

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335738	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Ocean Gardens Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 64 11 Beach Channel Drive Arverne, NY 11692	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48907</p> <p>Based on observation, record review, and interviews conducted during an Abbreviated Survey (NY00343684 and NY00337964), the facility did not ensure that the alleged violations involving abuse, neglect, exploitation, mistreatment, or misappropriation of resident property were reported immediately, but not later than two (2) hours after the allegation is made, if the events that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not involve abuse to the administrator of the facility and to other officials (including to the State Agency). This was evident for six (6) out of six (6) residents (Resident #2, #3, #4, #5, #6 and Resident #7) sampled. Specifically, on 04/18/2024 at 5:50 AM, License Practical Nurse #2 saw Resident #3 wander into Resident #2's room and sat on the bed. Resident #2 kicked and pulled Resident #3's arm to get Resident #3 out of the room. The facility reported the incident to New York State Department of Health on 04/19/2024 at 7:20 PM. On 05/09/2024 at approximately 6:40 AM, License Practical Nurse #2 as entered a room, Resident #4 was lying on their bed with private area exposed and Resident #2 was standing at Resident #4's bedside with their pants down and private area exposed. The facility reported the incident to New York State Department of Health on 05/09/2024 at 12:19 PM. On 05/28/2024 at 10:00 AM, Resident #7 told Licensed Practical Nurse #1 that Housekeeper #1 took their fifty dollars. The facility did not report the alleged misappropriation of property to local law enforcement. On 06/20/2024 at 10:55 PM, Resident #3 wandered into Resident #5's room and was found on the floor. Resident #3's cognition was severely impaired and therefore, they could not explain what had happened. Resident #5 stated they pushed Resident #3. The facility reported the incident to New York State Department of Health on 06/21/2024 at 4:02 PM. On 09/07/2024 at 9:45 PM, Resident #3 wandered into Resident #6's room and hit Resident #6's hands and shoulder when Resident #6 asked Resident #3 to stop going through their drawers. The facility reported the incident to New York State Department of Health on 09/08/2024 at 6:50 PM.</p> <p>The findings are:</p> <p>The facility's Policy and Procedure titled Prevention of Resident Abuse/Neglect and Misappropriation of Property dated on 06/20/2024, documented that all alleged violations involving mistreatment of residents, neglect, or abuses, including injuries of unknown source are reported when discovered to the Administrator, Director of Nursing, Director of Social Work and/or their designees. Facility will follow the NYSDOH Reporting mandates. When the results of the investigation are substantiated, a report is also made to the State Certification agency (New York State Department of Health) and to all other agencies as required, and according to the New York State Department of Health reporting requirements.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #2 was admitted to the facility with diagnosis including bipolar disorder (mental disorder), and Depression.</p> <p>The Minimum Data Set, dated dated dated [DATE], documented Resident #2 had intact cognition.</p> <p>Resident #3 was admitted to the facility with diagnosis including Schizophrenia (a mental health condition that affect how people think, feel, and behave), and Non-Alzheimer's Dementia.</p> <p>The Minimum Data Set, dated dated dated [DATE], documented Resident #3 had severely impaired cognition.</p> <p>The facility's investigation dated 04/18/2024 at 5:50 AM, documented License Practical Nurse # 2 responded to Resident #2 shouting at Resident #3 to get out of a room that did not belong to either resident. Licensed Practical Nurse #2 observed Resident #2 kick and pull Resident #3's arm in attempt to get them out. Licensed Practical Nurse #2 intervened and redirected Resident #2 to their room. The facility conclude that the incident was unavoidable and there may be reasonable cause to believe abuse occurred.</p> <p>Resident #4 was admitted to the facility with diagnosis including Depression and Schizophrenia.</p> <p>The Minimum Data Set, dated dated dated [DATE] documented Resident #4 had severely impaired cognition.</p> <p>The Resident Accident/Incident Report dated 05/09/2024 at 6:35 AM, documented Licensed Practical Nurse # 2 observed Resident #2 making frequent stops in front of other resident's room. Licensed Practical Nurse #2 went to check on Resident #2's whereabouts and observed them in Resident #4's room standing at their bedside with perineal (private parts) exposed. Resident #4 was on their bed with private area also exposed. Resident #2 was redirected and was later sent to the hospital for further evaluation. Resident #4 reported Resident #2 did not do anything to them and refused to be transferred to the hospital for evaluation. The facility concluded abuse did not occur, care plans and interventions were implemented.</p> <p>Resident #5 was admitted to the facility with diagnosis including Hypertension and Diabetes (High blood sugar).</p> <p>The Minimum Data Set, dated dated dated [DATE], documented Resident #5 had moderately impaired cognition.</p> <p>The Resident Accident/Incident Report dated 06/20/2024 at 10:55 PM, documented Resident #3 wandered into Resident #5's room and was standing over Resident #5 while they were sleeping. The facility's investigation revealed Resident #5 became upset when they woke up and saw Resident #3 standing over them and reacted. The facility concluded there may be reasonable cause to believe alleged resident abuse, mistreatment or neglect occurred, care plans and interventions were implemented.</p> <p>Resident #6 was admitted to the facility with diagnosis including Diabetes (sugar in the blood), and Dementia.</p> <p>The Minimum Data Set, dated dated dated [DATE], documented Resident #6 had intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Resident Accident/Incident Report dated 09/07/2024 documented at 9:45 PM, Resident #3 wandered into Resident #6's room and began opening Resident #6's drawers. Resident #3 hit Resident #6 after Resident #6 told them to stop. The facility concluded there may be reasonable cause to believe alleged resident abuse, mistreatment or neglect occurred and implemented care plans with interventions.</p> <p>Resident #7 was admitted to the facility with diagnoses including Alzheimer's Disease, Bipolar Disease, and Schizophrenia.</p> <p>The Minimum Data Set, dated dated [DATE], documented that Resident #7 had short term and long-term memory problems with moderately poor decision making, and disorganized thinking.</p> <p>The Resident Accident/Incident Report dated 05/30/2024, documented Resident #7 stated on 05/28/2024 at 10:00 AM, Housekeeper #1 took their money. The facility's initial investigation dated 06/01/2024, documented there may be reasonable cause to believe alleged resident abuse, mistreatment or neglect has occurred and Housekeeper #1 was removed from Resident #7's floor. The facility's final investigation dated 06/03/2024, documented the facility's findings were inconclusive, and it was undetermined whether there was reasonable cause to believe that abuse, neglect, or mistreatment occurred. Resident #7 was reimbursed, and Housekeeper #1 was reassigned to a different unit.</p> <p>There was no documented evidence that the New York City Law Enforcement was informed.</p> <p>During an interview on 3/20/2025 at 5:00 PM, the Director of Nursing stated that if the facility investigation determined there was reasonable cause to believe misappropriation of property, the police should have been called. A follow up interview conducted on 04/17/2025 at 11:56 AM, Director of Nursing stated any allegation of abuse must be reported to them immediately and should be reported to the Department of Health within 2 hours.</p> <p>During a telephone interview on 04/02/2025 at 9:17 AM, the Assistant Director of Nursing stated they are responsible for reporting all incidents to the New York State Department of Health. They stated they cannot recall when they were made aware of the incidents, but any allegation of abuse should be reported within 2 hours if there was injury and 24 hours if there wasn't injury.</p> <p>10 NYCRR 415.4(b)(2)</p>		