brown and black stains on the floor. During an interview on 08/14/2025 at 12:51 PM, the Physical Therapist stated that the bathroom has been in this condition over the last three (3) years. During an interview on 08/14/2025 at 3:48 PM, the Maintenance Director stated they made a list of issues that need to be addressed and provided it to the Administrator. During an interview on 08/14/2025 at 3:33 PM, the Administrator stated they walk around the facility daily and weekly and had no issues with the cleanliness of the resident units. The Administrator stated when doing rounds, they do not look at the door structure, but they look to see if the floor and counters are clean. 10 NYCRR 415.29

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure each resident received food that accommodated their allergies, intolerances, and preferences. This was evident in one (1) of 20 residents reviewed. Specifically, Resident #115 received lunch trays that included foods that did not accommodate their documented preferences and diet. The findings include: The facility policy titled Reading meal tickets/cards documented that it is the policy of the facility that there are accurately assembled meals for residents based on reading all of the information on the meal tickets. All staff will read and review for accuracy during meal assembly. This is essential to achieving resident satisfaction. Resident #115 had diagnoses of Diabetes Mellitus and Gastroesophageal Reflux disease without esophagitis. The Minimum Data Set, dated [DATE] documented that Resident #115 is cognitively intact, is supervision assistance for eating, has no swallowing disorder and no weight changes. The Physician's order dated 08/01/2025 documented Regular diet, regular texture and regular/thin consistency. The Dietary assessment dated [DATE] documented that Resident #115 is on a regular diet consistency, thin/regular fluid consistency with double portion size. Facility's Menu Ticket for Resident #115 dated 08/07/2025 documented: Lunch: Chef Salad, Double meat, Gravy, Grilled Cheese Sandwich (1 each), Garlic Mashed Potatoes (4oz), Ice Cream Sandwich (1 each). The bottom of the ticket documented Resident #115 to receive double entree. On 08/07/2025 at 12:56 PM, Resident #115 stated that they receive wrong items on their tray, while at other times items are missing from the tray. Resident #115 stated this happens daily and that they do not get what they are supposed to be getting. On 08/07/2025 at 12:56 PM, during the lunch meal, Resident #115 tray was observed with one grilled cheese sandwich, mashed potatoes and one ice cream sandwich. There was no double portion of meat on tray, no chef salad or gravy. The Facility's Menu Ticket for Resident #115 dated 08/11/2025 documented: Lunch: Chef Salad, Double meat, Gravy, cottage cheese and fruit plate with [NAME] sauce (1 each), white rice (4oz), mandarin oranges (4oz) and dinner roll/margarine (1 each). The bottom of the ticket documented that Resident #115 is to receive double entree. On 08/11/2025 at 12:27 PM, Resident #115 tray was observed and was noted to be missing cottage cheese. On 08/12/2025 at 10:59 AM, the Registered Nurse Supervisor #3 was interviewed and stated that the Dietitian will usually go around to each resident and ask them for their like/dislikes for that week or month. Then the ticket will be printed with residents' preference for their meals. The Registered Nurse Supervisor #3 stated that residents often have items missing from there tray. The residents will notify the staff and a call is then placed to the kitchen for a substitute. A resident is not notified beforehand if something is unavailable. When the tray is brought up then items are noted to be missing. The Registered Nurse Supervisor #3 further stated that residents should receive what is stated on their meal ticket because that's what they are expecting for lunch and since this is their home, it is important to respect their preferences. Regarding Resident #115, it is not often that items are missing from her tray. On 08/14/2025 at 10:28 AM, the Dietary Aide #1 was interviewed and stated that they sometimes help with setting up the meal trays for residents. Every resident has a tray ticket with their name and a list of everything they are supposed to get. The dietary staff is responsible for placing the respective items on the lunch tray. If there isn't a food item available, then it is marked on the sheet and alternatives are offered. The Dietary Aide #1 further stated that it is important residents receive what is on their ticket because they are paying for it and the facility is responsible for providing them with it. On 08/14/2025 at 10:34 AM, The Dietary Aide #6 was interviewed and stated that they have worked at the facility for 7 years and usually assist with the tray lines. The Dietary Aide #6 stated they read the ticket and assemble the listed items to ensure that residents receive whatever is documented in their meal ticket. The Dietary Aide #6 stated that when they work the tray lines, they don't usually have issues with residents complaining of missing (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	items from their tray or resident receiving wrong items because they always double check to make sure residents receive what is on their tray ticket. The Dietary Aide #6 further stated that it is important that residents receive what they ask for. If there are items unavailable, the manager is informed, and a substitute is offered. On 08/14/2025 at 10:38 AM, the Food Service Director was interviewed and stated that the supervisors are responsible for overseeing the tray line and the setting up of the food items. The tray tickets list residents allergies, preferences and their diet. If items are missing, staff are reprimanded, written up or disciplinary actions are taken. There are food committee meetings ongoing where topics such as accurate food assembly of resident's food are discussed. The Food Service Director further stated that while the kitchen puts together the tray, they are not responsible for distributing the food on the floor. Sometimes trays and food get switched out when carts arrive to the units. Other times things are taken off the tray and given to other residents. The Food Service Director stated that they do get calls from the units regarding missing items from residents tray, and they try to rectify it. The Food Service Director further stated that it is important that residents receive what they are supposed to get. 10 NYCRR 415.14(d)(4)