STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335211	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glengariff Health Care Center	141 Dosoris Lane Glen Cove, NY 11542

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(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** 41051 Based on record review and staff interviews during the Recertification Survey and Abbreviated Survey (Complaint #NY 00337626) initiated on 4/29/2024 and completed on 5/7/2024, the facility did not immediately notify the resident's Designated Representative when there was a significant change in the resident's physical status. This was identified for one (Resident #140) of one resident reviewed for Notification of Change. Specifically, on 3/17/2024 Resident #140 fell and hit their head on a radiator and was identified to have sustained a scalp laceration. Subsequently, the resident was transferred to the hospital for evaluation on 3/17/2024. There was no documented evidence that the resident's designated representative was notified of the resident's fall and the resident's transfer to the hospital until 3/19/2024. The finding is: The facility's policy titled, Notification of Change created in 12/2021 and revised in 12/2023 documented to notify the resident, their attending physician, and the resident representative of changes in the resident's condition and/or status. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: the resident is involved in any accident or incident that results in an injury including an injury of unknown origin, and when it is necessary to transfer the resident to a hospital or treatment center; except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. Resident #140 had diagnoses that included Dementia with Psychotic Disturbance, Anxiety Disorder, and Depression. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 0 which indicated the resident had severe cognitive impairment. An Accident and Incident report dated 3/17/2024 documented that Resident #140 fell and hit their head on the corner of a radiator. The report also documented Resident #140 had a skin laceration on the top of their head and they were transferred to the hospital for evaluation. A Nursing Progress Note dated 3/17/2024 documented Resident #140 was noted with a laceration to their head. The Medical Doctor was notified, and the resident was transported to the hospital for further evaluation. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medical record indicated there was no documented evidence that Resident #140's designated representative was immediately notified of the resident's fall or the resident's transfer to the hospital on 3/17/2024. An Electronic Medical Record Investigation Report documented Resident #140's designated representative was notified on 3/19/2024 (two days later) that Resident #140 had a scalp laceration because of a fall and was sent to the hospital on 3/17/2024. The Designated Representative was interviewed on 5/1/2024 at 4:47 PM and stated they were not notified of the resident's fall or their hospitalization on either 3/17/2024 or 3/19/2024. The Designative Representative stated they became aware of Resident #140's injury when they visited Resident #140 on 3/26/2024 The Designated Representative stated they did not receive a voice message from the facility, and they did not have a missed call from the facility on 3/17/2024 or 3/19/2024. Assistant Director of Nursing #2, the Risk Manager, was interviewed on 5/7/2024 at 5:02 PM. Assistant Director of Nursing #2 stated it is the Registered Nurse Supervisor's responsibility to ensure the resident's designated representative is notified of an injury or hospital transfer and to ensure the communication with the resident's designated representative is documented in the resident's medical record. The Registered Nurse Supervisor who was responsible for notifying Resident #140's designated representative on 3/17/2024 was not available for an interview. The Director of Nursing was interviewed on 5/7/2024 at 5:30 PM and stated the Registered Nurse Supervisors are responsible for notifying the resident's designated representatives when a resident has an injury and is transferred to the hospital. The Director of Nursing Services stated that the staff must document the date and the time in the resident's medical record when the resident's designated representative was notified. 10 NYCRR 415.3(f)(2)(ii)(d)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 34798 Based on record review and interviews during the Recertification Survey and Extended Survey (NY 00321997) initiated on 4/29/2024 and completed on 5/7/2024 the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. This was identified for two (Resident #151 and Resident #82) of three residents reviewed for Abuse. Specifically, Resident #151 and Resident #82 were involved in a resident-to-resident altercation on 8/11/2023, in which Resident #151 was allegedly pushed by Resident #82 and fell to the floor. The incident of resident to resident altercation was not reported to the New York State Department of Health until three days after the incident, on 8/14/2023. The finding is: The facility's policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program revised 5/3/2024, documented to identify and investigate all possible incidents of abuse, neglect, mistreatment, or misappropriation of resident property. Investigate and report any allegations within the timeframes required by federal requirements. Establish and implement a quality assurance and performance improvement review and analysis of reports, allegations, or findings of abuse, neglect, mistreatment, or misappropriation of property. Resident #151 was admitted with diagnoses including Non-Alzheimer's Dementia, Cerebrovascular Accident, and Hypertension. The 6/1/2023 quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 5, indicating the resident had severe cognitive impairment. Resident #82 was admitted with diagnoses including Schizophrenia, Peripheral Vascular Disease, and Anxiety Disorder. The 7/20/2023 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A nursing progress note written by Registered Nurse #1 (supervisor) on 8/11/2023 at 6:30 PM for Resident #151 documented an Accident and Incident Note. The resident was heard shouting for help. When checked, the resident was found lying on the floor, pushing their upper body with bilateral elbows. The resident claimed they were pushed by the resident next door (Resident #82) who wanted to use the toilet while Resident #151 was still inside the bathroom. The resident complained of pain in the lower back and claimed that they hit their head slightly on the floor. The resident was assessed for any visible injury. Placed back in their wheelchair via two-person assist. Referred to the primary physician. Tylenol was given by the medication nurse. Bilateral hip and lumbar X-rays were ordered. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note written by Registered Nurse #1, the nursing supervisor, on 8/11/2023 at 6:30 PM for Resident #82 documented that at 6:30 PM the resident was seen inside the shared toilet, appeared mad and was pointing a finger at Resident #151 who was found on the floor. Resident #151 alleged that Resident #82 pushed them. According to Resident #82, they were using the bathroom first when Resident #151 went inside to get a tissue. Resident #82 also alleged that Resident #151 pushed them first and that Resident #82 just pushed Resident #151 back out of the toilet causing Resident #151 to fall. The New York State Department of Health complaint intake revealed that the incident was received on 8/14/2023 at 12:10 PM. A physician's progress note dated 8/15/2023 documented X-rays for Resident #151 were reviewed. The findings were chronic without any acute fractures. A psychiatrist consults for Resident #82 dated 8/15/2023 documented the resident pushed another resident. The resident had a history of Schizoaffective disorder. The resident has involuntary movements and is not aware of it. The resident blames the other resident for taking toilet paper from the bathroom and not leaving for this resident. On 4/29/2024 Resident #151 and Resident #82's rooms were observed. Both residents reside on Unit 1 West. The resident rooms are adjacent to each other and there is a shared bathroom. The residents still reside in the same rooms/beds as they did on 8/11/2023. On 4/29/2024 at 11:24 AM Resident #151 was interviewed. Resident #151 stated they did not get hurt when they were pushed, but I was scared for sure. This resident was observed ambulating independently in their room. On 4/30/2024 at 12:49 PM Resident #82 was interviewed. Resident #82 stated they did not remember the incident. On 5/2/2024 at 11:57 AM Registered Nurse #1 was interviewed. Registered Nurse #1 stated they were the supervisor on the 3:00 PM-11:00 PM shift when the 8/11/2023 incident occurred. When they arrived at the unit, Resident #151 was on the floor and claimed they were pushed by Resident #82. Registered Nurse #1 stated there were no incidents between the two residents prior to the 8/11/2023 incident. On 5/2/2024 at 12:50 PM Resident #134, the resident who witnessed the incident, was interviewed. Resident #134 stated Resident #151 was in the bathroom first and was coming out when Resident #82 came into the bathroom from the other room and pushed Resident #151. Resident #151 fell right in front of Resident #134's bed. Resident #134 stated they did not know of any previous incidents between the two residents. On 5/3/2024 at 8:54 AM Certified Nursing Assistant #1, who was assigned to Resident #151 on 8/11/2024 during the 3:00 PM-11:00 PM shift, was interviewed. Certified Nursing Assistant #1 stated Resident #82 was very quiet; we did not know how this incident happened; everyone was surprised. Certified Nursing Assistant #1 did not observe any issues between the two residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant Director of Nursing #2, the Risk Manager was interviewed on 5/3/2024 at 11:11 AM. Assistant Director of Nursing #2 stated they were not employed at the facility when the 8/11/2023 incident occurred. The 8/11/2023 incident was reportable and should have been reported to the New York State Department of Health within 2 hours. Two residents pushing each other could be a willful act, which is why the incident between Resident #82 and Resident #151 should have been reported within 2 hours. The Director of Nursing Services was interviewed on 5/3/2024 at 1:20 PM and stated the incident on 8/11/2023 between the two residents should have been reported to the New York State Department of Health within two hours. The Director of Nursing Services stated they were involved in the investigation and concluded there was no abuse, neglect, or mistreatment. 10 NYCRR415.4 (b) (1) (ii)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00337626) initiated on 4/29/2024 and completed on 5/7/2024, the facility did not ensure that all incidents including the injury of unknown origin were thoroughly investigated. This was identified for two (Resident #530 and Resident #140) of six residents reviewed for Accidents and for one (Resident #133) of three residents reviewed for Abuse. Specifically, 1) on 2/16/2024 Resident #530 was found on the floor and sustained a hematoma (bruising) to the forehead and skin tears on both arms. The facility did not thoroughly investigate the incident to identify the root cause and to rule out Abuse, Neglect, and Mistreatment. Additionally, the facility did not ensure that the investigation summary of the incident was completed within 5 days as required. 2) Resident #140 had multiple injuries of unknown origin from 9/22/2023 to 5/6/2024 and the facility did not thoroughly investigate the injuries of unknown origin incidents to identify the root cause and to rule out Abuse, Neglect, and Mistreatment. 3) Resident #133 sustained an injury of unknown origin, discoloration to the left eye, on 3/28/2024 and the facility did not thoroughly investigate the incident to identify the root cause of the injury and to rule of Abuse, Neglect, and Mistreatment. The findings include but are not limited to: 1) The facility policy and procedure titled Accidents and Incidents-Investigating and Reporting last revised on 12/2023 documented that all incidents or accidents involving residents, employees, visitors, and vendors occurring in the facility shall be investigated and reported to the Director of Nursing Services and the Administrator. The nurse, supervisor, charge nurse, or department director shall complete a report of the incident/accident and submit it to the Risk Manager or the Director of Nursing. The following data, as applicable shall be included on the report of incident/accident form, the date and time the accident or incident took place, the nature of the injury, and illness, circumstances surrounding the accident or incident where the accident or incident took place. The names of the witnesses and their accounts of the incident or accident, if applicable should be included in the report. Resident #530 was admitted with Diagnoses of Malignant Neoplasm of the Lung, Chronic Kidney Disease, and Cerebrovascular Accident. The Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview of Mental Status (BIMS) score of 8 which indicated the resident had moderate cognitive impairment. The Minimum Data Set documented that Resident #530 needed maximum assistance from staff with sit-to-stand and chair-to-bed transfer. A Comprehensive Care Plan (CCP) dated 2/6/2024 documented that Resident #530 was at risk for fall due to impaired mobility. Interventions included but were not limited to a neurology examination (an assessment of motor responses, and reflexes to determine if the nervous system is impaired) will be conducted for each fall. A Progress Note dated 2/16/2024 at 11:58 AM documented that Resident #530 was observed lying on their left side adjacent to the bed. Head-to-toe assessment was completed by Registered Nurse #6. Resident #530 was noted with small skin tears and a hematoma (bruising) on their forehead. The physician was notified and a neuro check (neurologic examination that identifies and assesses the functions of vital portions of the nervous system) was ordered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Accident/Incident investigation for the 2/16/2024 incident was provided by the Risk Manager. An Investigation Statement by the Registered Nurse was included. The statement was signed on 2/28/2024 and did not include a description of the incident. The Registered Nurse statement documented the resident was not considered at high risk for falls and did not document the resident sustained skin tear or hematoma. The Accident/Incident Investigation Form did not include a statement from the assigned Licensed Practical Nurse #9, the provided form was blank. The statement from the assigned Certified Nursing Assistant #13 did not include the time the incident occurred. The statement was signed by the assigned Certified Nursing Assistant #13 on 3/20/2024. There was no documented evidence that a summary to conclude the investigation was completed by the facility within 5 days. A Comprehensive Care Plan (CCP) dated 2/21/2024 documented that Resident #530 had an actual fall on 2/16/2024. The interventions included to keep the bed in the lowest position; to obtain a Physical Therapy consult for strength and mobility; and to keep Resident #530 in highly visible areas while awake. Registered Nurse #6, Unit Manager, was interviewed on 5/2/2024 at 11:26 AM and stated that they assessed Resident #530 on 2/16/2024 at 11:15 AM when the resident was observed by the charge nurse on the floor. Registered Nurse #6 stated they started the Accident/Incident investigation and were able to get the statement from Certified Nursing Assistant #13 who was assigned to the resident on 2/16/2024. Registered Nurse #6 stated they could not remember why Licensed Practical Nurse #9, the charge nurse, did not provide a statement on 2/16/2024. Registered Nurse #6 stated that the following day, Licensed Practical Nurse #9 resigned. Registered Nurse #6 stated they gave the investigation form to the Risk Manager to complete. The Assistant Director of Nursing/Risk Manager was interviewed on 5/2/2024 at 11:46 AM and stated that all Accident/Incident Investigation should be completed within 5 days. The Assistant Director of Nursing/Risk Manager stated that Resident #530 Accident/Incident investigation from 2/16/2024 was not completed within the 5-day timeframe because they were waiting for Licensed Practical Nurse #9's statement. The Assistant Director of Nursing stated they were not aware that Licensed Practical Nurse #9 had resigned the day after the incident. The Assistant Director of Nursing/ Risk Manager stated that the investigation should have been concluded within 5 days. The Director of Nursing Services was interviewed on 5/3/2024 at 10:00 AM and stated that all Accident/Incident Investigations must be completed within 5 days. All statements must be obtained and all areas of the investigation form must be completed. During a subsequent interview with the Director of Nursing Services on 5/6/2024 at 12:51 PM they stated that Licensed Practical Nurse #9 changed their status to a per-diem staff on 2/17/2024 and did not return to the facility. Licensed Practical Nurse #9 was subsequently terminated on 3/17/2024. The Director of Nursing Services stated they were not aware that a statement from Licensed Practical Nurse #9 was not obtained. The Director of Nursing Services stated that Resident #530's Accident and Incident investigation forms related to the incident on 2/16/2024 should have been completed and a conclusion should have been documented within 5 days to rule out abuse, neglect, and mistreatment. 41051 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) Resident #140 had diagnoses that included Dementia with Psychotic Disturbance, Anxiety Disorder, and Depression. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 0 which indicated the resident had severe cognitive impairment. Resident #140 had no impairment in the upper and lower extremities. Resident #140 utilized a wheelchair for mobility. Resident #140's Fall Potential Care Plan revised on 11/16/2023 documented that Resident #140 was at high risk for falls related to impaired cognition, balance, and mobility due to Dementia, Depression, Anxiety with psychotropic medication use, and incontinence. The interventions included to identify the cause of falls. Resident #140's Abuse Care Plan revised on 10/4/2023 documented that Resident #140 was at risk of being a victim of abuse due to their inability to understand their surroundings related to being physically abusive, being verbally abusive, and having disruptive behavior. The interventions included to assess the resident for signs and symptoms of abuse and neglect (ex. bruises, behavior, weight loss, psychosocial status) and report to the appropriate resources. The interventions also included to investigate all allegations of abuse and neglect promptly, to provide support, and to ensure Resident #140 was free from abuse. Resident #140's Behavior Care Plan revised on 4/19/2024 documented that Resident #140 exhibited behavior symptoms which included being combative with care, being verbally aggressive and disruptive, vandalizing, and going from room to room to gather nightgowns, and pillows. The inventions were to assist Resident #140 to their room, redirect the resident, and remove the resident from the environment. A review of Resident #140's electronic medical record investigation report dated 12/3/2023 at 6:24 PM documented that Resident #140 was observed with a skin tear on their left flank and was unable to give a description. The electronic medical record investigation summary dated 12/3/2023 documented the resident had combative behavior and was observed with a skin tear to the left flank area. The resident was unable to describe the event. The Accident/Incident Investigation form Registered Nurse Investigation Statement dated 12/3/2023 documented a skin occurrence to the left hip at 9:40 PM. The statement did not include a description of the skin occurrence. The Accident/Incident Investigation form- Charge Nurse/Licensed Practical Nurse Statement (did not include the resident's name, date, or time) documented the Licensed Practical Nurse was informed by a Certified Nursing Assistant that a resident had a skin mark on their left hip. The Accident/Incident Investigation form- the Assigned Certified Nursing Assistant Statement dated 12/3/2023 at 9:40 PM documented they observed a mark on Resident #140's left hip and the incident was reported to the Charge Nurse. A Nursing Progress Note dated 12/4/2023 at 7:02 AM documented Resident #140 was observed with a skin tear on their left flank. The Medical Doctor was notified and a wound care consultation was ordered. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #140's electronic medical record investigation report dated 12/18/2023 at 8:35 PM documented the Registered Nurse Supervisor was informed by a Certified Nursing Assistant that Resident #140 was noted with a skin opening to the left hip. The electronic medical record investigation summary dated 1/11/2024 documented, Upon investigation of this incident, there was no care plan violation. Nursing standards have been followed, and there was no indication of neglect or abuse found. The summary did not indicate the root cause of the injury and was not signed by the Director of Nursing Services or the facility Administrator. The electronic medical record investigation summary note dated 12/29/2023 documented there was no care plan violation, nursing standards were followed and there was no evidence of abuse, neglect, or mistreatment. The Assistant Director of Nursing Services/Risk Manager was interviewed on 5/7/2024 at 4:09 PM and stated they completed the investigation for Resident #140's injury of unknown origin that was identified on 12/3/2023 and 12/18/2024. The Risk Manager stated they ruled out abuse, neglect, and mistreatment based on one Certified Nursing Assistant statement and one Licensed Practical Nurse statement. The Risk Manager stated they did not notice the discrepancy between the wound sites on 12/3/2023 and 12/4/2023. The Risk Manager stated they did not complete an investigation for the left flank skin tear because they thought the injury was old. The Risk Manager stated that when an injury of unknown origin is discovered an investigation should be conducted and staff persons who provided care for the resident should be interviewed for the previous 72 hours depending on the severity of the injury and whether the resident had a history of combative or abusive behavior. The Risk Manager stated that Resident #140 had a history of combative and abusive behavior and based on the statements collected they determined a more extensive investigation did not need to be completed. The Director of Nursing Services was interviewed on 5/7/2024 at 5:09 PM and stated the Registered Nurse Supervisor is responsible for getting statements from the staff who worked 72 hours prior to identification of the injury of unknown origin irrespective of the resident's behavior. The Director of Nursing Services stated they reviewed and signed off on all investigations. The Director of Nursing Services stated they reviewed the Investigation summaries and the electronic medical record investigation reports; however, they did not review the statements completed by the staff because they found the Investigation Summary and electronic medical record investigation report acceptable. The Director of Nursing Services stated the investigations for the incidents dated 12/3/2023 and 12/18/2023 for Resident #140 did not have statements from staff who cared for the resident in the last 72 hours prior to the injury identification. The Director of Nursing Services further stated that the investigations were not thorough. 40696 3) Resident #133 was admitted to the facility with the diagnoses of Dementia, Psychotic Disorder, and Depression. The Quarterly Minimum Data set assessment dated [DATE] documented Resident #133 had severely impaired cognitive skills for daily decision-making, no recall ability, as well as long-term and short-term memory problems. Resident #133 had no impairment in the upper and lower extremities. Resident #133 utilized a walker and wheelchair for mobility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #133's Abuse Care Plan revised on 4/20/2024 documented that Resident #133 was at risk of being a victim of abuse due to their inability to understand their surroundings related to Dementia and dependence on others for activities of daily living. The interventions included to help Resident #133 with activities of daily living and support to ensure that Resident #133 is free from abuse. Resident #133's Behavior care plan revised on 4/20/2024 documented that Resident #133 exhibited behavioral symptoms including wandering, anger towards staff and residents, continuous pacing, screaming, yelling, cursing, removing clothing, crawling on the floor, sitting on the floor, laying on the floor, and rolling on the floor. The interventions included assisting Resident #133 to the room; providing an activity of choice; redirecting Resident #133; and removing Resident #133 from the environment. The weekly skin observation note dated 3/28/2024 at 9:19 AM documented that Resident #133 was observed with a new skin bruise to the left eye. The nurse's progress note dated 3/28/2024 at 2:20 PM, written by Licensed Practical Nurse #5, documented the nurse was called to the unit at 1:00 PM and was made aware that Resident #133 had a discoloration to the left corner of the eye. Resident #133 and the unit staff were unable to state what happened. Resident #133 walks around freely in the unit. Resident #133 was evaluated by the Registered Nurse Supervisor. A review of all progress notes for March 2024 revealed that the resident had no documented behaviors on 3/25/2024, 3/26/2024, and 3/27/2024, preceding the incident on 3/28/2028. The Accident and Incident investigation report dated 3/28/2024 documented that on 3/28/2024 at 1:00 PM, Licensed Practical Nurse #5 observed Resident #133 with a dark spot to their left eye and notified the Registered Nurse Supervisor. Licensed Practical Nurse #5 documented that Resident #133 was agitated and then went to their room earlier in the day. Licensed Practical Nurse #5 administered medications to Resident #133 when they last saw Resident #133. The assigned Certified Nurse Aide #9's written statement dated 3/28/2024 documented that during the dayshift, Certified Nurse Aide #9 noticed a discoloration to Resident #133's left eye while providing morning care. Certified Nurse Aide #9 reported the observed discoloration to Licensed Practical Nurse #5. Certified Nurse Aide #9 documented they did not transfer Resident #133 and that Resident #133 required limited assistance with transfers. An undated written statement by the 11:00 PM to 7:00 AM shift Certified Nurse Aide #10 documented that on 3/27/2024 they made rounds all night and changed Resident #133 during the night. Certified Nurse Aide #10 documented they did not notice anything on Resident #133's face. The Investigation Summary dated 3/28/2024 at 1:10 PM documented that Resident #133 had Advanced Dementia and Diabetes Mellitus. Resident #133 was often aggressive towards staff and continued to display agitation. Resident #133 was redirected by staff numerous times throughout the day. The summary documented Can conclude that [Resident #133] may have acquired discoloration during [Resident #133's] periods of aggression. Upon investigation of this incident, there was no care plan violation. Nursing standards have been followed and no indication of neglect or abuse found. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Risk Manager was interviewed on 5/7/2024 at 10:56 AM and stated that they conducted the investigation for Resident #133 on 3/28/2024 and wrote the summary. The Risk Manager stated they interviewed the staff members who worked 24 hours before the discovery of the discoloration on Resident #133's left eye. The Risk Manager stated the staff told them that there were no physical behaviors that may have caused the incident during their shift. The Risk Manager stated that because of the resident's history of physically aggressive behavior, the discoloration of the resident's left eye may have been caused by the resident's aggressive behavior. The Director of Nursing Services was interviewed on 5/7/2024 at 11:12 AM and stated they reviewed the Accident and Incident report dated 3/28/2024. The statements from the staff members who provided care for Resident #133 did not include physical behaviors that may have caused the discoloration. The Director of Nursing Services stated that the staff statements should include whether the resident had a physical behavior that may have caused the discoloration. The Director of Nursing Services stated that the conclusion did not include how the resident sustained the discoloration to their left eye. The Director of Nursing Services stated that the investigation as written was not thorough. 10 NYCRR 415.4(b)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. 34798 Based on record review and interviews during the Recertification Survey and Extended Survey (NY 00337759) initiated on 4/29/2024 and completed on 5/7/2024, the facility did not ensure that a physician wrote, signed, and dated a progress note at each visit. This was identified for one (Resident #126) of two residents reviewed for hospitalization . Specifically, on 3/17/2024 Resident #126 reported experiencing stroke-like symptoms. Physician #1 examined the resident but did not document the examination findings in the resident's medical record. Subsequently, the resident was transferred to the hospital after the resident's family activated emergency medical services and was diagnosed with a possible acute Cerebral Vascular Insufficiency. The finding is: The facility's policy titled, Physician Services last revised 5/3/2024, documented an alternate physician supervises the care of residents when the attending physician is not available. Physician orders and progress notes are maintained in accordance with Omnibus Budget Reconciliation Act regulations and facility policy. Physician visits, frequency of visits, and emergency care of residents are provided in accordance with current Omnibus Budget Reconciliation Act regulations and facility policy. Resident #126 was admitted with diagnoses including End Stage Renal Disease, Diabetes Mellitus, and Depression. The 2/3/2024 quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact. A nursing transfer to the hospital progress note dated 3/17/2024 at 1:24 PM, written by Registered Nurse #3 (supervisor), documented Reason for Transfer: the resident complained of stroke-like symptoms, family activated emergency medical services. Condition of Resident Upon Transfer: The resident was alert and oriented and was able to make their needs known. The resident was transferred to the hospital via emergency medical services. The resident's family, the Assistant Director of Nursing Services, and the Primary Physician were made aware. Licensed Practical Nurse #3, who was the medication nurse on unit 2 [NAME] during the 7:00 AM-3:00 PM shift on 3/17/2024, was interviewed on 5/1/2024 at 11:36 AM. Licensed Practical Nurse #3 stated they were alerted by a Certified Nursing Assistant the resident reported that their one arm was feeling weak like they were having a stroke. Licensed Practical Nurse #3 went in to see the resident, took the resident's vital signs, and then called Registered Nurse #3 (the nursing supervisor). The nursing supervisor spoke to a Physician on the unit. Licensed Practical Nurse #3 could not recall the name of the Physician. Certified Nursing Assistant #3 was interviewed on 5/1/2024 at 12:27 PM and stated on 3/17/2024 Resident #126 called them to the resident's room and said they were not feeling well and that their hand was numb. Certified Nursing Assistant #3 stated they immediately notified Licensed Practical Nurse #3. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #126 was interviewed on 5/1/2024 at 12:42 PM and stated on 3/17/2024 they were on the phone with their family complaining about not feeling well their hands were numb and their family called 911. Resident #126 stated they had alerted a Certified Nursing Assistant about their symptoms and Registered Nurse #3 came into the room with a Doctor. The Doctor said there was nothing wrong even though they (Resident #126) were telling them they were having a stroke. Resident #126 stated they were having slurred speech and their family knew something was wrong and that is why their family called 911. A review of the medical record revealed no documentation from a Physician on 3/17/2024. Assistant Director of Nursing #3 was interviewed on 5/1/2024 at 2:16 PM and stated on 3/17/2024 Registered Nurse #3 had called them to assist with getting the transfer paperwork together for Resident #126 because the family had activated the emergency medical services. Assistant Director of Nursing #3 stated they did not assess the resident and all they saw was the resident leaving on a stretcher. Assistant Director of Nursing #3 stated they did not know if the resident was seen by a Physician at the facility on 3/17/2024. Registered Nurse #3 was interviewed on 5/2/2024 at 8:57 AM. Registered Nurse #3 stated they received a call on 3/17/2024 that Resident #126 reported stroke-like symptoms. Registered Nurse #3 went into the resident's room and the resident reported chest pain and trouble talking. The resident's vital signs were normal, and Registered Nurse #3 did not notice any issues with speech or weakness in the resident's hands. There was a physician on the unit seeing other residents. Registered Nurse #3 asked the Physician if they could examine the resident. The Physician went into the resident's room with Registered Nurse #3, asked the resident questions, and listened to the resident's heart rate. This Physician (name not recalled) then asked Registered Nurse #3 to follow up with the resident's Primary Physician for further interventions. The Primary Physician responded after the emergency services arrived at the facility. The Medical Director, who was also the resident's Primary Physician, was interviewed on 5/2/2024 at 11:27 AM. The Medical Director stated they did not know which Physician had examined Resident #126 on 3/17/2024. The Medical Director stated they found out about the incident when emergency medical services were already transferring the resident to the hospital. The Medical Director stated the Physician who assessed the resident should have written a note in the resident's medical record to describe the resident's condition at the time of their assessment. Physician #1 was interviewed on 5/2/2024 at 1:19 PM and stated on 3/17/2024 they were seeing their assigned resident when the nurse asked them to see Resident #126. Physician #1 stated they did not know Resident #126 and did not know the resident's baseline, but the resident's vital signs were normal. Physician #1 saw Resident #126 and did an examination and did not find anything abnormal with the resident. Physician #1 stated they asked the nurse to communicate with the resident's Primary Physician. Physician #1 stated they could not decide to send the resident to the emergency room because they did not see anything abnormal. Physician #1 stated they did not reach out to the resident's Primary Physician and did not write a progress note because there were no negative findings. Physician #1 stated they should have written a progress note. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the hospital discharge documentation dated 3/20/2024 documented that on 3/17/2024 the emergency medical services noted that the resident had a facial droop and slurred speech. In the emergency department, the resident had the same symptoms. The National Institutes of Health Stroke Scale was initially 2 in the emergency department and then increased to a score of 4 (a score of 1-4 indicates minor stroke). The resident received Tenecteplase (a medication to dissolve blood clots) with moderate improvement. The National Institutes of Health Stroke Scale returned to 0, which was the resident's baseline. A computed tomography scan of the brain was done but did not reveal a cerebrovascular accident. At this time, the resident possibly had an acute Cerebral Vascular Insufficiency. The Director of Nursing Services was interviewed On 5/2/2024 at 02:20 PM and stated the Physician who examined the resident on 3/17/2024 should have written a progress note. The Medical Director was re-interviewed On 5/3/2024 at 8:15 AM and stated that Physician #1 should have written a progress note after they examined the resident on 3/17/2024. 10 NYCRR 415.15(b)(2)(iii)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on interview, and record review during the Recertification Survey and Abbreviated Survey (Complaint # NY 00339556) initiated on [DATE] completed on [DATE], the facility did not ensure that all residents were provided medically-related social services to attain or maintain the highest practicable well-being. This was identified for one (Resident #380) of one Resident reviewed for Hospice and End of Life. Specifically, Resident #380 was admitted to the facility with a deteriorating health condition due to a diagnosis of Cancer. On [DATE] (Saturday) upon request of Resident #380's designated representative the Physician wrote an order to obtain a Hospice service referral. The facility's Social Worker or designee was not available to request the physician-ordered Hospice service referral until Monday ([DATE]). Resident #380 expired on [DATE] shortly after the referral to the Hospice services was made. The finding is: The facility Social Services policy and procedure revised on ,d+[DATE] documented that the Social Service Director or designee is responsible for ensuring appropriate departmental documentation. The policy and procedure did not document the procedure for medically related referrals. Resident #380 was admitted with the diagnoses of Cancer, Dysphagia (difficulty swallowing), and Depression. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #380 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #380's Care Plan dated [DATE] documented that Resident #380 had Medical Orders for Life-Sustaining Treatment. The interventions included do not intubate, do not resuscitate. The care plan was updated on [DATE] to include new interventions: to provide comfort measures only, and do not send to the hospital. Resident #380's Care Plan dated [DATE] documented that Resident #380 was at risk for Neoplastic disorders related to Gastric Adenocarcinoma Stage 4B (advanced stomach Cancer). The interventions included that the social work department would discuss palliative and comfort care with Resident #380, their family, and their significant other. A review of the Medical Orders for Life-Sustaining Treatment forms dated [DATE], [DATE], and [DATE] revealed that Family Member #1 was the Health Care Agent (the individual making health care decisions) for Resident #380. Resident #380 had Do Not Attempt Resuscitation (allow natural death), Do Not Intubate, send to the hospital when medically necessary and Limited medical interventions orders on the [DATE] form. The Medical Orders for Life-Sustaining Treatment form was updated on [DATE] and included: do not send to hospital and comfort measures only (provide medical care and treatment with the primary goal of relieving pain and other symptoms). The Physician's Progress note dated [DATE] documented that Physician #3 spoke to Resident #380's health care proxy (Family Member #1) who wanted Resident #380 to be on comfort measures and wished for a Hospice referral. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #380's Physician's order dated [DATE] documented to obtain Hospice Consult. A review of all progress notes revealed that there was no further documentation of Family Member #1's request for a Hospice referral or efforts made to provide the referral. The Discharge Summary note dated [DATE] documented that Resident #380 had advanced directives that directed for do not resuscitate and comfort care. Resident #380 was noted unresponsive to all stimuli and vital signs were unobtainable. Resident #380 was pronounced deceased by two Registered Nurses at approximately 4:20 PM. Family member #1 was interviewed on [DATE] at 2:44 PM and stated they were in touch with Social Worker #1 since Resident #380 was admitted to the facility in February 2024 and discussed the plan to place Resident #380 under Hospice services when Resident #380 starts to have a decline in health. Family Member #1 stated they visited Resident #384 on [DATE] and learned that Resident #384 was not eating for last 24 hours and told Licensed Practical Nurse #1 that they wanted to initiate Hospice services since Resident #380's end of life was imminent. Licensed Practical Nurse #1 then informed Assistant Director of Nursing #1. Assistant Director of Nursing #1 informed Family Member #1 that none of the Social Workers were available and that they would try to contact the Director of Social Work. Family Member #1 stated they (Family Member #1) never heard back from the Social Worker on [DATE] and [DATE]. On [DATE], Family Member #1 approached Social Worker #1 and requested to transfer Resident #384 to a Hospice program, and a referral was finally made on [DATE]. Family Member #1 stated that by the time the referral was made, it was too late. Resident #380 passed away on [DATE] before the resident could be transferred to the Hospice program. Social Worker #1 was interviewed on [DATE] at 1:00 PM and stated that Resident #380 had a care plan meeting on [DATE] and Family Member #1 attended the meeting. Social Worker #1 stated that comfort measures were discussed because Resident #380 was approaching the end of life and that the facility did not offer Hospice services. Social Worker #1 stated they did not offer a referral to Hospice services. Social Worker #1 stated that no one reached out to them over the weekend ([DATE] and [DATE]). Social Worker #1 stated that a Social Worker and or the Director of Social Work is on-call for the weekend coverage. Social Worker #1 stated they spoke with Family Member #1 on [DATE] and re-iterated comfort care measures. The Director of Social Work was interviewed on [DATE] at 2:06 PM and stated they were on call the weekend of [DATE] and [DATE]. The Director of Social Work stated they did receive a phone call from Physician #3 on [DATE]. The Director of Social Work stated that they (Director of Social Work) did not call Family Member #1 on [DATE] or [DATE] because the Director of Social Work was told that the family was exploring Hospice care and they (Director of Social Work) expected the resident's family to get in touch with them when the decision was made. The Director of Social Work stated that they did not speak to Family Member #1 about Hospice services. The Director of Social Work was not aware of the Physician's order for a Hospice consult on [DATE]. The Director of Social Work stated that ultimately, the assigned Social Worker (Social Worker #1) should facilitate the Hospice referral and document any communication with the Hospice services. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #1 was re-interviewed on [DATE] at 9:28 AM and stated they now recall that on [DATE] during the care plan meeting, Family Member #1 wanted to explore Hospice services. Social Worker #1 stated they were aware that Family Member #1 wanted Hospice service. Social Worker #1 stated that if they (Social Worker #1) were available on the weekend and received a notification that Family Member #1 wanted Hospice services for Resident #380, Social Worker #1 would have provided the referral the same day. Social Worker #1 stated that on Monday, [DATE], Family Member #1 approached them and requested the referral. Social Worker #1 stated that they were rushing to complete the referral on [DATE] because Resident #380 was actively dying. Social Worker #1 stated they did not document that they referred Resident #380 to the Hospice program because they were rushing. Social Worker #1 stated that they did not retain a copy of the referral in the resident's medical record because they forgot. Social Worker #1 stated that Resident #380 expired on [DATE], shortly after the referral was made. The Administrator was interviewed on [DATE] at 10:03 AM and stated that when the Physician initiates the order for a consultation, the nursing and social work department should follow up with the order. The Social Work department is ultimately responsible for initiating the referral and transfer to Hospice services. 10 NYCRR 415.5(g)(1)(i-xv)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on record review and interviews during the Recertification and Abbreviated (NY 00331067) Survey initiated on 4/29/2024 and completed on 5/7/2024, the facility did not ensure each resident received routine dental services to meet the needs of each resident. This was identified for one (Resident #127) of one resident reviewed for Dental Services. Specifically, Resident #127 had a dental consult completed on 3/18/2024. The dental consult documented recommendations for a dental follow-up visit in one week with medical clearance for tooth extraction. There was no documented evidence that the recommendations made by the Dentist were addressed until 5/7/2024. The finding is: The facility's Dental Services policy last revised in December 2023, documented to provide residents with routine and emergency dental services. Residents have the right to select Dentists of their choice when dental care or services are needed. A social services representative will assist residents with appointments and transportation arrangements. Resident #127 was admitted with diagnoses including Dysphagia (difficulty swallowing), Obesity, and Diabetes Mellitus. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident had a Brief Interview for Mental Status score of 15, indicating intact cognition. The Minimum Data Set assessment documented that the resident did not have any chewing or swallowing disorder and received a mechanically altered diet. A Physician's order dated 4/15/2022 last revised on 3/4/2024 documented Consistent Carbohydrate and Renal diet, Mechanically Altered Chopped texture, and thin liquid consistency. A Comprehensive Care Plan for Dental, effective 1/29/2020 and last revised 9/22/2023, documented the resident has an alteration in dental care, resident is edentulous (no teeth), and is not a candidate for dentures secondary to extreme class 3 occlusion (the lower jaw or teeth projected further forward than the upper jaw or teeth). The intervention included to obtain a dental consult as needed. A Dental consult dated 3/18/2024 documented that Resident #127 was seen by an outside Dentist. Resident #127 was to get full upper (FU) and partial lower (PL) extraction and other minor treatment and needed an appointment the following week. The Dentist documented that Resident #127 required medical clearance from the attending Physician to stop the Aspirin order before teeth extractions. A review of the medical record from 3/18/2024 to 5/7/2024 revealed there was no documented evidence that a follow-up visit to the Dentist was scheduled for Resident #127. Resident #127 was interviewed on 5/1/2024 at 2:44 PM and stated they did not have all their teeth and were only able to eat chopped or soft foods. Resident #127 stated that they could not tolerate tough meats because of their dentition status and wanted to be able to eat regular food. Resident #127 stated they went to the Dentist earlier this year and needed to go back. Resident #127 stated that the nurse forgot about scheduling the appointment for them and they had to call the dental office themselves. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #127 was re-interviewed on 5/6/2024 at 1:03 PM and stated that they (Resident #127) scheduled a dental appointment for 5/8/2024. Licensed Practical Nurse #1, who was the unit medication nurse, was interviewed on 5/6/2024 at 12:36 PM. Licensed Practical Nurse #1 stated that Resident #127 had no pending outside appointments or consults. Licensed Practical Nurse #1 stated they were not aware that Resident #127 needed a dental follow-up appointment. Licensed Practical Nurse #1 stated that they did not handle the paperwork or schedule appointments. Licensed Practical Nurse #1 stated that the unit manager is responsible for follow-up and arranging appointments and transportation for residents. Registered Nurse Supervisor #2 was interviewed on 5/6/2024 at 1:17 PM. Registered Nurse Supervisor #2 stated they did not recall reviewing Resident #127's dental consultation form on 3/18/2024 but recalled contacting Resident #127's dentist for follow-up. Registered Nurse Supervisor #2 stated that the Dentist stated that they would speak with Resident #127's attending physician directly to obtain medical clearance for Resident #127. Registered Nurse Supervisor #2 stated they did not obtain a medical clearance or schedule any follow-up appointment for Resident #127 after 3/18/2024. Registered Nurse Supervisor #2 was not aware of Resident #127's dental appointment on 5/8/2024. Licensed Practical Nurse #5, who was the unit manager, was interviewed on 5/6/2024 at 3:17 PM and stated they were responsible for reviewing all consultation forms brought back by residents and addressing all recommendations which included obtaining medical clearance, scheduling follow-up appointments, and arranging for transportation as needed. Licensed Practical Nurse #5 stated they did not review Resident #127's dental consultation form dated 3/18/2024. Licensed Practical Nurse #5 stated they did not schedule any follow-up appointment for Resident #127 after 3/18/2024. Licensed Practical Nurse #5 stated that Resident #127 preferred to schedule an appointment on their own and Licensed Practical Nurse #5 had provided Resident #127 with their contact information so that Resident #127 could contact them (Licensed Practical Nurse #5) as needed. Licensed Practical Nurse #5 stated they did not know if Resident #127 was seen by a Physician for a medical clearance. Licensed Practical Nurse #5 was not aware of Resident #127's dental appointment on 5/8/2024. A staff person from Resident #127's Dentist's office was interviewed on 5/7/2024 at 11:25 AM and stated Resident #127's last visit was on 3/18/2024. The staff person stated that Resident #127 was expected to return for a follow-up visit but Resident #127 had not been back since 3/18/2024. Physician #4 was interviewed on 5/7/2024 at 2:13 PM and stated they worked with Resident #127's attending physician who was also the facility's Medical Director. Physician #4 stated that they did not recall being notified to evaluate Resident #127 for medical clearance for dental procedures until today 5/7/2024. Physician #4 stated they expected all consultation forms and recommendations should be reviewed and addressed within 24 hours from when residents returned from their consultant appointments. Physician #4 stated that medical-related recommendations should be addressed with the resident's Physician as soon as possible because some recommendations are urgent and require immediate attention. The Medical Director, who was Resident #127's attending Physician, was interviewed on 5/7/2024 at 2:57 PM and stated they were not notified to evaluate Resident #127 for medical clearance for a dental follow-up. The Medical Director stated they should have been notified of the recommendations made by the Dentist as soon as possible so the recommendations were addressed timely. (continued on next page)

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	335211	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glengariff Health Care Center	141 Dosoris Lane Glen Cove, NY 11542

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing Services was interviewed on 5/7/2024 at 3:12 PM and stated the nursing supervisors should be responsible for reviewing and addressing all recommendations made by the consultants. The Director of Nursing Services stated Resident #127's Physician should have been notified to provide medical clearance for Resident #127 and a follow-up appointment and transportation should have been scheduled for Resident #127 after the recommendations made by the Dentist on 3/18/2024. 10 NYCRR 415.17(a-d)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40696 Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00339556) initiated on [DATE] and completed on [DATE], the facility did not ensure that all residents were assisted with the provision of Hospice services when a resident requested a transfer. This was identified for one (Resident #380) of one Resident reviewed for Hospice and End of Life. Specifically, Resident #380's designated representative requested Hospice services on [DATE] and a referral was not provided until [DATE]. Resident #380 expired on [DATE] shortly after the referral to the Hospice services was made. The finding is: The facility Comfort Care and Palliative Care policy and procedure revised on ,d+[DATE] documented it is the policy of the facility to respect the wishes of the residents and their designated representatives regarding end-of-life decisions. The policy documented that the interdisciplinary team explores Hospice where appropriate. The facility does not provide in-house Hospice service. The policy did not address the criteria for Hospice referral and the procedure to transfer residents to a Hospice program. The policy also did not address the protocol to facilitate a resident's or the designated representative's requests for Hospice services. Resident #380 was admitted with the diagnoses of Cancer, Dysphagia (difficulty swallowing), and Depression. The Admission Minimum Data Set (MDS) assessment dated [DATE] documented that Resident #380 had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderately impaired cognition. Resident #380's Care Plan dated [DATE] documented that Resident #380 had Medical Orders for Life-Sustaining Treatment. The interventions included do not intubate, do not resuscitate. The care plan was updated on [DATE] to include new interventions: to provide comfort measures only, and do not send to the hospital. Resident #380's Care Plan dated [DATE] documented that Resident #380 was at risk for Neoplastic disorders related to Gastric Adenocarcinoma Stage 4B (advanced stomach Cancer). The interventions included that the social work department would discuss palliative and comfort care with Resident #380, their family, and their significant other. A review of the Medical Orders for Life-Sustaining Treatment forms dated [DATE], [DATE], and [DATE] revealed that Family Member #1 was the Health Care Agent (the individual making health care decisions) for Resident #380. Resident #380 had Do Not Attempt Resuscitation (allow natural death), Do Not Intubate, send to the hospital when medically necessary and Limited medical interventions orders on the [DATE] form. The Medical Orders for Life-Sustaining Treatment form was updated on [DATE] and included: do not send to hospital and comfort measures only (provide medical care and treatment with the primary goal of relieving pain and other symptoms). (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Progress note dated [DATE] documented that Physician #3 spoke to Resident #380's health care proxy (Family Member #1) who wanted Resident #380 to be on comfort measures and wished for a Hospice referral. Resident #380's Physician's order dated [DATE] documented to obtain Hospice Consult. A review of all progress notes revealed that there was no further documentation of Family Member #1's request for a Hospice referral or efforts made to provide the referral. The Discharge Summary note dated [DATE] documented that Resident #380 had advanced directives that directed for do not resuscitate and comfort care. Resident #380 was noted unresponsive to all stimuli and vital signs were unobtainable. Resident #380 was pronounced deceased by two Registered Nurses at approximately 4:20 PM. Family member #1 was interviewed on [DATE] at 2:44 PM and stated they were in touch with Social Worker #1 since Resident #380 was admitted to the facility in February 2024 and discussed the plan to place Resident #380 under Hospice services when Resident #380 starts to have a decline in health. Family Member #1 stated they visited Resident #384 on [DATE] and learned that Resident #384 was not eating for the last 24 hours and told Licensed Practical Nurse #1 that they wanted to initiate Hospice services since Resident #380's end of life was imminent. Licensed Practical Nurse #1 then informed Assistant Director of Nursing #1. Assistant Director of Nursing #1 informed Family Member #1 that none of the Social Workers were available and that they would try to contact the Director of Social Work. Family Member #1 stated they (Family Member #1) never heard back from the Social Worker on [DATE] and [DATE]. On [DATE], Family Member #1 approached Social Worker #1 and requested to transfer Resident #384 to a Hospice program, and a referral was finally made on [DATE]. Family Member #1 stated that by the time the referral was made, it was too late. Resident #380 passed away on [DATE] before the resident could be transferred to the Hospice program. Licensed Practical Nurse #1 was interviewed on [DATE] at 11:09 AM and stated that they worked on the 7:00 AM to 3:00 PM shift on [DATE]. Family Member #1 approached them and wanted a care plan meeting to discuss Resident #380's decline in health and to transfer Resident #380 to a Hospice program. Licensed Practical Nurse #1 stated that they walked Family Member #1 over to Assistant Director of Nursing #1's office and explained Family Member #1's concerns to Assistant Director of Nursing #1. Assistant Director of Nursing #1 was interviewed on [DATE] at 12:18 PM and stated Family Member #1 requested Hospice services on Saturday, [DATE], during the 7:00 AM to 3:00 PM shift. Assistant Director of Nursing #1 told Family Member #1 that the Social Worker was not at the facility on the weekends, and they would call the Social Worker to move forward with the request for Hospice. Assistant Director of Nursing #1 stated that the Nursing staff could not provide the referral and that a Social Worker would have to arrange for an evaluation for Hospice services. Assistant Director of Nursing #1 told Family Member #1 that they (Family Member #1) would have to wait until Monday, [DATE], because the Hospice referral was a process. Assistant Director of Nursing #1 stated that they believed that the on-call Social Worker that weekend ([DATE] and [DATE]) was the Director of Social Work. Assistant Director of Nursing #1 stated that they could not recall if they were able to speak to the Director of Social Work on [DATE]. Assistant Director of Nursing #1 stated that they did not document the discussion with Family Member #1 in the resident's electronic medical record. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #1 was interviewed on [DATE] at 1:00 PM and stated that Resident #380 had a care plan meeting on [DATE] and Family Member #1 attended the meeting. Social Worker #1 stated that comfort measures were discussed because Resident #380 was approaching the end of life and the facility did not offer Hospice services. Social Worker #1 stated they did not offer a referral to Hospice services. Social Worker #1 stated that no one reached out to them over the weekend ([DATE] and [DATE]). Social Worker #1 stated that a Social Worker and or the Director of Social Work is on-call for the weekend coverage. Social Worker #1 stated they spoke with Family Member #1 on [DATE] and re-iterated comfort care measures. Social Worker #1 was re-interviewed on [DATE] at 1:29 PM and stated that upon review of their emails and progress notes, Social Worker #1 did not document any referrals made to Hospice services or Family Member #1's request for Hospice service. Physician #3 was interviewed on [DATE] at 1:39 PM and stated that on [DATE] they spoke with Family Member #1 via phone. Family Member #1 wanted a Hospice consult for Resident #380. Physician #3 stated they ordered a Hospice consult for Resident #380 on [DATE]. Physician #3 stated that in the meantime, comfort measures were implemented, and the resident's pain management regimen was modified. Physician #3 stated they spoke with the Director of Social Work on [DATE] about Family Member #1's request for Hospice services. Physician #3 stated that they (Physician #3) did not think that the Hospice program was open on the weekend and expected a follow-up on Monday, [DATE]. Physician #3 stated that on Monday ([DATE]) a Hospice referral was made, and they spoke to a representative from the Hospice program. Resident #380 expired shortly after they spoke with the Hospice program staff. The Director of Social Work was interviewed on [DATE] at 2:06 PM and stated they were on call the weekend of [DATE] and [DATE]. The Director of Social Work stated they did receive a phone call from Physician #3 on [DATE]. The Director of Social Work stated that they (Director of Social Work) did not call Family Member #1 on [DATE] or [DATE] because the Director of Social Work was told that the family was exploring Hospice care and they (Director of Social Work) expected the resident's family to get in touch with them when the decision was made. The Director of Social Work stated that they did not speak to Family Member #1 about Hospice services. The Director of Social Work was not aware of the Physician's order for a Hospice consult on [DATE]. The Director of Social Work stated that ultimately, the assigned Social Worker (Social Worker #1) should facilitate the Hospice referral and document any communication with the Hospice services. The Quality Assurance Manager at the hospice program was interviewed on [DATE] at 2:17 PM and stated that Resident #380 was registered in the Hospice program's system as of [DATE] and the referral was received from Social Worker #1 on [DATE] at 2:19 PM. The Quality Assurance Manager stated that 3 hours later, a telephone call from Family Member #1 was documented in the system informing the Hospice program that Resident #380 expired. The Quality Assurance Manager stated that the Hospice program was available seven days a week to receive referrals. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Social Worker #1 was re-interviewed on [DATE] at 9:28 AM and stated during the care plan meeting on [DATE] Family Member #1 wanted to explore Hospice services for Resident #380. Social Worker #1 stated that if they (Social Worker #1) were available on the weekend and received a notification that Family Member #1 wanted Hospice services for Resident #380, Social Worker #1 would have provided the referral the same day. Social Worker #1 stated that on Monday, [DATE], Family Member #1 approached them and requested the referral. Social Worker #1 stated that they were rushing to complete the referral on [DATE] because Resident #380 was actively dying. Social Worker #1 stated they did not document that they referred Resident #380 to the Hospice program because they were rushing. Social Worker #1 stated that they did not retain a copy of the referral in the resident's medical record because they forgot. Social Worker #1 stated that Resident #380 expired on [DATE], shortly after the referral was made. The Administrator was interviewed on [DATE] at 10:03 AM. The Administrator stated that the facility should initiate the referral for Hospice within the day when a family requests Hospice services. The Administrator stated that the facility provides comfort care until Hospice services take over the care for the resident. When the Physician initiates the order for a consultation, the nursing and social work department follows up with the order. The social work department is ultimately responsible for initiating the referral and transfer to Hospice services. 10 NYCRR 415.12