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	02/05/2026

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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure that residents had the right to formulate advance directives that would be honored. This was evident for two (2) of three (3) residents (Resident #10, #28) reviewed for Advance Directives out of total 38 sampled residents. Specifically, the facility did not ensure Resident #10 and Resident #28's advance directive wishes were accurately reflected in the medical record. The findings included: The facility's policy and procedure titled Advance Directives reviewed 01/21/2026 documented it is the policy of the facility to inform all adult residents of their rights to accept or refuse medical treatment by providing written and/or verbal information on Advance Directives. The individual's wishes on advance directive will be identified and honored by the facility. Resident's Advance Directives will be reviewed upon admission, re-admission from the hospital, quarterly and annually. Advance Directives are also reviewed at the request of the resident/surrogate or at any time during their stay by the social worker. 1) Resident #10 was admitted to the facility with diagnoses including Hypertension, Non-Alzheimer's Dementia and Diabetes Mellitus. The Minimum Data Set, dated [DATE] documented Resident #10 has moderately impaired cognition.ˆ The Hospital Patient Review Instrument completed 11/20/2025 documented Resident #10's code status was Do Not Resuscitate and Do Not Intubate. The Physician Orders initiated on 11/22/2025 documented Do Not Resuscitate and Do Not Intubate. The Medical Orders for Life-Sustaining Treatment form documented Resident #10 and/or their representative requested for Cardiopulmonary Resuscitation (to perform chest compressions to restart the heart) and Intubation; the form was signed 11/20/2024. The form was last reviewed by the physician on 12/01/2025. The Social Services Note dated 12/10/2025 documented admission care plan meeting was held with Resident #10's family and the interdisciplinary team. Advance directives were reviewed and family verbalized that Resident #10's prior code was Do Not Resuscitate and Do Not Intubate in the hospital, but that they wished to rescind the hospital advance directive order and requested full code. The Care Plan for Advance Directive for Resident #10 was revised on 12/10/2025 to reflect Full Code (every medical intervention possible to keep alive) status. Review of Resident #10's physician orders from 11/22/2025 to 1/28/2026 revealed there was no documented evidence that resident's advance directive was changed from Do Not Resuscitate, Do Not Intubate to Cardiopulmonary Resuscitation status as per family request. Resident #10 remained on Do Not Resuscitate and Do Not Intubate status. ˆ 2) Resident #28 was admitted to the facility with diagnoses including Diabetes Mellitus, Hypertension and Deep Venous Thrombosis. The Minimum Data Set, dated [DATE] documented Resident #28 has cognition is intact.ˆ The Physician Note dated 01/23/2026 documented that Medical Orders for Life-Sustaining Treatment form were reviewed, completed and witnessed documenting Do Not Resuscitate, Do Not Intubate, and Do NotˆHospitalize status, and noted their family was also in agreement. The Medical Orders for Life-Sustaining Treatment form documented Do Not Resuscitate, Do Not Intubate, and Do Not Hospitalize was signed/completed on 01/23/2026. The Advance Directive Care Plan initiated 01/24/2026 documented Resident #28 is Do Not Resuscitate, Do Not Intubate, and Do Not Hospitalize. Interventions included placing yellow dot on chart/arm band (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when applicable to indicate the resident is a Do Not Resuscitate. Resident #28's current physician orders were reviewed on 01/29/2026 at 11:30AM and revealed resident has active orders for Full Code initiated 01/07/2026 in addition to active orders for Do Not Resuscitate, Do Not Intubate and Do Not Hospitalize initiated on 01/23/2026. On 01/29/2026 at 3:00 PM, the Director of Social Services was interviewed and stated they were responsible for establishing residents' advance directive wishes upon admission, readmission and when there are any changes. Director of Social Services stated Resident #10 was a prior resident who was hospitalized and readmitted to the facility with Do Not Resuscitate, Do Not Intubate code status. Resident #10's family requested resident's advance directives to full code status on 12/10/2025. Director of Social Services stated nursing was informed of the Do Not Resuscitate, Do Not Intubate to Full Code change, the care plan was updated to full code and they requested the Medical Orders for Life-Sustaining Treatment form to be reviewed/renewed by the physician. Director of Social Services also confirmed Resident #28 wished to execute Do Not Resuscitate, Do Not Intubate, and Do Not Hospitalize with family and physician all in agreement on 01/23/2026. Nurse Managers were informed of the change code so they could ensure the physician orders were updated in the electronic medical record. On 02/02/2026 at 3:13 PM, Registered Nurse #2 stated they had an admission care plan meeting with Resident #10's family sometime after they were readmitted from hospital and recalled that they requested a change to Full Code status. Registered Nurse #2 stated they were supposed to change the physician orders from Do Not Resuscitate, Do Not Intubate to Full Code, but it was not done. Registered Nurse #2 stated it was their fault for not changing the order. On 02/02/2026 at 3:34 PM, Registered Nurse #5 was interviewed and stated Resident #28 completed the Medical Orders for Life-Sustaining Treatment form and requested Do Not Resuscitate, Do Not Intubate, and Do Not Hospitalize status. Registered Nurse #5 acknowledged that full code was initiated upon admission as default and should have been discontinued when the Do Not Resuscitate, Do Not Intubate, and Do Not Hospitalize orders were initiated on 01/23/2026. Registered Nurse #5 stated it was a mistake on their part. On 01/30/2026 at 11:20 AM, Medical Doctor was interviewed and stated Resident #10 is well known resident to them who was Do Not Resuscitate, Do Not Intubate in the hospital. Therefore, Resident #10 was admitted to the facility with Do Not Resuscitate, Do Not Intubate status and code orders were initiated upon admission. However, if the resident/family requested a code change, they would have been informed, and code orders would be updated by the nurses. The Medical Doctor could not explain why Resident #10's physician orders did not reflect the same code status as the Medical Orders for Life-Sustaining Treatment form.ˆ 10NYCRR 400.21(c)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure that a resident with limited range of motion received appropriate treatment and services, including provision of equipment, to prevent further decline in range of motion. This was evident for one (1) (Resident #16) of two (2) residents reviewed for rehabilitation and restorative services out of a total sample of 38 residents. Specifically, Resident #16 was observed without a left-hand splint in place as per physician order. The findings include: The facility's policy titled, Splints and Orthotic Management Policy and Procedure, last review dated 09/2025 documented that splinting and orthotic management is a therapeutic procedure designed to prevent worsening contractures of a joint to increase range of motion and/or to prevent skin breakdown. ˆTherapists will collaborate with nursing to get an order in place once trial has completed for ongoing orthotic wearing schedule. At which time the orthotic may be donned and doffed by nursing staff or certified nursing assistant or other designated trained personnel. Orthotic management will be continued until the goals are met, the patient reaches maximum rehabilitation potential, or the interventions are no longer appropriate. Resident #16 has active diagnosis of Hemiplegia following cerebral infarction affecting left non-dominant side and Diabetes Mellitus. ˆThe Quarterly Minimum Data Set, dated [DATE] documented that Resident #16 had relatively intact cognition and was dependent in upper and lower body dressing. The Minimum Data Set assessment also documented that Resident #16 had an impairment on both sides of the upper and lower extremities.ˆ A care plan focused on Activities of Daily Care: Self Care Performance Deficit related to Activity Intolerance, Impaired balance, decreased muscle strength and Cerebral Vascular Accident with left hemiparesis was last reviewed on 12/29/2025. Interventions included the use of a Left Resting Hand Splint and to remove/release it for activities of daily living care and skin checks. A physician's order dated 11/27/2025, and last revised on 11/30/2025, documented Left Resting Hand Splint and to remove/release for Activities of Daily Living care and skin checks. On 01/30/2026 at 10:50 AM and 1:16 PM, and on 02/02/2026 at 10:37AM and 2:20 PM, Resident #16 was observed in their room with no left hand splint in place. On ˆ 02/02/2026 at 2:23 PM, Certified Nursing Assistant #4 was interviewed and stated that as per the task, Resident #16 should have a left-hand splint. Certified Nursing Assistant #4 stated that they noticed that the left-hand splint was missing from the resident's room last Friday and they were not able to locate it.ˆ Certified Nursing Assistant #4 further stated that they reported to Nurse Manager #4 of the missing left hand splint ˆon Friday and was informed that one would be obtained from the rehab department.ˆ On 02/02/2026 at 2:42 PM, Certified Nursing Assistant #4 and Registered Nurse #3 went through Resident #16 drawers and searched for the left-hand splint and failed to locate it. On 02/04/2026 at 2:15PM, in a subsequent interview, Certified Nursing Assistant #4 stated that they had documented code 5 (Refused) on the Certified Nursing Accountability for the left hand splint on 01/20/2026 because there were no other options to document it was missing. On 02/02/2026 at 2:34 PM, Nurse Manager #4 was interviewed and stated that Certified Nursing Assistant #4 notified them that morning that the left-hand splint was missing for Resident #16. The Nursing Manager #4 stated they requested another splint from the rehab department right away and was informed that rehab would deliver one. Nurse Manager #4 stated that they do not recall if Certified Nursing Assistant #4 had reported to them about a missing left-hand splint on Friday. Nurse Manager #4 further stated that Certified Nursing Assistants are always encouraged to make sure that residents wear assistive devices. Rounds are done by charge nurses and nursing managers frequently to ensure assistive devices are applied for residents. Nursing Manager #4 further stated that Resident #16 is status post stroke and wears a left hand splint to prevent contractures.ˆˆ On 02/04/2026 at 11:56 AM, the Occupational Therapist was interviewed and stated that Resident #16 was on an occupational therapy program from 08/20/2025 to (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/27/2025.ˆ At that time Resident #16 had a decline with their activities of daily living, self-feeding and grooming. When Resident #16 was reassessed, the Occupational Therapist noted the left hand had increased tightness. The Occupational Therapist stated that Resident #16 is status post Cerebral Vascular Accident on the left arm and the left upper extremity was declining as it was very tight. The Occupational Therapist further stated that if Resident #16 doesn't wear the left-hand splint consistently, they would continue to experience increased tightness, and providing daily care will become harder as the extremity would constrict permanently. It is the expectation that Resident #16 should have it on at all times. On 02/05/2025 at 10:15AM, the Director of Nursing Services was interviewed and stated that if there is a rehab recommendation for an assistive device, particularly a hand splint, it is to prevent further contractures. ˆThe Director of Nursing Services further stated that if there is a recommendation by rehab for an assistive device, it is important that it is in place for the proper physical functioning of that resident. 10 NYCRR 415.12 (e)(2)

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F 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interviews, the facility did not ensure residents, or their designated representatives were provided appropriate notification at the termination of Medicare Part A benefits. This was evident for three (3) of three (3) residents (Resident #95, #204, and #205) reviewed for Beneficiary Notification out of total 38 sampled residents. Specifically, the facility did not ensure the resident/representative received timely written Notice of Medicare Non-Coverage of potential liability and appeals rights.The findings are: The facility's policy and procedure titled, Medicare Beneficiary Notices, last review dated 01/21/2026 documented the purpose of Medicare Beneficiary Notices are to ensure that Medicare beneficiaries receive proper notice when items and services Medicare usually covers but may not pay because they are medically unnecessary or custodial in nature or the service are no longer medically necessary. Advance written notice of noncoverage should be issued to and understood by Medicare beneficiary or their representative and issued far enough in advance of potentially noncovered items or services so the beneficiary can consider available options. Resident #95 was discharged from Medicare skilled services on 09/14/2025 with no remaining days. Resident #95 remained in the facility. The Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage documented Resident #95's designated representative was notified on 09/13/2025 and written notice was mailed via regular mail postmarked 09/15/2025. Resident #204 was discharged from Medicare skilled services on 11/03/2025 with 62 remaining days. Resident #204 was discharged home.ˆ The Notice of Medicare Non-Coverage documented Resident #204's designated representative was notified on 10/30/2025 and written notice was mailed via regular mail postmarked 11/03/2025. Resident #205 was discharged from Medicare skilled services on 12/12/2025 with 41 remaining days. Resident #205 was discharged home.ˆ The Notice of Medicare Non-Coverage documented Resident #204's designated representative was notified on 12/10/2025 and written notice was mailed via regular mail postmarked 12/11/2025. The Notice of Medicare Non-Coverage and Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage forms were not mailed out on the same date that notification was made. In addition, there was no documented evidence that resident/designated representatives received the notices which were sent via regular mail. On 02/02/2026 at 2:29 PM, the Director of Social Services was interviewed and, they stated they were responsible for making sure residents or their designated representatives are notified of their Medicare Part A benefit ending date in advance and are provided with the written notice. The Director of Social Services stated Resident #204's and Resident #205's designated representatives were informed over the phone two days prior to the last coverage date. However, the Director of Social Services stated they could not confirm the exact date when the written notices were mailed out or if the designated representatives received the notices in the mail because they were mailed out by regular mail. ˆ On 02/05/2026 at 12:13 PM, the Minimum Data Set Coordinator was interviewed and stated it is the Director of Social Services who oversees Medicare benefits and notifies the appropriate residents and their representatives. 10 NYCRR 415.3(g)(2)(i)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that Minimum Data Set 3.0 comprehensive and non-comprehensive assessments were submitted and transmitted into the Internet Quality Improvement Evaluation System (IQIES) Assessment Submission and Processing (ASAP) system in a timely manner. Specifically, resident's Quarterly, Discharge and comprehensive Minimum Data Set were not submitted and transmitted within 14 calendar days after the assessments were completed. This was evident for, but not limited to, 3 of the 12 residents reviewed for Resident Assessment. (Residents #19, #32 and #48), out of a total of 38 sampled residents. ˆThe findings include: The Center for Medicaid/Medicare Services Resident Assessment Instrument Manual Version 3.0 (Dated October 2017)Chapter 5 titled, Submission and Correction of the MDS Assessments, states The Minimum Data Set completion date must be no later than 14 days after the Assessment Reference Date for all non-admission, Omnibus Budget Reconciliation Act, and Prospective Payment System assessments and no later than 13 days after the entry date for admission assessments. Comprehensive assessments must be transmitted electronically within 14 days of the care plan completion date. All other Minimum Data Set assessments must be submitted within 14 days of the Minimum Data Set completion date. The facility policy for, Minimum Data Set 3.0 Submission, last review dated 09/2025 documented that all Minimum Data Set 3.0 assessments must be completed, encoded, and submitted to Center for Medicare/Medicaid Services within the established time frames to ensure regulatory compliance and the accuracy of resident assessment data. For Resident #19, admitted [DATE], the Quarterly Minimum Data Set Assessment Reference Date was 08/14/2025; it was completed on 08/28/2025 and submitted on 09/19/2025.For Resident #32, admitted [DATE], the Quarterly Minimum Data Set Assessment Reference Date was 08/07/2025; it was completed on 08/21/2025 and submitted on 09/19/2025. For Resident #48, admitted [DATE], the Annual Minimum Data Set Assessment Reference Date was 08/13/2025; it was completed on 08/27/2025 and submitted 09/19/2025.ˆ The Facility Minimum Data Set submission report printed 02/02/2026 documented that the submission date for all the residents reviewed is more than 14 days after the assessment. On 02/05/2026 at 10:45 AM, Registered Nurse #1 was interviewed and stated that they are not involved in documentation and completion of residents' Minimum Data Set. Registered Nurse #1 stated that they only update and document residents' assessment in the Point Click for the Minimum Data Set Coordinator to check and review when completing the resident assessments. On 02/05/2026 at11:06 AM, the Director of Social Services was interviewed and stated that they have not been involved in completion of residents' assessments in the Minimum Data Set, and that a separate staff is hired for the documentation, completion and submission of the residents' Minimum Data Set. The Director of Social Services further stated that they were just being informed that their sections of the Minimum Data Set will should be completed by them henceforth. On 02/05/2026 at 11:09 AM, the Minimum Data Set Coordinator was interviewed and stated that they are responsible for completing nursing and social services sections of the assessments, and that the Rehab, Dietary and Activity sections are completed by the respective trained staff of those departments. Minimum Data Set Coordinator stated that they check for the completion of all sections before submitting the assessments. Minimum Data Set Coordinator further stated that for quarterly, and discharge assessments, they have14 days from assessment reference date to complete, and another 14 days from the date of completion to transmit the assessment. They also stated that for admission assessment, there will be 7 days from assessment reference date to complete, but they are not sure of how many days from the date of completion to submit. The Minimum Data Set Coordinator stated that they submitted some of the assessments within 14 days of completion; and others were transmitted late because they were not completed timely: the information was not provided within the (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	appropriate time frame. On 02/05/2026 at 1:37 PM, the Director of Nursing was interviewed and stated the Minimum Data Set Coordinator is responsible for the completion and submission of residents' assessments. The Director of Nursing stated that they are aware of the late submissions and the facility is hiring another Assessor to ensure that the assessment is completed and submitted in a timely manner. On 02/05/2026 at 1:49 PM, the Administrator was interviewed and stated that the Minimum Data Set Coordinator is responsible for prompt submission of the residents' assessments, and if they are not available, the consultant may be contacted to assist in the completion and submission of the assessment. The Administrator also stated that they are aware that some Minimum Data Set submissions are late, and they have been addressing the issue in QAPI meetings to correct the situation. Additionally, they are also planning to hire another staff to ensure timely completion and submission. 10 NYCRR 415.11(a)(1-5)