

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335716	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/17/2024
NAME OF PROVIDER OR SUPPLIER Glen Cove Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6 Medical Plaza Glen Cove, NY 11542	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</p> <p>Based on observation, record review, and interviews conducted during the recertification survey initiated on 5/13/2024 and completed on 5/17/2024 the facility did not ensure that each resident had a call bell accessible to alert staff of the resident's needs. This was identified for one (Resident #80) of two residents reviewed for the Environmental Task. Specifically, on two occasions, Resident #80 was observed in bed with the call bell out of reach.</p> <p>The finding is:</p> <p>The facility's policy titled, Resident Call System, effective 10/2022 documented call lights are to be placed within the reach of residents. Staff will ensure the call bell is properly placed within the reach of a resident before exiting the room.</p> <p>Resident #80 was admitted with diagnoses that included Cerebral Infarction (Stroke), Dementia, and a History of Falls. The Quarterly Minimum Data Set, dated dated [DATE] documented Resident #80's Brief Interview for Mental Status score was four which indicated a severely impaired cognition. Resident #80 received partial/moderate assistance for bed mobility and transfers and had no impairment in functional range of motion in the upper and lower extremities.</p> <p>The Behavior Symptoms Care Plan initiated on 12/20/2023 and last modified on 3/20/2024 documented that Resident #80 had the potential to exhibit inappropriate behavioral problems as evidenced by wandering, poor safety awareness, physical aggression, and wearing surgical gloves. There was no documented evidence that Resident #80 exhibited the behavior of hanging the call bell on the knob of their nightstand.</p> <p>Resident #80 was observed laying in their bed with a sheet pulled up to their chin on 5/13/2024 at 10:08 AM. The head of the bed was elevated, and the right half-side rail was in the up position. Resident #80 had a nightstand located on the right side of the head of their bed. Resident #80's call bell was observed hanging over the top knob of their nightstand. Resident #80 stated they did not have a call bell.</p> <p>Resident #80 was observed laying in their bed with a sheet pulled up to their chin on 5/13/2024 at 12:38 PM. The head of Resident #80's bed was elevated, and the right half-side rail was in the up position. Resident #80 had a nightstand located on the right side of the head of their bed. Resident #80's call bell was observed hanging over the top knob of their nightstand.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #80 was interviewed on 5/13/2024 at 12:38 PM and stated they could not reach the call bell and did not know why the call bell was hanging on the knob of the nightstand. Resident #80 did not know where the call bell was normally placed.</p> <p>Certified Nursing Assistant #9 was interviewed on 5/13/2024 at 12:57 PM and stated they assisted Resident #80 with morning care and checked in on the resident at lunch. Certified Nursing Assistant #9 stated Resident #80 can use the call bell and the call bell should be within reach of the resident. Certified Nursing Assistant #9 observed Resident #80's call bell hanging over the top knob of the nightstand. Certified Nursing Assistant #9 stated Resident #80 would not be able to reach the call bell if they were lying in bed. Certified Nursing Assistant #9 stated they forgot to place the call bell next to the resident when they left the room. Certified Nursing Assistant #9 stated they should have clipped the call bell to the resident's fitted bed sheet.</p> <p>Licensed Practical Nurse #5 was interviewed on 5/13/2024 at 1:07 PM and stated Resident #80 was able to use the call bell and the call bell should be within reach of the resident. Licensed Practical Nurse #5 observed Resident #80's call bell hanging over the top knob of the nightstand. Licensed Practical Nurse #5 stated if Resident #80 was lying in bed and was in distress they (Resident #80) would not be able to reach the call bell. Licensed Practical Nurse #5 stated the call bell should be clipped on the sheet next to the resident while the resident is in bed.</p> <p>Registered Nurse #3, the Unit Manager, was interviewed on 5/14/2024 at 11:06 AM and stated the call bell should be within reach of each resident, and after providing care the call bell should be checked before a staff person exits the resident's room.</p> <p>The Director of Nursing Services was interviewed on 5/17/2024 at 10:51 AM and stated they expected the call bell to be within the resident's reach. The Director of Nursing Services stated if the resident is in bed, the call bell should be clipped to the bed linen or pillow. The Director of Nursing Services stated the Certified Nursing Assistant should check the call bell every two hours and as needed.</p> <p>10 NYCRR 415.5(e)(1)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051</p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 5/13/2024 and completed on 5/17/2024, the facility did not ensure that a clean, comfortable, and homelike environment was maintained for two (Resident #24 and Resident #80) of two residents reviewed for the Environmental Task. Specifically, 1) The privacy curtain in Resident #24's room was observed with large stained/soiled areas and 2) Resident #80's room had no window covering for one of the two windows observed in the room.</p> <p>The findings are:</p> <p>1) The facility's policy titled Resident Room Terminal Cleaning, effective 8/10/2022 documented that all resident rooms receive a complete room cleaning on a rotating basis every five weeks. The maintenance will remove the privacy curtain and the laundry will launder the privacy curtain.</p> <p>Resident #24 was admitted with diagnoses that included Complete Intestinal Obstruction, Acute Respiratory Failure, and Muscle Wasting and Atrophy. The Admission Minimum Data Set assessment dated [DATE] documented Resident #24's Brief Interview for Mental Status score was 15 which indicated an intact cognition.</p> <p>A review of the maintenance logs from 4/9/2024 through 5/14/2024 did not include documentation related to the soiled privacy curtain in Resident #24's room.</p> <p>During an observation on 5/13/2024 at 10:38 AM the privacy curtain in Resident #24's room was observed with numerous large stains.</p> <p>Resident #24 was interviewed on 5/13/2024 immediately after the observation and stated the stains on the privacy curtains were present when they were admitted to the facility approximately three weeks ago. Resident #24 stated they would appreciate a clean privacy curtain.</p> <p>An observation of Resident #24's stained privacy curtain was made with Certified Nursing Assistant #10 on 5/14/2024 at 10:30 AM. Certified Nursing Assistant #10 stated they assisted Resident #24 with morning care and did not notice the stained privacy curtain. Certified Nursing Assistant #10 stated normally, when they observe maintenance concerns, they would report the concerns to the Unit Manager.</p> <p>An observation of Resident #24's stained privacy curtain was made with Registered Nurse #3 on 5/14/2024 at 10:35 AM. Registered Nurse #3 stated they were not aware that Resident #24's room had soiled curtains. If they knew of the concern, they would have reported it to the maintenance staff. Registered Nurse #3 stated resident's privacy curtain should be clean and without stains.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Maintenance Mechanic #1 was interviewed on 5/14/2024 at 11:13 AM and stated they were not aware that Resident #24's privacy curtain was soiled. Maintenance Mechanic #1 stated each Resident's privacy curtain should be clean and without stains. Maintenance Mechanic #1 stated maintenance issues are generally reported to them verbally; however, there was a maintenance log on each unit at the nurse's station and they reviewed the log at the beginning of their shift. Maintenance Mechanic #1 stated when they completed a request they signed the log book to indicate the concern was addressed.</p> <p>Housekeeper #1 was interviewed on 5/14/2024 at 11:25 AM and stated they cleaned each resident's room daily and visually scanned the room for any soiled areas before they started their cleaning tasks. Housekeeper #1 stated they did not observe the soiled privacy curtain in Resident #24's room.</p> <p>The Director of Engineering and Environmental Services was interviewed on 5/16/2024 at 3:41 PM and stated the resident's privacy curtains should be clean and free of stains. The housekeeper and maintenance mechanic complete room checks daily and the privacy curtains should be part of their inspections.</p> <p>The Administrator was interviewed on 5/17/2024 at 10:10 AM and stated the housekeeper should have observed the stained privacy curtain during their daily rounds. The Administrator stated they expected the privacy curtains to be clean and without stains.</p> <p>2) The facility's policy titled Resident Room Window Covering, effective 1/2/2024 documented the facility is responsible for maintaining resident privacy and a homelike environment with appropriate window treatments and/or blinds. The facility will maintain either window treatments or blinds in each resident's room. All blinds/window treatments will be maintained in good repair by building services.</p> <p>Resident #80 was admitted to the facility with diagnoses that included Cerebral Infarction (Stroke), Dementia, and a history of Falls. The Quarterly Minimum Data Set assessment dated [DATE] documented Resident #80's Brief Interview for Mental Status score was four which indicated a severely impaired cognition.</p> <p>A review of the maintenance logs from 4/9/2024 through 5/14/2024 did not include documentation related to a need for window covering in Resident #80's room.</p> <p>During an observation of Resident #80's room on 5/13/2024 at 10:08 AM, one of the two windows did not have window covering. Resident #80 stated they were not sure if they ever had a window covering for the window.</p> <p>An observation of Resident #80's window was made on 5/14/2024 at 10:38 AM with Certified Nursing Assistant #2. Certified Nursing Assistant #2 stated each resident's room window should have a window covering; however, they did not notice Resident #24's room window did not have a window covering.</p> <p>An observation of Resident #80's window was made on 5/14/2024 at 10:42 AM with Licensed Practical Nurse #5. Licensed Practical Nurse #5 observed Resident #80's window without a window covering and stated each window in a resident's room should have a window covering. Licensed Practical Nurse #5 stated they regularly came into the resident's room to administer medications on the 7:00 AM-3:00 PM shift and did not notice the window did not have a covering.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation of Resident #80's window was made on 5/14/2024 at 11:00 AM with Registered Nurse #3, the Unit Manager. Registered Nurse #3 stated each resident should have window coverings on their windows. Registered Nurse #3 stated they would report the need for a window covering to the maintenance mechanic verbally or via the maintenance log.</p> <p>Maintenance Mechanic #1 was interviewed on 5/14/2024 at 11:13 AM and stated they were not aware that Resident #80's window did not have a window covering. Maintenance Mechanic #1 stated maintenance issues are generally reported to them verbally; however, they were not told about the missing window covering in Resident #24's room. Maintenance Mechanic #1 stated the unit maintenance log also did not have any documentation related to the missing window covering.</p> <p>Housekeeper #1 was interviewed on 5/14/2024 at 11:25 AM and stated they cleaned each resident's room daily and were not aware that Resident #80's room did not have a window covering. Housekeeper #1 stated they would have reported the missing window covering to the medication nurse.</p> <p>The Director of Engineering and Environmental Services was interviewed on 5/16/2024 at 3:41 PM and stated each window in a resident's room should have a window covering. The Director of Engineering and Environmental Services stated they expected the housekeeper or maintenance mechanic to ensure the resident rooms are checked during their daily rounds or during the terminal room cleaning.</p> <p>The Administrator was interviewed on 5/17/2024 at 10:10 AM and stated the staff persons on the unit should have observed the missing window covering during their daily rounds. The Administrator stated they expected each window in a resident's room to have a window covering.</p> <p>10 NYCRR 415.5(h)(2)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798</p> <p>Based on observation, record review, and staff interviews during the Recertification Survey, initiated on 5/13/2024 and completed on 5/17/2024, the facility did not ensure that each resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, for one (Resident #109) of four residents reviewed for Pressure Ulcers. Specifically, Resident #109 was admitted to the facility with a Deep Tissue Injury (a pressure injury caused by damage to the underlying soft tissues) to the sacrum (a bone at the base of the spine). The resident had a physician's order for an alternating pressure relief air mattress. During multiple observations, the adjustable weight setting for the mattress, which is meant to correspond to the resident's weight, was not set accurately. In addition, a re-assessment of the sacrum wound, by the Director of Nursing Services and the Wound Physician, did not classify the stage of the pressure ulcer.</p> <p>The finding is:</p> <p>The facility policy titled Pressure Injury-Prevention and Care, dated February 2022, documented that suspected deep tissue injury is due to damage of underlying soft tissue from pressure and/or shear. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment. A Stage 2 pressure ulcer is a partial thickness loss of dermis (skin) presenting as a shallow open injury with a red, pink wound bed, without slough (defined as dead tissue containing white blood cells and wound debris). The wound care team members will weekly evaluate each pressure site for the effectiveness of treatment, improvement/healing, deterioration, or if the site remains the same.</p> <p>The operation manual for the Alternating Pressure System with Low Air Loss documented adjusting the mattress' internal pressure according to the resident weight by using the weight button.</p> <p>Resident #109 was admitted to the facility with diagnoses including Cerebrovascular Accident, Non-Alzheimer's Dementia, and Hip Fracture. The 4/4/2024 Admission Minimum Data Set assessment documented no Brief Interview for Mental Status score due to the resident's severely impaired cognitive skills for daily decision-making. The Minimum Data Set assessment documented that the resident had one Stage 2 pressure ulcer (defined as partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising).</p> <p>The nursing admission assessment dated [DATE] documented that the resident had a Deep Tissue Injury at the lower back/sacrum area measuring three centimeters by two centimeters. The nursing admission assessment documented the resident's Braden Scale (a numerical system used to predict pressure ulcer risk) score was 16, which indicated the resident had a mild risk for developing pressure ulcers.</p> <p>A physician's order, dated 4/1/2024 and last on 4/22/2024, documented to cleanse the sacral wound with normal saline, pat dry, and apply Medihoney (a wound healing medication) topically followed by dry protective dressing twice a day and when needed for diagnosis of Stage 2 pressure ulcer of the sacral region.</p> <p>A physician's order dated 4/23/2024 documented Air Mattress for pressure relief, check for proper functioning and placement every shift.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Comprehensive Care Plan, titled Pressure Ulcer-Sacrum effective 4/1/2024, documented the resident was admitted with a sacral pressure ulcer and was at risk for further breakdown. An intervention documented on 4/1/2023 included providing a pressure-relieving mattress.</p> <p>The wound care physician consultant note dated 5/13/2024 documented the resident had a Stage 2 pressure ulcer to the sacrum. The wound measurements: 1.2 centimeters by 1.0 centimeters by 0.2 centimeters, with 100% epithelial tissue (pink or pearly white and occurs in the final stage of healing when the wound is covered by healthy skin cells) with light serous drainage (defined as a clear to yellow fluid that leaks out of a wound. This type of wound drainage is a normal). Interventions included the use of a low-air loss mattress.</p> <p>A review of the electronic medical record indicated Resident #109's most recent weight, dated 5/9/2024, was 108.3 pounds.</p> <p>On 5/13/2024 at 10:20 AM Resident #109 was observed in bed. The air mattress pump weight setting was set at 230 pounds.</p> <p>On 5/14/2024 at 08:05 AM Resident #109 was observed sitting in their wheelchair next to the bed. The weight setting on the air mattress pump was set at 230 pounds.</p> <p>Licensed Practical Nurse #3 (medication nurse) was interviewed in Resident #109's room on 05/14/2024 at 8:07 AM. Licensed Practical Nurse #3 observed the weight setting of 230 pounds on the air mattress pump and stated they were not sure who adjusts the weight setting on the air mattress.</p> <p>Licensed Practical Nurse #4, the charge nurse, was interviewed in Resident #109's room on 5/14/2024 at 8:59 AM. Licensed Practical Nurse #4 observed the weight setting of 230 pounds on the air mattress pump and stated the initial weight setting on the air mattress is set by the wound care nurse and the weight setting should match the resident's weight. Licensed Practical Nurse #4 attempted to adjust the weight setting but did not know how and stated they would call the maintenance staff.</p> <p>A review of the May 2024 Treatment Administration Record revealed that nurses have been documenting every shift that the air mattress is functioning properly as per the physician's order.</p> <p>The Director of Maintenance was interviewed in Resident #109's room on 5/14/2024 at 9:51 AM. The weight setting on the mattress was now set at 120 pounds. The Director of Maintenance stated they had just adjusted the weight setting on 5/14/2024 at 9:50. The Director of Maintenance stated the air mattress was not malfunctioning and that the weight adjustment on the air mattress pump was just a matter of pressing a button on the pump panel.</p> <p>Licensed Practical Nurse #2 (wound care nurse) was interviewed on 5/15/2024 at 8:17 AM and stated the setting on the mattress should be consistent with the resident's weight. Resident #109's air mattress should not have been set at 230 pounds. Licensed Practical Nurse #2 stated they did not recall checking the mattress weight setting during wound rounds on 5/13/2024. Licensed Practical Nurse #2 stated the unit nurses are responsible for checking the weight setting on the air mattress as per the physician's order.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A wound care observation for Resident #109 was conducted on 5/15/2024 at 10:03 AM. Licensed Practical Nurse #2, the wound care nurse, administered the wound care and was assisted by Licensed Practical Nurse #4. The sacral wound appeared as a full-thickness wound (damage extends below all layers of the skin into the subcutaneous tissue or beyond). The wound bed was observed with approximately 90% granulation (healthy) tissues and 10% yellow slough (a yellow/white material in the wound bed).</p> <p>Licensed Practical Nurse #2 was interviewed on 5/15/2024 at 10:04 AM and stated they were not licensed to classify the staging of the sacral pressure ulcer.</p> <p>The Wound Physician was interviewed on 5/15/2024 at 10:57 AM and stated for Resident #109, the weight setting of 230 pounds on an air mattress would be on the firm side. The Wound Physician stated the air mattress weight setting should be consistent with the resident's weight to promote wound healing.</p> <p>The Director of Nursing Services was interviewed on 5/15/2024 at 12:14 PM and stated the weight setting of 230 pounds was a little high for Resident #109's air mattress. The Director of Nursing Services stated the weight setting on an air mattress should be consistent with the resident's weight to ensure optimal wound healing.</p> <p>An update dated 5/16/2024 to the pressure ulcer comprehensive care plan, written by the Director of Nursing Services, documented that on 5/15/2024 sacral wound was re-assessed and was noted with 95% granulation tissue and 5% yellow slough. The wound measured 2.0 centimeters in length, 1.0 centimeters in width, and 0.3 centimeters in depth. The note did not classify the sacral pressure ulcer staging.</p> <p>The Director of Nursing Services was re-interviewed on 5/17/2024 at 11:42 AM and stated they re-assessed Resident #109's sacral wound on 5/15/2024. The Director of Nursing Services stated during the assessment they noticed there was a change in the wound status. The wound was increased in size and there was slough present. The Director of Nursing Services stated they then called the Wound Physician to re-evaluate the wound. The Director of Nursing Services stated they do not determine the wound stages, only the Wound Physician classifies the staging of the pressure ulcer wounds.</p> <p>The wound Physician's progress note dated 5/17/2024 documented the wound was comprised of 95% granulation tissue and 5% slough and measured 2.0 centimeters in length, 1.0 centimeters in width, and 0.3 centimeters in depth. The wound had no foul odor, signs of infection, or purulent discharge. The wound was unavoidable secondary to the resident being at high risk for skin breakdown due to multiple comorbidities. The progress note did not classify the staging of the sacral pressure ulcer.</p> <p>Attempts were made to re-interview the Wound Physician on 5/17/2024. The Wound Physician was not available for an interview.</p> <p>10 NYCRR 415.12(c)(1)</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>44963</p> <p>Based on observations, interviews, and record review during the Recertification Survey initiated on 5/13/2024 and completed on 5/17/2024, the facility did not ensure nursing staffing was posted daily and included the total number of licensed and unlicensed staff working per shift. Specifically, the facility's entrance lobby was observed on 5/13/2024 at 9:00 AM with the nursing staffing sheet dated 5/10/2024. Additionally, the nursing staffing sheets posted from 5/13/2024 to 5/16/2024 did not include the total number of licensed and unlicensed nursing staff working per shift.</p> <p>The finding is:</p> <p>A nursing staffing sheet was observed at the facility entrance by the receptionist area on 5/13/2024 at 9:00 AM. The nursing staffing sheet was dated 5/10/2024 and did not contain the number of licensed and unlicensed nursing staff directly responsible for resident care for each nursing shift: 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM.</p> <p>A nursing staffing sheet was observed at the facility entrance by the receptionist area on 5/14/2024 at 12:30 PM. The nursing staffing sheet was dated 5/14/2024 and did not contain the number of licensed and unlicensed nursing staff providing care for each nursing shift: 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM.</p> <p>A nursing staffing sheet was observed at the facility entrance by the receptionist area on 5/15/2024 at 9:23 AM. The nursing staffing sheet was dated 5/15/2024 and did not contain the number of licensed and unlicensed nursing staff providing care for each nursing shift: 7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM.</p> <p>The Staffing Coordinator was interviewed on 5/16/2024 at 11:43 AM and stated they were responsible for completing and posting the nursing staffing sheet daily on days they are working. The Staffing Coordinator stated they were not sure who was responsible for completing and posting the nursing staffing sheets on the weekends or when they were not working. The Staffing Coordinator stated that the nursing staffing sheet should contain the date, resident census, and total number and hours worked by licensed and unlicensed nursing staff. The Staffing Coordinator further stated they were not aware why the facility's nursing staffing sheet does not include the total number of nursing staff on each shift.</p> <p>The Director of Nursing Services was interviewed on 5/17/2024 at 9:54 AM and stated that the night (11:00 PM-7:00 AM) Registered Nurse Supervisor is responsible for completing and posting the staff information daily, including the weekends. The Director of Nursing Services stated that they spoke with the Registered Nurse Supervisor who worked this past weekend (5/11/2024 and 5/12/2024) and the Registered Nurse Supervisor forgot to post the staffing information. The Director of Nursing Services stated they were not sure why the facility's nursing staffing sheet did not include the total number of nursing staff on each shift and would revise it to include that information.</p> <p>The weekend Registered Nurse Supervisor #2 was contacted on 5/17/2024 at 11:28 AM and 1:24 PM and was unable to be interviewed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Glen Cove Center for Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 6 Medical Plaza Glen Cove, NY 11542	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 NYCRR 415.13

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34798</p> <p>Based on record review and interviews during the Recertification Survey initiated on 5/13/2024 and completed on 5/17/2024 the facility did not ensure that each resident received the use of outside resources in a timely manner. This was identified for one (Resident #91) of five residents reviewed for Unnecessary Medications. Specifically, Resident #91 had a physician's order, dated 4/2/2024, for an initial psychiatry consult following the resident's admission to the facility on [DATE]; however, the resident did not receive their initial psychiatry consult until 5/15/2024.</p> <p>The finding is:</p> <p>The facility's policy titled, Physician Consultations effective 4/2023, documented it is the policy of this organization to ensure all residents receive medical care in a timely manner. The attending physician will indicate the appropriate time frame within which the specialist should see the resident.</p> <p>Resident #91 was admitted with diagnoses including Alzheimer's Disease, Parkinson's Disease, and Psychotic Disorder. The 4/8/2024 admission Minimum Data Set assessment documented a Brief Interview for Mental Status score of 99, indicating the resident had severely impaired cognitive skills for daily decision-making. The Minimum Data Set assessment documented that the resident had frequent problems related to mood, such as little interest in doing things, trouble with sleep, trouble concentrating, and being restless.</p> <p>A physician's order dated 4/1/2024 documented Quetiapine (an antipsychotic medication), 25 milligrams tablet; give one tablet by oral route every 12 hours, for diagnosis of Anxiety Disorder.</p> <p>A physician's order, dated 4/2/2024, documented to obtain an Initial Psychiatry Consult.</p> <p>A Comprehensive Care Plan titled, Psychotropic Medications effective 4/2/2024, documented an intervention to obtain a psychiatry consultation as ordered.</p> <p>A Pharmacist medication regimen review dated 4/4/2024 documented resident was recently admitted to the facility and receiving Quetiapine with no clear diagnosis to support current use. Please consider obtaining a psychosocial work-up along with performing a medical work-up as soon as possible to assess the underlying causes of behaviors. Should the workups and nursing behavioral monitoring reveal no significant behaviors or identification of a chronic psychiatric condition, please consider implementing a tapering schedule and/or discontinuation of the medication.</p> <p>The physician response, dated 4/8/2024, documented: Disagree, would observe for now. Resident with psychosis and new admission.</p> <p>A Pharmacist medication regimen review dated 4/13/2024 documented currently receiving Quetiapine, which can increase the risk of falls. Per clinical record, with recent falls. Please evaluate and consider tapering dose or implementing alternative treatment.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Physician's response, dated 4/15/2024, documented: Disagree: Resident still with target symptoms. Continue current dose.</p> <p>A physician's order dated 5/8/2024 documented Quetiapine, 25 milligrams tablet; give one tablet by oral route every 12 hours, for diagnosis of Other Psychotic Disorder not due to a Substance or Known Physiological Condition.</p> <p>A Comprehensive Care Plan, titled Mood State, effective 4/2/2024, documented psychiatric consult and follow-up as ordered. A note entry dated 5/8/2024 documented the interdisciplinary team discussed the resident behaviors and current management. The resident was being followed by the facility Psychiatrist due to a diagnosis of Alzheimer's Disease and Anxiety Disorder. The resident continued to have intermittent episodes of being combative and yelling during morning care. The resident will continue to be followed by the facility Psychiatrist.</p> <p>A review of the medical record revealed no previous evaluation by the Psychiatrist.</p> <p>A nursing progress note dated 5/9/2024 at 1:07 AM documented the resident pulled out their peripheral intravenous line. Attempts were made to re-insert the intravenous line, but the resident refused and was combative. The resident was trying to hit bite and pinch staff and used inappropriate words towards staff. The Primary Physician was notified, and the Psychiatrist was made aware for re-evaluation.</p> <p>A review of the medical record revealed no previous evaluation by the Psychiatrist.</p> <p>A review of the medical record revealed that there had been no documented psychiatric evaluation as of 5/15/2024.</p> <p>The Director of Nursing Services was interviewed on 5/15/2024 at 9:39 AM. The Director of Nursing Services stated the psychiatry consult for Resident #91 is pending and the initial consult has not been done yet. The Director of Nursing Services stated generally, the initial psychiatry consult should be done within 14 days of a new admission.</p> <p>Psychiatrist #1 was interviewed on 5/15/2024 at 1:00 PM. Psychiatrist #1 reviewed their notes and stated they had not seen Resident #91 yet. Psychiatrist #1 stated generally, they like to see a new resident as soon as possible, within 1-2 weeks after the resident is admitted . Psychiatrist #1 stated the facility asked them to see the resident today. Psychiatrist #1 stated when a consult is needed for newly admitted residents, the staff either texts them or puts the consult request in the consult book.</p> <p>Primary Physician #1 was interviewed on 5/15/2024 at 1:55 PM and stated they expect the psychiatry consult to be done rather quickly. Primary Physician #1 stated they did not change the Seroquel (Quetiapine), dosage because the resident was very aggressive and almost attacked them a couple of times. Primary Physician #1 stated they were waiting for the Psychiatrist to assess the resident because they (Primary Physician #1) are not an expert. Primary Physician #1 stated the Quetiapine order written on 4/1/2024 indicated a diagnosis of Anxiety as a reason for the medication use, which may have been an oversight.</p> <p>(continued on next page)</p>		

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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing Services was re-interviewed on 5/15/2024 at 2:05 PM and stated all newly admitted residents who receive psychotropic medications are automatically referred to psychiatry services. Resident #91 is a newly admitted resident who receives antipsychotic medications and should have been seen by the Psychiatrist within 14 days of their admission to the facility.</p> <p>A Psychiatry consult dated 5/15/2024 documented a recommendation for a dose reduction of Quetiapine. The resident has been intermittently combative, agitated, and depressed at times, with poor sleep sometimes. The resident has been extremely confused, and unable to answer questions due to cognitive impairment. The Psychiatrist recommended to continue Seroquel 12.5 milligrams every 12 hours.</p> <p>10 NYCRR 415.26(e)</p>