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	09/27/2024

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 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** 50429 Based on observation, interviews and record review during an abbreviated survey conducted on 9/3/24 through 9/27/24, the facility did not ensure that the alleged violations involving abuse, including injuries of unknown source, neglect, or mistreatment were reported within 24 hours to the New York State Department of Health. This was identified for two (Resident #1 and Resident #2) of three resident records reviewed for Abuse. 1) Specifically, Resident #1 was observed with areas of bruises to their forehead and area above their right eye. The cause of this injury was unknown. 2) Resident #2 was pushed by another resident and fell to the ground hitting their head on 08/06/2024 and neither (Resident #1 and Resident #2) incidents were not reported to the New York State Department of Health as required. The findings are: 1) The facility's policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating created on 3/2022 and revised on 6/21/24 documented that if resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. The administrator or the individual making the allegation immediately reports their suspicion to the state licensing/certification agency responsible for surveying/licensing the facility immediately within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Resident #1 admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Anxiety and Depression. The Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status score of 4 which identified Resident #1's cognitive status as severely impaired. There was no documented hallucination, delusions, or behaviors. Resident #1 required supervision to moderate assistance with activities of daily living. The Occurrence Investigative Summary dated 9/2/24 and completed by Unit Manager #2 documented that the type of occurrence was an ecchymoses (bruise) area to Resident #1's right side of forehead and above the right eye. The Occurrence Investigative Summary that on 9/2/24 at 8:15AM during rounds Resident #1 was noted with Ecchymoses (bruise) area to right side of their forehead. There was no documented evidence that the facility reported Resident #1's injury of unknown origin to the New York State Department of Health. (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

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	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	During an interview with Certified Nursing Assistant #1 on 9/3/24 at 11:45 AM, they stated that they observed the bruise to Resident #1's face at 8:15 AM on 9/2/24 and reported it to License Practical Nurse #1. During an interview with the Director of Nursing on 9/3/24 at 3:53 PM they stated they were only aware of the incident today. Resident #1 had gone out with family member and returned with a bruise. Resident #1 was noted with ecchymosis (bruise) to right side of forehead and area above right eye of unknown origin. They stated any injury of unknown origin is reportable and they were not able to rule out that abuse occurred. During an interview with Licensed Practical Nurse #1 on 9/3/24 at 4:21 PM, they stated that on 9/2/24 at 8:15 AM Certified Nursing Assistant #1 reported that Resident #1 had a bruise on their face. Unit Manager #2 and Assistant Director of Nursing checked Resident #1. During an interview with Assistant Director of Nursing on 9/5/24 at 11:35 AM, they stated that they were informed by Unit Manager #2 that Resident #1 had discoloration to area above right eye. During the assessment by the Assistant Director of Nursing they stated that they did not think it was an abuse case because of what Resident #1 had told them and they did not report it. During an interview with Unit Manager #2 on 9/5/24 at 1:04 PM they stated that Licensed Practical Nurse #1 informed them that Resident #1 had discoloration to right side of their forehead and area above their right eye. Unit Manager #2 stated they did not think of it as abuse and reported to the Assistant Director of Nursing because the resident did not know what happened. During a phone interview with the Risk Manager on 9/11/24 at 3:38 PM, they stated that they were off during the investigation of the incident. They stated that the Incident Report was completed by the supervisor and reviewed by Director of Nursing. During a phone interview with the Risk Manager on 9/24/24 at 9:19 AM they stated that they reviewed the incident and they did not report it because it was not considered an injury of unknown origin since Resident #1's family member was able to tell them that the bruise was from a bug bite when they went to the botanical garden. 50951 2) Resident #2 was admitted on [DATE] with documented diagnosis that included mild cognitive impairment, history of falls, and osteoarthritis. Resident had a Minimum Data Set, dated dated dated [DATE] that documented a Brief Interview of Mental Status score of 12. Resident #2 passed away at the facility on 08/09/24. A Nurses Note dated 8/6/2024 at 10:20 AM documented that Resident #6 pushed Resident #2 to the floor. Resident #2 fell to the floor onto their buttock and elbows and then hit their head on floor. The physician assessed the resident and ordered Ativan for agitation. During a record review there was no documented evidence that the facility reported the altercation between Resident #2 and Resident #6 which resulted in a fall of Resident #2. (continued on next page)

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	335211	A. Building B. Wing	09/27/2024

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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	During an interview with Administrator on 09/25/2024 at 2:13 PM the Administrator was interviewed and stated that the facility could not find an Accident and Investigation report for Resident #2 and Resident #6 on 08/06/2024 at 10:20. During an interview with Manager on 09/25/2024 at 4:49 PM Risk Manager stated that they did not know why a report was not made to the New York State Department of Health for this incident. During an interview with the Licensed Practical Nurse Unit Manager on 09/26/2024 at 12:59 PM that the reason an Accident and Investigation was not completed for this incident was because the Administrator looked at the video and did not see any altercation, push, or fall for Resident #2. During an interview with Administrator on 09/26/2024 at 1:52 PM The administrator stated they could not recall reviewing the video for this incident. The Administrator stated that if they had seen a fall or altercation on the video there would have been an Accident and Investigation form completed and the incident would have been reported to the New York State Department of Health within two hours. During a telephone Interview with Director of Nursing on 09/26/2024 at 2:18 PM the Director of Nursing stated they arrived on unit when resident to resident incident and fall was reported on 08/06/2024. The Director of Nursing stated they did not start an Accident and Investigation because when they arrived on the unit, Resident #1 was alert and agitated, walking around. The Administrator viewed the video footage and did not see the altercation or fall. 10NYCRR 415.4 (b) (1) (ii)

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	09/27/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50429 Based on observation, interviews and record review during an abbreviated survey conducted on 9/3/24 through 9/18/24, the facility did not ensure that all alleged violations of resident abuse, neglect, exploitation, or mistreatment, including an injury of unknown origin were thoroughly investigated. This was identified for 2 of 3 residents reviewed for abuse. Specifically, 1) Resident # 1 was observed with an injury of unknown origin to the right side of their face and eyebrow area on 9/1/24. 2) Resident #2 was pushed by another resident and fell to the ground hitting their head on 08/06/2024.There is no documented evidence that the facility did a thorough investigation of the incidents to identify the root cause of the injury and to rule out Abuse, Neglect, and Mistreatment. This is a repeat deficiency. The findings are: 1) The facility's policy titled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating created on 3/2022 and revised on 6/21/24 documented that all allegations are thoroughly investigated. The administrator initiates investigations. Investigations may be assigned to an individual trained in reviewing, investigating, and reporting such allegations. The administrator provides supporting documents and evidence related to the alleged incident to the individual in charge of the investigation. Resident #1 admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Anxiety and Depression. The Minimum Data Set, dated dated dated [DATE] documented a Brief Interview for Mental Status score of 4 which identified Resident #1's cognitive status as severely impaired. There was no documented hallucination, delusions, or behaviors. Resident #1 required supervision to moderate assistance with activities of daily living. A nurses note dated 9/2/24 and completed by Unit Manager #2 documented that they were called to unit at 8:15 AM and informed that Resident #1 was observed with an ecchymosis (bruise) area to their forehead and above their right eye. Resident #1 denied any pain or discomfort. Resident#1's physician and family member were informed. A late entry nurses note dated 9/2/24 and completed by the Assistant Director of Nursing documented that they spoke with Resident #1 regarding the discoloration above their right eye and Resident #1 stated they were in bed when the phone rang and banged their face trying to answer the phone. A late entry nurses note dated 9/3/24 and completed by License Practical Nurse #2 documented that Resident #1 returned from out on pass on 9/1/24 and was noted with redness to the right side of their head/forehead. Resident #1's family member was questioned and stated, this is normal for them. The report from the morning shift nurse stated Resident #1 left the facility with no injury. The Medical Director note dated 9/3/24 documented that they were asked to see Resident #1 to check their right upper eye and forehead bruises after they returned from out on pass. Resident #1 provided different reasons on how they may have gotten the bruise. Resident #1 was prone to ecchymosis (bruises) due to fragile skin aging related to smoking. The ecchymosis (bruise) area was not tender to touch, eye muscles were intact and neurologic exam was at their baseline. (continued on next page)

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	335211	A. Building B. Wing	09/27/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Incident Report dated 9/2/24 completed by Unit Manager #2 documented that the type of occurrence was an ecchymosis (bruise) area to right side of forehead and above the right eye that Resident #1 went out on pass on 9/1/24 and that on 9/2/24 Resident #1 was noted with an ecchymosis (bruise) area to right side of their forehead. The conclusion documented Resident #1 was in facility with no alteration in skin integrity prior to going out on pass. Resident #1 went out on pass with family member and returned with redness to right side of face and forehead. Family member was questioned and stated, this is normal and when further questioned they stated it could be from a bug bite when they went to the botanical park. Video surveillance was reviewed and confirmed that Resident #1 left without any ecchymosis (bruise). Upon discussion with Medical Director, they stated that Resident #1 was noted with a very vascular superficial forehead area and ecchymosis may have been from a burst capillary or vein. Upon investigation of this incident, there was no care plan violation and no indication of neglect or abuse found Comprehensive Care plan titled at risk for potential for abuse initiated on 4/9/24 noted with intervention to follow up with social services. During an interview with Resident #1 on 9/3/24 at 11:36 AM, they stated that they fell when they were walking outside of the building. During an interview with Certified Nursing Assistant #1 on 9/3/24 at 11:45 AM, they stated that they observed the bruise to Resident #1's face at 8:15 AM on 9/2/24 and reported it to License Practical Nurse #1. During a phone interview with Licensed Practical Nurse #2 on 9/3/24 at 2:57 PM, they stated that on 9/1/24 Resident #1 and their family member returned to the unit around dinner time. Licensed Practical Nurse #2 noticed a small redness to Resident #1's right side of face and brow area and when the family member was questioned, they stated that that's normal for them. Licensed Practical Nurse #2 did not report to their nursing supervisor because of what the family member had told them, and they did not think there was abuse. During a phone interview with Licensed Practical Nurse #3 on 9/3/24 at 3:46 PM they stated that they worked 11-7 shift on 9/1/24, they did not get report that Resident #1 returned to the facility from out on pass with a bruise and did not see Resident #1 during their shift. Licensed Practical Nurse #3 added that they don't see residents during their shift if they don't have scheduled medication for the resident. During an interview with the Director of Nursing on 9/3/24 at 3:53 PM they stated they were only aware of the incident today. Resident #1 had gone out with family member and returned with a bruise. Resident #1 was noted with ecchymosis (bruise) to right side of forehead and area above right eye of unknown origin. They stated any injury of unknown origin is reportable and they were not able to rule out that abuse occurred. During an interview with Licensed Practical Nurse #1 on 9/3/24 at 4:21 PM, they stated that on 9/1/24 around 1-1:30 PM Resident #1 left the unit with a family member for an out on pass with no skin impairment on their face. On 9/2/24 at 8:15 AM Certified Nursing Assistant #1 reported that Resident #1 had a bruise on their face and Unit Manager #2 and Assistant Director of Nursing checked Resident #1. Resident #1 was asked how they got the bruise, and they were told 5-6 different versions. (continued on next page)

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	335211	A. Building B. Wing	09/27/2024

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Unit Manager #2 on 9/5/24 at 1:04 PM they stated that Licensed Practical Nurse #1 informed them that Resident #1 had discoloration to right side of their forehead and area above their right eye. Resident #1 was evaluated for pain and Resident #1 could not remember how they got the bruise. The staff from 9/1/24 were interviewed and they did not see the bruise prior to Resident #1 going out on pass. Unit Manager #2 stated they did not think of it as abuse and reported to the Assistant Director of Nursing who also assessed Resident #1. During a phone interview with the Medical Director on 9/5/24 at 1:37 PM, they stated that Resident #1 was examined, area was not painful, and the discoloration may have been from a broken blood vessel without an injury. The Medical Director responded that they did not know, when asked if they can rule out abuse. During an interview with the Administrator on 9/5/24 at 4:18 PM they stated that they interviewed Resident #1 and was told that they got hit by their own phone but Resident #1's family member stated that it could be from a bug bite when they went to a botanical garden. Physician stated that it was vascular related, and that nursing and the physician did not suspect it was abuse related nor an injury of unknown origin. The video surveillance was reviewed, and Resident #1 left the facility with no bruise to their face. During an interview with Certified Nursing Assistant #4 on 9/18/24 at 2:30 PM, they stated that they worked 11-7 shift on 9/1/24 but they did not remember Resident #1 with a bruise, and no one asked them for a written statement regarding the incident. 50951 2) Resident #2 was admitted on [DATE] with documented diagnosis that included mild cognitive impairment, history of falls, and osteoarthritis. Resident had a Minimum Data Set, dated dated dated [DATE] that documented a Brief Interview of Mental Status score of 12. Resident #2 passed away at the facility on 08/09/24. A Nurses Note dated 8/6/2024 at 10:20 AM documented that Resident #6 pushed Resident #2 to the floor. Resident #2 fell to the floor onto their buttock and elbows and then hit their head on floor. The physician ordered Ativan for agitation. During a record review there was no documented evidence that the facility investigated the altercation between Resident #2 and Resident #6 which resulted in a fall of Resident #2. During an interview with Administrator on 09/25/2024 at 2:13 PM the Administrator was interviewed and stated that the facility could not find an Accident and Investigation report for Resident #2 and Resident #6 on 08/06/2024 at 10:20. During an interview with Manager on 09/25/2024 at 4:49 PM Risk Manager stated that the they did not know why an Accident and Investigation form was not completed for this incident. (continued on next page)

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	335211	A. Building B. Wing	09/27/2024

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Unit Manager on 09/26/2024 at 12:59 PM that the reason an Accident and Investigation was not completed for this incident was because the Administrator looked at the video and did not see any altercation, push, or fall for Resident #2. During an interview with Administrator on 09/26/2024 at 1:52 PM The administrator stated they could not recall reviewing the video for this incident. The Administrator stated that if they had seen a fall or altercation on the video there would have been an Accident and Investigation form completed. During a telephone Interview with Director of Nursing on 09/26/2024 at 2:18 PM the Director of Nursing stated they arrived on unit when resident to resident incident and fall was reported on 08/06/2024. The Director of Nursing stated they did not start an Accident and Investigation because when they arrived on the unit, Resident #1 was alert and agitated, walking around. The Administrator viewed the video footage and did not see the altercation or fall. 10 NYCRR 415.4(b)(1) (ii

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	335211	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50951 Based on observation, interviews and record review during an abbreviated survey conducted on 9/25/24 through 9/27/24, the facility did not ensure that care was provided in accordance with professional standards and by individuals qualified to do so. Specifically, the facility had a Licensed Practical Nurse serving in the capacity of Unit Manager completing assessments for 17 out of 17 reviewed records following accidents and falls on their unit. This Licensed Practical Nurse placed their name on the form in the space titled Registered Nurse Supervisor and signed their name and title on the completed document which is out of the scope of practice for a Licensed Practical Nurse. The findings are: An undated job description for Registered Nurse or Licensed Practical Nurse Unit Manager was reviewed and documented Prepare incident/accident reports events and observations using the Electronic Medical Record system. There was no documented evidence of who should complete the assessment in the Unit Manager Job Description. Resident #2 was admitted on [DATE] with documented diagnosis that included mild cognitive impairment, history of falls, and osteoarthritis. Resident had a Minimum Data Set, dated dated dated [DATE] that documented a Brief Interview of Mental Status score of 12. Resident #2 passed away at the facility on 08/09/24. Accident and Investigation form for Resident #2 on 08/06/2024 was completed by Unit Manager Licensed Practical Nurse # 1 Accident and Incident form documented a title of: Registered Nurse Supervisor on the top of the first page. On page two (2) of the Accident and Incident form Registered Nurse Supervisor was identified as Unit Manager Licensed Practical Nurse #1 by their printed name in black ink. A review of Accident and Incident reports completed by Unit manager Licensed Practical Nurse #1 documented that Seventeen of Seventeen Accident and Incident reports were completed and Signed by Unit Manager Licensed Practical Nurse #1 included an assessment on the form outside of their scope of practice. Unit Manager Licensed Practical Nurse #1 was printing their name on the line that states Registered Nurse Supervisor: acknowledging that the assessment was completed by them and not a Registered Nurse as required. During an interview with the Administrator on 09/25/2024 at 4:49 PM they stated they were aware that Registered Nurses must make assessments not Licensed Practical Nurses. During an interview with Unit Manager Licensed Practical Nurse #1 on 09/26/2024 at 1:35 PM they stated they were given a job description of the Unit Manager responsibilities when they were promoted. The job description states that the Unit Manager completes Accident and Investigation forms. (continued on next page)

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	335211	A. Building B. Wing	09/27/2024

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Unit Manager Licensed Practical Nurse #1 on 09/25/2024, at 3:52PM they stated that their role was to help with everything if there is an incident or accident, they are called. Unit Manager Licensed Practical Nurse #1 stated they do an assessment of the resident, provide care, complete the investigation, and notify the family of the incident. The Unit Manager Licensed Practical Nurse #1 reviewed an Accident and Investigation Report that was completed and signed by them Unit Manager Licensed Practical Nurse #1 acknowledged it was their handwriting and signature in the Registered Nurse Supervisor Box and signature line. Unit Manager Licensed Practical Nurse #1 stated they printed their name in the Registered Nurse Supervisor box because it was their job. Unit Manager Licensed Practical Nurse #1 denied completing the assessment contained in the report and stated that they only wrote down the assessment that the Registered Nurse or physician completed. There is no documented evidence that a Registered Nurse or Physician signed any of the documents reviewed. During a telephonic reinterview with the Director of Nursing on 10/07/2024 at 12:41 PM they stated that they were aware that Unit Manager Licensed Practical Nurse #1 was completing the Accident and Investigation forms. 10NYCRR 483.21(b)(3)(i)