STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335755	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellhaven Center for Rehab and Nursing Care	110 Beaver Dam Road Brookhaven, NY 11719

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on record review and interviews conducted during the Recertification Survey and Abbreviated Survey (NY 00336468) initiated on 8/14/2024 and completed on 8/21/2024, the facility did not ensure that all incidents including an injury of unknown origin were thoroughly investigated. This was identified for one resident (Resident #430) of six residents reviewed for Accidents. Specifically, on 3/19/2024 Resident #430 sustained a fracture of their left leg, an injury of unknown origin. The facility did not thoroughly investigate the incident to identify the root cause of the injury to rule out abuse, neglect, and mistreatment. The finding is: The facility's policy titled Accidents/Incidents Involving Residents revised in July 2021 documented the facility's aim is to protect all the residents from accidents and incidents. If a resident has an accident, incident, or fall, including but not limited to an injury of unknown origin, appropriate treatment is provided, applicable persons are notified, and there is a thorough investigation and follow-up to ensure that the resident is safe from harm. The purpose of the policy is to monitor for abuse, mistreatment, exploitation, or neglect; identify the facts of the accident, incident, or fall; and ensure appropriate follow-up and preventative measures. Resident #430 had diagnoses that included Dementia, Type 2 Diabetes, and Major Depressive Disorder. The Significant Change Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 9, indicating the resident had moderate cognitive impairment. Resident #430 used a walker and wheelchair for mobility. Resident #430 required partial/moderate assistance for bed mobility and transfer. The Nursing Home Investigation Report dated 3/22/2024 documented the staff did not witness falls or trauma involving the resident since 3/7/2024. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An undated Accident and Incident Summary documented on 3/18/2024 Resident #430 complained of left leg pain; the resident was medicated with Oxycodone (narcotic pain medication) and extra strength Acetaminophen (Tylenol-pain medication). Resident #430 continued to report discomfort and could not move their left leg. The Nurse Practitioner was notified and ordered an x-ray of the left leg. The x-ray results of the left knee were received on 3/19/2024 and revealed a recent femoral (leg bone) fracture. The Medical Doctor was notified, and Resident #430 was sent to the hospital. The summary concluded there was no evidence of abuse, mistreatment, exploitation, or neglect. The written statements from staff only had information regarding the resident's complaint of pain. The written statements did not include whether the staff witnessed falls or trauma before the resident complained of pain on 3/18/2024 and before the discovery of the fracture. The summary did not identify the possible root cause of the injury. The summary did not include a statement from Resident #430. The Registered Nurse Risk Manager was interviewed on 8/20/2024 at 3:04 PM and stated they completed the Accident and Incident Report for Resident #430 on 3/18/2024. The Registered Nurse Risk Manager stated they interviewed and took statements from the staff who took care of the resident 48 hours prior to the incident. The Registered Nurse Risk Manager stated they asked each staff member about any unusual events regarding the resident's care, such as falls or mistreatment. The Risk Manager stated the staff responses were not documented on the statement forms. Registered Nurse Risk Manager stated they concluded that there were no signs of abuse, mistreatment, or neglect based on their assessment of the resident which noted no bruising or swelling to the affected area and based on the resident's clinical history. The Director of Nursing Services was interviewed on 8/21/2024 at 10:37 AM and stated the staff statements should have reflected any instances of falls or trauma to rule out abuse, neglect, or mistreatment. The Director of Nursing Services stated the facility's policy was to investigate concerns related to an injury of unknown origin and based on the documented statements regarding Resident #430's injury abuse, neglect, and mistreatment could not be ruled out. 10 NYCRR 415.4 (b)

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F 0656 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on observation, record review, and interviews conducted during the Recertification Survey initiated on 8/14/2024 and completed on 8/21/2024 the facility did not ensure that a comprehensive person-centered care plan was developed for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental, and psychosocial needs. This was identified for one (Resident #132) of two residents reviewed for hearing and vision. Specifically, Resident #132 did not speak English as their primary language. The Comprehensive Care Plan did not identify that Resident #132 had a language barrier. The finding is: The facility's policy titled Language Services dated July 2023, documented that in the event a resident is admitted who does not speak English as their preferred language, the facility will attempt to locate staff that speak the language to communicate with the resident; however, the facility also makes use of a phone service that provides a translator in the language of choice. The facility did not have a policy on Comprehensive Care Planning. Resident #132 was admitted with the diagnoses of Dementia, Hyperlipidemia (high cholesterol), and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, indicating the resident was unable to complete the interview. The Minimum Data Set documented Resident #132's hearing was adequate, their speech was clear, they made themselves understood, and they usually understood others. Resident #132's admission nursing assessment dated [DATE] documented that Resident #132's primary language was French Creole. Resident #132 was observed sitting in a chair in their room on 8/14/2024 at 10:13 AM. Resident #132 responded to the surveyor in French-Creole. Resident #132's Comprehensive Care Plan for Communication effective 7/19/2023 last updated on 7/23/2024, documented that Resident #132 was at risk for decline due to an impaired ability to make themselves understood. Interventions included but were not limited to expand nonverbal communication skills and to provide auditory stimuli by speaking to the resident during care. The Comprehensive Care Plan did not include the resident's language barrier. The Comprehensive Care Plan was updated on 8/21/2024 to include an intervention for the use of a communication board. Certified Nursing Assistant #5, Resident #132 regularly assigned Certified Nursing Assistant, was interviewed on 8/20/2024 at 11:53 AM. Certified Nursing Assistant #5 stated Resident #132 spoke French Creole and did not speak any English. Certified Nursing Assistant #5 stated they were able to communicate with Resident #132 because they also spoke French Creole. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse #2 was interviewed on 8/21/2024 at 12:46 PM and stated they were aware that Resident #132 did not speak English. Registered Nurse #2 stated they did not know that the resident's Comprehensive Care Plan did not include the resident's language barrier status because they were not regularly assigned to the unit and were the covering Unit Manager. Registered Nurse #2 stated the communication care plan should have included that Resident #132 did not speak English along with the interventions to meet the resident's communication needs related to the language barrier. Registered Nurse #2 stated the regularly assigned unit Registered Nurse was responsible for updating the care plans. The Administrator was interviewed on 8/21/2024 at 2:02 PM and stated a resident who does not speak English as a primary language, should have a Comprehensive Care plan related to their preferred language with interventions in place such as the use of family members, employees, and translation services to effectively communicate with the resident. 10 NYCRR 415.11(c)(1)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on record review and interviews conducted during the Recertification Survey initiated on 8/14/2024 and completed on 8/21/2024 the facility did not ensure that a Physician reviewed each resident's total program of care, including treatments and medications. Specifically, Resident #132's Medical Orders for Life-Sustaining Treatment form documented the resident is to be intubated (when a tube is inserted through a person's mouth or nose to open an airway) and provided with long-term mechanical ventilation (to use a ventilator for breathing), including tracheostomy (an opening into the trachea from outside of the neck). Resident #132's Medical Orders for Life-Sustaining Treatment form was not reviewed since the form was first completed on 7/20/2023. Resident #132's physician orders documented the resident was not to be intubated, which did not match the Medical Orders for Life-Sustaining Treatment form. The finding is: The facility's Medical Orders for Life-Sustaining Treatment policy last revised in March 2024 documented the Medical Orders for Life-Sustaining Treatment form is a medical order that converts an individual's wishes regarding life-sustaining treatment into medical orders. The purpose of the Medical Orders for Life-Sustaining Treatment form is to help the Physician/Nurse Practitioner/Physician's Assistant and other health care providers to discuss and convey a resident's wishes regarding cardiopulmonary resuscitation and other life-sustaining treatment. The Physician/Physician Assistant/Nurse Practitioner will review the Medical Orders for Life-Sustaining Treatment form with each 90-day resident review (assessment). When a resident is admitted or readmitted to the facility, the Social Worker, or the Unit Nurse in the absence of the Social Worker, will copy the Medical Orders for Life-Sustaining Treatment form on bright pink paper and file the form in the Resident's Medical record along with the Resident's advance directive. As the resident moves from one healthcare setting to another, the bright pink Medical Orders for Life-Sustaining Treatment form is to accompany the resident. Resident #132 was admitted with the diagnoses of Dementia, Hyperlipidemia (high cholesterol), and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status of 99, indicating the resident was unable to complete the interview. The Minimum Data Set assessment documented Resident #132's Advanced Directives as Do Not Intubate. Resident #132's Medical Orders for Life-Sustaining Treatment form dated 7/20/2023 documented providing intubation and long-term mechanical ventilation, including a tracheostomy if the resident required respiratory support. The Review and Renewal section of the Medical Orders for Life-Sustaining Treatment form was blank indicating the Medical Orders for Life-Sustaining Treatment form had not been reviewed since 7/20/2023. A physician's order dated 8/10/2024 documented not to intubate Resident #132. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Adult-Gerontology Nurse Practitioner was interviewed on 8/21/2024 at 11:28 AM and stated they reviewed the Medical Orders for Life-Sustaining Treatment form for Resident #132 on 7/20/2023. The Adult Gerontology Nurse Practitioner stated the Medical Orders for Life-Sustaining Treatment form should be reviewed to ensure that the form matched the physician's order for advance directives including wishes regarding intubation. The Medical Director was interviewed on 8/21/2024 at 11:38 AM and stated the Medical Orders for Life-Sustaining Treatment form is completed with the Resident's Representative and the facility's nursing and social work staff. The Medical Director stated the instructions documented on the Medical Orders for Life-Sustaining Treatment form are the standard of care and the Medical Orders for Life-Sustaining Treatment form and physician's order should match. 415.15(b)(2)(iii)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41051 Based on record review and interviews conducted during the recertification survey initiated on 8/14/2024 and completed on 8/21/2024 the facility did not ensure that all residents were provided with medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This was identified for one of two residents reviewed for Advanced Directives. Specifically, Resident #132's Medical Orders for Life-Sustaining Treatment dated 7/20/2023 indicated the resident was to be intubated (when a tube is inserted through a person's mouth or nose to open an airway) and provided with long-term mechanical ventilation (to use a ventilator for breathing), including tracheostomy (an opening into the trachea from outside of the neck). The facility did not review/revise Resident #132's Medical Orders for Life-Sustaining Treatment form since the form was first completed on 7/20/2023. Additionally, Resident #132's Comprehensive Care Plan and the advance directive physician's order did not match the Medical Orders for Life-Sustaining Treatment form. The finding is: The facility's Medical Orders for Life-Sustaining Treatment policy last revised in March 2024 documented the Medical Orders for Life-Sustaining Treatment form is a medical order that converts an individual's wishes regarding life-sustaining treatment into medical orders. The purpose of the Medical Orders for Life-Sustaining Treatment form is to help the Physician/Nurse Practitioner/Physician's Assistant and other health care providers to discuss and convey a resident's wishes regarding cardiopulmonary resuscitation and other life-sustaining treatment. The Physician/Physician Assistant/Nurse Practitioner will review the Medical Orders for Life-Sustaining Treatment form with each 90-day resident review (assessment). When a resident is admitted or readmitted to the facility, the Social Worker, or the Unit Nurse in the absence of the Social Worker, will copy the Medical Orders for Life-Sustaining Treatment form on bright pink paper and file the form in the Resident's Medical record along with the Resident's advance directive. As the resident moves from one healthcare setting to another, the bright pink Medical Orders for Life-Sustaining Treatment form is to accompany the resident. Resident #132 was admitted with the diagnoses of Dementia, Hyperlipidemia (high cholesterol), and Hypertension. The Annual Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 99, indicating the resident was unable to complete the interview. The Admission Minimum Data Set Assessment documented Resident #132's Advanced Directives as Do Not Intubate. Resident #132's Medical Orders for Life-Sustaining Treatment form dated 7/20/2023 documented to provide intubation and long-term mechanical ventilation, including a tracheostomy, if the resident required respiratory support. The Review and Renewal section of the Medical Orders for Life-Sustaining Treatment form was blank indicating the Medical Orders for Life-Sustaining Treatment form had not been reviewed since 7/20/2023. A physician's order dated 8/10/2024 documented not to intubate Resident #132. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #132's Advanced Directives care plan effective 7/19/2023 and last reviewed on 7/24/2024 documented Do Not Intubate. This care plan was updated on 10/25/2023, 1/18/2024, 4/20/2024, and 7/24/2024 and documented Quarterly - Advanced directives reviewed with resident's sponsor. No changes at this time. Education ongoing. On 8/20/2024 the Care Plan was revised to include that advanced directives were reviewed with the resident's family member and a new Medical Orders for Life-Sustaining Treatment (MOLST) form was completed with the following orders: Do Not Resuscitate, Do Not Intubate, no feeding tube, and to send the resident to the hospital when medically necessary. The Social Worker assigned to Resident #132 was unavailable for an interview. Social Worker #1 was interviewed on 8/20/2024 at 4:13 PM and stated the Medical Orders for Life-Sustaining Treatment form should be reviewed quarterly with the designated representative, nursing, and social worker during the care plan meeting. The Director of Social Work was interviewed on 8/21/2024 at 9:32 AM and stated the Medical Orders for Life-Sustaining Treatment form is reviewed at the quarterly care plan meetings; if there is a change in condition; or when the designated representative requested a change. The Director of Social Work stated the Medical Orders for Life-Sustaining Treatment form should have matched the physician's orders and the resident's care plan. The discrepancy between the physician's orders and the Medical Orders for Life-Sustaining Treatment form was an oversight. The Director of Social Work was interviewed on 8/21/2024 at 3:38 PM and stated the Social Worker is responsible for ensuring that the Medical Orders for Life-Sustaining Treatment form, Comprehensive Care Plan, and physician's orders match and are accurate. The Director of Nursing Services was interviewed on 8/21/2024 at 3:45 PM and stated the resident's Social Worker should review the Medical Orders for Life-Sustaining Treatment form at the quarterly Comprehensive Care Plan Meeting and ensure the physician's orders and Care Plan are consistent with the Medical Orders for Life-Sustaining Treatment form. 10 NYCRR 415.5(g)(1)(i-xv)