| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335211 | A. Building<br>B. Wing | 04/21/2025 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50951<br><br>Based on observation, interviews and record review during an abbreviated survey conducted on 3/19/2025 through 04/21/2025 for case number NY00375018 the facility failed to protect each resident's right to be free from physical abuse. This was identified for one (Resident #1) of three residents reviewed for physical abuse. Specifically, video surveillance showed Licensed Practical Nurse #1 pointing their right finger at Resident #1's face. Licensed Practical Nurse #1 reaches forward with both hands, places them at Resident #1's neck, and pushes them backwards in their wheelchair. The incident was discovered when a staff member was reported as injured by Resident #1.<br><br>The findings are:<br><br>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.<br><br>Resident #1 was admitted on [DATE] with diagnosis that include dementia, major depressive disorder, and obesity. A Minimum Data Set Brief Interview for Mental Status dated 03/08/2025 documented a score of 13 indicating full cognition.<br><br>A Comprehensive Care Plan titled, 'At risk for abuse' dated 11/05/2024 documented interventions which include investigate all allegations of abuse and neglect promptly and provide a safe person to report abuse/ neglect to and Provide support and ensure resident is free from abuse or neglect. The Comprehensive Care Plan was not updated or amended following the incident.<br><br>Accident and Investigation report for Resident #1 dated 03/13/2025 documented Licensed Practical Nurse #1 was immediately removed from the care of Residents and terminated from employment. Resident #1 had a full body assessment and follow-up assessment with Medical Doctor. There were no signs of physical injury. The investigation concluded that abuse had occurred. Licensed Practical Nurse #1 refused to provide a statement.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Video surveillance of the unit's Nurse station and hallway submitted by the facility was reviewed with the Administrator on 03/18/2025 at 10:01AM. Licensed Practical Nurse #1 can be seen pointing their right finger at Resident #1's face. Resident #1 was seated in a wheelchair in the hallway. Licensed Practical Nurse #1 reaches forward with both hands, places them at Resident #1's neck, and pushes them backwards in their wheelchair. Certified Nursing Assistant #2 was seen by the computer and lifted their head from the computer and stood up and watched the incident. Certified Nursing Assistant #1 intervened and separated Resident #1 from Licensed Practical Nurse #1. Certified Nursing Assistant #2, Certified Nursing Assistant #3, and Licensed Practical Nurse #2 can be seen seated behind the nurse's station.<br><br>During an interview with Certified Nursing Assistant #1 on 3/19/25 at 09:44AM they stated they heard Resident #1 arguing with the Licensed Practical Nurse #1. Certified Nursing Assistant #1 stated they got into an altercation, and they separated them by standing in between them to de-escalate situation. Certified Nursing Assistant #1 stated they did not report Licensed Practical Nurse to the supervisor because they did not see Licensed Practical Nurse #1 push Resident #1.<br><br>During an interview with Certified Nursing Assistant #2 on 03/19/2025 at 13:03 they stated that at the time of incident they were by the nurse's station working on the computer. They stated they did not report the alteration between Licensed Practical Nurse #1 and Resident #1 to anyone. Certified Nursing Assistant #2 added that shortly after the incident Resident #1 attacked them (Certified Nursing Assistant #2), which they reported to the supervisor.<br><br>During an interview with Resident #1 on 03/19/2025 at 1:05 PM they stated they have no recollection of an incident with Licensed Practical Nurse #1 on 03/13/2025.<br><br>On 03/19/2025 at 10:35 AM a telephone interview with Licensed Practical Nurse #1 they stated they will not answer any questions regarding the incident.<br><br>During an interview with Medical Doctor on 3/19/25 at 2:07 PM they stated they did not witness incident. They assessed Resident #1 following the incident with no signs or symptoms of injury. No change in appetite or sleeping. No behavioral incidents since. The recommendation was to continue monitoring Resident #1.<br><br>During an interview with Registered Nurse Supervisor #1 on 3/19/2025 at 1:30 PM they stated they were informed by Certified Nursing Assistant #2 that Resident #1 attacked them. Registered Nurse Supervisor #1 stated they did an assessment on Resident #1 following the incident on 03/13/2025. Resident #1 denied pain and had no physical signs of injury, and they made a referral for psychiatry for further evaluations. Registered Nurse Supervisor #1 stated they were unaware of the incident involving Licensed Practical Nurse #1 and Resident #1.<br><br>During an interview with Director of Nursing on 04/03/2025 at 08:58 AM they stated they learned of the incident when Nursing Supervisor #1 called about a staff fall. Nursing Supervisor #1 did not report Licensed Practical Nurse #1 grabbing and pushing Resident #1. Director of Nursing stated they learned of the assault when they viewed the video of the staff member being kicked and falling. They began to investigate the assault on Resident #1 by Licensed Practical Nurse #1. The findings of the investigation were that it was wrong of Licensed Practical Nurse #1 to grab and push Resident #1.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a telephonic reinterview with Director of Nursing on 04/21/2025 at 2:29 PM they reiterated the incident and stated that Licensed Practical Nurse #1 refused to provide a statement.<br><br>10NYCRR 483.12 (a)(1) |