STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335738	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Gardens Care Center	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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record observation, record review and interviews conducted during the Recertification and Abbreviated Survey (Complaint #607115 and #2630760), the facility failed to ensure the resident and/or the resident's representative was immediately informed of an accident which resulted in an injury and/or hospitalization. This was evident for two (2) of two (2) residents (Resident #139 & Resident #242) reviewed for Notification of Change out of 38 total sampled residents. Specifically, 1). On 03/25/2024 at 09:30 PM, Resident #139 was found sitting on the floor with a laceration to the left eyebrow that required hospitalization. There was no documented evidence Resident #139's designated representative and/or next of kin was notified of the change in their condition, and 2). On 12/03/2025 at 03:09 PM, Resident #242 was noted with a skin opening to the left dorsal foot. There was no documented evidence Resident #242 designated representative and/or next of kin was notified of the change in their condition. The facility's policy titled 'Notification of Changes', last reviewed 12/2025, documented it is the policy of the facility to immediately inform the resident; consult the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident or incident involving the resident, upon significant change in status or condition, or regarding changes in resident's rights. 1. Resident #139 was admitted to the facility with diagnoses that included Schizophrenia, Anxiety, and Dementia. The Quarterly Minimum Data Set, dated [DATE] revealed Resident #139 was severely cognitively impaired. Family provided source of information. The Accident/Incident Report dated 03/25/2024 at 09:30 PM, documented Resident #139 was seen sitting on their wheelchair with laceration on their left eyebrow. The report also documented 'Family notified: No. No Next of Kin.' The Nursing progress note dated 03/25/2024 at 10:46 PM revealed Resident #139 was sitting on floor in their room described as an unwitnessed fall with laceration to their left eyebrow. Designated Representative Notified: No next of kin. Review of Resident139's Face sheet documented next of kin contact information listed. There was no documented evidence the facility attempted to call the designated representative. On 01/08/2026 at 09:45 AM, an interview was conducted with the Director of Nursing who stated they have looked into all of the documentation and could not find any documentation of where the next of (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kin was notified of the fall and the hospitalization that occurred on 03/25/2024. The Director of Nursing also stated staff is supposed to look into the chart to see if the resident has a next of kin and they are to call the next of kin to notify the next of kin of any changes. The Director of Nursing further stated the Registered Nurse Supervisor on duty that day, who no longer works at the facility, did not look or attempt to call the family and the sibling is very involved and is the next of kin. The Director of Nursing stated the staff did not follow facility protocol because there was a next of kin in the chart and on the resident's face sheet. 2.Resident #242 was admitted with diagnoses that included Non-Alzheimer's Dementia, Parkinson's Disease, and Cerebrovascular Disease. The Annual Minimum Data Set assessment for Resident #242 dated 10/17/2025 documented Resident #242 had sort and long-term memory and severely impaired cognitive skills for decision-making. The Nursing progress notes dated 12/03/2025 at 03:09 PM, documented Resident #242 was noted with a skin opening to the left dorsal foot. The primary Medical Doctor was informed, and a telephone order was given for Bacitracin treatment daily. Resident #242 is pending a venous doppler secondary to swelling prior to the opening. The Nursing progress notes dated 12/03/2025 at 04:35 PM, documented called residents next of kin to update about skin opening on residents' foot. Will re-attempt at a later time. There was no documented evidence Resident #242's representative was notified of the change in resident's condition. On 01/12/2026 at 10:59 AM, Registered Nurse Supervisor #2 stated they wrote the note on 12/03/2025 at 4:35PM in Resident #242's medical record. Registered Nurse Supervisor #2 also stated that while they wrote in the note on 12/03/2025 that they would attempt to call the resident's sibling later they do not recall if they called the sibling. Registered Nurse Supervisor #2 further stated they were then out sick and not in the facility for at least a month after writing this note. Registered Nurse Supervisor #2 stated they are not sure if anyone else called the sibling and did not state if this was endorsed to staff on the oncoming shift. On 01/12/2026 at 1:54 PM, the Director of Nursing stated the next of kin notification is done by either Nursing or Social Work. The Director of Nursing also stated Registered Nurse Supervisor #2 reached out to the family but did not speak to the family member, and it is the facility policy not to leave a voice mail. The Director of Nursing further stated the Registered Nurse Supervisor #2 did not leave a voicemail, and while they documented in the note, they would follow-up, they did not and failed to communicate this to other staff so it could be followed up on. The Director of Nursing stated there is an end of shift report and Registered Nurse Supervisor #2 should have communicated they were no able to reach the next of kin and that this needed to be followed up on. 10 NYCRR 415.3(f)(2)(ii)(c)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Number of residents sampled: 5Number of residents cited: 2 Based on record review and interviews during the Recertification and Complaint (#2630760 and #607117), the facility failed to ensure all alleged violations involving abuse, neglect, or mistreatment including injuries of unknown origin are reported immediately, but not later than two (2) hours after the allegation is made to the State Survey Agency. This was evident for two (2) of five (5) residents reviewed for Abuse (Resident #126 & Resident #242) out of 38 total sampled residents. Specifically, 1.) On 4/12/2024 at 7:00 AM Resident #126 was observed with facial discoloration/redness to right and left eye and surrounding skin and redness/mild swelling to forehead and eyelids. Resident #126 was unable to explain the injury and the Administrator was first made aware of the incident at 9:00 AM. The injury of unknown source was not reported to the New York State Department of Health until 04/12/2024 at 1:57 PM, and 2.) On 11/21/2025 at 6:00 AM, Resident #242 was observed sitting in a wheelchair in another resident's room and was observed with a left eyebrow laceration measuring 2 centimeters which was bleeding. Resident #242 was transferred to the hospital and returned with Steri-Strips to left eyebrow. Facility concluded resident #242 likely resident had hit/bumped their head on a hard surface which caused the injury to their left eyebrow and did not report the injury of unknown source to the New York State Department of Health. The findings are: The facility's policy titled 'Prohibition of Resident Abuse, Neglect and Misappropriation of Property' with a revised date of 05/06/2025 documented all alleged violations involving serious injuries of unknown source must be reported and investigated immediately and findings of such investigations must be reported to the New York State Department of Health within two (2) hours as well as other required agencies that is law Enforcement. The policy further documented the facility will follow the New York State Department reporting mandates. 1.) Resident #126 was admitted to the facility with diagnoses that included Cellulitis, Sepsis, and Dementia. The Annual Minimum Data Set assessment dated [DATE] documented Resident #126 had moderately impaired cognitive skills. The assessment further documented Resident #126 needed supervision for eating, oral hygiene, and personal hygiene, and moderate assistance for toileting. A facility's Accident/Incident Report documented on 04/12/2024 at 7:05 AM, Resident #126 was observed sitting in a wheelchair in the hallway with discoloration to face, redness to right forehead, right cheek, and ecchymosis to right lower eyelids. The Accident/Incident report also documented Resident #126 was unable to give a statement due to cognitive impairment, and employee statements did not indicate there was a witness to Resident #126's injury. The Nursing progress note dated 04/12/2024 documented Resident #126 was observed with facial discoloration, right and left eyes surrounding skin redness. Mild swelling to forehead and eyelid. Resident was unable to explain what happened due to language barrier and cognition impairment. Primary physician and family informed. As per record review, the facility Incident Report submission was submitted to the New York State Department of Health on 04/12/2024 at 1:57 PM. As per the report this was an injury of unknown source (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and staff made aware at 7:00 AM, and the Administrator was made aware at 9:00 AM, however the incident was not submitted until 4/12/2024 at 1:57 PM. On 1/12/2026 at 10:48 AM, the Assistant Director of Nursing was interviewed and stated that the incident was reported to the New York State Department of Health and provided no explanation as to why it was reported late. 2. Resident #242 was admitted with diagnoses that included Non-Alzheimer's Dementia, Parkinson's Disease, and Cerebrovascular Disease. The Annual Minimum Data Set assessment for Resident #242 dated 10/17/2025 documented Resident #242 had sort and long-term memory and severely impaired cognitive skills for decision-making. The facility Incident Report dated 11/21/2025 documented Resident #242 was observed sitting in wheelchair in another resident's room with blood dripping from the left side of their face. Location of occurrence unknown. 911 was called and Resident #242 was transferred to the hospital for evaluation. Resident #242 was unable to state what occurred due to severely impaired cognition. The assigned Certified Nursing Assistant reported they observed Resident #242 walking in the hallway at 5:30 AM. The facility investigation contained no conclusion as to what occurred. The Nursing progress notes dated 11/22/2025 at 06:35 AM, documented Resident #242 returned from the hospital related to a fall evaluation. Steri strip to left eyebrow laceration, with swelling present. There was no documented evidence Resident #242's injury of unknown origin with laceration to left eyebrow was reported to the New York State Department of Health. On 01/12/2026 at 1:52 PM, the Director of Nursing stated if this incident falls under the rules for the Department of Health reporting, then it should be reported. The Director of Nursing also stated management meets every Friday and in morning report they discuss all accident and incidents. The Director of Nursing also stated the initial documentation on this incident was a fall, but after reviewing this incident they do see how it can be presented as an injury of unknown origin as Resident #242 was unable to verbalize what happened. The Director of Nursing further stated it was not reported to the Department of Health because it was reported as a fall. On 01/12/2026 at 10:19 AM, Assistant Director of Nursing #1 stated they are responsible for reporting accident/incidents for the facility. Assistant Director of Nursing #1 also stated this incident should have been reported as an injury of unknown origin, because there was no clear evidence Resident #242 fell. Assistant Director of Nursing #1 further they did not recall any discussion about reporting this incident. 415.4 (b)(2)