STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335611	A. Building B. Wing	01/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glen Island Center for Nursing and Rehabilitation	490 Pelham Road New Rochelle, NY 10805

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (2654597) the facility did not ensure the residents right to a dignified existence the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 1 out of 3 residents (Resident #5) reviewed for dignity. Specifically, on 12/05/2025 the Surveyor observed Certified Nurse Aide #2 providing personal care to Resident #5 with the door to their room open. Resident #5 was observed lying in bed, without a shirt on, and was noted to be exposed from the waist up and visible from the hallway. The findings are:The facility Resident Rights policy last reviewed 10/01/2025 documented it is the policy to provide care and services in such a manner to acknowledge and respect resident rights. Each resident has the right to be treated with dignity and respect. All interactions and activities with residents by any staff must focus on assisting the resident in maintaining and enhancing his or her self-esteem and self-worth and incorporating the resident's goals, preferences, and choices. When providing care and services, staff will respect each resident's individuality as well as honor and value their input.Resident #5 admitted to the facility on [DATE] with diagnoses including but not limited to Chronic Obstructive Pulmonary Disease, General Anxiety Disorder and Muscle Wasting and Atrophy.A Quarterly Minimum Data Set, dated [DATE] documented Resident #5 was cognitively intact with no behaviors noted. The resident had functional limitations to both lower extremities and used a wheelchair for locomotion. The resident required moderate assistance for eating, dependent for bathing, toileting, bed mobility and transfers. Review of a psychosocial wellbeing care plan last revised 12/30/2025 documented Resident #5 was at risk related to their anxiety and major depressive disorder diagnoses. Interventions listed included encourage participation from resident that depends on others to make their own decisions and provide opportunities for the resident to participate in care.During rounds on 12/05/2025, on the second floor, at 11:13 AM the door to Room-200 was noted to be open, and Certified Nurse Aide #2 was observed providing morning care, with the door open. Resident #5 was lying in bed undressed with a sheet covering them from the waist down, the resident chest was fully exposed. Certified Nurse Aide #2 was gloved up and started to provide care to Resident #5. The surveyor went to find the unit manager and went back to the room and Certified Nurse Aide #2 had pulled the curtain around Resident #5's bed, but the door was still open while they were providing care. The Surveyor informed the unit manager, Registered Nurse #2 and they addressed the Certified Nurse Aide #2. Certified Nurse Aide #2 popped their head out of the curtain and stated they cannot breathe in the room, that is why they had the door open while providing care.During an interview on 12/05/2025 at 11:15 AM Registered Nurse #2 stated they informed Certified Nurse Aide #2 that Residents #5's door should be closed when they are providing care. Registered Nurse #2 stated they always inform the certified nurse aides that they should always close the door for (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	privacy and Certified Nurse Aide #2 informed them they cannot breathe in the room because of the heater. Registered Nurse #2 stated the process is the resident should be provided privacy regardless of anything when providing personal care.During an interview on 12/30/2025 at 1:49 PM Certified Nurse Aide #2 stated for the last couple of weeks the residents have been coughing a lot, and they do not cover their mouths, so they sometimes leave the door ajar when they are providing care. Certified Nurse Aide #2 stated they know the curtain around the resident's bed and the door should be closed when providing personal care to a resident.10 NYCRR 415.3(d)(1)(i)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during a survey, the facility did not ensure that all alleged violations are thoroughly investigated for 3 out of 3 residents (Resident #2, Resident # 3, Resident #4) reviewed for falls. Specifically, (1) on 11/09/2025 Resident #2 had an unwitnessed fall. The Accident/Incident report was missing the time of supervisor notification and did not document if the Physician and the family representative were notified. In addition, the certified nurse aide occurrence statement had no time the resident was last seen. The top portion of the post occurrence investigation conclusion statement -steps taken that led to conclusion dated 11/10/2025 was not completed. (2) On, 10/17/2025 Resident #3's representative called and reported the resident had fallen in their room. Review of the accident/incident report dated 10/17/2025 revealed no documentation of Physician notification and there were no staff statements attached to the accident/incident report. Review of the post occurrence investigation report dated 10/17/2025 documented Resident #3's site of injury was re-assessed. There was no documented evidence in the accident/incident report of Resident #3 sustaining any injury during their fall. The certified nurse aide occurrence statement dated 10/19/2025 did not document the name of the aide or time of occurrence. The post occurrence investigation conclusion dated 10/20/2025 was not signed and dated by the Administrator. (3) On 11/01/2025, Resident #4 was observed lying on the floor on their back to the left side of their bed. The resident was assessed and noted to have an abrasion to their right outer back. Review of the accident/incident report documented no injuries observed at the time of the incident despite the abrasion noted the residents back.The findings are:The facility Accident/Incident Reporting policy last reviewed 10/21/2025 documented the following data must be included on all accidents/incident report forms: date and time the accident/incident occurred, circumstances surrounding the accident/incident, where the accident/incident occurred and other pertinent facts as appropriate.1)Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Dementia, Bipolar Disorder and History of falling.A Significant Change Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. The resident had impairment on one side of their lower extremities and required a wheelchair for locomotion. The resident required maximal assistance with eating, moderate assistance with bed mobility and dependent for toileting and transfers. The resident had a history of two or more falls without injury. The resident did not have restraints (bed rail). The resident did not have a bed alarm, chair alarm, floor mat alarm or a motion sensor alarm.The accident/incident report dated 11/09/2025 had attached statements from the licensed nurse and the certified nurse aide. Further review of the licensed nurse statement revealed it did not document the time the supervisor was notified, if the Physician was notified and which family member was notified. The certified nurse aide occurrence statement did not document the last time the resident was seen and documented that Resident #2 used alarms.Review of the facility post occurrence investigation conclusion dated 11/10/2025 revealed the top portion of the document labelled: Steps taken that led to conclusion of investigation was not completed by Nursing Administration.2) Resident #3 admitted to the facility on [DATE] with diagnoses including but not limited to Sequalae of Cerebral Infarction, Seizures and Hemiplegia left non-dominant side.A Comprehensive Minimum Data Set assessment dated [DATE] documented Resident #3 was cognitively intact. The resident required a walker or a wheelchair for locomotion and supervision for eating, toileting, bed mobility and transfers. The resident was occasionally incontinent of bladder and bowel. The resident did not have a history of falls.Review of an accident/incident report dated 10/17/2025 at 2:45 PM documented per the Registered Nurse on 2 [NAME] a telephone call was received from the resident's representative reporting Resident #3 called them and (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	stated they were on the floor. The Accident/Incident report documented they immediately went to Resident #3's room and observed the resident lying in bed. Resident #3 verbally reported that they slid off the bed but was able to get themselves-up. The resident was advised to use their call bell for assistance. Resident #3 denied hitting their head and denied pain. Resident #3's bed was in the lowest position possible.There was no documentation of Physician notification and staff no statements attached to the accident/incident report. Review of the certified nurse aide occurrence statement dated 10/19/2025 did not document a time of the occurrence and did not document the certified nurse aide's name. The post occurrence investigation conclusion dated 10/20/2025 was not signed and dated by the Administrator.Review of the post occurrence investigation report dated 10/17/2025 documented Resident #3's site of injury was re-assessed. There was no documented evidence in the accident/incident report of Resident #3 sustaining any injury during their fall.3) Resident #4 admitted to the facility 05/08/2022 with diagnoses including but not limited to Dementia, Parkinson's disease and History of Falling.A Quarterly Minimum Data Set, dated [DATE] documented Resident #4 had severe cognitive impairment with no behaviors noted.The facility accident/incident report dated 11/01/2025 documented Resident #4 was observed lying on their back to the left side of their bed. The resident was immediately placed back to bed with the assistance of three staff members. The resident was assessed and noted to have an abrasion to their right outer back. The resident denied hitting their head and denied any pain. Range of motion in all extremities was within normal limits. Documented Resident #4 was unable to give a description of the occurrence. Further review of the accident/incident report revealed it documented no injuries observed at the time of the incident.During an interview on 12/05/2025 at 2:46 PM the Director of Nursing stated when there Is a reported fall, they collect statements from all the staff whether they witnessed the fall or not, to determine root cause- if there was a change in the resident prior to the fall. The Director of Nursing stated a statement must be obtained from the staff assigned to the resident, and any witnesses. And a time for all incidents. The Physician/the resident's representative will be notified and documented immediately. An assessment is also completed. is safe and the assessment is completed. Incident is reviewed to determine the cause of the fall. The Director of Nursing reviewed the post occurrence investigation and stated the documentation not being completed was an oversight and moving forward they will make sure the details are completed before they sign the report. The Director of Nursing reviewed the accident/incident report for Resident #3 dated 10/17/2025 and confirmed there were no statements attached, and they signed the report. The Director of Nursing stated they are responsible for reviewing and signing the accident/incident reports before they are sent to the Administrator for review and signature. The Director of Nursing stated this was an oversight by the Administrator as well.During an interview on 12/30/2025 at 11:34 AM Registered Nurse #3 reviewed the accident/incident report dated 11/01/2025 they completed for Resident #3 and stated documenting there was no injury was an error on their part. Registered Nurse #3 stated an abrasion is also an injury and they should have documented it that way. Registered Nurse #3 stated this was their fault. The Abrasion should have been entered on the injury section of the report.During an interview on 12/30/2025 at 11:20 AM the Administrator stated they were not aware of the missing components in the accident/incident reports provided for review. The Administrator stated they review the statements attached to the accident/incident reports and sign them. The Administrator stated they are the last step before the accident/incident report is filed. The Administrator stated it was an oversight that they did not sign the investigative conclusion for Resident #3's accident/incident that occurred on 10/17/2025. 10 NYCRR 415.4 (b)(1)(ii)

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey the facility did not ensure that the comprehensive care plan was reviewed and revised for 2 out of 3 residents (Resident #2, Resident #3) reviewed for falls. Specifically, (1) Resident #2 had an unwitnessed fall on 11/09/2025 and the residents care plan was updated to reflect the use of a chair/bed alarm and to ensure the device is in place as needed. There was no documented evidence of Resident #2 using any alarms during their stay in the facility. The Director of Nursing stated this was documented erroneously as the facility does not use alarms. (2) Resident #3 had an unwitnessed fall on 10/19/2025 and was found by the certified nurse aide on the floor in a sitting position. Review of the post occurrence investigation documented the steps that led to conclusion of investigation were Resident #3's care plan was reviewed and revised. Review of Resident #3's risk for falls care plan last revised 10/19/2025 revealed there were no safety interventions implemented for Resident #3 after their fall on 10/19/2025.The findings are:The facility Care Planning Process policy last reviewed 10/01/2025 documented the facility shall have a care planning process in place which includes integrating assessment findings in care planning, developing and interdisciplinary care plan and regularly reviewing and revising the care plan. The purpose is to ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psycho-social wellbeing. 1)Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Dementia, Bipolar Disorder and History of falling. A Significant Change Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. The resident had impairment on one side of their lower extremities and required a wheelchair for locomotion. The resident required maximal assistance with eating, moderate assistance with bed mobility and dependent for toileting and transfers. The resident had a history of two or more falls without injury. The resident did not have restraints (bed rail). The resident did not have a bed alarm, chair alarm, floor mat alarm or a motion sensor alarm.Review of a risk for falls care plan initiated 11/09/2025 documented Resident #2 was at risk for falls related to gait/balance problems. Interventions listed included the resident uses chair/bed alarm ensure the devices is in place as needed, anticipate and meet the resident's needs prompt response to all requests for assistance and educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.There was no documented evidence of Resident #2 having an alarm in use during their stay in the facility.2) Resident #3 admitted to the facility on [DATE] with diagnoses including but not limited to Sequalae of Cerebral Infarction, Seizures and Hemiplegia left non-dominant side.A Comprehensive Minimum Data Set assessment dated [DATE] documented Resident #3 was cognitively intact. The resident required a walker or a wheelchair for locomotion and supervision for eating, toileting, bed mobility and transfers. The resident was occasionally incontinent of bladder and bowel. The resident did not have a history of falls.Review of an accident/incident report dated 10/19/2025 documented Resident #3 was found by the certified nurse aide on the floor in a sitting position and informed the charge nurse. Documented Resident #3 stated they slid off the bed and ended up on the floor in a sitting position. Review of the post occurrence investigation documented the steps that led to conclusion of investigation documented Resident #3's care plan was reviewed and revised. Review of a risk for falls care plan last revised 10/19/2025 documented Resident #3 was found sitting on the floor at the foot of their bed. Further review revealed there were no safety interventions implemented for Resident #3 after their fall on 10/19/2025.During an interview on 12/05/2025 at 11:15 AM Certified Nurse Aide #1 stated Resident #2 required total care, and they recall the (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	resident did not have an alarm on their wheelchair during their stay in the facility. During an interview on 12/05/2025 at 2:46 PM the Director of Nursing stated after the notification is made regarding a fall, they review the incident to determine the cause of the fall, and they also review the care plans and implement an intervention related to the incident. The Director of Nursing stated the chair/bed alarm was erroneously entered on Resident #2's risk for falls care plan as an intervention, because they do not use alarms in the facility. The Director of Nursing stated they are going to review the template for the care plan because some of the options for selection no longer apply in the facility. The Director of Nursing reviewed Resident #3's care plan and stated they did not see an intervention, but they do not know why it was not entered on the resident's care plan.10 NYCRR 415.11 (c)(2)(ii)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on record review and interviews during an abbreviated survey (2669836) the facility did not ensure that the resident environment remained as free of accident hazards as is possible; and each resident received adequate supervision and assistance devices to prevent accidents for 1 out of 3 residents (Resident #2) reviewed for falls. Specifically, Resident #2 had a known history of attempting to stand and trying to walk without supervision and multiple falls. There was no documented evidence of Resident #2 having safety measures in place to prevent falls from occurring when attempting to stand or walk. On 11/09/2025 the resident was found on the floor in the hallway by staff, after attempting to stand from their wheelchair. Resident #2 complained of back pain after their fall and had an x-ray done which showed a compression fracture of their T12 vertebrae age undetermined. Resident #2 was transferred to the hospital for further evaluation on 11/11/2025.The findings are:The facility Accidents/Incidents Reporting policy last reviewed 10/21/2025 documented the intent of the policy is to ensure this facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices are provided for each resident to prevent avoidable accidents. This includes implementing interventions to reduce hazards and risks and monitoring for effectiveness and modifying interventions when necessary. The policy defines position change alarms are alerting devices intended to monitor a resident's movement. The device emits a audible signal when the resident moves in a certain way. Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms and infrared beam motion detectors. Resident #2 admitted to the facility on [DATE] with diagnoses including but not limited to Dementia, Bipolar Disorder and History of falling. A Significant Change Minimum Data Set, dated [DATE] documented Resident #2 had severe cognitive impairment. The resident had impairment on one side of their lower extremities and required a wheelchair for locomotion. The resident required moderate assistance with bed mobility and was dependent for toileting and transfers. The resident had a history of two or more falls without injury and did not have any position change alarms (bed rail), a bed alarm, chair alarm, floor mat alarm or a motion sensor alarm. Review of Resident #2's fall risk assessment dated [DATE] documented the resident had a fall risk score of 16, indicting a high risk for falls. There was no documented evidence of Resident #2 having safety measures in place to prevent them from falling when attempting to stand or walk unsupervised. Review of a behavior care plan last revised 11/06/2025 documented Resident #2 has potential to demonstrate behaviors related to attempts unsafe maneuvers like standing, attempting to walk with no supervision, poor cognition, poor safety awareness and poor impulse control. Interventions listed included assess and anticipate resident's needs, give the resident as many choices as possible about care and activities, monitor and document observed behavior and attempted interventions in behavior log. Review of a risk for falls care plan last revised 11/09/2025 documented Resident #2 was a high risk for falls related to confusion and gait/balance problems. Interventions listed included anticipate and meet the resident's needs and educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. Review of a risk for falls care plan initiated 11/09/2025 documented Resident #2 was at risk for falls related to gait/balance problems. Interventions listed included the resident uses chair/bed alarm ensure the devices is in place as needed, anticipate and meet the resident's needs prompt response to all requests for assistance and educate the resident/family/caregivers about safety reminders and what to do if a fall occurs. The facility accident/incident report dated 11/09/2025 at 3:10 PM documented the writer was called by a certified nurse aide to inform them Resident #2 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was found sitting on the floor in the hallway. When they arrived on the unit Resident #2 was still on the floor with their wheelchair on their left side. There were no visible injuries noted. Resident #2 was instructed not to get up on their own, their wheelchair was locked, and the certified nurse aide was informed to check on the resident to address their needs. Resident #2 was oriented to person and situation and had a known history of gait imbalance. Review of Registered Nurse #4's progress note dated 11/09/2025 at 3:39 PM documented Resident #2 was found on the on the floor following an unwitnessed fall. According to Resident #2, they were attempting to stand up and lost their balance, resulting in the fall. Resident #2 complained of back pain and their representative was notified. Review of Resident #2's fall risk assessment dated [DATE] documented the resident had a fall risk score of 16, indicating they were a high risk for falls. There was no documented evidence of Resident #2 having safety measures in place to prevent them from falling when attempting to stand or walk unsupervised. Review of Resident #2's Kardex revealed the resident had accidents with injury and was a fall risk. There was no documented evidence of Resident #2's having any assistive devices listed. Review of Medical Director #1's progress note dated 11/10/2025 at 4:40 PM documented Resident #2 was found on the floor in the hallway near their room. Resident #2 denied hitting their head, reported no pain and no injuries were noted by staff. Review of Resident #2's radiology report dated 11/10/2025 documented a two or three view of the lumbosacral region, due to low back pain. Osteopenia noted. Compression fracture T12 vertebral body age best determined by MRI. No additional fracture noted. The impression documented osteopenia noted. Compression fracture T12 vertebral body age best determined by MRI. Review of Attending Physician #1's progress note dated 11/11/2025 at 11:35 AM documented the assessment/plan as Resident #2 was status post fall yesterday when trying to stand and their legs gave out and they fell. Resident #2 complained of back pain. Resident #2 was noted to have T12 compression fracture and will be sent to the emergency room for evaluation by Orthopedics. During an interview on 12/05/2025 at 11:15 AM Certified Nurse Aide #1 stated Resident #2 required total care, and they recall the resident had bedside floor mats and they did not have an alarm on their wheelchair during their stay in the facility or any safety devices. Certified Nurse Aide #1 stated Resident #2 would always be seated outside of their room, which is front of the nurse's station and the resident would edge closer and closer to the edge of their wheelchair, and then they would end up falling on the floor. During an interview on 12/05/2025 at 2:46 PM the Director of Nursing stated when there Is a reported fall the Registered Nurse does the initial assessment of the resident to check for any injury. The Director of Nursing stated for the frequent fall residents sometimes they run out of interventions to implement. The Director of Nursing stated Resident #2 was on close supervision/monitoring because of their behaviors and the resident was aggressive, non-compliant and not easily redirected. The Director of Nursing stated Resident #2 was given a private room by the nurse's station so the resident could be monitored by staff. During an interview on 12/30/2025 at 11:20 AM the Administrator they know who the frequent fallers are and no matter what interventions they put into place the residents still fall. 10 NYCRR 415.12(h)(2)