

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335141	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Emerge Nursing and Rehabilitation at Glen Cove		STREET ADDRESS, CITY, STATE, ZIP CODE 2 Medical Plaza Glen Cove, NY 11542	
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interviews during the survey, the facility failed to ensure that it implemented a person-centered care plan for each resident to meet medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. This was identified for one (1) (Resident #99) of one (1) resident reviewed for death. Specifically, Resident #99 had a physician's order for furosemide (a diuretic used to treat heart failure) to be administered on 03/14/2026, one (1) time dose, at 6:00 PM. Review of the medical record revealed no documented evidence that the medication was administered as per the physician's orders. The findings include: The facility's policy titled Transcription of Physician's Orders, dated April 2025, documented the facility shall ensure that medication and other prescribed orders are picked up, transcribed, administered and/or carried out according to the physician's orders. New physician orders will be verified for accuracy and implementation to ensure the accuracy and timeliness of implementation of all physician orders. Resident #99 was admitted with diagnoses including hypertensive heart disease with heart failure (heart does not pump blood efficiently), pulmonary hypertension (high blood pressure in the lung arteries), and diabetes mellitus. The 03/08/2026 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. An attending physician progress note dated 03/14/2026 at 3:54 PM documented under assessment and plan: Lasix (furosemide) intravenous (directly into the vein) twice a day was extended until 03/13/2026. On 03/14/2026 reduce intravenous Lasix to 40 milligrams intravenously daily. A physician's order dated 03/14/2026 at 5:00 PM, entered by Registered Nurse Supervisor #1, documented furosemide 10 milligram/milliliter solution, inject 40 milligrams (4 milliliter) by intravenous push once daily at 9:00 AM for a diagnosis of hypertensive heart disease with heart failure. The order was signed off by the physician on 03/14/2026 at 9:15 PM. The order was discontinued on 03/20/2026. A second physician's order dated 03/14/2026 at 5:04 PM, entered by Registered Nurse Supervisor #1, documented furosemide 10 milligram/milliliter solution, inject 40 milligrams (4 milliliter) by injection route as one [time] dose on 03/14/2026 at 6:00 PM, for a diagnosis of hypertensive heart disease with heart failure. The order was signed off by the Physician on 03/14/2026 at 9:15 PM. The order was discontinued on 03/20/2026. A review of the March 2026 Medication Administration Record revealed that the 6:00 PM dose of furosemide was not administered on 03/14/2026 as per the physician's orders. The resident received furosemide twice a day on 03/13/2026 and began receiving furosemide once a day on 03/15/2026. The resident did not receive a dose of furosemide on 03/14/2026. There were no comments in the medication administration record indicating why the physician-ordered 6:00 PM dose of furosemide was not administered on 03/14/2026. A review of the medical record revealed no progress notes indicating the reason the 6:00 PM dose of furosemide on 03/14/2026 was not administered. During an interview on 04/27/2026 at 2:44 PM, Registered Nurse Supervisor #1 stated they did not know why the 6:00 PM dose of furosemide was not administered on 03/14/2026. Registered Nurse Supervisor #1 stated if the medication was not given, the reason should have been documented in the medication administration record and in the medical record. During an interview on 04/28/2026 at 8:50 AM, the Attending (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician stated they did not know why the 6:00 PM dose of furosemide was not administered to Resident #99 on 03/14/2026. The order was very specifically written, and they expected the staff to notify them if the medication was not administered as ordered. During an interview on 04/28/2026 at 9:35 AM, the Director of Nursing Services stated the facility protocol is to administer furosemide in the morning. The Director of Nursing Services stated the staff should have communicated the facility protocol with the Physician and documented the reason for not administering the furosemide. 10 New York Code Rules and Regulations 415.11(c)(1)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review during survey, the facility failed to ensure that it maintained medical records that are complete and accurate. This was identified for one (1) (Resident #4) of two (2) residents reviewed for urinary tract infections. Specifically, Resident #4 had a physician order for ceftriaxone (antibiotic) by intravenous route once a day for five (5) days. The intravenous peripheral line was dislodged on 04/25/2026. The resident refused the reinsertion of the intravenous peripheral line and refused the antibiotic therapy. There was no documented evidence in the electronic medical record that a physician was notified of the dislodgement of intravenous peripheral line, the resident's refusal for the reinsertion of the intravenous peripheral line, and the antibiotic treatment. The findings include: The facility policy titled Transcription of Physician's Orders, effective 04/2025, documented the Charge Nurse/Supervisor will notify the physician of changes in the resident's condition in accordance with specific physician orders. Resident #4 was admitted with diagnoses that included urinary tract infection, chronic obstructive pulmonary disease (lung disease that restricts airflow, making it difficult to breathe), and diabetes mellitus (the body resists insulin and fails to maintain normal blood sugar levels). The admission Minimum Data Set assessment dated [DATE], documented a Brief Interview for Mental Status score of 10, indicating Resident #4 had moderately impaired cognition. The Minimum Data Set assessment documented Resident #4 did not have a behavior of rejecting care. The resident had a urinary tract infection in the past 30 days, did not use antibiotics, and did not have a peripheral intravenous catheter within the look back period. A comprehensive care plan titled Infection-Urinary Tract Infection, dated 04/23/2026, documented interventions that included administering medications as ordered, intravenous ceftriaxone, observe for side effects from antibiotic therapy, report to physician, and monitor for effectiveness. A physician's order dated 04/23/2026 documented ceftriaxone 1 (one) gram in 50 milliliters of 5% dextrose by intravenous route once a day for five (5) days. A progress note dated 04/25/2026 documented intravenous line dislodged, the resident refused reinsertion and treatment, and the nurse supervisor was made aware. A review of the Medication Administration Record for April 2026, documented Resident #4 did not receive ceftriaxone on 04/25/2026 and 04/26/2026 as Resident #4's peripheral intravenous catheter was dislodged, and the resident refused to have a new peripheral intravenous catheter. A review of the Treatment Administration Record for April 2026, documented on 04/25/2026 the peripheral intravenous catheter was dislodged and Resident refused to have a new one re-inserted during the evening shift. On all shifts for 04/26/2026 the nurses documented the resident refused the new peripheral intravenous catheter. A review of Resident #4's medical records revealed no documented evidence that the physician was made aware of the peripheral intravenous catheter being dislodged and that the resident did not receive the physician ordered antibiotics for two days. During an interview on 04/27/2026 at 10:27 AM, Resident #4 stated they did not have a peripheral intravenous catheter any longer and did not want one. They were done with having a peripheral intravenous catheter. During an interview on 04/27/2026 at 02:19 PM, the Medical Director (Resident #4's physician) stated they were made aware by a nurse on Saturday night that Resident #4's peripheral intravenous catheter came out. The Medical Director stated they came in on Sunday and assessed the resident. The resident's condition seemed to be improved so they offered oral antibiotics, but Resident #4 refused the oral antibiotics. The Medical Director stated the new plan was to monitor Resident #4 without the antibiotics; however, they did not document their assessment and the communication with the resident in the resident's medical record. During an interview on 04/27/2026 2:26 PM, Licensed Practical Nurse #1 stated they notified the Registered Nurse Supervisor #1 that the peripheral intravenous catheter was dislodged on Saturday night, they did not notify the physician, they do not notify the physician the Nursing Supervisor would do that. During an (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 04/28/2026 at 9:31 AM, the Director of Nursing Services stated the nurses should have documented the physician notification regarding the resident's refusal for reinsertion of the peripheral intravenous access and that the resident missed two days of antibiotics. 10 New York Code Rules and Regulations 415.22(a)(1-4)		