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 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. (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 (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. 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. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on interviews and record review during the Recertification Survey initiated on 4/29/2024 and completed on 5/7/2024, the facility did not ensure that preadmission screening for individuals with a mental disorder and individuals with intellectual disability was conducted prior to their admission to the facility. This was identified for one (Resident #18) of 40 residents reviewed for Pre-admission Screening and Resident Review (a federal requirement to ensure that residents were not inappropriately placed in a skilled nursing facility). Specifically, Resident # 18 was admitted [DATE], the Level 1 Pre-admission Screening and Resident Review (PASARR) screening was not completed by the facility staff until 7/16/2023, two days after the resident's admission to the facility. The finding is: The facility's policy and procedure titled, Pre-Admission Screening and Resident Review (PASARR) last revised in December 2023 documented all residents to have the required pre-admission screen prior to admission to the facility. Prior to a resident's admission, the Admission Department or designee will obtain a screen and Level 1 referral and a Level II referral if indicated. Upon admission, the screen will be incorporated into the resident's clinical record. Resident #18 was admitted to the facility on [DATE] with diagnoses of Schizoaffective Disorder Bipolar Type, Major Depressive Disorder, and End Stage Renal Disease. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognition. The assessment's Pre-Admission Screening and Resident Review section documented that Resident #18 was not currently considered by the state level II Pre-Admission Screening and Resident Review process to have a serious mental illness, intellectual disability, or other related conditions. The Pre-admission Screening and Resident Review screen dated 7/16/2023 was reviewed on 5/2/2024. The screen was completed and signed by the facility's Director of Social Services. The Admission office staff who admitted Resident #18 no longer worked in the facility and therefore was not interviewed. The Co-Director of Admission was interviewed on 5/2/2024 at 12:17 PM and stated that they had been in the role since October 2023 and were not involved in Resident #18's admission. The Co-Director of Admission stated that the Admission department was responsible for reviewing and ensuring that all admission documents, including the Pre-admission Screening and Resident Review forms, were present, completed, and accurate prior to the resident's admission. The Co-Director of Admission stated that the Pre-admission Screening and Resident Review form must be completed by the facility that is transferring the resident to this facility and if the screen was missing prior to admission they (Co-Director of Admission) would contact the case worker of the previous facility to obtain a copy. The Co-Director of Admission stated Resident #18's screen should have been completed prior to (Resident #18) admission to the facility. (continued on next page)

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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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Social Services was interviewed on 5/2/2024 at 2:57 PM and stated the Admission department is responsible for ensuring the Pre-admission Screening and Resident Review form was completed and sent by the discharging facility prior to the resident's admission to this facility. The Director of Social Services stated that the Pre-admission Screening and Resident Review form was noted missing on 7/15/2023, the day after Resident #18 was admitted . The Director of Social Services stated they then completed the Pre-admission Screening and Resident Review form the following day 7/16/2023 because they did not want to wait any longer. The Director of Social Services stated Resident #18's Pre-Admission Screening and Resident Review screen should have been completed prior to their admission to this facility. The Administrator was interviewed on 5/2/2024 at 3:55 PM and stated that the admission office should ensure all resident's pre-admission documents including the Pre-Admission Screening and Resident Review screen were thoroughly reviewed, and all resident information was completed accurately and appropriately. The Administrator stated that if the screen was not sent, or if an issue was identified, the admission office should request the sending facility to redo the screen prior to the resident's admission. The Administrator stated that Resident #18's Pre-Admission Screening and Resident Review screen should have been completed prior to their (Resident #18) admission. 10 NYCRR 415.11(e)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on [DATE] and completed on [DATE], the facility did not ensure that each resident's environment remained as free of accident hazards as possible. This was identified for one (Resident #531) of six residents reviewed for Accidents. Specifically, Resident #531 was not assessed to safely self-administer their medications. On [DATE] an inhaler (handheld devices that allow you to breathe medicine in through your mouth, directly to your lungs) was observed in Resident #531's room with no staff member present. The inhaler did not have a label that indicated the resident's name or direction for the administration. Additionally, Resident #531 did not have a Physician's order for the use of the inhaler. The finding is: The facility policy and procedure titled, Medication Administration last revised in ,d+[DATE] documented only people licensed or permitted by the state to prepare, administer, and document the administration of medications may do so. Medications are determined per prescriber orders, including any required time frame. Residents may self-administer their medication only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely. Resident #531 was admitted with Diagnoses of Asthma, End Stage Renal Disease, and Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14 which indicated Resident #531 had intact cognition. The Physician's orders dated [DATE] documented to administer Budesonide (a steroid that can treat Asthma) Inhalation Suspension of 0.5 milligrams per 2 milliliters via nebulizer every 12 hours due to shortness of breath, wheezing, and bronchospasm (a contraction in the airways that can make it hard to catch your breath) and to administer Montelukast (an anti-inflammatory medication to treat and prevent Asthma attacks) 10 milligrams one tablet daily. A Comprehensive Care Plan (CCP) dated [DATE] documented that Resident #531 had Asthma. Interventions included administering medication as ordered, elevating the head of the bed to 45 degrees, and monitoring for signs and symptoms of an impending Asthma attack including coughing spells, rapid breathing, complaints of chest tightness, malaise, or fatigue. During an observation on [DATE] at 11:09 AM, Resident #531 was observed sitting in bed in their room. Resident #531 was alert, oriented, and responsive. A Breo-Ellipta inhaler was observed on top of the resident's overbed table. The inhaler did not have a label with the resident's name or directions for administration. There was no staff member present in Resident #531's room at the time of the observation. Resident #531 was interviewed on [DATE] at 11:15 AM and stated they brought the Breo-Ellipta inhaler from home. They had been using the inhaler at home prior to their admission to the facility and also at the facility since they were admitted . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #531's Physician's orders did not include an order for the Breo-Ellipta ,d+[DATE] microgram inhaler. The Physician's order did not document for the resident to self-administer any of their medications. A review of the electronic medical record revealed that Resident #531 was not assessed to self-administer their medications. Licensed Practical Nurse #8 was interviewed on [DATE] at 11:30 AM and stated that Resident #531 was not supposed to have any medications from home. Licensed Practical Nurse #8 stated they did not see any inhalers when Resident #531 received their medications this morning ([DATE]). Licensed Practical Nurse #8 stated that Resident #531 was receiving the nebulizer treatments at the facility and had no orders to use the inhaler. Licensed Practical Nurse #8 stated that Resident #531's family member was insisting on bringing vitamins and other medications from home because they had plenty of supplies. Licensed Practical Nurse #8 stated they told the resident's family member to not bring any medications from home unless ordered by the Physician. Registered Nurse #5 was interviewed on [DATE] at 12:55 PM and stated that all medications should be labeled with the resident's name and directions for administration. Each medication should have a Physician's order, and staff should make sure that medications are properly stored and not expired. Registered Nurse #5 stated Resident #531's family member insisted on bringing vitamin supplements from home for the resident. Registered Nurse #5 stated they had called the resident's Physician and obtained an order for the vitamin supplements. Registered Nurse #5 stated that Resident #531 did not have any assessment to self-administer medications. The Director of Nursing Services was interviewed on [DATE] at 9:06 AM and stated that no medications should be left with a resident without supervision. The Director of Nursing Services stated that all medications brought by the resident or their family members from home should be properly labeled and should have a Physician's order for administration. The Director of Nursing Services stated that to self-administer medications, the residents must be assessed and deemed capable of administering their medication safely. The Director of Nursing Services stated Resident #531 was not assessed to self-administer their medications as they did not request to self-administer their medications. 10 NYCRR 415.12(h)(1)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/29/2024 and completed on 5/7/2024, 1) the facility did not ensure that 1) medications were administered within one hour of the ordered administration time on two (Unit 2 [NAME] and Unit 1 West) of four units during unit observations, and 2) the drug records were in order and accounted for all controlled drugs on one (Unit [NAME] 1) of six units observed during the medication storage task. Specifically, 1) on 4/29/2024 on Unit 2 [NAME] in the Glengariff building, three residents (Resident #126, #131, and #32) did not get their 9:00 AM medications within one hour of the physician-ordered administration time; and on 4/30/2024 on Unit 1 [NAME] in the Glengariff building eleven residents (Resident #134, #151, #331, #82, #34, #92, #95, #8, #46, #157, #178) did not get their 9:00 AM medications within one hour of the physician-ordered administration time; and 2) During the medication storage task observation the controlled substance administration record for Resident #538 indicated a zero balance of Oxycodone (controlled substance medication) 10-milligram tablet; however, the medication blister pack had one tablet remaining. The findings include but are not limited to: The facility's Medication Administration policy, last revised 5/3/2024, documented that medications are administered in a safe and timely manner, and as prescribed; and medication administration times are determined by resident need and benefit. 1a) An example of one of the three residents affected on Unit 2 [NAME] in the Glengariff building: 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. Resident #126's physician orders as of 4/29/2024 included the following medications due for 9:00 AM administration: -Apixaban Oral Tablet 2.5 milligrams Give 1 tablet by mouth every 12 hours for Blood thinning. -Carvedilol Tablet 3.125 milligram Give 1 tablet by mouth every 12 hours for Hypertension. -Isosorbide Mononitrate ER Tablet Extended Release 24 Hour 120 milligram Give 1 tablet by mouth one time a day for Hypertension; and -Tylenol Oral Tablet 325 milligram (Acetaminophen) Give 2 tablets by mouth two times a day for pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #6, Unit 2 West's medication nurse, was observed administering medications on 4/29/2024 at 12:02 PM. Licensed Practical Nurse #6 stated they were still administering the 9:00 AM medications and there are three (Resident #126, #131, and #32) more residents remaining who still need their 9:00 AM medications administered. Licensed Practical Nurse #6 stated they were late with administering medications because they were the only nurse for 39 residents today (4/29/2024). Licensed Practical Nurse #6 stated they did not inform their supervisor that they were late with medications, they were just trying to finish up. A review of the Medication Administration Audit Report (a report indicating medication administration time) for 4/29/2024 for Resident #126 revealed that Licensed Practical Nurse #6 documented the 9:00 AM medications were administered at 12:27 PM. Registered Nurse #4, Unit 2 West's Supervisor, was interviewed on 5/2/2024 at 7:58 AM and stated they were a new supervisor and were not sure what the medication nurse should do if they (the medication nurse) were late with the medication administration. Registered Nurse #4 stated I assume the medication nurse has to reach out to the supervisor to let me know they need help. 1b) An example of one of the eleven residents affected on Unit 1 [NAME] in the Glengariff building: 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 #151's physician orders as of 4/30/2024 included the following medications due for 9:00 AM administration: -B-Complex Oral Capsule, give one capsule by mouth one time a day for Anemia. -Calcium-Vitamin D Tablet 600-200 milligrams, give one tablet by mouth one time a day for supplementation. -Eliquis oral tablet 2.5 milligrams, give one tablet by mouth two times a day for Anticoagulant. -Furosemide (Diuretic) tablet 20 milligrams, give one tablet by mouth one time a day. -Lisinopril tablet 40 milligrams, give one tablet by mouth one time a day for Hypertension. -Metoprolol Succinate Extended Release, 25 milligrams, give three tablets by mouth one time a day for Hypertension. -Potassium Chloride extended-release tablet, 10 milliequivalents, give one tablet by mouth one time a day for a supplement. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Licensed Practical Nurse #1, Unit 1 [NAME] Medication Nurse, was observed on 4/30/2024 at 11:12 AM administering the 9:00 AM medications. Licensed Practical Nurse #1 stated they were still administering the 9:00 Medications and there were 11 residents (Resident #134, Resident #151, Resident #331, Resident #82, Resident #34, Resident #92, Resident #95, Resident #8, Resident #46, Resident #157, Resident #178) that still needed to get their 9:00 AM medications. Licensed Practical Nurse #1 stated there are 37 residents on the unit and it is very time-consuming for one nurse to administer all the medications. Licensed Practical Nurse #1 stated they did not ask for help. A review of the Medication Administration Audit Report (a report indicating medication administration time) for 4/30/2024 for Resident #151 revealed that the 9:00 AM medications were administered at 11:56 AM by Licensed Practical Nurse #1. Registered Nurse #2, Unit 1 [NAME] Supervisor, was interviewed on 5/2/2024 at 8:07 AM. Registered Nurse #2 stated when a medication nurse is late with the medication administration, they should have reached out to the supervisor for assistance. The Director of Nursing Services was interviewed on 5/2/2024 at 2:20 PM and stated the nurses have one hour before and one hour after the ordered administration time to administer the medications. The nurses should have requested help from the supervisor if they were running late with their medication administration. The Medical Director was interviewed on 5/7/2024 at 8:44 AM and stated if the nurses are late in administering medications, they should ask for help. Generally, the nurses should stick to the time frame of when the medications are due as per the nursing policy. There are certain medications, like antibiotics, that are critical and need to be given on time. 49245 2) The facility policy and procedure titled, Storage of Controlled Substances last revised on 12/22/2022 documented that all controlled substance medications must be stored in a metal, double-locked, double-door stationary cabinet, in a locked medication room. Only one authorized medication nurse may have possession of the keys. When the keys are transferred to an on-coming medication nurse, a shift-to-shift count of narcotics will be performed and documented. When medications are to be administered during the medication pass, the container (e.g., blister pack) may be removed from the double-locked cabinet and stored in the narcotic lock box within the medication cart. Upon completion of the medication pass, the medication container must be immediately returned to the stationary, double-door, double-locked cabinet. Resident #538 was admitted with Diagnoses of the right foot Amputation, Sepsis, and Congestive Heart Failure. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13 which indicated that Resident #538 had intact cognition. Resident #538 received scheduled pain medication. A Physician's order dated 4/10/2024 documented to administer Oxycodone Hydrochloride (a type of analgesic controlled substance medication to treat moderate to severe pain) 10 milligrams, give one tablet by mouth every four hours as needed for severe pain for seven days. The order was completed on 4/17/2024. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Comprehensive Care Plan (CCP) dated 4/11/2024 documented that Resident #538 had amputation of the right foot. The intervention included analgesics as ordered by the Physician. Monitor and document for any side effects and effectiveness of the medications. A Physician's order dated 4/30/3024 documented to administer Oxycodone Hydrochloride 5 milligrams, give one tablet by mouth every six hours for Pain. The Medication Storage room on Unit 1 was observed with Registered Nurse #1 on 5/3/2024 at 10:23 AM. An Oxycodone 10 milligram blister pack, that was labeled with Resident #538's name, was observed inside the double-locked narcotic cabinet. A Controlled Medication Administration Record form was attached to the blister pack. The Controlled Medication Administration Record form documented a zero balance as of 5/1/2024 at 7:34 PM; however, the medication blister pack was observed with one tablet remaining. Registered Nurse #1 was interviewed on 5/3/2024 at 10:40 AM. Stated that the oxycodone 10 milligrams was discontinued on 4/29/2024 and the remaining tablet in the blister pack was put in the double-locked narcotic box. Resident #538 has an active order for Oxycodone Hydrochloride 5 milligrams one tablet every six hours for pain which was administered to Resident #538 on 5/1/2024 at 7:34 PM by Licensed Practical Nurse #7. Registered Nurse #1 stated that Licensed Practical Nurse #7 erroneously documented on both 5 milligrams and the discontinued 10-milligram Oxycodone Controlled Medication Administration Record form instead of the 5 milligrams Oxycodone Controlled Medication Administration Record form. Licensed Practical Nurse #7 was interviewed on 5/3/2024 at 11:00 AM and stated they administered Oxycodone 5 milligrams for Resident #538 as per the Physician's order on 5/1/2024 at 7:34 PM. Licensed Practical Nurse #7 stated they mistakenly documented the same entry on both the discontinued 10-milligram Controlled Medication Administration Record form and the active 5-milligram Controlled Medication Administration Record form. The Director of Nursing Services was interviewed on 5/3/2024 at 11:15 AM. Stated that discontinued controlled medications should be brought to the Nursing Office and should not be stored on the units and all controlled medications that are stored on the unit should be counted every shift by the nurse. The Director of Nursing Services stated there are times when a discontinued controlled medication is kept in the unit's medication storage room in a double-locked box if it is the weekend or if the Nursing Office is closed. 10 NYCRR 415.18(a)(b)(1)(2)(3)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 34798 Based on record review and interviews during the Recertification Survey initiated on 4/29/2024 and completed on 5/7/2024 the facility did not ensure that the medication regimen review recommendations that were approved by the physician were implemented. This was identified for one (Resident #24) of five residents reviewed for unnecessary medications. Specifically, on 3/12/2024 the consultant Pharmacist recommended the addition of a calcium supplement to Resident #24's medication regimen. The resident's Physician approved the recommendation made by the consultant Pharmacist; however, there was no physician's order written for the calcium supplement and the resident did not receive the recommended supplement. The finding is: The facility's policy titled Drug Regimen Review, dated 12/2023, documented the consultant Pharmacist shall identify, document, and report possible medication irregularities for review and action by the attending Physician. The attending Physician or licensed designee shall respond to the drug regimen review within 7-14 days or more promptly, whenever possible. The Prescriber/Licensed Designee shall act upon the Drug Regimen Review findings/recommendations in a timely manner and shall document on the drug regimen review form whether they agree or disagree with the recommendation and provide a brief clinical rationale if no change is to be made. Resident #24 was admitted with diagnoses including Diabetes Mellitus, Cerebrovascular Accident, and Non-Alzheimer's Dementia. The 1/22/2024 Quarterly Minimum Data Set assessment documented a Brief Interview for Mental Status score of 0, indicating the resident had severe cognitive impairment. A current physician's order, effective 9/28/2023, documented to administer Alendronate Sodium (a medication to treat osteoporosis, which is a condition characterized by loss of bone density) tablet 70 milligrams, give 1 tablet by mouth one time a day every Monday for Osteoporosis, give 30 minutes before first food, drink, or medication. A consultant pharmacist medication review form dated 3/12/2024 documented that Resident #24 has a standing order for Alendronate. Please consider starting either a Calcium 500 milligrams plus vitamin D tablet twice daily or a Calcium 600 milligrams plus vitamin D tablet twice daily. The Physician agreed with the recommendations on 3/12/2024 and signed the form to start Calcium 600 milligrams plus vitamin D tablet twice daily. A physician's progress note dated 3/18/2024 documented the resident was seen and examined at the bedside. Medications are reviewed by the Pharmacist. The resident is on Fosamax (Alendronate). Will start Calcium 500 milligrams plus vitamin D tablet twice daily. A review of the medical record revealed that the calcium supplement, 500 milligrams or 600 milligrams, was not ordered. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #2, Unit 1 [NAME] supervisor, was interviewed on 5/1/2024 at 10:39 AM. Registered Nurse #2 reviewed the 3/12/2024 consultant pharmacist medication review form and stated they have never written a physician's order based on the recommendations written on the consultant pharmacist medication review form. Registered Nurse #2 stated they were not sure if the facility policy required the Physician to provide a verbal order to the nurses to change the existing orders and/or provide a new order after the physician approved the recommendations on the consultant pharmacist medication review form. Licensed Practical Nurse #5, Unit 1 [NAME] charge nurse, was interviewed on 5/1/2024 at 10:51 AM. Licensed Practical Nurse #5 stated the Director of Nursing Services would give us the consultant pharmacist medication review form that was approved by the physician to implement the recommended orders. Licensed Practical Nurse #5 reviewed Resident 324's orders and stated the calcium supplement was not ordered. The Director of Nursing Services was interviewed on 5/1/2024 at 3:24 PM and stated when the Physician agrees with the recommendation made by the Pharmacist, the Physician must go into the electronic medical record system, update the order, and then write a progress note. Physician #2 was interviewed on 5/2/2024 at 8:29 AM and stated the Physician usually gives the consultant pharmacist medication review form to the nursing supervisor to write the recommended changes. Recently, to help streamline the process, the Physicians are supposed to be placing the orders. Physician #2 stated they were not sure why an order for calcium supplements was not written. The Medical Director was interviewed on 5/2/2024 at 8:43 AM and stated the facility had identified a problem with the pharmacy medication regimen review process where a large percentage of recommendations were not being implemented. The Medical Director stated once the Pharmacist makes the recommendation, the Pharmacist has to alert the physician, not just by email but by phone call, and put the recommendation in the Physician's box. The Physician should recommend to the nursing supervisor to make the order change and document the recommended changes in the progress note. 10 NYCRR 415.18(c)(2)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review, and interviews during the Recertification Survey initiated on 4/29/2024 and completed on 5/7/2024, the facility did not ensure that each resident's drug regimen was free from unnecessary medication. This was identified for one (Resident #166) of five residents reviewed for Unnecessary Medications. Specifically, on 2/20/2024 and again on 3/12/2024, Resident #166's Physician agreed to discontinue Oxybutynin (medication to treat bladder overactivity) and Benadryl (anti-allergy medication) as per the recommendations made by the consultant Pharmacist because the medications were no longer medically required. Resident #166 continued to receive Oxybutynin Extended Release 5 milligrams from 2/20/2024 to 5/5/2024 and received Benadryl Allergy oral tablet 25 milligrams on 3/22/2024, 3/29/2024, 5/4/2024 and 5/5/2024. The finding is: Resident #166 was admitted to the facility with diagnoses that included an Overactive Bladder, Hyperuricemia (high uric acid level), and Seizures. The Quarterly Minimum Data Set assessment dated [DATE] documented the resident's Brief Interview for Mental Status Score was 6, which indicated severe cognitive impairment. The resident was always incontinent of bladder and bowel. A Comprehensive Care Plan for Incontinence last reviewed on 6/13/2023 documented the resident had bladder incontinence related to Alzheimer's, Impaired Mobility, and a diagnosis of Overactive Bladder. Interventions included to monitor and document signs and symptoms of Urinary Tract Infection and report to the Physician as needed. A Physician's order dated 10/10/2023 documented to administer Oxybutynin Chloride Extended Release (ER) Tablet 5 milligrams, give 1 tablet by mouth one time a day for Urinary Antispasmodic (a drug used to treat spasms). The order was discontinued on 5/5/2024. A Pharmacy Regimen Review Recommendation dated 2/20/2024 documented a recommendation to discontinue Oxybutynin (Ditropan). The recommendation was approved by Physician #2 to discontinue Oxybutynin. The Pharmacy Regimen Review Recommendation form was signed and dated by Physician #2 on 2/20/2024. A Physician progress note dated 2/20/2024 documented that Physician #2 saw Resident #166 at the bedside with chief complaints of electrolyte imbalance, Hypertension, and Seizure. There was no documentation of discontinuation of Oxybutynin. A Physician progress note dated 2/29/2024 documented that Physician #2 saw Resident #166 at the bedside with chief complaints of Hypertension and an Overactive Bladder. Physician #2 documented that the pharmacy recommendation was appreciated and would discontinue the Oxybutynin order because the medication was no longer medically necessary. Resident #166's Medication Administration Record was reviewed for February 2024, March 2024, April 2024, and May 2024. Resident #166 continued to receive Oxybutynin Extended Release 5 milligrams by mouth daily from 2/20/2024 until 5/5/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335211	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan for Scabies dated 3/1/2024 documented that the resident has actual scabies and has been exposed to scabies. Interventions included to administer anti-pruritic (anti-itch) medication as per the Physician's order. A Physician's order dated 3/1/2024 documented to administer Benadryl Allergy oral Tablet (Diphenhydramine HCl) 25 milligrams, give 1 tablet by mouth every 6 hours as needed for itching. The order was discontinued on 5/5/2024. A Pharmacy Regimen Review Recommendation dated 3/12/2024 recommended adding a stop date or discontinuing Benadryl (Diphenhydramine) order due to Benadryl meets the criteria as a potentially inappropriate medication for geriatrics in a skilled nursing facility. The recommendation was approved by Physician #2 documenting to discontinuation of Benadryl as the resident no longer medically required the medication. The Pharmacy Regimen Review Recommendation form was signed and dated 3/12/2024 by Physician #2. A Physician progress note dated 3/12/2024 documented that Physician #2 saw Resident #166 at the bedside with chief complaints of Hypertension and Cystitis (bladder infection). There was no documentation of discontinuation of Benadryl. A Physician progress note dated 3/18/2024 documented that Physician #2 saw Resident #166 at the bedside with chief complaints of Hypertension and a follow-up related to Scabies. Resident #166's Scabies improved and the Benadryl order would be discontinued as the medication is no longer necessary. Resident #166's Medication Administration Record was reviewed for March 2024, April 2024, and May 2024. Resident #166 received Benadryl Allergy oral Tablet (Diphenhydramine HCl) 25 milligrams 1 tablet by mouth as needed on 3/22/2024, 3/29/2024, 5/4/2024 and 5/5/2024. Resident #166 was observed on 4/29/2024 at 11:11 AM. Resident #166 was seated in a wheelchair in their room and was sleeping. Resident #166 was observed on 5/1/2024 at 11:03 AM. Resident #166 was seated in a wheelchair next to their bed. The resident was awake but was not able to answer questions. Physician #2, who was Resident #166's attending physician, was interviewed on 5/3/2024 at 2:18 PM. Physician #2 stated they most likely gave verbal orders for the two medications to be discontinued but could not recall whom they spoke with. Physician #2 stated they were not aware that both Oxybutynin and Benadryl were not discontinued. Physician # 2 stated that if the resident no longer required the medications, then the medications should be discontinued. The Medical Director was interviewed on 5/6/2024 at 11:27 AM and stated that if a Physician reviewed the recommendations on the Pharmacy Regimen Review and agreed to discontinue a medication, the medication should be discontinued and the ordering Physician should ensure that the order was executed. The Medical Director stated that the resident's Physician is responsible for ensuring that the medication was discontinued as intended. 10 NYCRR 415.12 (l)(1)

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NAME OF PROVIDER OR SUPPLIER Glengariff Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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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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)