STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335726	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Rehabilitation and Nursing Center	140 Beach 113th Street Rockaway Park, NY 11694

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility did not ensure that food was stored, prepared, distributed, and served in accordance with professional standards for food service safety. This was identified during the Kitchen Task. Specifically, multiple refrigerated food items were undated and stored in open packaging. Additionally, the kitchen staff were not monitoring the cold food temperatures. The findings are: A facility policy titled Food Storage documented all food stored is maintained in a safe, sanitary, and temperature-controlled manner in order to prevent foodborne illnesses, contamination, and spoilage. All food items shall be stored, labeled, dated, and monitored in accordance with the accepted food safety standards and regulatory requirements. All refrigerated food items must be covered, labeled, dated, and discarded according to the facility's guidelines. All prepared, opened or thawed foods must be labeled with date prepared/opened. Unlabeled or expired food shall be discarded immediately. A facility policy titled Food Temperature Control and Food Safety documented all food served to residents is prepared, held, transported, served, and stored at safe temperatures. Food temperatures are monitored, documented, and corrected when out of range. All cold foods must be maintained at 41 F or below. During a Kitchen observation, in the presence of the Food Service Director, on 01/08/2026 at 9:43 AM, the walk-in dairy refrigerator contained an open package of American cheese with no label, an open package of shredded cheddar cheese, an open one-gallon bottle of Italian salad dressing, and an open 64-ounce bottle of cranberry juice. All the items were not dated to indicate the open date. A low-boy refrigerator was observed with an unlabeled and undated pan of grape jelly that was covered with a plastic wrap cover. There were spots of peanut butter on the plastic wrap cover. During a concurrent interview on 01/08/2026 at 9:57 AM, Dietary Aide #1 stated that they forgot to put a date on the pan of grape jelly when they stored it. The Food Service Director stated that having the peanut butter on the plastic cover of the grape jelly pan was a concern due to potential cross contamination and the possibility of an allergic reaction to peanut butter. During an interview on 01/14/2026 at 11:43 AM, [NAME] #1 stated they only take the temperature of the hot food items at the start of the lunch meal service. They do not take the temperature of cold food items. During the kitchen observation and interview on 01/14/2026 at 11:46 AM, a tray of sandwiches was observed at the end of the tray line table. Dietary Aide #2 stated they do not take the temperature of the sandwiches because they just took them out of the refrigerator. Dietary Aide #3 measured the temperature of an American Cheese sandwich, and the temperature measured to be 50.5 degrees Fahrenheit. Dietary Aide #3 stated the cold food should be at or below 40 degrees Fahrenheit. During an interview on 01/14/2026 at 11:47 AM, the Food Service Director stated that food out of the proper temperature range is a hazard and increases the possibility of foodborne illness. 10 NYCRR 415.14(h)

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
	335726	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Rehabilitation and Nursing Center	140 Beach 113th Street Rockaway Park, NY 11694

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and interviews the facility did not ensure each resident was treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality. This was identified for one (1) (Resident #70) of two (2) residents reviewed for Dignity. Specifically, on 01/12/2026 Certified Nursing Assistant #1 was observed in the hallway pulling Resident #70 backwards for approximately 100 feet while the resident was laying completely flat on a shower bed. At the time, there were other residents and staff in the hallway.The finding is:The facility's policy titled Resident Dignity, Respect, and Self-Determination, last reviewed 01/15/2025, documented the facility is committed to protecting and promoting each resident's right to dignity, respect, privacy, individuality, and self-determination. All residents shall receive care in a manner that supports their dignity, privacy, independence, and quality of life. All residents have a right to privacy in treatment, personal care, and communications. All staff must protect residents from embarrassment or humiliation. All staff must provide privacy during toileting, bathing, dressing, and treatments and protect residents from unnecessary exposure.Resident #70 was admitted with diagnoses including seizure disorder, fractures of right clavicle (collar bone) and right tibia (lower leg bone), and hypertension. The 10/30/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact.During an observation on 01/12/2026 at 10:00 AM on the second-floor nursing unit, Certified Nursing Assistant #1 was observed pulling Resident #70 backwards through the hallway from the resident's room to the shower room for approximately 100 feet while the resident was laying completely flat on a shower bed. The resident had a hospital gown covering the upper body and a sheet was covering the resident's legs. Other staff and residents were in the hallway at the time.During an interview on 01/12/2026 at 11:45 AM, Certified Nursing Assistant #1 stated they pulled Resident #70 backwards on the shower bed because they could see better where they were going and felt they could control the shower bed that way. Certified Nursing Assistant #1 stated they felt there may have been something wrong with the shower bed and it felt unstable.During an interview on 01/12/2026 at 11:55 AM, Resident #70 stated they were wondering why they were being pulled backwards. The resident also stated they would have preferred to be fully covered with a sheet during the transfer process because it was cold in the hallway.During an interview on 01/13/2026 at 08:30 AM, Registered Nurse Supervisor #1 stated after the observation by the surveyor, Certified Nursing Assistant #1 notified them that there was something wrong with the shower bed, and they were having difficulty pushing the shower bed. Registered Nurse Supervisor #1 stated if Certified Nursing Assistant #1 thought there was a problem with the shower bed, they should not have used the shower bed. Registered Nurse Supervisor #1 stated the maintenance department checked the shower bed on 01/13/2026, after the issue was brought to their attention. During an interview on 01/14/2026 at 1:30 PM the Director of Nursing Services stated pulling a resident backwards is a dignity issue and staff should ensure the resident is facing forward while being transported. The Director of Nursing Services stated residents should also be covered rather than just wearing a gown when being transferred through the hallway.10 NYCRR 415.5(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335726	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Rehabilitation and Nursing Center	140 Beach 113th Street Rockaway Park, NY 11694

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, record review, and interviews the facility did not ensure that each resident with pressure ulcers received the necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing. This was identified for two (2) (Resident #7 and Resident #10) of three (3) residents reviewed for Pressure Ulcers. Specifically, 1) during the wound care observation for Resident #7, Licensed Practical Nurse #1 did not cleanse all surfaces of the wound bed, including the part of the wound with undermining (a pocket or shelf beneath the surface of the skin extending beyond the visible opening, making it harder to heal and prone to infection). Additionally, the air mattress weight setting for Resident #7 was not consistent with the resident's weight. 2) Resident #10's air mattress weight setting was not consistent with the resident's weight and the facility staff was unfamiliar with the pump functions and settings.The findings are:The facility's policy titled Wound Care and Dressing Change, last reviewed 01/15/2025, documented the facility provides safe, sterile, timely, and evidence-based wound care to promote healing, prevent infection, and prevent deterioration of all wounds, including pressure injuries. The procedure includes cleanse wound bed in a circular motion inside to outside and irrigate if needed.The facility's policy titled Pressure Injury (Pressure Ulcer) Prevention, Assessment and Treatment, last reviewed 03/20/2025, documented pressure injuries will receive appropriate treatment and monitoring to promote healing, prevent deterioration, and prevent new injuries. Treatment includes infection control and treating wounds according to physician or wound-care specialist orders. A Braden (a scale for determining pressure ulcer risk) score of 10-12: High Risk (needs intensive interventions).The facility's policy titled Air Mattress / Pressure-Reducing Support Surface, last reviewed 01/15/2025, documented air mattresses shall be implemented promptly, monitored routinely, and maintained in safe and working condition to support resident dignity, comfort, safety, and wound prevention. Nursing staff shall verify the mattress is functioning and set properly every shift and report any malfunction immediately. All nursing staff will receive training on proper use of air mattresses.1) Resident #7 was admitted with diagnoses including diabetes mellitus, non-Alzheimer's dementia, and cerebrovascular accident. The 12/02/2025 Minimum Data Set assessment documented no Brief Interview for Mental Status score as the resident had severely impaired cognitive skills for daily decision making. The Minimum Data Set assessment documented that the resident had one Stage 3 pressure ulcer (a deep wound involving full-thickness skin loss, where fat tissue is visible, but bone, tendon, or muscle are not exposed) and one Stage 4 pressure ulcer (a deep wound involving full-thickness skin and tissue loss with exposed muscle, tendon, or bone).A Comprehensive Care Plan, initiated 06/20/2025, titled Actual Alteration in Skin Integrity as Evidenced by Stage 4 Pressure Ulcer, documented an intervention dated 10/27/2025 for an air mattress.A Braden scale (a scale for determining pressure ulcer risk) dated 11/26/2025 revealed a score of 12, indicating the resident was at high risk for pressure ulcer development.A wound consult dated 12/31/2025 documented a sacral Stage 4 Pressure Injury measuring 5 centimeters length x 3 centimeters width x 2.5 centimeters depth with exposed muscle. Undermining at 3:00 o'clock and ends at 5:00 o'clock (as per a clock face), with a maximum distance of 4 centimeters was present. There was a moderate amount of purulent (pus) drainage. Wound bed had 40% granulation (healthy) tissue and 60% slough (dead tissue). The recommendations were to initiate antibiotics.A physician's order dated 12/31/2025 documented cleanse wound with Dakin's 1/4 strength (a topical antimicrobial liquid, essentially diluted bleach, used for cleansing wounds), then loosely packed the wound bed with a wet to moist Dakins moistened gauze, cover with dry protective dressing, twice daily.A physician's order dated 12/31/2025 documented Cephalexin (antibiotic) tablet 500 milligrams, give one (1) tablet by mouth every 12 hours for infection for 14 Days.The resident's weight as of 01/05/2026 documented in the weight monitoring section of the electronic medical record was 123 pounds.A wound consult dated 01/07/2026 documented a sacral Stage 4 Pressure (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335726	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Rehabilitation and Nursing Center	140 Beach 113th Street Rockaway Park, NY 11694

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Injury measuring 4.5 centimeters length x 2.8 centimeters width x 1.5 centimeters depth with exposed muscle. Undermining at 3:00 o'clock and ends at 5:00 o'clock with a maximum distance of 3.5 centimeters was present. There was a Moderate amount of purulent drainage. The wound bed had 40% granulation tissue and 60% slough.During an observation on 01/12/2026 at 9:36 AM, Resident #7 was in bed sleeping. The air mattress weight setting was set at 220 pounds.A review of the medical record revealed no physician's order for the air mattress or monitoring of the mattress.During the wound care treatment observation on 01/13/2026 at 08:35 AM, performed by Licensed Practical Nurse #1 and assisted by Certified Nursing Assistant #2, the air mattress weight setting was set at 220 pounds. Licensed Practical Nurse #1 stated the resident weighed about 200 pounds. After the surveyor informed Licensed Practical Nurse #1 that the resident's weight was 123 pounds, Licensed Practical Nurse #1 then adjusted the weight setting to 150 pounds. Periodically, the air mattress low-pressure light illuminated and sounded. Licensed Practical Nurse #1 and Certified Nursing Assistant #2 both stated the low air pressure alarm, and the light has been illuminating for about a day and the maintenance staff were aware. Neither of them checked if the bed was inflated properly. During the wound treatment, the wound appeared clean with light to moderate amount of serosanguinous drainage (blood tinged). Licensed Practical Nurse #1 only cleansed the center of the wound and not the entire surface of the wound bed including the undermining area. Licensed Practical Nurse #1 stated they always cleaned the wound this way and continued with the wound care. The nurse did not pack the Dakin's moistened gauze into the undermining area as ordered by the Physician.Resident #7's air mattress operating manual documented to press the weight button to set according to patient weight.During an interview on 01/13/2026 at 1:06 PM, the Registered Nurse Wound Care #1 (who is also the Infection Preventionists) stated the peri wound (around the wound) skin should be spread out and all areas of the wound, including the undermining, should be cleansed, and the moistened gauze should be packed into the undermining area. The air mattress weight setting should be consistent with the resident's weight to assist with wound healing. Registered Nurse Wound Care #1 stated the certified nursing assistants are supposed to check the air mattress for inflation and the weight setting. Registered Nurse Wound Care #1 stated they heard about the low-pressure alarm issue and the air mattress was changed today.During an interview on 01/13/2026 at 2:45 PM, Registered Nurse Wound Care #1 stated an order for air mattress and monitoring was just added on 1/13/2026.A physician's order dated 01/13/2026, documented apply pressure devices: Air Mattress- check air mattress inflation every shift. Machine weight should be the same as the patient weight.During an interview on 01/14/2026 at 1:00 PM, Certified Nursing Assistant #2 stated they do not adjust weight setting on the air mattress; they just look at the mattress to see if it is deflated.During an interview on 01/14/2026 at 1:30 PM, the Director of Nursing Services stated, for years the maintenance department was responsible for the weight setting adjustments on the air mattresses. The nursing staff is now responsible to ensure the air mattress weight setting was accurate. The air mattress weight setting should be consistent with the resident weight to aid in wound healing. The nurses are responsible for ensuring and changing the air mattress weight setting according to the resident's weight. The Director of Nursing Services stated the entire wound surface including the undermining area of the wound should be cleansed. The undermining area should be packed according to the Physician's order, especially if the wound is being treated for an infection. During an interview on 01/15/2026 at 2:45 PM, Maintenance Director #1 stated they were not informed of Resident #7's air mattress low-pressure alarm until 01/13/2025. The air mattress was changed as soon as they were informed. The flashing low-pressure light on the air mattress pump indicated a potential problem in maintaining proper inflation.2) Resident #10 was admitted with diagnoses including diabetes mellitus, paraplegia (paralysis affecting the lower half of the body), and opioid dependence. The 12/12/2025 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. The Minimum Data Set assessment documented a weight of 298 pounds. The resident had two Stage 3 (a serious wound involving full-thickness skin (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335726	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Rehabilitation and Nursing Center	140 Beach 113th Street Rockaway Park, NY 11694

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss, where fat is visible, but bone, muscle, or tendon are not exposed) pressure ulcers. The resident utilized a pressure reducing device for the chair.A Comprehensive Care Plan titled, Actual Alteration in Skin Integrity, initiated 04/02/2025 and last updated 01/14/2026, added pressure ulcer unstageable to Right Heel (04/18/2025) and left heel pressure ulcer Stage 3 (06/11/2025). There was no documentation in the care plan that the resident had an air mattress. The Braden scale (a scale to determine pressure ulcer risk), dated 12/06/2025, documented a score of 15 indicating a mild risk for pressure ulcer development.A wound Consult dated 12/31/2025 documented right heel Stage 3 Pressure Ulcer measuring 1 centimeter length x 1 centimeter width x 0.2-centimeter depth; and left heel Stage 3 Pressure Ulcer measuring 0.2 centimeters length x 0.2 centimeters width x 0.1 centimeters depth.A physician's order dated 12/03/2025 documented cleanse left and right heel with normal saline, pat dry, apply collagen powder (a protein powder that helps heal the wound, absorbs drainage, and keeps the wound moist), then cover with dry protective dressing every evening shift.The resident's most recent weight in the electronic medical record was 305 pounds as of 01/07/2026.During an observation and interview on 01/08/2026 at 11:18 AM Resident #10 was in bed. The weight setting on the air mattress pump was set at 220 pounds. The resident stated they weighed about 300 pounds.A review of the medical record revealed no physician's order for the use of an air mattress and no documentation that the air mattress function and weight setting were being monitored.During an observation with Licensed Practical Nurse #2 on 01/14/2026 at 9:35 AM, Resident #10 was in bed. The air mattress pump weight setting was set at 220 pounds. Licensed Practical Nurse #2 observed the air mattress pump and stated they were supposed to check the mattress weight setting, but there was no physician's order, so the weight setting was not something that they sign off for in the treatment administration record. Licensed Practical Nurse #2 stated resident's weight was 305 pounds, and they were not sure how to set the weight on this type of air mattress to correspond with the resident's weight.During a re-interview in Resident #10's room on 01/14/2026 at 10:15 AM, Licensed Practical Nurse #2 stated they just had the Maintenance Director look at the air mattress pump who changed the air mattress pump mode to bariatric setting, because the resident weighed more than 300 pounds. Licensed Practical Nurse #2 stated the air mattress was previously on a standard mode. Licensed Practical Nurse #2 stated they did not know the setting was supposed to be on bariatric mode.During an interview on 01/14/2026 at 10:37 AM, Maintenance Director #1 stated the standard mode weight settings is from 80 pounds to 300 pounds. The bariatric mode weight settings are from 350 pounds to 1,000 pounds. Maintenance Director #1 stated they changed the mode to bariatric.During an interview on 01/14/2026 at 2:19 PM Wound Care Nurse Practitioner #1 stated the air mattress weight setting should be set as close to the resident's weight as possible. The correct weight setting helps with wound healing. 415.12(c)(1)