| 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 | 11/19/2025 |

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| Glengariff Health Care Center | 141 Dosoris Lane<br>Glen Cove, NY 11542 |

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|---|---|
| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that there was sufficient nursing staff to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified on one (1) (Unit 2) of six (6) resident units reviewed for the Sufficient Nursing Staffing Task. Specifically, the Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Three (3) 2025 (April 1st- June 30th) indicated that the facility had excessively low weekend staffing. Additionally, two (2) (Resident #4 and #214) out of nine (9) residents in the Resident Council Task reported complaints about short staffing; and a random sampling of facility nursing staffing assignments did not reflect the staffing ratio as indicated in the Facility Assessment for Certified Nursing Assistants. The finding is:The Centers for Medicare and Medicaid Services Payroll-Based Journal Staffing Data Report for Fiscal Year Quarter Three (3) 2025 (April 1st- June 30th) documented the facility triggered for the Metric of Excessively Low Weekend Staffing based on the facility's submitted staffing data.The Facility Assessment, last reviewed 09/04/2025, indicated the assessment had been reviewed previously on 07/31/2024, and again on 02/19/2025. The facility has a 262-bed capacity with an average daily census between 245-255 residents. The Facility Assessment did not include a census of each unit at full capacity. Part three (3) of the Facility Assessment documented facility resources needed to provide competent support and care for the resident population every day and during emergencies.The following staffing plan was determined for Unit [NAME] 2 :-During the Day shift (7:00 AM-3:00 PM), the unit required two (2) Licensed Practical Nurses and five (5) Certified Nursing Assistants.During an interview on 09/16/2025 at 09:34 AM, the Administrator stated that no update was required upon periodic review of the Facility Assessment since 07/31/2024. The Administrator stated the last review was completed on 09/04/2025.A review of the 7:00 AM-3:00 PM shift staffing schedule for Unit [NAME] 2, which had a capacity of 39 residents, indicated the following:- On 04/11/2025 (Friday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 34 residents.- On 05/02/2025 (Friday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 35 residents.- On 05/03/2025 (Saturday) and 05/04/2025 (Sunday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 36 residents.-On 05/05/2025 (Monday), there were three (3) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 36 residents.- On 05/23/2025 (Friday), 05/24/2025 (Saturday), and 05/25/2025 (Sunday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 36 residents.- On 05/26/2025 (Monday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 35 residents.-On 06/13/2025 (Friday), there were three (3) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 33 residents.- On 06/14/2025 (Saturday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 35 residents.- On 06/15/2025 (Sunday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0725<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | with a census of 36 residents.- On 09/13/2025 (Saturday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 35 residents.- On 09/14/2025 (Sunday), 09/15/2025 (Monday), and 09/16/2026 (Tuesday), there were four (4) Certified Nursing Assistants assigned to Unit [NAME] 2 with a census of 34 residents.During the Resident Council meeting on 09/12/2025 at 12:32 PM, two (2) out of nine (9) residents stated the facility is very short-staffed. Resident #4 and Resident #214 both expressed staffing concerns, especially during the weekends. Both residents stated that poor staffing had led to a delayed response to the call bells for up to an hour, which affected their care.During an interview on 09/17/2025 at 02:03 PM, the Staffing Coordinator stated Unit [NAME] 2 had a maximum bed capacity of 39 residents, which would require two (2) licensed nurses and five (5) Certified Nursing Assistants to meet all residents' needs based on the par levels (required amount of nursing staff determined by the facility). The Staffing Coordinator provided a sheet of paper with no title, which showed the names of the units and the staffing par levels for each shift. The sheet indicated the Unit [NAME] 2 required five (5) Certified Nursing Assistants during the 7:00 AM-3:00 PM shift for a census of 39 residents. During interviews with two (2) anonymous nursing staff members, concerns were expressed related to overall nursing staff coverage during the day shift (weekdays and weekends), and the number of residents assigned to each Certified Nursing Assistant on a regular basis. Anonymous Nursing staff members stated that work can get overwhelming without sufficient staffing, which affects the quality of care they provide for each resident They stated they need to prioritize their work, for example getting residents ready for rehabilitation therapy or dialysis first and in trying to get to every resident, the last residents on their assignement may be rushed or may not receive timely care. Nursing staff members stated they often had to stay beyond their shift to finish their work. During an interview on 09/18/2025 at 01:25 PM, the Staffing Coordinator stated they scheduled Certified Nursing Assistants on each unit based on the current census and acuity. The Staffing Coordinator stated that four (4) Certified Nursing Assistants were adequate for Unit [NAME] 2 when the resident census was between 29-36 residents. The Staffing Coordinator stated that although a ratio of one (1) Certified Nursing Assistant to eight (8) residents was generally applied when considering staffing, one (1) to two (2) Certified Nursing Assistants could take one extra assignment if the census was slightly over.During an interview on 09/18/2025 at 02:49 PM, the Director of Nursing Services stated that there was no staff shortage on [NAME] 2. The Director of Nursing Services stated that the actual staffing need on each unit is determined by the actual resident census and acuity level of those residents. The Director of Nursing Services stated that four (4) Certified Nursing Assistants are sufficient unless the unit has a full census or the acuity of the resident is assessed otherwise.During an interview on 09/18/2025 at 02:53 PM, the Administrator stated the Facility Assessment was developed to represent what the facility had assessed and suggested the staffing needs to meet all residents' needs based on census and acuity. The Administrator stated the actual staffing schedule is determined based on the actual census and acuity at the time of the schedule. The Administrator stated the facility does not have to follow the Facility Assessment regarding the staffing needs because the Assessment was a suggestion of staffing ratio under full capacity. The Administrator stated there was no Certified Nursing Assistant shortage on Unit [NAME] 2, despite a discrepancy reflected on the actual staffing schedule with fewer Certified Nursing Assistants than indicated on the Facility Assessment. The Administrator stated they were aware that the Payroll-Based Journal triggered for low weekend staffing; however, they did not implement any new intervention or measures to address the low weekend staffing. 10 NYCRR 415.13(a)(1)(i-iii) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that each resident was treated with respect and dignity and in a manner and in an environment that promotes maintenance or enhancement of their quality of life. This was identified for one (1) (Resident #5) of one (1) resident reviewed for Dignity. Specifically, on 09/11/2025, Resident #5 was observed in bed sleeping with a clear plastic bag tied to their bed rail, visible from the hallway. The plastic bag was filled with soiled briefs, smeared feces, and used tissues. There was no staff within the vicinity of Resident #5's room. The finding is:The facility's policy titled Dignity, last revised on 09/04/2025, documented that residents are treated with dignity and respect at all times. Each resident shall be cared for in a manner that promotes and enhances their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain, and protect resident privacy, including bodily privacy. Resident #5 was admitted with diagnoses including Type 2 Diabetes, End Stage Renal Disease, and Hypotension (low Blood Pressure). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The Quarterly Minimum Data Set (MDS) assessment documented that Resident #5 had frequent bowel and bladder incontinence. A Comprehensive Care Plan (CCP) dated 04/15/2025 documented that Resident #5 had bladder incontinence. The interventions included changing clothing after incontinence episodes and incontinence care that includes washing, rinsing, and drying the perineum. A Comprehensive Care Plan (CCP) dated 04/15/2025 documented that Resident #5 had bowel incontinence with interventions including checking the resident every two hours and assisting with toileting as needed. A Physician's Order dated 07/30/2025 documented Sennoside (stool softener) tablet 8.6 milligrams, two tablets by mouth twice a day for Constipation. A Physician's Order dated 07/30/2025 documented Lactobacillus Capsule, one capsule by mouth twice a day for Diarrhea (watery stool). During an observation on 09/11/2025 at 10:40 AM, Resident #5 was sleeping in bed. A clear plastic bag was tied to Resident #5's bed rail, beside Resident #5's head. The bag was visible from the hallway. The plastic bag was filled with used incontinence briefs smeared with feces and used tissues. There was no staff within the vicinity of Resident #5's room. During an observation on 09/12/2025 at 10:52 AM, an empty clear plastic bag was tied to Resident #5's bed rail. Resident #5 was out of bed in a wheelchair in their room. The resident did not remember who put the bag there. During an interview on 09/12/2025 at 10:57 AM, Certified Nursing Assistant #1 stated that they did not put the clear plastic bag at the resident's bedside the morning of 09/11/2025. Certified Nursing Assistant #1 stated that a family member had visited Resident #5, and they were not sure if they (family member) were the one who put the plastic bag. Certified Nursing Assistant #1stated they always pick up any soiled garbage, including dirty incontinence products, after providing care to Resident #5. During an interview on 09/15/2025, Registered Nurse #1, the charge nurse, stated that the staff should not be tying plastic bags as a trash bag and leaving the bag hanging by the resident's bed due to infection control. During an interview on 09/16/2025 at 3:17 PM, the Infection Preventionist stated that the plastic bag filled with soiled incontinence products should not have been tied and left tied to the resident's bed. The Infection Preventionist stated that soiled incontinence products should be disposed of immediately. During an interview on 09/18/2025 at 9:00 AM, the Director of Nursing Services stated that their expectation is for the nursing staff to throw any soiled incontinence products and not leave them by the resident's bed. The Director of Nursing Services stated that they expect all staff to keep the residents' environment clean. 10 NYCRR 415.5(a) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure the Minimum Data Set (MDS) assessment was completed to accurately reflect each resident's status. This was identified for one (1) (Resident #6) of five (5) residents reviewed for Nutrition and for one (1) (Resident #7) of two (2) residents reviewed for Urinary Catheter or UTI (Urinary Tract Infection). Specifically, 1) Resident #6 had a significant weight loss, which was not identified in the 5-Day Minimum Data Set assessment dated [DATE], and 2) Resident #7's bladder and bowel function related to the use of an indwelling catheter was not accurately reflected in the quarterly Minimum Data Set assessment dated [DATE].The findings are:<br><br>The facility's policy titled MDS (Minimum Data Set) Accuracy, dated 09/04/2025, documented the information captured on the assessment reflects the status of the resident during the observation period for that assessment. Any person who completes any portion of the Minimum Data Set assessment is required to sign the assessment certifying the accuracy of that portion of that assessment.<br><br>1) Resident #6 had diagnoses that included Diabetes Mellitus and Hypertension. The 5-Day Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderately impaired cognitive skills for daily decision making. Section K - Swallowing/Nutritional Status documented the resident's height was 67 inches, and the resident's weight was 190 pounds. The Minimum Data Set documented the resident had no weight gain or loss of 5% or more in the last one (1) month or 10% or more in the last six (6) months. Section K was completed by Dietitian #1 on 08/20/2025 and 08/21/2025. The entire 5-Day Minimum Data Set assessment dated [DATE] was signed off by Registered Nurse Minimum Data Set Assessor #1.<br><br>The resident's weight history documented the resident weighed 202.4 pounds on 07/15/2025 and 190.2 pounds on 08/14/2025, which reflected a 6.03% weight loss in one (1) month.<br><br>During an interview on 09/15/2025 at 10:30 AM, Registered Dietitian #1 stated they should have documented in the resident's 5-Day Minimum Data Set (MDS) assessment dated [DATE], the resident's weight of 190 pounds reflected a weight loss of 5% or more in the last one (1) month. Registered Dietitian #1 stated it was their mistake and probably miscalculated when filling out the weight question in Section K.<br><br>During an interview on 09/15/2025 at 10:50 AM, Registered Dietitian Chief Clinical Nutrition Manager #1 stated Registered Dietitian #1 made a data entry error when filling out the weight question in Section K in the resident's 5-Day Minimum Data Set (MDS) assessment dated [DATE].<br><br>During an interview on 09/15/2025 at 11:15 AM, Registered Nurse Minimum Data Set Assessment Coordinator #1 stated it was the responsibility of Registered Nurse Minimum Data Set Assessor #1 to ensure the completion and accuracy of the resident's 5-Day Minimum Data Set assessment dated [DATE], based on the resident's medical record, because it was their final signature on the assessment before it was submitted.<br><br>During an interview on 09/15/2025 at 11:45 AM, Registered Nurse Minimum Data Set Assessor #1 stated when they sign off at the end of any Minimum Data Set assessment, they are attesting only<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that the assessment was completed on that date, and each discipline was responsible for the accuracy of their own section they are completing.<br><br>During an interview on 09/18/2025 at 09:00 AM, the Director of Nursing Services stated that by signing at the end of the resident's 5-Day Minimum Data Set assessment dated [DATE], Registered Nurse Minimum Data Set Assessor #1 was attesting to the completion and accuracy of that Minimum Data Set assessment, whether it was their discipline or not.<br><br>2) Resident #7 was admitted with diagnoses including Obstructive and Reflux Uropathy (urine cannot drain through the urinary tract and may back up into the kidneys) and Functional Urinary Incontinence. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set assessment Section H documented that the resident had an indwelling catheter. Resident #7's urinary continence was not rated due to catheter use.<br><br>A physician's order dated 06/03/2025 documented to use a Foley catheter 16 French, ten (10) cubic centimeter balloon, and to change every month and as needed for Neuromuscular Dysfunction of Bladder. The order was discontinued on 09/16/2025.<br><br>A physician's progress note dated 06/11/2025 documented that Resident #7 was seen for [urine] voiding trial, day one (1). The resident was alert and oriented. The Foley catheter was removed, and Resident #7 denied any abdominal pain. The Physician documented a trial of voiding initiated and recommended a new order for bladder scan every 6 hours, straight catheter as needed.<br><br>A physician's progress note dated 06/12/2025 documented that Resident #7 was seen for a [urine] voiding trial, day two (2). The Foley catheter was removed, and Resident #7 was voiding well. Resident denied abdominal or pelvic pain, no hesitancy, urgency, or dysuria.<br><br>A physician's monthly progress note dated 06/30/2025 documented Resident #7 had a positive trial of void, and will be followed periodically for diagnosis of Uropathy.<br><br>A review of the progress note from June 2025 to September 2025 revealed Foley catheter was not re-inserted for Resident #7.<br><br>The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had moderately impaired cognition. The Minimum Data Set assessment Section H documented that the resident had an indwelling catheter. Resident #7's urinary continence was not rated due to catheter use.<br><br>The Minimum Data Set Assessor, who completed the Quarterly Minimum Data Set assessment dated [DATE], was no longer employed in the facility and, therefore, was not interviewed.<br><br>During an interview on 09/17/2025 at 12:03 PM, the Director of Minimum Data Set stated the Quarterly Minimum Data Set assessment dated [DATE] did not accurately reflect Resident #7's bladder function, as the assessment inaccurately indicated Resident #7 had an indwelling catheter. The Director of Minimum Data Set stated that the Minimum Data Set assessors mainly review the resident's medical record when completing a Minimum Data Set assessment. The Director of Minimum Data Set stated that they did not know if the assessor who completed the Quarterly assessment observed the resident for the presence of the Foley catheter. The Director of Minimum Data Set<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated that the Minimum Data Set assessors may not have time to check on each resident in person when completing the Minimum Data Set assessments, due to the number of assessors on staff and the number of assessments they are required to complete and submit.<br><br>During an interview on 09/18/2025 at 08:49 AM, the Director of Nursing Services stated that all Minimum Data Set assessments should accurately reflect each resident's condition.<br><br>10 NYCRR 415.11(b) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not develop and implement a comprehensive person-centered care plan that includes measurable objectives and time frames to meet the resident's medical and nursing needs. This was identified for one (1) resident (Resident #1) of three (3) residents reviewed for Respiratory Care and for one (1) (Resident #80) of one (1) resident reviewed for Insulin. Specifically, 1) Resident #1 had a Physician Order for Oxygen continuously at two (2) liters per minute. During observations on 09/11/2025, Resident #1 was receiving oxygen at five (5) liters per minute, and on 09/12/2025, the resident was receiving oxygen at three (3) liters per minute. 2) Resident #80's comprehensive care plan was not person centered to include the use of a continuous glucose monitoring device used by the resident for Diabetes management.The findings are:<br><br>The facility's policy titled Oxygen Administration was last revised on 09/04/2025, documented that Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. Licensed Nursing staff are responsible for administering and monitoring oxygen therapy and verifying that a physician's Order is available for oxygen therapy.<br><br>1) Resident #1 was admitted with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), End Stage Renal Disease, and Pulmonary Hypertension. The Significant Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of five (5), which indicated Resident #1 had severe cognitive impairment. The Significant Minimum Data Set (MDS) assessment documented that Resident #1 had an active diagnosis of Pneumonia and Asthma. The Significant Minimum Data Set (MDS) documented that Resident #1 was receiving continuous oxygen therapy.<br><br>A Physician Order dated 06/10/2025 documented Oxygen at two (2) liters per minute via nasal cannula continuously every shift. Change oxygen tubing and storage bag, wipe down oxygen equipment, and date weekly on Wednesday night: every night shift.<br><br>A Comprehensive Care Plan (CCP) titled, Alteration in Respiratory Status related to Chronic Obstructive Pulmonary Disease (COPD) dated 08/06/2025, documented intervention including administering oxygen therapy as ordered by the Physician and monitoring signs and symptoms of Chronic Obstructive Pulmonary Disease (COPD), including shortness of breath, wheezing, chest tightness, and chronic cough.<br><br>During an observation on 09/11/1015 at 10:48 AM, Resident #1 was in bed using an oxygen concentrator through a nasal cannula. The oxygen concentrator was set to deliver oxygen at five (5) liters per minute.<br><br>During an observation on 09/12/2025 at 2:34 PM, Resident #1 was sitting in their wheelchair in their room. Resident #1 was using an E-Cylinder oxygen tank (a portable, lightweight metal cylinder for oxygen), which was set to deliver oxygen at three (3) liters per minute.<br><br>During an interview on 09/12/2025 at 2:40 PM, Registered Nurse #1, charge nurse, stated that the Nurses were responsible for making sure that Resident #1 received the correct amount of oxygen as per the physician's order at two (2) liters per minute continuously.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 09/16/2025 at 11:13 AM, Licensed Practical Nurse #2, the medication nurse, stated that the medication nurses were responsible for ensuring the resident was receiving the correct oxygen amount. Licensed Practical Nurse #2 stated that Resident #1 goes to dialysis, and usually returns to the unit during the medication administration time, and at times, the Nurses are busy administering medications to other residents. The Nurses should be checking that Resident #1 is using two (2) liters of oxygen continuously when Resident #1 returned to the unit.<br><br>During an interview on 09/17/2025 at 9:43 AM, Licensed Practical Nurse #1 stated that they were the Medication Nurse in the unit on 09/11/2025. Licensed Practical Nurse #1 stated that the resident was receiving oxygen at two (2) liters when they saw Resident #1 early that morning. Licensed Practical Nurse #1 stated that when Resident #1 returned from therapy and was placed back in the bed, they were not sure how many liters of oxygen Resident #1 was receiving. Licensed Practical Nurse #1 stated they should have checked the oxygen when Resident #1 returned, but they were busy doing their medication administration with other residents.<br><br>During an interview on 09/18/2025 at 8:19 AM, the Director of Nursing Services stated that the Nurses in the unit are responsible for making sure that Resident #1's oxygen was at two (2) liters continuously as ordered by the Physician. The Director of Nursing Services stated that the Nurses should be checking the oxygen before Resident #1 goes to dialysis and when they (Resident #1) return to the unit.<br><br>2) The facility's policy and procedure titled Comprehensive Care Plans, last revised 09/04/2025, documented the interdisciplinary team, in conjunction with the resident, develops and implements a comprehensive person-centered care plan for each resident. Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of their plan of care. Assessment of residents is ongoing, and care plans are revised as information about the resident and the resident's conditions change.<br><br>Resident # 80 was admitted with diagnoses including Type 2 Diabetes Mellitus and Acute Respiratory Failure. The admission Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The Minimum Data Set assessment documented that Resident #80 received hypoglycemic medication, including insulin injections.<br><br>A physician's order dated 8/22/2025 documented to administer Insulin Glargine Subcutaneous solution 14 units at bedtime for Diabetes Mellitus.<br><br>A physician's order dated 9/6/2025 documented to administer Metformin oral tablet 500milligrams one (1) tablet by mouth every 12 hours for Diabetes Mellitus.<br><br>A physician's order dated 9/9/2025 documented to administer Insulin Lispro Subcutaneous solution 22 units with meals for Diabetes Mellitus. Hold if the fingerstick blood glucose level is less than 130 [milligrams per deciliter].<br><br>During an observation and interview on 09/11/2025 at 10:31 AM, Resident #80 stated that they had Diabetes and utilized a continuous glucose monitoring device, which they acquired themselves through their insurance, to track their glycemic level. A round adhesive patch was observed on Resident #80's left upper inner arm, which Resident #80 indicated was where the device was attached. Resident #80 stated that the device continuously measured their blood glucose level and (continued on next page) |

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| | 335211 | A. Building<br>B. Wing | 11/19/2025 |

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| Glengariff Health Care Center | 141 Dosoris Lane<br>Glen Cove, NY 11542 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | alerted them (Resident #80) of the readings through their cellphone, including the critically low levels. Resident #80 stated that they replaced the monitoring device themselves after every ten (10) days. Resident #80 stated that facility staff were aware that they were using the continuous blood glucose monitoring device. Resident #80 stated they continued to comply with nurses checking their fingerstick as ordered by the Physician despite the use of the continuous glucose monitor.<br><br>The Comprehensive Care Plan for Diabetes Mellitus, dated 08/23/2025, documented interventions including Diabetes medication as ordered by the doctor and monitor/document for side effects and effectiveness; educate [resident] regarding medications and importance of compliance, and to have the resident verbally state an understanding; and consult dietary for nutritional regimen and ongoing monitoring. The Comprehensive Care Plan did not include documentation of the use of a continuous glucose monitoring device.<br><br>During an interview on 09/15/2025 at 12:42 PM, Licensed Practical Nurse #8 stated that they were aware that Resident #80 utilized a continuous glucose monitoring device that they (Resident #80) brought with them from admission. Licensed Practical Nurse #8 stated the device provided Resident #80 a 'peace of mind' to know their blood glucose level at all times. Licensed Practical Nurse # 8 stated that Resident #80 was able to care for the device on their own, and the nurses were not responsible for the device, as there were no physician's orders or nursing instructions for the device. Licensed Practical Nurse # 8 stated they were not responsible for creating or revising the care plans.<br><br>During an interview on 09/15/2025 at 03:19 PM, Physician #2 stated they were aware Resident #80 wore a continuous glucose monitoring device to monitor their own blood glucose level. Physician #2 stated they did not give any order for the care and monitoring of the device. Physician #2 stated they expected that when the resident reported an episode, especially one of hypoglycemia, from the monitoring device, staff would check and confirm the resident's blood glucose level right away and notify them (Physician #2) as necessary.<br><br>During an interview on 09/17/2025 at 9:19 AM, the Minimum Data Set Assessor, a Registered Nurse, stated that a care plan for the use of the continuous glucose monitoring device should have been developed because the resident preferred to use the device to manage their Diabetes.<br><br>During an interview on 09/17/2025 at 11:00 AM, Registered Nurse #2, stated they were one of the Registered Nurses responsible for ensuring the completion and revision of residents' comprehensive care plans. Registered Nurse # 2 stated they were aware Resident #80 utilized the continuous glucose monitor and periodically checked the device; however, they did not develop a care plan as the facility staff was not responsible for caring for the device.<br><br>During an interview on 09/18/2025 at 08/43 PM, the Director of Nursing Services stated they did not believe a care plan for the use of continuous glucose monitoring was needed as the resident was utilizing the device on their own.<br><br>10 NYCRR 415.11(c)(1) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that a resident who is unable to carry out Activities of Daily Living (ADL) receives the necessary services to maintain grooming and personal hygiene. This was identified for one (1) (Resident #131) of two (2) residents reviewed for Activities of Daily Living. Specifically, Resident #131, who had severely impaired cognition and required staff assistance with Activities of Daily Living, was not dressed and assisted out of bed until after 2:00 PM. The assigned Certified Nursing Assistant #2 did not provide morning care to Resident #131 because they were providing care to the other residents on their assignment. The finding is:The facility's policy titled Activities of Daily Living, dated 12/09/2022, documented that all residents shall be supported in performing Activities of Daily Living to the greatest extent of their ability. Staff will provide individualized care and assistance in accordance with each resident's care plan, promoting autonomy, safety, and quality of life. Activities of Daily Living include basic self-care tasks, including but not limited to: dressing and mobility (walking, transferring, positioning). Activities of Daily Living assistance levels will be documented in the care plan. Staff are responsible for providing Activity of Daily Living support in accordance with care plans and best practices. Resident #131 was admitted with diagnoses of Dementia, Alzheimer's Disease, and Unsteady on Feet. The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of four (4), which indicated the resident had severely impaired cognition. The Minimum Data Set under the mood section documented that the resident had little interest or pleasure in doing things and was feeling down, depressed, or hopeless. The resident had no behavioral symptoms and did not reject care. The resident required supervision assistance for sit to stand and upper body dressing; partial/moderate assistance of one (1) staff member for lower body dressing. The resident was frequently incontinent of bladder and bowel. The Comprehensive Care Plan (CCP) for Activities of Daily Living, dated 08/21/2025, documented the resident had an actual self-care deficit related to impaired cognition, balance, and mobility. Interventions included but were not limited to: assist with bed mobility, transfers, toileting, and bathing as required; encourage the resident to participate to the fullest extent possible with each interaction; supervision assistance for sit to stand and upper body dressing, and partial assistance of one (1) staff member for lower body dressing. The Certified Nursing Aide Kardex Report (instruction for resident care to the Certified Nursing Assistants) documented that the resident required supervision assistance for sit to stand and upper body dressing; partial/moderate assistance of one (1) staff member for lower body dressing.A review of the resident's electronic medical record revealed no documented history of refusal or non-compliance with care.During an observation on 09/11/2025 at 10:05 AM, Resident #131 was observed sitting upright on the side of their bed. Resident #131 was wearing a hospital gown with a white bed blanket wrapped around their upper body. Resident #131 stated they wanted to get changed but did not know who was supposed to help them. Resident #131 was unable to state when and what care had been offered and provided to them this morning (09/11/2025). During an observation on 09/15/2025 at 10:33 AM, Resident #131 was observed sleeping in bed in a side position facing the door. Resident #131 was wearing a gray top with a zipper and a white brief, which was visible because the resident was not wearing any bottom clothing. During an observation on 09/15/2025 at 02:10 PM, Resident #131 was again observed sleeping in bed in a side position facing the door. Resident #131 was still wearing the same gray top with a zipper and a white brief, which was visible because the resident was not wearing any bottom clothing.During an interview on 09/15/2025 at 02:18 PM, Certified Nursing Assistant #2, who was assigned to Resident #131 during the 7:00 AM - 3:00 PM shift on 09/15/2025. Certified Nursing Assistant #2 stated they had not yet provided the morning care to Resident#131. They were about to go to the resident's room now because Resident #131 was the last<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident on their assignment that they had to provide care for. Certified Nursing Assistant # 2 stated they first provided care to the residents who required Dialysis or Rehabilitation Therapy to make sure those residents were ready for their appointments. Certified Nursing Assistant # 2 stated they checked in on Resident #131 during the day and moved on to the other residents' rooms without providing any care to this resident because the resident was sleeping. Certified Nursing Assistant # 2 stated they did not try to wake the resident because they had to provide care to other residents first. During an interview on 09/18/2025 at 08:43 AM, the Director of Nursing Services stated that Certified Nursing Assistants should assist residents in their Activities of Daily Living if the resident requires it. The Director of Nursing Services stated they do not expect residents to still be waiting for care at 2:30 PM in the afternoon unless the resident preferred to be in bed or refused care. The Director of Nursing Services stated that Certified Nursing Assistant #2 should have notified the nurse of any care-related issues. 10NYCRR- 415.12(a)(2) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (1) (Resident #27) of three (3) residents reviewed for Hydration. Specifically, Resident #27 was observed on 9/11/2025 at 10:53 AM with a peripheral intravenous catheter (a short flexible tube inserted into a peripheral vein to deliver fluids, medications, and blood products directly into a patient's bloodstream) to the left forearm covered with a transparent dressing that was dated 08/28/2025. Additionally, there was no Physician's order to flush the intravenous catheter and monitor the area. The finding is:The facility's policy titled Peripheral Intravenous Catheter Insertion, last revised on 09/04/2025, documented that Peripheral Intravenous Catheter Insertion is performed by the Licensed Nurses according to state law and facility policy. The policy included that a catheter shall be placed for a definitive therapeutic and/or diagnostic indication upon the order of a Physician. A new peripheral catheter shall be utilized for each catheter insertion attempt. Peripheral catheter sites are rotated every 72-96 hours and sooner for signs or symptoms of complications. After catheter insertion, label dressing with date, time, catheter gauge, and length, and initials of the person who inserted the catheter. Document date and time of procedure, site location and assessment, dressing type, patient response to procedure and/or medication, and patient teaching on the appropriate nursing document. Resident # 27 was admitted with diagnoses including Atrial Fibrillation, Anemia, and Muscle Weakness. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #27 had intact cognition. The Quarterly Minimum Data Set (MDS) assessment documented that Resident #27 did not receive any intravenous medications. The Quarterly Minimum Data Set (MDS) assessment documented an Active Diagnosis of a Medically Complex Condition. A Comprehensive Care Plan dated 07/21/2025 titled High Nutrition/Dehydration Risk related to low albumin (protein that is synthesized in the liver and released into the bloodstream) levels, documented interventions including monitoring oral intake of food and fluids, monitoring for signs and symptoms of dehydration, and educating the resident and family regarding diet and fluid intake. A Physician's order dated 08/27/2025 documented Dextrose -Sodium Chloride Intravenous Solution 5-0.45 percent (an intravenous solution that provides water, electrolytes, and calories to the body). Use 75 milliliters per hour intravenously every hour for hydration for three (3) days. The order was completed on 08/30/2025.A Physician's order dated 09/01/2025 documented Dextrose -Sodium Chloride Intravenous Solution 5-0.45 percent. Use 75 milliliters per hour intravenously every hour for hydration for three (3) days. This order was completed on 09/04/2025.A review of the electronic medical record revealed no Physician's order for the insertion of an intravenous catheter, including flushing and monitoring the intravenous catheter site area from 08/27/2025 until 09/11/2025. A review of the electronic medication administration record revealed that Resident #5 was receiving Dextrose -Sodium Chloride Intravenous Solution every hour for hydration for three (3) days from 08/27/2025 until 08/30/2025 and from 09/01/2025 until 09/04/2025. A review of the electronic medical record revealed that Resident #5's intravenous catheter was not rotated, and there was no documentation of the catheter care or monitoring of the intravenous catheter site by the Nursing staff. A Comprehensive Care Plan dated 09/01/2025 titled Intravenous Line Administration of Intravenous Fluids documented interventions, including assessing the intravenous line insertion site for redness, tenderness, or swelling; assessing the dressing to make sure it is clean, dry, and intact; and changing the dressing as ordered and as needed. During an observation on 09/11/2025 at 10:53 AM, Resident #27 was in bed with a loose Kling wrap (a gauze roll) on the left wrist. A transparent dressing was observed on Resident #27's left forearm covering a peripheral intravenous catheter dated 08/28/2025. The resident was not receiving any intravenous<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | therapy. During an interview on 09/11/2025 at 11:00 AM, Resident #27 stated there is a needle in their arm, and they did not remember the last time the Nurses took care of the dressing on their arm. Resident #27 stated they have not been receiving intravenous fluids. During an interview on 09/15/2025 at 11:20 AM, Registered Nurse #1, the Charge Nurse, stated that they were not aware that Resident #27 had a peripherally inserted intravenous line on their left forearm. Registered Nurse #1 stated that the intravenous line on Resident #27 should have been discontinued after the intravenous therapy was completed. During an interview on 09/16/2025 at 1:57 AM, Physician #1 stated the intravenous dressing should be changed every five days to avoid any infection. Physician #1 stated that the intravenous line should be flushed every day to keep the patency of the intravenous line. Physician #1 stated that the Nursing staff should have called them (Physician #1) to discontinue the intravenous catheter after the intravenous therapy was completed. During an interview on 09/17/2025 at 9:39 AM, Licensed Practical Nurse #1 stated they took out the intravenous catheter for Resident #27 on 09/11/2025 after the Physician had given the order to discontinue the catheter. Licensed Practical Nurse #1 stated they forgot to document that they took out the intravenous catheter and should have documented that the intravenous catheter was removed, including the resident's response, and how the skin area around the catheter was.During an interview on 09/18/2025 at 8:33 AM, the Director of Nursing Services stated that they expect the dressing change on the intravenous site to be changed weekly. The Director of Nursing Services stated that a saline flush on the intravenous catheter should be done before and after intravenous therapy daily. The Director of Nursing Services stated that the intravenous catheter should have been discontinued on 09/04/2025 after the intravenous therapy was completed. The Director of Nursing Services stated the Nurses should have documented the resident's response to the treatment, the order from the Physician, and the monitoring of the site for signs and symptoms of infiltration and infection.10 NYCRR 415.12 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that the resident maintained, to the extent possible, acceptable parameters of nutritional and hydration status. This was identified for one (1) (Resident #240) of five (5) residents reviewed for Nutrition. Specifically, Dietitian #2 recommended Resident #240 to receive a liquid nutritional supplement of Two Cal HN (protein and calorie-dense supplement) twice daily for additional calories and protein; however, the supplement was never ordered. The finding is: The facility's policy titled, Interdisciplinary Management and Prevention of Significant Weight Loss Nursing Facility Residents, reviewed 09/04/2025, documented the Clinical Dietitian will communicate to the Physician and Head/Charge Nurse any nutritional recommendations based on assessment.Resident #240 had diagnoses that included Urinary Obstruction and Shortness of Breath. The 5-Day Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderately impaired cognitive skills for daily decision making. Section K - Swallowing/Nutritional Status documented the resident's height was 60 inches, and the resident's weight was 115 pounds. Section K also documented that the resident had a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months and was not on a physician-prescribed weight-loss regimen. The Weight Loss Nutrition Note dated 08/20/2025, written by Dietitian #2, documented: Resident triggered for a significant weight loss during the first month of their stay (06/12/2025-07/15/2025). Provide Two Cal HN Medication Pass (4 ounces of the supplement provided when the resident receives their medications) twice daily, which provides 475 kilocalories and 20 grams of protein. The Comprehensive Care Plan entitled Resident at high nutrition risk related to diagnosis of brain cancer, advanced age, initiated on 06/13/2025, documented as an intervention/task: Provide Two Cal HN BID (twice daily) (475 kilocalories, 20 grams protein), initiated on 08/20/2025.A review of the resident's current Physician Orders in their Electronic Medical Record (EMR) on 09/17/2025 at 04:05 PM revealed no documented evidence that the resident was receiving the Two Cal HN supplement.A review of the resident's Medication Administration Records (MARs) dated August 2025 and September 2025 on 09/17/2025 at 04:10 PM revealed no documented evidence that the resident was provided with the Two Cal HN supplement.During an interview on 09/18/2025 at 09:40 AM, Registered Dietitian #2 stated they made an error and should have put a Physician's Order into the resident's Electronic Medical Record, for the Two Cal HN supplement they were recommending, for the resident's Physician to sign. Registered Dietitian #2 stated they had recommended the Two Cal HN supplement to help the resident maintain their weight or regain the significant weight they had lost. During an interview on 09/18/2025 at 9:50 AM, Registered Dietitian Chief Clinical Nutrition Manager #1 stated Registered Dietitian #2 should have put a Physician's Order into the resident's Electronic Medical Record after recommending the resident receive the Two Cal HN supplement on 08/20/2025. Nursing would then contact the resident's Physician, review the Order with the Physician, and the Physician would either confirm the Order or deny it. 10 NYCRR 415.12(i)(1) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care.<br><br>Based on record review and interviews during the Recertification Survey and Abbreviated Survey (2609906) initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure the medical care of each resident was supervised by a Physician. This was identified for one (1) (Resident #246) of three (3) residents reviewed for Hospitalization. Specifically, Resident #246's Physician indicated in multiple progress notes that the resident's Foley urinary catheter should be flushed with normal saline. However, there was no physician's order written for flushing the catheter, and no documented evidence that the catheter was flushed by the nursing staff.The finding is:The undated facility policy titled Foley Catheter Care and Privacy documented the catheter should be monitored for patency (free flowing). If signs of blockage occur, for example, reduced or no urinary output, appropriate steps should be taken, including irrigating the catheter, if necessary, with a physician's order.Resident #246 was admitted with diagnoses including Obstructive Uropathy (a blockage in the urinary tract that prevents normal urine flow), Chronic Obstructive Pulmonary Disease, and Malnutrition. The 04/04/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 11, indicating the resident had moderate cognitive impairment. The resident had a urinary catheter and a diagnosis of Benign Prostatic Hyperplasia (enlargement of the prostate gland that can affect urine flow).A physician order dated 03/29/2025 documented a 16 French (a scale indicating diameter of catheter) Foley catheter; Foley catheter care every shift; and to document [urinary] output. Change the Foley catheter every month and when needed.A The nursing progress note dated 04/04/2025 documented the resident had 450 milliliters of brown color urine output.A nursing progress note dated 04/06/2025 documented the resident had brown colored 600 milliliters of urine output.A progress note dated 04/08/2025, written by Physician #2, documented a Foley catheter in place, change every month, urology referral, Flush with 60 cubic centimeters twice a day; hematuria (blood in urine) likely traumatic; continue to follow, if worsening hold Eliquis (blood thinner) twice a day.A Urology consult note dated 04/14/2025 documented Assessment/Plan: Obstructive and reflux Uropathy, Foley care-Flush as needed.A progress note dated 04/18/2025, written by Physician #2, documented obstructive uropathy; Foley catheter in place; change every month; Flush [urinary catheter] with 60 cubic centimeters as needed.A review of the medical record revealed that there was no physician's order placed for flushing of the Foley catheter.A review of the April 2025 Treatment Administration Record revealed no documentation that the nurses had flushed the Foley catheter.During an interview on 09/15/2025 at 3:20 PM, Physician #2 stated when they write recommendations in their progress notes, they notify the nursing staff to enter an order related to those recommendations. Physician #2 stated that if their progress notes indicated recommendations for flushing the Foley catheter, then that was verbalized to the charge nurse. Physician #2 could not state why there was no physician order to flush Resident #246's Foley catheter.During an interview on 09/16/2025 at 9:10 AM, Licensed Practical Nurse #3 stated they did not remember Resident #246. Licensed Practical Nurse #3 stated they would need a physician's order to flush a Foley catheter, and after the procedure, they would document provision of care on the treatment administration record.During an interview on 09/16/2025 at 9:43 AM, Licensed Practical Nurse #4 stated a physician's order is required to flush the Foley catheter, and then the nurses must document that the care was provided according to the physician's order on the treatment administration record.During an interview on 09/16/2025 at 9:50 AM, Registered Nurse Supervisor #2 stated if a resident's Foley catheter needed flushing, the nurses must obtain an order from the Physician. As-needed orders to flush the Foley catheter are not acceptable because, then it is difficult to keep track of when the Foley was flushed.During a re-interview on 09/16/2025 at 12:57 PM, Registered Nurse Supervisor #2 stated they had reviewed all the notes; the Physician may have thought they gave an order for flushing the Foley catheter, but there was no order; there may have been a miscommunication between the Physician and the nursing staff.During an interview on<br>(continued on next page) |

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| F 0710<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 09/16/2025 at 2:28 PM, the Director of Nursing Services stated nurses need an order to flush the catheter, including the amount of fluid needed to flush the catheter. If the Physician indicated the need to flush the catheter in the medical progress note, the Physician should have written an order or given a verbal order to the nursing staff. During an interview on 09/16/2025 at 3:21 PM, Medical Director #1 stated as per the facility protocol, an order to flush the Foley catheter should have been placed by the Physician or provided a verbal order for the nursing staff to enter the order in the electronic medical record. 10 NYCRR 415.15(b)(1)(i)(ii) |

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| | 335211 | A. Building<br>B. Wing | 11/19/2025 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that drugs and biologicals were stored in a locked compartment. This was identified for one (Resident #5) of five (5) residents reviewed for Accident Hazards. Specifically, a tube of unlabeled Lidocaine and Prilocaine (local anesthetic that numbs tissue) cream 2.5 percent was observed on Resident #5's overbed table. There was no Nursing staff in the vicinity of Resident #5 's room. Resident #5 was not assessed to self-administer their medications. The finding is:The facility's policy titled Medication Labeling Storage Policy, last revised on 06/19/2025, documented that the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to the keys. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Only the dispensing pharmacy may label or alter the label on a medication container or package. Resident #5 was admitted with Diagnoses including Type 2 Diabetes, End Stage Renal Disease, and Hypotension (low Blood Pressure). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The Quarterly Minimum Data Set (MDS) assessment documented that Resident #5 had pain and received scheduled pain medications. A review of Resident #5's Electronic Medical Records revealed that Resident #5 did not have a Physician's Order for the Lidocaine and Prilocaine 2/5 percent cream. A review of Resident #5's Electronic Medical Records revealed that Resident #5 did not have a self-administration of medication assessment. A Comprehensive Care Plan (CCP) dated 12/18/2024 documented that Resident #5 was at risk for pain related to a decrease in mobility. Resident #5 had interventions including administering medications as ordered by the Physician and monitoring, recording, and reporting to the Nurse any complaint of pain or request for pain treatment. During an observation on 09/11/2024 at 10:40 AM, Resident #5 was in bed sleeping. A tube of unlabeled Lidocaine and Prilocaine 2.5 percent cream with an expiration date of 03/2026 was stored on top of Resident #5's overbed table. During an interview on 09/11/2025 at 10:45 AM, Licensed Practical Nurse #7, charge nurse, stated that they did not know why Resident #5 had medications on their overbed table. Licensed Practical Nurse #7 stated that the resident did not have an order for the Lidocaine and Prilocaine cream and should not have any medications in their room that were left unattended. Licensed Practical Nurse #7 stated that the Nurses administer Resident #5 their medications. During an interview on 09/11/2025 at 11:15 AM, Licensed Practical Nurse #1 stated that they did not see the Lidocaine and Prilocaine cream on Resident #5's overbed table when they did the medication administration in the morning. Licensed Practical Nurse #1 stated that Resident #5 should not have any unattended medications left in their room. During an interview on 09/18/2025 at 8:23 AM, the Director of Nursing Services stated that Resident #5 should not have any medications stored in their room. The Director of Nursing Services stated that all medications should be labeled and stored in a locked compartment. The Director of Nursing Services stated there is an ongoing issue at the facility with resident family members bringing medications from home, despite education. The Director of Nursing Services stated that staff should be vigilant in checking rooms and reporting any unattended medications in the resident's room. 10NYCRR 415.18(e) (1-4) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that each resident's medical record was in accordance with accepted professional standards and practices and was complete and accurately documented. This was identified for one (1) (Resident #7) of two residents reviewed for Urinary Catheter. Specifically, Resident #7's Foley Catheter was removed on 06/11/2025 for a voiding trial (an assessment to see if the resident can effectively urinate after a catheter is removed); however, the Physician's order, comprehensive care plan, and nursing assistant instruction (Kardex report) continued to document that Resident #7 required Foley Catheter care until September 2025.The finding is:The facility's policy titled Physician Orders last revised on 09/04/2025, documented if any order is unclear or appears incorrect, the nurse must contact the ordering Physician for clarification prior to confirming the order in the medical record. Resident #7 was admitted with diagnoses including Obstructive and Reflux Uropathy (urine cannot drain through the urinary tract and may back up into the kidneys) and Functional Urinary Incontinence. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had intact cognition. The Minimum Data Set assessment Section H documented the resident had an indwelling catheter. Resident #7's urinary continence was not rated due to catheter use.A physician's order dated 06/03/2025 documented to use Foley Catheter 16 French, ten (10) cubic centimeter balloon, and to change the Foley catheter every month and as needed for Neuromuscular Dysfunction of Bladder. The order was discontinued on 09/16/2025.A physician's progress note dated 06/10/2025 documented Resident #7 was seen for a complaint of low back pain and dysuria (painful urination). The resident's family member reported that the resident was screaming during the Foley catheter [placement]. The Physician documented Resident #7's Foley Catheter was draining clear urine, and there was no hematuria (blood in urine). Plan to start voiding trial: to remove the Foley catheter and continue bladder scan every six (6) hours for three (3) days.A physician's progress note dated 06/11/2025 documented Resident #7 was seen for [urine] voiding trial, day one (1). The resident was alert and oriented. The Foley catheter was removed, and Resident #7 denied any abdominal pain. The Physician documented a trial of voiding initiated, and recommended a new order for bladder scan every 6 hours, straight catheter as needed.A physician's progress note dated 06/12/2025 documented Resident #7 was seen for a [urine] voiding trial, day two (2). The Foley catheter was removed, and Resident #7 was voiding well. Resident denied abdominal or pelvic pain, no hesitancy, urgency, or dysuria.A physician's monthly progress note dated 06/30/2025 documented Resident #7 had a positive trial of void and will be followed periodically for diagnosis of Uropathy. A review of the progress note from June 2025 to September 2025 revealed Foley catheter was not re-inserted for Resident #7. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 12, which indicated the resident had intact cognition. The Minimum Data Set assessment Section H documented that the resident had an indwelling catheter. Resident #7's urinary continence was not rated due to catheter use.The Comprehensive Care plan titled Indwelling Foley Catheter dated 6/3/2025 and last revised 7/30/2025 documented that the resident has an indwelling Foley catheter related to the diagnosis of Obstructive Uropathy. The last care plan review was completed on 09/12/2025, and the Foley catheter care plan remained active.A review of Resident #7's September 2025 nursing task instruction report (Kardex report- care instructions provided to the Certified Nursing Assistants) included providing catheter care with soap and water, checking for leaks, documenting the output, and monitoring Resident #7 for pain and discomfort due to catheter use.A review of Resident #7's September 2025 Certified Nursing Assistant Accountability Record revealed that catheter care was not performed due to the care not being<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | applicable.During an interview on 09/11/2025 at 10:26 AM, Resident #7 stated they did not have an indwelling Foley catheter. The resident was unable to state how long they had not been using the Foley catheter.During a re-interview on 09/16/2025 at 01:33 PM, Resident #7 again stated they voided in their brief. Resident #7 stated that when their brief is soiled, they ask staff to change them (Resident #7).During an interview on 09/16/2025 at 01:42 PM, Licensed Practical Nurse # 9 stated that Resident #7 required a Foley catheter briefly when they returned from the hospital back in June 2025. Licensed Practical Nurse #9 stated the Foley catheter was discontinued a while ago, and Resident #7 did not currently have an indwelling catheter. Licensed Practical Nurse #9 was not aware that the resident had an active Physician's order for a Foley catheter and stated that the order should have been discontinued.During an interview on 09/16/2025 at 01:53 PM, Physician #1 stated that Resident #7 had a diagnosis of Obstructive Uropathy and a history of Dysuria and briefly required a Foley catheter, which was discontinued after the resident had a successful voiding trial in June 2025. Physician #1 stated Resident #7 did not need a Foley catheter at this time, and the order for the Foley catheter should be discontinued. During an interview on 09/17/2025 at 10:18 AM, Certified Nursing Assistant #3 stated that they had been regularly assigned to Resident #7 in the past month, and Resident #7 did not have an indwelling catheter. Certified Nursing Assistant # 3 stated that last month, they had reported the discrepancy to the unit nurses regarding the Foley catheter care instruction documented on the Kardex and that the resident did not have a Foley catheter. Certified Nursing Assistant # 3 stated that they continued to document Not applicable under catheter care because the resident did not have a Foley catheter.During an interview on 09/18/2025 at 08:49 AM, the Director of Nursing Services stated the documentation of care for Resident #7 did not accurately reflect the resident's actual needs. The Director of Nursing Services stated the resident's care profile should be updated and revised when the resident no longer requires their Foley catheter.10 NYCRR 415.22(a)(1-4) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews during the Recertification Survey, initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure it maintained an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. This was identified for two (2) (Resident #99 and #238) of four (4) residents observed during Medication Administration. Specifically, during the medication administration observation, Licensed Practical Nurse #5 did not perform hand hygiene after administering medications for Resident #238 and before preparing the medications to administer to Resident #99.The finding is:Resident #238 was admitted to the facility with diagnoses including Cerebral Infarction, Chronic Obstructive Pulmonary Disease, and Diabetes. The Quarterly Minimum Data Set, dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition.Resident #9 was admitted to the facility with diagnoses including Cerebral Palsy and Muscle Weakness. The Quarterly Minimum Data Set, dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated the resident had intact cognition.During an observation on 09/12/2025 at 08:30 AM, Licensed Practical Nurse #5 administered medications to Resident #238. The nurse prepared and administered the following medications:Lisinopril 10 milligram Oral Tablet for Hypertension.Aspirin 81 milligram Oral Tablet (prophylactic).Gapagliflozin 10 milligram Oral Tablet for Diabetes.Haloperidol 2 milligram per milliliter, give 2.5 milliliter for Schizophrenia.The oral tablets were put in a souffle cup. The liquid Haloperidol was poured into a cup of water at the resident's request. The nurse handed the cup of water/Haloperidol, and the souffle cup to the resident who was sitting in their wheelchair in the hallway. The resident swallowed the oral tablets and drank the water/Haloperidol, and handed the souffle cup and the water cup back to the nurse to discard. Directly after completing the medication administration for Resident #238, Licensed Practical Nurse #5 began preparing medications for Resident #99. The nurse did not perform hand hygiene between the two residents. The nurse opened the medication cart drawer and took out Resident #99's first blister pack for Furosemide (diuretic) 40 milligram Oral Tablet and popped one of the tablets into a souffle cup. At this time, the surveyor told the nurse that the nurse did not perform hand hygiene. The nurse stated they should have performed hand hygiene, but forgot. The nurse then performed hand hygiene by using the alcohol gel dispenser on the wall, and then the nurse stated they had just noticed the hand hygiene wipes on top of the medication cart. The nurse did not discard the Furosemide and continued with the medication pass.During an interview on 09/15/2025 at 8:15 AM, Assistant Director of Nursing Services/Infection Preventionist #1 stated Licensed Practical Nurse #5 was required to perform hand hygiene between residents during medication administration. During an interview on 09/17/2025 at 7:55 AM, Registered Nurse Educator #1 stated nurses are taught to wash or sanitize their hands before starting medication pass for a resident, so after they finish with one resident, they have to sanitize or wash their hands before starting medication administration for the next resident.During an interview on 09/17/2025 at 8:08 AM, the Director of Nursing Services stated the standard of practice is to perform hand hygiene between residents when performing medication administration.10 NYCRR 415.19(b)(4) |

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| F 0847<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the Recertification Survey initiated on 09/11/2025 and completed on 09/18/2025, the facility did not ensure that residents and their representatives had a full understanding of arbitration agreements. This was identified for four (Residents #14, #24, #15, and #131) of the four residents reviewed for the Arbitration task. Specifically, interviews with Residents #14, #24, #15, and a representative for Resident #131 all stated they were not aware that they had accepted an arbitration agreement and did not have a full understanding of the agreement.The finding is:The facility's policy titled Binding Arbitration, dated 11/05/2024, documented residents or representatives are informed of the nature and implications of any proposed binding arbitration agreement so as to make informed decisions on whether to enter into such agreements. The terms and conditions of a binding arbitration agreement are explained to the resident or representative in a way that ensures understanding of the agreement, including that the resident may be giving up their right to have a dispute decided in a court proceeding. The terms and conditions of the binding arbitration agreement are explained to the resident or representative in a form and a manner that they understand. A signature alone is not a sufficient acknowledgement of understanding. The resident or representative must verbally acknowledge understanding, and that the verbal acknowledgement is documented by the staff member who explains the agreement. Residents or representatives are provided 30 days after signing to fully review and rescind any agreement not understood at the time of admission.During an interview on 09/17/2025 at 1:14 PM, the Administrator stated that the arbitration agreement documents are part of the admission package. The Administrator stated the facility offers the arbitration agreements as of 02/15/2025, and at this time, there were no residents who signed an arbitration agreement. The Administrator stated that if any resident entered into an arbitration agreement, this would be brought to their attention.During an interview on 09/17/2025 at 1:55 PM, Concierge #2 stated they were not very familiar with the arbitration agreement process, and that residents either signed that they accepted or declined the agreement. Concierge #2 stated they were not aware of any record or list of residents who may have signed an arbitration agreement.During an interview on 09/17/2025 at 2:18 PM, the Administrator stated that as of 02/15/2025, all residents have accepted arbitration agreements, and no resident has declined. The Administrator stated that the resident/representative are provided with a copy of the agreement, and a copy is kept in the resident's Electronic Medical Record.Resident #14's 07/25/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact.During an interview on 09/18/2025 at 8:25 AM, Resident #14 stated they do not remember signing an arbitration agreement, and they did not know what an arbitration agreement was. When the surveyor explained the arbitration agreement to the resident, the resident stated they would prefer to use their own attorney if there were any problems with the facility.A review of Resident #14's Electronic Medical Record revealed the resident accepted the Alternative Dispute Resolution (arbitration) Agreement on 07/19/2025 as indicated by the resident's signature.Resident #15's 04/10/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact.During an interview on 09/18/2025 at 8:30 AM, Resident #15 stated I do not remember signing the arbitration agreement, and I do not know what it is.A review of Resident #15's Electronic Medical Record revealed the resident accepted the Alternative Dispute Resolution (arbitration) Agreement accepted the Alternative Dispute Resolution Agreement on 04/03/2025, evidenced by the resident's signature.Resident #24's 07/03/2025 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact.During an interview on 09/18/2025 at 9:30 AM, Resident #24 stated they did not really understand the binding<br>(continued on next page) |

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| F 0847<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | arbitration agreement. When the surveyor explained the binding arbitration agreement to the resident, the resident stated they were surprised they accepted the binding arbitration agreement and did not know there was a 30-day requirement to rescind the agreement; Resident #24 stated maybe the facility should explain the agreement better.A review of Resident #24's Electronic Medical Record revealed the resident accepted the Alternative Dispute Resolution (arbitration) Agreement accepted the Alternative Dispute Resolution Agreement on 06/27/2025, evidenced by the resident's signature.Resident #131 was admitted with diagnoses including Alzheimer's disease and Dementia. The admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 4, indicating the resident had severe cognitive impairment.On 09/18/2025 at 8:35 AM, Resident #131 was sleeping in bed and not easily arousable for an interview. The accepted Alternative Dispute Resolution Agreement on 08/21/2025 was signed by the resident as indicated by the resident's signature. The legal representative space was blank.During an interview on 09/18/2025 10:25 AM, Concierge #1 stated they and Concierge #2 are responsible for reviewing the admission documents with residents and representatives and having them sign the documents. Concierge #1 stated they could not specifically explain what the arbitration agreement is. I am not going to give the resident the whole law on arbitration, but we explain that the resident will be using arbitration and giving up their right to file a lawsuit in court. We use a computer tablet to go through the documents. At the beginning of the admission packet is a signature page, and on each attachment, there is an accept button. As we go through the admission packet and each attachment, each attachment (for example, Attachment F, Alternative Dispute Resolution Agreement) has an accept button that I will press as being accepted or declined. If accepted, the signature from the signature page gets prepopulated to that attachment, so the resident does not have to sign each attachment.Review of the admission Agreement Signature Page from the admission Packet documented the following: By signing below, the undersigned consents to be legally bound by this Agreement and acknowledges that, in advance of signing, the undersigned read the Agreement, any questions asked regarding the Agreement were adequately answered, and after the parties signed the Agreement, the undersigned received a complete copy of the executed Agreement and all parts of this Agreement that are attached and incorporated by reference. I also certify that my signature in this Agreement and its Attachments, whether by my name, a mark, or my initials, represent my present intention to authenticate this Agreement.During an interview on 09/18/2025 at 11:29 AM, the family member (first contact) of Resident #131 stated they did not sign the tablet device to accept the arbitration agreement. If explained, they would have never accepted the arbitration agreement. The family member stated they would want outside representation in the case of a dispute.During an interview on 09/18/2025 at 12:38 PM, the Administrator stated there are no residents who declined the arbitration agreement, and therefore, the facility did not maintain a list of residents who accepted the arbitration agreement. The Administrator stated that the concierge can read the arbitration agreement to the residents and/or representatives, and if the resident does not understand the agreement, the concierge should explain the agreement to them.10 NYCRR 415.30 |