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	05/19/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, and interviews during a survey, the facility failed to ensure that a resident was free from physical abuse. This was evident in one (1) (Resident #1) out of two (2) residents reviewed and sampled for abuse. Specifically, on 04/20/2026 at about 12:45 PM, in the resident's dining room, Resident #1 suddenly grabbed Certified Nursing Assistant #1's left breast when Certified Nursing Assistant #1 was feeding Resident #1. Certified Nursing Assistant #1 reacted to having her breast suddenly grabbed by pushed or slapped Resident #1's hand. Registered Nurse #1 and Certified Nursing Assistants # 2 were in the dining room and provided conflicting statements regarding if Resident #1 was slapped or Resident #1's hand was pushed away. The findings are: The facility's policy titled, Prohibition of Residents abuse/ neglect and Misappropriation of Property dated 02/01/2008 and last revised 05/16/2025, documented: Residents have the right to be free from abuse, neglect, exploitation and misappropriation of property. All alleged violations involving mistreatment of residents, neglect, or abuses including injuries of unknown source must be verbally reported immediately when discovered to the Administrator, Director of Nursing, Director of Social Work, or designee immediately. Resident #1 was admitted to the facility with diagnoses of dementia (damage to the brain that affect daily life), anxiety (the body response to stress), and bipolar disorder (changes in mood,energy, or activity levels). The Minimum Data Set (a resident assessment tool) dated 01/21/2026, documented Resident #1 was severe cognitively impaired. Resident #1 requires assistance with most activities of daily living and was fed by staff. Resident #1's Behavior Care Plan /Activity Reports dated 07/09/2024, documented Resident #1 has a history of grabbing and inappropriate behaviors. Interventions included approach calmly, redirect and stepping away. It also stated Resident #1 remained easily redirected. Review of Registered Nurse Supervisor #1 Progress Note of 04/21/2026 at 07:11 PM, documented Certified Nursing Assistant #1 and Registered Nurse #1 stated Resident #1's hand was redirected and Certified Nursing Assistant 2 stated that no incident occurred. Review of Accident/Incident Report and employee statements dated 04/21/2026, revealed that on 04/20/2026 at about 12:45 PM, when feeding Resident #1 in the dining room, Resident #1 suddenly grabbed Certified Nursing Assistant #1's left breast. Staff statements are contradictory. Certified Nursing Assistant #1 documented that they pushed Resident #1's hand away. Statements from Registered Nurse #1 and Certified Nursing Assistant #2 dated 04/21/20026 stated they witnessed Certified Nursing #1 hit Resident #1. Attempted to interview Resident #1 on 04/30/2026 at 2 PM, Resident #1 just responded they were ok. During an interview on 04/30/2026 at 10:20 AM, Registered Nurse #1 stated that on entering the dining room on 04/20/2026 at lunch time about 12:45 PM they witnessed Resident #1 grab the breast of Nursing Assistant #1 and Nursing Assistant #1 angrily and with one swing knocked Resident #1's hand off their breast. They informed the Certified Nursing Assistant #1 they cannot do that to a resident and informed the Registered Nurse Supervisor #1 who was on the unit. No written statements were requested. During an interview on 04/30/2026 at 12:43 PM, Nursing Assistant #1 demonstrated they placed Resident #1's hand gently down and denied they hit or slapped Resident #1. During an interview on 04/30/2026 at 2:42 PM, the Director of Nursing stated they were informed by the Assistant Director of Nursing/Risk Manager on the morning (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of 04/21/2026 that there was an incident on 04/20/2026, however, statements received were contradictory. Registered Nurse #1 and Certified Nursing Assistant # 2 were called for interview and an investigation was started, law enforcement, and the New York State Department of Health were informed. No arrests were made. During an interview on 05/01/2026 at 10:43 AM, the Assistant Director of Nursing / Risk Manager stated that close to 3PM on 04/20/2026 Registered Nurse Supervisor #1 informed them of the incident and they requested Nurse Supervisor #1 to obtain statements from the eyewitnesses. The statements and information that were initially received on 04/21/2026 were conflicting and not from the eyewitnesses because they were off duty on 04/21/2026. During an interview on 05/04/2026 at 2:29 PM, the Assistant Administrator stated they were informed of an incident when the issue was mentioned during morning meeting on 04/21/2026. A Certified nursing assistant was grabbed on 04/20/2026. An employee incident report was requested. It was not known at that time that there was an allegation of abuse until after the meeting and the investigation was in progress on 04/21/2026. During a telephone interview on 05/06/2026 at 11:48 AM, Certified Nursing Assistant # 2 stated they witnessed Certified Nursing Assistant #1 hit Resident #1 twice after the Resident #1 grabbed their breast on 04/20/2026. Registered Nurse #1 was coming into the dining room and witnessed the incident and informed Certified Nursing Assistant #1 they cannot do that to a resident. Registered Nurse Supervisor #1 who was in the unit office, was informed of what occurred in the dining room and they were never asked to write any statements on 04/20/2026. During a telephone interview on 5/19/2026 at 12:40 PM, the Administrator stated that initially it was reported in morning meeting (does not remember by whom) that Resident #1 touched a Certified Nursing Assistant #1 and an incident report was done. There were no reports of hitting or slapping to Resident #1. The Administrator stated at least 5 days later they received a call that there was an allegation of Resident #1 being hit or slapped and that the Director of Nursing will investigate and that there are ongoing in-services on resident rights and abuse. These in-services are now weekly in addition to the mandatory in-services. 10 New York Code, Rules, Regulations 415.4(b)