STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43368 Based on observation, record review and staff interviews conducted during the Recertification/Complaint/Extended survey (NY00257457, NY00290720 & NY00266488), 01/31/2022 through 02/11/2022, and 02/23/2022 through 03/03/2022, the facility failed to ensure residents remained free from abuse and neglect. This was evident for 3 (Resident #24, Resident #367, and Resident #203) of 10 residents reviewed. Specifically: 1). On 05/21/2020 at 6:05AM, Licensed Practical Nurse (LPN #1) witnessed Resident #24 being punched in the right thigh area by Certified Nursing Assistant (CNA) #1. CNA #1 was suspended and later returned to work (direct resident care) on 05/27/2020 and was assigned to the unit on which Resident #24 resided. 2). On 10/28/2020 at 07:30PM, LPN #2 witnessed Resident #367 being punched on the right arm by CNA #2. While CNA #2 was in the process of exiting Resident #367's room, CNA #2 threw a pillow that hit Resident #367 on the face. Resident #367 was observed with slight redness with dry yellow drainage to corner of the right eye and was later observed with bruise on the right hand. 3). On 02/03/2022, during the 7:00AM to 3:00PM shift, CNA #4 did not provide Activity of Daily Living (ADL) care to Resident #203. This resulted in Immediate Jeopardy and Substandard Quality of Care with the likelihood for serious, injury, serious harm, serious impairment, or death to all residents. Serious adverse outcome is likely to occur if the facility fails to immediately remove staff accused of abuse or neglect from direct resident care. The Findings Include but are not limited to: The facility's Policy and Procedure entitled Protection of Residents dated 07/2010 documented that During Abuse Investigation, as soon as someone is identified as suspected of abuse, neglect, or mistreatment, the employee may be immediately removed from duty or have duties reassigned pending completion of an investigation. The facility will ensure that the complainant will not have any direct contact with the individual identified. (continued on next page)

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
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility policy Prohibition of Abuse, Neglect, Mistreatment and the Misappropriation of Resident Property revised 7/2010 documents that residents of Golden Gate Rehabilitation and Health Care Center shall not be subjected to abuse, neglect or mistreatment by anyone, including but not limited to facility employees, medical staff, other residents, visitors, consultants, volunteers, and staff of other agencies servicing the facility. The facility's Policy and Procedure entitled Identification of Abuse, Neglect, Mistreatment, and Misappropriation of Property dated 07/2010 documented that abuse means the willful infliction of injury with resulting physical harm, pain, or mental anguish. The policy further documented that Physical Abuse includes hitting, pinching, and kicking. Review of the facility policy Training of Staff in the Prevention, Identification, Investigation, and Reporting of Abuse, Neglect, Mistreatment and Misappropriation of Resident Property revised 7/2010 documents that each new employee will receive a full explanation of regulations including resident abuse, neglect and how it relates to every day working situations. 1. Resident #24 Resident #24 was initially admitted to the facility on [DATE] with diagnoses including Dementia and Muscle Wasting. The Minimum Data Set (MDS, a resident assessment tool) dated 05/05/2020 documented Resident #24 had a Brief Interview of Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) and score of 03/15 indicating severely impaired cognition. Resident #24 required supervision with setup help only for most areas of ADLs. Review of the Facility's Physical Abuse Allegations Investigation Report dated 05/26/2020 documented that on 05/21/2020 at about 6:05 AM, LPN #1 heard commotion coming from Resident #24's room. LPN #1 entered the room and observed CNA #1 hit Resident #24 on the right thigh twice with a closed fist. LPN #1 yelled out I saw you. CNA #1 proceeded to complete care that was being provided. LPN #1 remained in the room and later informed the supervisor. An investigation was initiated, and the Police were called. LPN #1 looked at Resident #24's right thigh area and there was no redness or visible injury. The nurse manager and the Medical Doctor (MD) assessed the resident and there was no visible injury to the right thigh area. Resident #24 was observed with discoloration to the left finger. CNA #1 reported that Resident #24 was resistive to care and kicked CNA #1 who instinctively pushed back on Resident #24's right leg to prevent being struck. The facility investigation concluded although LPN #1 was an eyewitness to an actual physical encounter between Resident #24 and CNA #1, it is questionable if this interaction was actual abuse or an instinctive response by CNA #1. There were no findings of abuse or assault by the police. Both LPN #1 and CNA #1 were re-educated on abuse. A Nursing Progress Note dated 05/21/2020 documented that the unit nurse (LPN #1) reported that they had observed Resident #24 being "punched with closed fist twice in upper right thigh by CNA. Body assessment was done, and no visible injury was noted to the area. CNA #1 was instructed to leave the unit and wait downstairs. The Police were called and responded. A Medical Progress Note dated 05/21/2020 documented that Resident #24 alleged to have been punched by aide into Right thigh. Appears to have no recollection and appears to be at baseline. No acute distress noted. No injury noted to right thigh. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Multiple attempts were made to contact CNA #1, but all were unsuccessful. LPN #1 is no longer employed at the facility. An attempt was made to contact LPN #1, but the phone number was disconnected. During an interview on 01/31/2022 at 03:15 PM, the Director of Nursing (DON) stated that he/she was not familiar with the case related to Resident #24 since they were not the DON at the time of the incident. The DON stated that if the investigation reveals that abuse has occurred or that the witness was credible, without any motive to provide false information, the alleged abuser would immediately be terminated. During an interview on 02/11/2022 at 11:59 AM, the Administrator stated that CNA #1 was immediately suspended pending the investigation outcome. The Administrator stated that CNA #1 had worked in the facility for about [AGE] years with no prior history of abuse. The Administrator stated that they believe that CNA #1 was acting in self-defense due to Resident #24 being combative. The Administrator stated that regarding the contact, the facility could not determine if this was an open fist or a closed fist. The Administrator stated, despite LPN #1 being a credible witness, abuse could not definitively be determined, so CNA #1 was re-instated and able to work with residents in the facility. A review of CNA #1's personnel file revealed that CNA #1 was suspended from 05/23/2020 to 05/25/2020, disciplined, and was reinstated on 05/27/2020 and continued to provide direct resident care on the same unit. 2. Resident #367 Resident #367 was initially admitted to the facility on [DATE] with diagnoses including Unspecified Dementia without behavioral disturbance and schizoaffective disorder. The MDS dated [DATE] documented that Resident #367 had a BIMS score of 06/15 indicating severely impaired cognition. The resident required extensive assistance with one-person physical assist for most areas of ADLs. Review of the Facility's Investigation Summary Report for Occurrence dated 10/28/2020 documented that LPN #2 observed CNA #2 punching Resident #367 on the right arm. Resident #367 was trying to kick CNA #2 and CNA #2 pushed the resident's feet away towards the resident's face. LPN #2 immediately intervened. CNA #2 left the room, but on the way out threw a pillow that hit Resident #367 on the face. Resident #367 had slight redness to the right eye and a bruise noted on the top of the right hand. CNA #2 reported that LPN #2 asked them to assist Resident #367 and the resident was kicking and punching CNA #2. CNA #2 reported that the nurse entered the room and asked CNA #2 to be patient and nice. CNA #2 proceeded to leave the room and noticed that a pillow was on the floor. CNA #2 picked up the pillow and threw it on the bed. The Police were contacted. The investigation concluded that it was reasonable to conclude that there was an altercation between CNA #2 and Resident #367. CNA #2 agreed with most of what LPN #2 stated other than punching Resident #367. There was no reasonable cause to believe that LPN #2 would lie. CNA #2 was counseled and reeducated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A Nursing Progress Note dated 10/28/2020 documented that at approximately 7:30PM the nurse stated that CNA #2 was abusing Resident #367. Resident #367 stated that CNA #2 threw a pillow at me. No injury was noted, just slight redness with yellow dry drainage to corner of Right eye. The resident denied any pain. A Nursing Progress Note dated 10/29/2020 documented Status Post Incident, day 1: Resident #367 was observed with a bruise on right hand. A Medical Progress Note dated 10/30/2020 documented that Resident #367 had a very superficial bruise noted right hand. A review of CNA #2's personnel file revealed that CNA #2 resigned on 11/02/2020. During an interview on 01/31/2022 at 03:13 PM, CNA #2 stated that he/she was sitting close to the nursing station when LPN #2 told him/her that Resident #367's legs were hanging off the bed and that he/she should help the resident. CNA #2 stated that when he/she attempted to reposition Resident #367, the resident began to kick him/her. CNA #2 stated he/she was trapped between the wall and the bed and was trying to get away from Resident #367 so he/she would not be kicked. CNA #2 stated that he/she yelled help, help. CNA #2 stated that he/she ran out of the room as soon as LPN #2 entered the room. CNA #2 stated that while running out of the room, the pillow fell from the bed, and he/she picked up the pillow and threw it back on the bed. CNA #2 stated that the pillow might have hit Resident #367. CNA #2 stated that he/she did not hit or punch Resident #367. LPN #2 is no longer employed by the facility. Multiple attempts were made to contact LPN #2, but all were unsuccessful. During an interview on 01/31/2022 at 03:15 PM, the Director of Nursing (DON) stated that he/she was not familiar with the cases related to Resident #24 and Resident #367 since they were not the DON at the time of the incident. The DON stated that if the investigation reveals that abuse has occurred or that the witness is credible, without any motive to provide false information, the alleged abuser would immediately be terminated. During an interview on 02/11/2022 at 11:59 AM, the Administrator stated that regarding the incident with Resident #367, CNA #2 was immediately suspended pending investigation. The Administrator stated that despite it not being documented in the investigation, CNA #2 was informed that the facility was looking towards termination. The Administrator stated that CNA #2 immediately resigned on their own. A review of CNA #2's personnel file revealed that CNA #2 resigned on 11/02/2020. 3. Resident #203 Resident #203 was admitted to the facility on [DATE] with diagnoses including type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary disease. The MDS dated [DATE], documented that Resident #203 had a BIMS score of 15/15 associated with intact cognition. The MDS also documented Resident #203 had clear speech and was able to understand others and be understood. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Facility's Incident Report submitted to the NYS Department of Health on 02/04/2022 revealed that Assistant Director of Nursing (ADON) received a verbal report from psychologist (PsyD) that Resident #203 had complained to PsyD that he/she had been neglected on 02/03/2022 as he/she had not received any care from any CNA. ADON #1 discovered on 02/03/2022 that CNA #4 had not entered Resident #203's room from 7:00AM and 3:00PM. CNA #4 stated to ADON #1 that he/she must have mistakenly omitted Resident #203's room number on the assignment sheet when he/she wrote down the residents for the day. CNA #4, when asked by ADON #1 about the fact that all CNA #4's administration records were completed for the day as though all care was provided, stated that he/she must have overlooked and thought he/she was documenting on someone else. It was further revealed that CNA #4 did not provide some ADL care to residents #178, #40 and #183, and failed to provide the Floor Ambulation Program (FAP) to #38, #75, #15, #40, and #203. A Physician's Orders, for Resident #203, dated 03/12/2021 documented orders for CNA Care, Floor Ambulation Program (FAP) 200 feet with RW and stand by assist without wheelchair follow, Toilet Use (extensive assistance with one person assist), Turning and positioning (7am, 9am, 11am, 1pm) during the 7AM-3PM shift. Review of the Resident CNA Accountability Record and Resident CNA Documentation History dated 02/03/2022, indicated that CNA #4 provided care to Resident #203 on 02/03/2022 as evident by CNA #4's initials in the following care areas: CNA #4 documented in the care areas on the forms that he/she provided care from 1:00PM-3:00PM, (FAP) 200 feet for 30 minutes, Toilet Use (extensive assistance with one person assist), turned and positioned Resident #203 at 7:00AM, 9:00AM, 11:00AM, and 1:00PM during the 7AM-3PM shift. During an interview on 02/28/2022 at 03:06 PM, Resident #203 stated that CNA #4 just did not come in at all that day, he/she just didn't come in at all. Resident #203 stated that he/she did not experience any psychosocial aftermath from the incident and that he/she was more concerned about the other residents who were not able to speak for themselves. During an interview with DON #1 on 02/28/22 at 04:25 PM, DON #1 stated that CNA #4 was new. DON #1 stated that on 02/03/2022, it appeared that CNA #4 was studying. DON #1 stated that he/she felt confident that CNA #4 was now performing his/her job, and that CNA #4 understands that if he/she does not do their job he/she will be terminated. During a telephone interview on 03/01/2022 at 10:18 AM, CNA #4 stated that on that day (02/03/2022) he/she came in late, around 8:25AM and the supervisor instructed him/her to write done the names of the residents. CNA #4 stated that he/she forgot to write down Resident #203's room number. CNA #4 stated that he/she provided care to everyone else on his/her assignment. CNA #4 stated that Resident #203's room door was closed most of the day and that he/she did not go into the room. CNA #4 stated that he/she did not provide care to Resident #203 because he/she (CNA #4) was not feeling well. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/01/2022 at 01:59 PM, LPN #1 stated that Resident #203 handles a lot of care by themselves and that he/she did not observe that anything was wrong with Resident #203. LPN #1 stated that around 1:50PM, he/she observed that another resident (#183) had not been changed. LPN #1 stated that he/she paged CNA #4 and instructed CNA #4 to go and change Resident #183. LPN #1 stated that other staff members told him/her that CNA #4 was in the day room on a break and that CNA #4 spent a lot of the day in the day room. LPN #1 stated at around 2:00PM, the Psych MD notified him/her that Resident #203 complained about not receiving care for the day. LPN #1 stated that he/she asked CNA #4 about the residents that were not changed or showered, and CNA #4 stated that he/she provided care. LPN #1 stated that he/she would normally have notified the supervisor, but that the supervisor was out on leave. During an interview on 03/01/2022 at 2:28 PM, Assistant Director of Nursing (ADON) #1 stated that he/she received a phone call from Resident #203's Psych MD who stated that during a session with Resident #203, the resident reported that no one took care of him/her that day (02/03/2022). ADON #1 stated that CNA #4 stated that he/she was not aware that he/she had the residents. ADON #1 stated that CNA #4 documented that he/she provided care to all residents. ADON #1 stated that the nurses reported that CNA #4 had not been doing his/her work. ADON #1 stated that he/she had a long conversation with CNA #4 regarding not providing care to the residents. ADON #1 stated that CNA #4 reported that he/she was just clicking on everything. ADON #1 stated that CNA #4 was suspended for one day. Immediate Jeopardy (IJ) was identified and declared. The facility Administrator and Director of Nursing were notified on 03/01/2022 at 7:47PM. The facility submitted a removal plan that was reviewed and accepted by NYS DOH on 03/01/2022 at 11:00PM. 415.4(b)(1)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43368 Based on observation, interviews and record review conducted during the Recertification/Complaint/Extended survey (NY00257457, NY00266488, NY00290720, NY00291433, NY00291683, and NY00291833) conducted from 02/23/2022 through 03/04/2022 the facility failed to report all alleged violations involving abuse, neglect, including injuries of unknown source, immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury. This was evident for 5 out of 10 residents reviewed for Abuse, Neglect, and Mistreatment (Resident #24, Resident #367, Resident #211, Resident #10, and Resident #192). Specifically: 1. On 05/21/2020 at 6:05AM, Licensed Practical Nurse (LPN #1) witnessed Resident #24 being punched in the right thigh area by Certified Nursing Assistant (CNA) #1. The facility reported this to The New York State Department of Health (NYSDOH) on 05/22/2020 at 03:20 PM. 2. On 10/28/2020 at 07:30PM, LPN #2 witnessed Resident #367 being punched on the right arm by CNA #2. While CNA #2 was in the process of exiting Resident #367's room, CNA #2 threw a pillow that hit Resident #367 on the face. Resident #367 was observed with slight redness with dry yellow drainage to corner of the right eye and was later observed with bruise on the right hand. The facility reported this to the NYSDOH on 10/29/2020 at 04:42 PM. 3. On 02/22/2022, (time not documented) Resident #10 was observed with increased swelling and pain to the right elbow. An x-ray result dated 02/22/2022 documented that Resident #10 had an acute mildly displaced transverse fracture across the right distal humeral metadiaphysis (elbow). Resident #10 was transferred to the hospital on 02/22/2022. On 02/23/2022, in the morning, the Medical Director notified the Director of Nursing (DON) #1 that Resident #10 accused CNA #5 of abuse, potentially causing a fracture to the right elbow. This allegation of abuse was reported to NYSDOH on 2/23/2022 at 7:05 PM. 4. On 02/12/2022, Resident #211's child reported that Resident #211 was abused by a staff member between 6pm and 7pm. The facility reported this to the NYSDOH on 02/17/2022 at 08:41 PM. 5. On 02/23/2022 at 10:42 AM, Resident #192 reported that CNA #3 called him/her a fat little elephant every night between Midnight and 4:00 AM to the state agent (SA) who immediately informed the facility. The facility reported this to the NYSDOH on 02/25/2022 at 07:05 PM after being directed to do so by the NYSDOH. The findings include but are not limited to: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy dated 07/2010 titled Reporting/Response of Alleged Abuse documented that The Administrator, after consultation with the Administrative Investigating team determines if abuse, neglect, mistreatment or misappropriation of property has occurred. The policy further documents that actions to be taken if there is reasonable cause that abuse, neglect, mistreatment has occurred: report to New York State Office of Health Systems Management ([NAME]) or Central Office or State Health Department's Hotline. The policy documents that all alleged and all substantial incidents will also be reported to all other agencies as required. 1) Resident #24 was admitted to the facility with diagnoses which include Dementia and Muscle Wasting. The Minimum Data Set 3.0 (MDS) assessment dated [DATE] documented Resident #24 had severely impaired cognition. The MDS further documented Resident #24 required supervision with setup help only for most areas of Activities for Daily Living (ADLs). The Physical Abuse Allegations Investigation Report dated 05/26/2020 documented that on 05/21/2020 at about 6:05 AM, the LPN #1 heard commotion coming from Resident #24's room. LPN #1 entered the room and observed CNA #1 hit Resident #24 on the right thigh twice with a closed fist. LPN #1 yelled out I saw you. CNA #1 proceeded to complete care that was being provided. LPN #1 remained in the room and later informed the supervisor. An investigation was initiated, and the Police were called. LPN #1 looked at Resident #24's right thigh area and there was no redness or visible injury. The nurse manager and the Medical Doctor (MD) assessed the resident and there was no visible injury to the right thigh area. Resident #24 was observed with discoloration to the left finger. CNA #1 reported that Resident #24 was resistive to care and kicked CNA #1 who instinctively pushed back on Resident #24's right leg to prevent being struck. The facility investigation concluded although LPN #1 was an eyewitness to an actual physical encounter between Resident #24 and CNA #1, it is questionable if this interaction was actual abuse or an instinctive response by CNA #1. There were no findings of abuse or assault by the police. Both LPN #1 and CNA #1 were re-educated on abuse. A Nursing Progress Note dated 05/21/2020 documented that the unit nurse (LPN #1) reported that they had observed Resident #24 being "punched with closed fist twice in upper right thigh by CNA. Body assessment was done, and no visible injury was noted to the area. CNA #1 was instructed to leave the unit and wait downstairs. The Police were called and responded. A Medical Progress Note dated 05/21/2020 documented that Resident #24 alleged to have been punched by aide into Right thigh. Appears to have no recollection and appears to be at baseline. No acute distress noted. No injury noted to right thigh. Review of the HERDS submission report revealed that the facility reported this to The New York State Department of Health (NYSDOH) on 05/22/2020 at 03:20 PM. This allegation of physical abuse was not reported to NYSDOH within 2 hours. Multiple attempts were made to contact CNA #1, but all were unsuccessful. LPN #1 is no longer employed at the facility. An attempt was made to contact LPN #1, but the phone number was disconnected. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 01/31/2022 at 03:15 PM, the Director of Nursing (DON) stated that he/she was not familiar with the case related to Resident #24 since they were not the DON at the time of the incident. 2) Resident #367 was initially admitted with diagnoses which include Unspecified Dementia without behavioral disturbance and schizoaffective disorder. The MDS dated [DATE] documented Resident #367 had a Brief Interview of Mental Status (BIMS) score of 6/15, indicating severely impaired cognition. The resident required extensive assistance with one-person physical assist for most areas of ADLs. The Investigation Summary Report for Occurrence dated 10/28/2020 documented LPN #2 observed CNA #2 punching Resident #367 on the right arm. Resident #367 was trying to kick CNA #2 and CNA #2 pushed the resident's feet away towards the resident's face. LPN #2 immediately intervened. CNA #2 left the room, but on the way out threw a pillow that hit Resident #367 on the face. Resident #367 had slight redness to the right eye and a bruise noted on the top of the right hand. CNA #2 reported that LPN #2 asked them to assist Resident #367 and the resident was kicking and punching CNA #2. CNA #2 reported that the nurse entered the room and asked CNA #2 to be patient and nice. CNA #2 proceeded to leave the room and noticed that a pillow was on the floor. CNA #2 picked up the pillow and threw it on the bed. The Police were contacted. The investigation concluded that it was reasonable to conclude that there was an altercation between CNA #2 and Resident #367. CNA #2 agreed with most of what LPN #2 stated other than punching Resident #367. There was no reasonable cause to believe that LPN #2 would lie. CNA #2 was counseled and reeducated. A Nursing Progress Note dated 10/28/2020 documented that at approximately 7:30PM the nurse stated that CNA #2 was abusing Resident #367. Resident #367 stated that CNA #2 threw a pillow at me. No injury was noted, just slight redness with yellow dry drainage to corner of Right eye. The resident denied any pain. A Nursing Progress Note dated 10/29/2020 documented Status Post Incident, day 1: Resident #367 was observed with a bruise on right hand. A review of the HERDS submission report revealed that the facility reported this to the NYSDOH on 10/29/2020 at 04:42 PM. This allegation of Physical abuse was not reported to NYSDOH within 2 hours. During an interview on 01/31/2022 at 03:13 PM, CNA #2 stated that he/she was sitting close to the nursing station when LPN #2 told him/her that Resident #367's legs were hanging off the bed and that he/she should help the resident. CNA #2 stated that when he/she attempted to repositioned Resident #367, the resident began to kick him/her. CNA #2 stated he/she was trapped between the wall and the bed and was trying to get away from Resident #367 so he/she would not be kicked. CNA #2 stated that he/she yelled help, help. CNA #2 stated that he/she ran out of the room as soon as LPN #2 entered the room. CNA #2 stated that while running out of the room, the pillow fell from the bed, and he/she picked up the pillow and threw it back on the bed. CNA #2 stated that the pillow might have hit Resident #367. CNA #2 stated that he/she did not hit or punch Resident #367. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LPN #2 is no longer employed by the facility. Multiple attempts were made to contact LPN #2, but all were unsuccessful. During an interview on 01/31/2022 at 03:15 PM, the Director of Nursing (DON) #1 stated that he/she was not familiar with the cases related to Resident #24 and Resident #367 since they were not the DON at the time of the incident. During an interview with on 02/25/2022 at 04:20 PM, DON #1 stated that either the Assistant Director of Nursing of the DON are responsible for submitting cases to the NYSDOH (HERDS) system. DON #1 stated that cases that involve abuse and result in serious injury are reported with in 2 hours, cases without serious injury are reported within 24 hours. 3) Resident #10 was admitted with diagnoses which include Rheumatoid Arthritis, Osteoarthritis, and Cellulitis of Right Upper Limb. The MDS dated [DATE] documented that Resident #10 had a BIMS score of 14/15, indicating intact cognition. Resident #10 required extensive assistance with one-person physical assist for most areas of ADLs. The Accident/Incident Investigation Report - Summary dated 02/27/2022 documented Resident #10 was diagnosed with cellulitis of the right elbow since 02/08/2022 and was treated with antibiotic. On 02/22/2022, Resident #10 was noted with increased swelling and pain to the site. RNS #4 evaluated the resident and notified the Medical Doctor who ordered x-ray which in turn resulted in right elbow fracture. An X-Ray of the Right elbow was done on 02/22/2022 and revealed a fracture to the right elbow and Resident #10 was transferred to the hospital. The next morning, on 02/23/2022 (time unknown) the Medical Director reported to the DON that Resident #10, while at the hospital, had stated to staff that he/she was abused at the facility. Resident #10 claimed that CNA #5 twisted their arm behind their back and hurt him/her. The CNA who worked with the resident was identified (CNA #5). CNA #5 was interviewed and described CNA's interaction with the resident on that day. CNA #5 stated that the resident was guarding his/her right elbow, both elbows are very contracted, and resident does not allow staff to properly clean around the area. CNA #5 stated that he/she was providing care with nurse on that day and did not touch the resident's elbow and did not manipulate the arm in any way other than just cleaning the hand. Resident #10 would not allow it otherwise. The nurse who assisted CNA #5 was identified as LPN #4. The LPN was interviewed and confirmed the statement of CNA #5. The investigation concluded that there is no reasonable cause to believe that any alleged resident abuse, neglect, or mistreatment regarding this resident had occurred. A Nursing Note Progress Note dated 02/22/2022 documented that Resident #10 complained of right shoulder pain. An x-ray was ordered for right shoulder, arm, and elbow. A Nursing Progress Note dated 02/22/2022 documented that x-ray of Resident #10's right shoulder and right elbow revealed acute mildly displaced transverse fracture across the distal humeral metadiaphysis with severe Osteoporosis. Resident #10 has severe pain to right elbow area. The Nurse practitioner (NP) ordered to send the resident to the hospital. A Patient Report dated 02/22/2022, revealed that an x-ray of Resident #10's right shoulder was done and documented acute displaced transverse fracture across the distal humeral metadiaphysis and severe Osteoporosis. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence in the medical record that Resident #10 had any accident or injury prior to the injury being identified on 2/22/2022. There was no documented evidence in the medical record that the facility interviewed the resident and/or staff about the possible cause of the injury on 2/22/2022. Review of the HERDS submission report revealed that the facility reported this to the NYSDOH on 02/23/2022 at 07:05 PM. This serious injury of unknown origin was not reported to NYSDOH within 2 hours on 2/22/2022 when the fracture was identified. Once the facility became aware of the allegation of abuse connected to the injury, the facility still did not report the allegation to NYSDOH within 2 hours. During telephone interview on 03/02/2022 at 11:03 PM, Resident #10 stated that staff have always been rough with him/her and their roommate. Resident #10 stated that on 02/22/2022 (does not recall the time) CNA #5 and LPN # 4 came to the room to clean Resident #10's right arm. Resident #10 stated that CNA #5 lifted their right arm so that the nurse could clean it and at that point Resident #10 stated that he/she heard a crack in the bone. Resident #10 stated that CNA #5 also twisted their left arm behind their back, however, could not elaborate as to why CNA #5 did this or the exact date and time that it occurred. Resident #10 stated that CNA #5 has anger management problems and yells at the residents when he/she gets mad. During an interview on 03/01/2022 at 02:58 PM, CNA #5 stated that if a resident is resistive to care, they step away and inform their supervisor, they do not continue to provide care. CNA #5 stated that if a resident has contractures, they start dressing them on the non-contracted side first. CNA #5 stated that Resident #10 had bilateral contractures - clothing could be put onto the left side and then draped over the right side due to severe contractures. CNA #5 stated that Resident #10's right arm is contracted close to the resident's chest. CNA #5 stated that Resident #10 would frequently resist care - never forced to receive care. CNA #5 stated that they would step away, inform the supervisor and re-attempt later. CNA #5 stated that on 02/22/2022 they assisted LPN #4 in providing treatment #10. CNA #5 stated that he/she held Resident #10's wrist - pulling the arm open slightly 1-2 inches (CNA re-enacted) so that LPN #4 could do the treatment to the resident's antecubital area. CNA #5 stated that LPN #4 instructed him/her to do this. CNA #5 stated that Resident #10 did not scream during this interaction. CNA #5 stated that this was the only time CNA #5 assisted LPN #4 in doing this procedure. CNA #5 stated that Resident #10 had no reaction at the time. During an interview on 03/02/2022 at 12:02 PM, LPN #4 stated that on 02/22/2022 they had to do a treatment on Resident #10 during which they had to pour saline on the antecubital area of the right arm then wipe it dry with gauze. LPN #4 stated that they asked CNA #5 to assist and hold Resident #10's right arm in place so that arm doesn't move - and saline doesn't get everywhere. LPN #4 stated that CNA #5 held Resident #10's right arm by the elbow area. LPN #4 stated that CNA #5 was not instructed to pull Resident #10's arm and at no point did CNA #5 do such a thing. LPN #4 stated that for residents that are contracted, they would never pull their extremities or asked a CNA to pull the residents extremities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/02/2022 at 04:08 PM The DON #1 stated that they conducted the investigation for Resident #10 regarding the broken elbow. The DON stated that local law enforcement was contacted on 03/02/2022 as a part of IJ Removal Plan. The DON could not state why the case was not submitted to the NYSDOH within 2 hours of receiving the allegation. The DON stated that I am new in this role and was not familiar with all the regulation. 39136 4) Resident #192 was admitted to the facility on [DATE] with diagnoses which include Chronic Obstructive Pulmonary Diseases, Heart Failure, and Hypertension. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 192 cognition as moderately impaired with a Brief Interview for Mental Status a (BIMS) score of 12. Resident # 192 requires extensive assistance of one person for personal hygiene. During an interview on 02/23/2022 at 10:15 AM, Resident #192 reported Certified Nursing Assistant # 3 (CNA) # 3 verbally abused them at approximately 4:30 AM on 02/23/2022. The Surveyor reported the allegations to the Nursing Supervisor immediately as the resident had not reported the incident. A Nurse's Progress Note dated 02/23/2022 at 10:42 AM documented that Resident # 192 reported one of the workers calls me a fat little elephant every night between 12 midnight and 4:00 AM. The resident denied any physical abuse the social worker and Administration were notified. A review of the facility records revealed as of 02/25/2022 at 4:20 PM, the allegation had not been reported to NYSDOH. This allegation of verbal abuse was not reported to NYS DOH within 2 hours. A Social Service Progress Note dated 02/25/2022 at 5:39 PM documented as per Department of Health (DOH) surveyor advice, the Police were called, and Officers arrived at the facility. The Officers interviewed Resident # 192. The Officers informed Resident # 192 the occurrence was not a crime but inappropriate. A review of the facility Investigation Findings Summary dated 02/27/2022 revealed Law Enforcement was informed on 02/25/2022. The Director of Social Services called the Police Precinct and reported the allegation as per the advice of the Department of Health. The facility reported the incident to NYSDOH via the HERDS system on 02/25/2022 at 8:09 PM after being directed at 5:45 PM by State Agency. During an interview on 03/03/2022 at 12:22 PM, the Nursing Supervisor stated that administration was notified immediately. Social service, the Director of Nursing (DON), and the Assistant Director of Nursing (ADON) were informed of the allegation immediately on 02/23/2022 at around 10:30 AM. During an interview on 03/01/2022 at 10:30 AM, the Director of Nursing (DON) stated the nursing supervisor informed them of the alleged abuse allegation on 02/23/2022 at approximately 10:30 AM. The DON initiated an investigation immediately and concluded that a crime did not occur. The case was not reported to NYSDOH because they did not see the severity and did not see severe injury or serious harm. The incident was reported to NYSDOH on 02/25/2022 at 8:09 PM after being directed by State Agency. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	415.4(b)(1)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39136 Based on observation, record review and staff interviews conducted during a Recertification/Complaint/Extended survey (NY00257457, NY00291683 & NY00291833) conducted from 02/23/2022 through 03/03/2022, the facility failed to thoroughly investigate allegations of abuse, neglect, exploitation, or mistreatment and to prevent further potential abuse, neglect, exploitation, or mistreatment. This was evident for 3 (Resident #24, Resident #10, and Resident #192) out of 10 residents reviewed. Specifically: 1). On 05/21/2020 at 6:05AM, Licensed Practical Nurse (LPN #1) witnessed Resident #24 being punched in the right thigh area by Certified Nursing Assistant (CNA) #1. CNA #1 was suspended and later returned to work (direct resident care) on 05/27/2020 and was assigned to the unit on which Resident #24 resided. 2). On 02/22/2022, Resident #10 was observed with increased swelling and pain to the right elbow. An x-ray result dated 02/22/2022 documented that Resident #10 had an acute mildly displaced transverse fracture across the right distal humeral metadiaphysis (elbow). Resident #10 was transferred to the hospital on 02/22/2022. On 02/23/2022, in the morning, the Medical Director notified the Director of Nursing (DON) #1 that Resident #10 accused CNA #5 of abuse, potentially causing a fracture to the right elbow. The facility did not initiate an investigation on 02/22/2022 to ascertain how Resident #10 sustained the fracture and Resident #10 was not interviewed. CNA #5 continued to provide direct care to residents on the same unit while the investigation was pending. 3). On 02/23/2022 at 10:42 AM, Resident #192 reported that CNA #3 called him/her a fat little elephant every night between Midnight and 4:00 AM. While the investigation was pending, CNA #3 continued to work on the same unit providing direct resident care. This resulted in Immediate Jeopardy and Substandard Quality of Care with the likelihood for serious, injury, serious harm, serious impairment, or death to all residents. The pattern of failing to remove accused staff from direct care pending investigation puts residents at risk for continued potential abuse which could result in serious injury, harm, impairment, or death. Failure to thoroughly investigate and determine if abuse occurred puts residents at risk for continued abuse because the facility may not take appropriate corrective actions and monitor effectiveness to ensure there is not recurrence. The Findings Include, but are not limited to: The facility's Policy and Procedure entitled Protection of Residents dated 07/2010 documented that During Abuse Investigation, as soon as someone is identified as suspected of abuse, neglect, or mistreatment, the employee may be immediately removed from duty or have duties reassigned pending completion of an investigation. The facility will ensure that the complainant will not have any direct contact with the individual identified. 1. Resident #24 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #24 was admitted to the facility with diagnoses including Dementia and Muscle Wasting. The Minimum Data Set (MDS, a resident assessment tool) dated 05/05/2020 documented Resident #24 had a Brief Interview of Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) of 03/15 indicating severely impaired cognition. Resident #24 required supervision with setup help only for most areas of ADLs. Review of the Facility's Physical Abuse Allegations Investigation Report dated 05/26/2020 documented that on 05/21/2020 at about 6:05 AM, LPN #1 heard commotion coming from Resident #24's room. LPN #1 entered the room and observed CNA #1 hit Resident #24 on the right thigh twice with a closed fist. LPN #1 yelled out I saw you. CNA #1 proceeded to complete care that was being provided. LPN #1 remained in the room and later informed the supervisor. An investigation was initiated, and the Police were called. LPN #1 looked at Resident #24's right thigh area and there was no redness or visible injury. The nurse manager and the Medical Doctor (MD) assessed the resident and there was no visible injury to the right thigh area. Resident #24 was observed with discoloration to the left finger. CNA #1 reported that Resident #24 was resistive to care and kicked CNA #1 who instinctively pushed back on Resident #24's right leg to prevent being struck. The facility investigation concluded although LPN #1 was an eyewitness to an actual physical encounter between Resident #24 and CNA #1, it is questionable if this interaction was actual abuse or an instinctive response by CNA #1. There were no findings of abuse or assault by the police. Both LPN #1 and CNA #1 were re-educated on abuse. A Nursing Progress Note dated 05/21/2020 documented that the unit nurse (LPN #1) reported that they had observed Resident #24 being "punched with closed fist twice in upper right thigh by CNA. Body assessment was done, and no visible injury was noted to the area. CNA #1 was instructed to leave the unit and wait downstairs. The Police were called and responded. A review of CNA #1's personnel file revealed that CNA #1 was suspended from 05/23/2020 to 05/25/2020 and disciplined for allegation of physical abuse. CNA #1 was reinstated on 05/27/2020 and continued to provide direct resident care on the same unit that Resident #24 resided on. It also documented that CNA #1 retired on 12/31/2020. During an interview on 01/31/2022 at 03:15 PM, the Director of Nursing (DON) #1 stated if the investigation reveals that abuse has occurred or that the witness is credible and without any motive to provide false information, the alleged abuser would immediately be terminated. During an interview on 02/11/2022 at 11:59 AM, the Administrator stated that CNA #1 was immediately suspended pending the investigation outcome. The Administrator stated that they believe that CNA #1 was acting in self-defense due to Resident #24 being combative. The Administrator stated that regarding the contact, the facility could not determine if this was an open fist or a closed fist. The Administrator stated that LPN #1 was a credible witness, however, abuse could not definitively be determined, so CNA #1 was re-instated and able to work with residents in the facility. 2. Resident #10 Resident #10 was initially admitted with diagnosis including Rheumatoid Arthritis, Osteoarthritis, and Cellulitis of Right Upper Limb. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The MDS dated [DATE] documented that Resident #10 had a BIMS score of 14/15 indicating intact cognition. Resident #10 required extensive assistance with one-person physical assist for most areas of ADLs. The Facility's Accident/Incident Investigation Report - Summary dated 02/27/2022 documented that Resident #10 was diagnosed with cellulitis of the right elbow since 02/08/2022 and was treated with antibiotic. On 02/22/2022, Resident #10 was noted with increased swelling and pain to the site. RNS #4 evaluated the resident and notified the Medical Doctor who ordered x-ray. An X-Ray of the Right elbow was done on 02/22/2022 and revealed a fracture to the right elbow and Resident #10 was transferred to the hospital. On 02/23/2022 the Medical Director reported to the DON that Resident #10, while at the hospital, had stated to staff that he/she was abused at the facility. Resident #10 claimed that CNA #5 had twisted their arm behind their back and hurt him/her. The CNA who worked with the resident was identified (CNA #5). CNA #5 was interviewed and described CNA's interaction with the resident on that day. CNA #5 stated that the resident was guarding his/her right elbow, both elbows are very contracted, and resident does not allow staff to properly clean around the area. CNA #5 stated that he/she was providing care with nurse on that day and did not touch the resident's elbow and did not manipulate the arm in any way other than just cleaning the hand. Resident #10 would not allow it otherwise. The nurse who assisted CNA #5 was identified as LPN #4. The LPN was interviewed and confirmed the statement of CNA #5. The investigation concluded that there is no reasonable cause to believe that any alleged resident abuse, neglect, or mistreatment regarding this resident had occurred. A Nursing Note Progress Note dated 02/22/2022 documented that Resident #10 complained of right shoulder pain. An x-ray was ordered for right shoulder, arm, and elbow. A Nursing Progress Note dated 02/22/2022 documented that x-ray of Resident #10's right shoulder and right elbow revealed acute mildly displaced transverse fracture across the distal humeral metadiaphysis with severe Osteoporosis. Resident #10 has severe pain to right elbow area. The Nurse practitioner (NP) ordered to send the resident to the hospital. A Physician's Order dated 02/22/2022 documented an order for Tylenol 325mg, give 2 Tablets every 6 hours as needed for pain. During an interview on 03/01/2022 at 11:46 AM, DON #1 and the Administrator stated that Resident #10 had a fracture, and that CNA #5 was identified as the staff who took care of the resident. DON #1 and Administrator stated that local law enforcement was not called, and CNA #5 was not removed from the schedule and was not reassigned to other duties. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/01/2022 at 02:58 PM, CNA #5 stated that if a resident is resistive to care, they step away and inform their supervisor, they do not continue to provide care. CNA #5 stated that if a resident has contractures, they start dressing them on the non-contracted side first. CNA #5 stated that Resident #10 had bilateral contractures - clothing could be put onto the left side and then draped over the right side due to severe contractures. CNA #5 stated that Resident #10's right arm is contracted close to the resident's chest. CNA #5 stated that Resident #10 would frequently resist care - never forced to receive care. CNA #5 stated that they would step away, inform the supervisor and re-attempt later. CNA #5 stated that on 02/22/2022 they assisted LPN #4 in providing treatment #10. CNA #5 stated that he/she held Resident #10's wrist - pulling the arm open slightly 1-2 inches (CNA re-enacted) so that LPN #4 could do the treatment to the resident's antecubital area. CNA #5 stated that LPN #4 instructed him/her to do this. CNA #5 stated that Resident #10 did not scream during this interaction. CNA #5 stated that this was the only time CNA #5 assisted LPN #4 in doing this procedure. CNA #5 stated that Resident #10 had no reaction at the time. During an interview on 03/02/2022 at 12:02 PM, LPN #4 stated that on 02/22/2022 they had to do a treatment on Resident #10 during which they had to pour saline on the antecubital area of the right arm then wipe it dry with gauze. LPN #4 stated that they asked CNA #5 to assist and hold Resident #10's right arm in place so that arm doesn't move - and saline doesn't get everywhere. LPN #4 stated that CNA #5 held Resident #10's right arm by the elbow area. LPN #4 stated that CNA #5 was not instructed to pull Resident #10's arm and at no point did CNA #5 do such a thing. LPN #4 stated that for residents that are contracted, they would never pull their extremities or asked a CNA to pull the residents extremities. During an interview on 03/02/2022 at 02:45 PM, MD #1 stated that they examined Resident #10 (does not recall dates) and the was observed with some minor swelling to the right elbow, thinking that it was due to lymphatic drainage and then later decided that they will give antibiotics for cellulitis. MD #1 stated that they do not recall what instructions they gave to staff regarding cleaning the antecubital area. MD #1 stated that staff should not pull Resident #10's right arm away from the body to clean since it can theoretically cause a pathological fracture, due to Resident #10's comorbidities. During an interview on 03/02/2022 at 02:57 PM, MD #2 stated that they followed Resident #10 while the resident was in the hospital. MD #2 stated that after reading the X-Ray results in the hospital, it was noted that Resident #10 had a fracture of the distal humerus. MD #2 stated that the X-Ray report does not indicate that this was a pathological fracture. MD #2 stated that they are not sure how staff should clean the antecubital area and that this was not being done at the hospital. MD #2 stated that pulling the arm to clean the antecubital area can cause a fracture on Resident #10. During an interview on 03/02/2022 at 03:40 PM, RNS #4 stated that Resident #10 had bilateral upper extremity contractures, more significant on the right side. RNS #4 stated that Resident #10 had slight range of motion on the left upper extremity (UE) and no range of motion on the Right UE, except for the hand and fingers and tiny amount in the elbow. RNS #4 stated that for stability, someone would assist nurses in holding Resident #10's right UE while treatment is being performed. RNS #4 stated that Resident #10's arm was never pulled open for treatment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/02/2022 at 04:08 PM, the DON #1 stated that they conducted the investigation for Resident #10 regarding the broken elbow. DON #1 stated at the time of the investigation, they did not interview Resident #10 since they were in the hospital. Resident #10 interview was still pending. DON #1 stated that local law enforcement was contacted on 03/02/2022 as a part of IJ Removal Plan. The DON stated that Resident #10's guardian was contacted on 03/02/2022 by the facility and follow up is pending. The DON stated that to perform the treatment to the Right antecubital area, two staff are required - a nurse and a CNA so that the nurse can get into the area to clean and treat. 3. Resident #192 Resident # 192 was admitted to the facility on [DATE] with diagnoses which include Chronic Obstructive Pulmonary Diseases, Heart Failure, and Hypertension. The Minimum Data Set (MDS, a resident assessment tool) dated 02/03/2022 documented that Resident #192 had a Brief Interview for Mental Status (BIMS, used to determine attention, orientation, and ability to recall information) and scored 12/15 associated with moderately impaired cognition. The Facility's Investigation Findings Summary Report dated 02/27/2022, documented that Resident #192 reported to Registered Nurse Unit Manager, who was doing rounds with State Surveyor, on 02/23/2022 at 10:30AM, that someone referred to the resident as a fat little elephant every night between 12:00AM and 4:00AM. Resident #192 denied any physical abuse had occurred. The unit manager notified the DON and Director of Social Services about the allegation of abuse. The investigation immediately began by identifying the allegedly accused aide. Based on investigation findings, there is no reasonable cause to believe that a crime had occurred. On 02/25/2022, Department of Health Director of Nursing advised the facility to take further action. Was informed to ensure that proper steps for residents' safety and the following actions must be done immediately. Notify law enforcement in addition to education provided to allegedly accused staff and reporting to the DOH. Review of the facility's incident report revealed that CNA #3 was not removed from direct resident care pending the investigation outcome. Review of the 3rd Floor 11:00PM-7:00AM Night CNA Assignment dated 02/24/2022, revealed that CNA #3 was scheduled and worked on the night shift of 02/24/2022 and was scheduled to work on 02/25/2022 performing direct resident care. DON #1 removed CNA #3 from direct resident care after concerns were brought to their attention by the state survey agency. A Nursing Progress Note dated 02/23/2022 at 10:42 AM documented that Resident #192 reported that one of the workers called him/her a fat little elephant every night between 12:00AM and 4:00 AM. A Nursing Progress Note dated 02/24/2022 at 4:09 PM documented that the Director of Nursing interviewed Resident #192 and that the resident was consistent with his/her earlier statement. Resident #192 denied being fearful of the aide. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 - Immediate jeopardy to resident health or safety Residents Affected - Some	A Social Service Progress Note dated 02/25/2022 at 5:39 PM documented that the Police were called, and officers arrived at the facility. Resident #192 was interviewed and stated that they were frightened by CNA #3 but that the worse was over. Resident # 192 told the Social Worker that CNA #3 was in the hallway last night, but there was no interaction. DON #1 removed CNA #3 from direct resident care on 02/25/2022. During an interview on 03/01/2022 at 10:30 AM, DON #1 stated that the nursing supervisor informed him/her that an investigation was initiated immediately. DON #1 stated that CNA #3 was identified, and Resident #192 was made safe. DON #1 stated that CNA #3 was off on 02/23/2022 but worked on 02/24/2022 during the night shift. DON #1 stated that Resident #192 was removed from CNA #3's assignment and that the CNA was instructed not to provide care to Resident #192 pending the outcome of the investigation. DON #1 reported that CNA #3 was removed from the schedule on 02/25/2022. Immediate Jeopardy (IJ) was identified and declared. The facility Administrator and Director of Nursing were notified on 03/01/2022 at 7:47PM. The facility submitted a removal plan that was reviewed and accepted by NYS DOH on 03/01/2022 at 11:00PM. 415.4(b)(1)(i)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40565 Based on observation, record reviews, and interviews conducted during the Recertification/Complaint survey, the facility did not ensure that Minimum Data Set (MDS) 3.0 assessments were completed accurately to reflect the resident's status. Specifically, Resident's use of oxygen therapy was not coded on the latest Quarterly MDS. This was evident for 1 of 1 resident reviewed for respiratory therapy out of a total investigation sample of 44 residents. (Resident #134). The findings are: The facility Policy on Minimum Data Set (MDS) Completion dated 10/01/2019, last revised 10/4/2021 documented All MDS assessments are maintained electronically with electronic signatures to assure accurate and timely completion of the MDS 3.0 and to fulfill Federal regulations. Resident #134 was admitted to the facility on [DATE], with diagnoses that included Congestive Heart Failure (CHF) and Pulmonary Edema, Chronic Obstructive Pulmonary Disease (COPD), or Chronic Lung Disease, and Respiratory Failure. The Quarterly Minimum Data Set (MDS), Assessment Reference dated 01/19/2022 documented the resident has intact cognitive status. The MDS further documented the resident required extensive assistance of staff for most Activities of Daily Living (ADL). The assessment did not include oxygen therapy as a treatment received in the last 14 days. Physician's order, initiated 11/22/2021, and renewed 02/10/2022 documented: DuoNeb 0.5 mg-3 mg (2.5 mg base)/3 mL solution for nebulization - inhale 3 milliliters by nebulization route every 6 hours as needed for shortness of breath. Oxygen at 2-4 liter per minute via NC (Nasal cannula). The Comprehensive Care Plan (CCP) for Respiratory: Oxygen Use/Neb dated 11/22/2021 documented the resident required use of oxygen due to episodes of shortness of breath. CCP goals included: -Resident will have oxygen saturation (pulse oximeter reading) within normal limits. Interventions included: - Assess for pain and discomfort with breathing, check proper placement of oxygen tubing: not too tight nor too loose, prevent irritation or pressure from developing caused by oxygen tubing, monitor vital signs every shift, provide oxygen as ordered by MD, pulse oximetry as ordered by MD, and report to MD if below normal limits. The facility did not ensure the MDS assessment accurately reflected the resident's status. On 02/23/2022 at 12:01 PM, 02/24/2022 between 08:42 and 01:00 PM, 02/25/2022 between 9:39 AM and 01:00 PM, Resident #134 was observed in the room, with continuous oxygen on from oxygen concentrator, via Nasal Canula. Nebulizer tubing observed placed on the nightstand. The resident was interviewed and stated that the oxygen is used every time to assist in breathing better. 03/01/22 at 10:38 AM an interview was conducted with Certified Nursing Assistant (CNA) #12). CNA #12 stated the resident has been on continuous oxygen since they began taking care of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/01/22 at 11:01 AM, an interview was conducted with Unit Manager - Registered Nurse (RN) #2. RN #2 stated the resident is on continuous oxygen therapy for COPD and has been on oxygen prior transfer to the hospital last November, and the order was renewed when resident returned from the hospital on 11/22/2021. RN#2 stated they did not realize that oxygen therapy was not coded on the current MDS. On 03/02/22 at 01:20 PM, an interview was conducted with the Registered Nurse MDS assessor (RN#3). RN#3 stated each portion of assessment is completed by reviewing nursing and medical progress notes, reviewing Medication Administration/Treatment Records, Physician's orders, by physically assessing the resident, and interviewing the resident to ensure accurate documentation of the assessments. RN #3 stated that the coding for Resident #134's use of oxygen therapy was missed on the current MDS, and it will be modified. On 03/02/22 at 01:28 PM, an interview was conducted with the MDS Coordinator. MDSC stated the skills and qualifications of the staff that assess relevant care areas to complete the resident assessments comprise of Interdisciplinary Team (IDT) members of Registered Nurse, Registered Dietician, Licensed Social Worker, Activity Director and Rehab Director. RN/MDSC stated each of the members have to be a graduate in their fields and have proper clinical assessment skills, both learned in school and from the experience - knowledge based. MDSC stated the resident is supposed to be physically assessed by the assessor when completing the MDS. There is also a review the progress notes and physician's order with the certain look back period specified in MDS to ensure accuracy of the documentation. MDSC further stated that the accuracy of the MDS assessment is the responsibility of the staff completing and signing each of the section completed. The MDS Coordinator is supposed to monitor for the completion and timely submission of the assessment. MDSC stated that the error of not coding the oxygen therapy for Resident #134 in the current MDS is an oversight which will be modified. 415.11(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 41227 Based on observation, interviews, and record review conducted during the recertification survey, the facility did not ensure that all medications and biologicals were labeled in accordance with currently accepted pharmaceutical principles and practices. Specifically, three metered dose inhalers and two bottles of ophthalmic solution were not labelled with the opening date. This was evident for 1 of 4 carts on 1 of 4 units observed for medication and storage labeling (3rd floor). The findings are: The facility policy titled Medication / Clinical Supplies & Equipment Management dated 9/2012 documented the nursing department will maintain all prescription and over the counter (OTC) medications, treatment supplies and other clinical equipment's that are stored in designated storage areas on the unit (i.e., cart, cabinet, refrigerator, closet or box) as secure, clean and orderly with appropriate packaging and labeling to identify directions and expiration date. All expired and discontinued medications will be removed from the storage area for return to the pharmacy or resident (when appropriate) or off unit storage, disposal, or destruction. All licensed nurses are responsible for the ongoing maintenance and the management of medications clinical supplies, and equipment stored in designated storage areas on the unit. The licensed nurse responsible for medication/ treatment administration will maintain the medication/treatment cart as clean and orderly and replenish supply (i.e., medications, gauze, tape, etc.) and remove any unused, discontinued or expired medications / supplies during each shift worked. On 03/01/22 at 09:59 AM, the 3rd floor unit medication cart was observed with the Registered Nurse (RN #3). Three open metered dose inhalers (Asmanex Twisthaler Mometasone Furoate Inhalation Powder 220 Mcg, Fluticason Propionate and Salmeterol Inhalation Powder USP 250 mcg / 50 mcg, Anoro Ellipta 62.5 mcg 25 mcg / actuation powder) and two open bottles of ophthalmic solution (Rocklatan (netarsudil and one Latanoprost ophthalmic solution) were not labelled with the open date. Rocklatan (netarsudil and Latanoprost ophthalmic solution) 0.02 %, 0.005% for topical ophthalmic use- The manufacturers insert how supplied/ storage and handling documented after opening the product may be kept at 2 degree Celsius to 25 degrees Celsius for up to 6 weeks. If after opening the product is kept refrigerated at 2 degrees Celsius to 8 degrees Celsius then the product can be used until the expiration date stamped on the bottle. Asmanex Twisthaler Mometasone Furoate Inhalation Powder 220 Mcg per actuation- The manufacturers insert supplied/ storage and handling documented to discard the inhaler 45 days after opening the foil pouch or when dose counter reads 00, whichever comes first. Fluticasone Propionate and Salmeterol, inhalation powder for oral inhalation- The manufacturers insert supplied/ storage and handling documented Fluticasone propionate and salmeterol inhalation powder should be stored inside the unopened moisture protective foil pouch and only removed from the pouch immediately before initial use. Discard fluticasone Propionate and Salmeterol inhalation powder 1 month after opening the foil pouch or when the counter reads 0. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335502	A. Building B. Wing	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Gate Rehabilitation & Health Care Center	191 Bradley Ave Staten Island, NY 10314

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Anore Ellipta (umeclidinium and vilanterol inhalation powder) for oral inhalation use- The manufacturers Insert storage instruction documented to safely throw away Anoro Ellipta in the trash 6 weeks after you open the tray or when the counter reads 0, whichever comes first. On 03/01/22 at 09:59 AM, an interview with RN #3 was conducted. RN#3 stated that he/she is not a regular on the unit and is currently being assign as a float nurse who works per diem. RN #3 added that he/she does not know why the inhalers and eyedrops were not dated the proper way to ensure all medications such as inhalers and eyedrops are stored and discarded properly. RN #3 stated that she/he was in-serviced about medication storage and handling and noticed that the inhalers and eyedrops were not dated as they should be. On 03/01/22 at 10:23 AM, an interview with the 3rd floor RN Manager, RN #4, was conducted. RN #4 stated all eyedrops and inhalers should be dated properly when opened. RN #4 stated whoever opened the inhalers and eyedrops wrote the designated resident's information but failed to date the medication. As per RN #4, all nurses are well aware that inhalers and eyedrops should be dated upon opening for storage and handling purposes. The nurses should have followed the medication insert instructions. On 03/01/22 at 5:30 PM , an interview with the Director of Nursing (DON) was conducted. The DON stated that he/she does not know why the nursing staff on the unit failed to date the inhaler and eyedrops once opened. The DON added that all inhalers and eyedrops should be dated due to the insert storage and handling instructions that needed to be followed. The DON added that all nurses were re in-serviced and educated of this information and still failed to follow. 415.18 (d)