STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335213	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Massapequa Center Rehabilitation & Nursing	101 Louden Ave Amityville, NY 11701

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observations, record review, and interviews during the Recertification Survey initiated on 12/3/2024 and completed on 12/11/2024, the facility did not ensure that each resident who is unable to carry out activities of daily living received the necessary services to maintain grooming, personal, and oral hygiene. This was identified for one (Resident #146) of two residents reviewed for Activities of Daily Living. Specifically, Resident #146 was observed with long and yellow fingernails on their contracted right hand on multiple occasions. The finding is: The facility's policy and procedure titled Activities of Daily Livings (ADLs) last reviewed 1/2024 documented that residents who are unable to carry out Activities of Daily Living independently will receive the necessary services including but not limited to hygiene such as bathing, dressing, grooming and oral care. Resident #146 was admitted with diagnoses including Hemiplegia and Hemiparesis on the Right Dominant Side, Cerebral Infarction, and Type 2 Diabetes Mellitus. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10, indicating the resident had moderately impaired cognition. The Minimum Data Set assessment documented functional limitations in the range of motion on one side of the upper and lower extremity. The resident required moderate assistance for personal hygiene tasks. A Comprehensive Care Plan titled Activity of Daily Living (ADL) dated 9/18/2024 documented Resident #146 had a self-care deficit and potential decline in Activity of Daily Living function due to muscle weakness and/or muscle wasting and atrophy (muscle weakness). Resident #146 required moderate assistance for general hygiene. The Nursing Instructions for Certified Nursing Assistants, as of 12/9/2024, documented that Resident #146 had Hemiplegia (paralysis) on the right side and required moderate assistance for general hygiene. The instructions included skin checks and care every day at all shifts. A review of nursing progress notes from 11/1/2024 to 12/3/2024 revealed no documentation that Resident #146 refused to have their fingernails trimmed. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335213	A. Building B. Wing	12/11/2024

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an initial tour conducted on 12/3/2024 at 10:51 AM, Resident #146 was observed in their room lying in bed. Resident #146 was alert and able to provide appropriate answers when asked. Resident #146 stated that they suffered right-side paralysis from a Stroke for a long time and had made limited progress in regaining function. Resident #146 stated they required assistance from staff for most of their daily needs. Resident #146 was observed reaching under their blanket with their left hand to lift their right hand. Resident #146's right hand was contracted into a fist and the fingernails on the right hand (all) digits were long and yellow. Resident #146's left-hand fingernails were trimmed. Resident #146 stated they would like their nails trimmed but could not do so on their own. During a follow-up observation on 12/3/2024 at 2:46 PM, Resident #146's right-hand fingernails remained long, yellow, and untrimmed. Resident #146 stated they received their morning care and ate lunch. Resident #146 stated staff has not offered to trim their nails and that they (Resident #146) would not refuse to have their nails trimmed. During an observation and interview on 12/3/2024 at 2:50 PM, Certified Nursing Assistant #3 stated they were the assigned aide to the resident this shift; however, they were not regularly assigned to Resident #146. Certified Nursing Assistant #3 stated they did not notice the resident's long nails until after the lunch meal. Certified Nursing Assistant #3 stated they left Resident #146's room about 10 minutes ago and were on their way to get a nail clipper. Certified Nursing Assistant #3 stated they should ask a nurse to see if it was appropriate for them (Certified Nursing Assistant #3) to cut the resident's nails. During an observation and interview on 12/3/2024 at 2:59 PM, Licensed Practical Nurse #6 (unit nurse) Resident #146's right-hand fingernails were observed to be long and yellow. Licensed Practical Nurse #6 stated Certified Nursing Assistant should check the resident's hands and report to the nurse if the nails were long and required trimming. Licensed Practical Nurse #6 stated if the resident has a diagnosis of Diabetes, then a nurse must trim the nails but the Certified Nursing Assistant could file the nails to prevent any skin breakdown. Resident #146's nails should have been cut as overgrown nails on the resident's contracted right hand could cut into their skin causing skin tears. During an interview on 12/4/2024 at 3:41 PM, Certified Nursing Assistant #7, who was the resident's regularly assigned Certified Nursing Assistant, stated they noticed Resident #146's nails getting long about a week ago. Certified Nursing Assistant #7 stated they encouraged Resident #146 to cut their nails but Resident #146 was nervous about getting their nails trimmed. Certified Nursing Assistant #7 stated they reported the refusal to a nurse; however, they could not recall the name of the nurse. Certified Nursing Assistant #7 stated they did not follow up and did not cut the resident's fingernails. During an interview on 12/10/2024 at 9:38 AM, the Director of Nursing Services stated Certified Nursing Assistant who provided care to the resident should look at the resident's skin and check their fingernails. The Director of Nursing Services stated Certified Nursing Assistants should report to the nurse if the resident's nails are long. The Director of Nursing Services stated that Certified Nursing Assistant could trim nails for non-diabetic residents but a nurse must trim the nails for residents with Diabetes diagnosis. The Director of Nursing Services stated overgrown nails with contracted hands could lead to possible skin breakdown. 10 NYCRR 415.12(a)(3)

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	335213	A. Building B. Wing	12/11/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observations, record review, and staff interviews during the Recertification Survey initiated on 12/3/2024 and completed on 12/11/2024, the facility did not ensure that a resident received treatment and care in accordance with professional standards of practice. This was identified for one (Resident #120) of two residents reviewed for Skin Conditions and for one (Resident #93) of one resident reviewed for Communication-Sensory. Specifically, 1) Resident #120 was observed with a dressing on the left side of the forehead on 12/3/2024 and 12/5/2024; however, there was no physician's order for any assessment treatment for the left side of the forehead lesion. Additionally, the facility did not initiate a care plan for the left side of the forehead lesion. 2) Resident #93 had Physician's Orders to receive an antibiotic eye drop indefinitely until seen again by their Retinal Surgeon and the resident did not receive dosages of their eye drops from 11/19/2024 through 11/25/2024. The finding is: 1) The facility's undated policy and procedure titled Skin Care Protocol documented that the Nurse will initiate an analysis, to identify risk factors, contributing factors, and source of the impaired skin. It may include but is not limited to a review of the medical record, medications, nutritional status, functional and self-care status, present plan of care for prevention of skin impairment, and staff statements. Notify the attending Physician upon identification or change in skin condition. Orders will be obtained for treatment specific to the wound for cleaning, treatment, dressing, and frequency. The Certified Nursing Assistant is responsible for monitoring the resident's skin during care and reporting any changes in skin integrity immediately to the Nurse in charge. Resident # 120 was admitted with diagnoses including Pulmonary Embolism, Atrial Fibrillation, and Disorder of the Skin and Subcutaneous Tissue. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #120 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident # 120 had a skin condition that included open lesions other than ulcers, rashes, and cuts. A Progress Note dated 10/18/2024 documented the Nurse Practitioner had seen Resident #120 to evaluate the left-side forehead lesion that had gotten bigger and changed color. The nurses reported Resident #120 scratched the area (left-sided forehead lesion) with their nails at times. A Dermatology consult for biopsy was recommended but Resident #120's family member refused and requested that Resident #120 be treated by the facility as best as possible. Bacitracin (topical antibiotic) ointment was ordered twice a day for one week for the left side forehead lesion. A Physician order dated 10/18/2024 documented Bacitracin (topical antibiotic) ointment to the left side forehead lesion, twice a day for one week. The order was completed on 10/25/2024 and was not revised. Resident #120's medical record review revealed no care plan for Resident #120's lesion on the left forehead. Resident #120 was observed lying in bed on 12/3/2024 at 10:25 AM with a small band-aid on the left side of the forehead. An irregular, red-scabbed area was sticking out of the band-aid. (continued on next page)

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	335213	A. Building B. Wing	12/11/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a second observation on 12/5/2024 at 9:04 AM, Resident #120 was lying in bed. A small band-aid was observed on Resident #120's left side of the forehead. The band-aid appeared loose and soiled. A scabbed area was sticking out of the band-aid. During an interview on 12/5/2024 at 10:42 AM, Certified Nursing Assistant #2 stated at times Resident #120 scratched the lesion on the left forehead, which made the area bleed. Certified Nursing Assistant #2 stated they reported the bleeding skin lesion to the nurses numerous times and the nurses applied dressing to cover the area. During an interview on 12/5/2024 at 10:54 AM, Licensed Practical Nurse #4 (Charge Nurse) stated when Certified Nursing Assistants reported that Resident #120's left forehead lesion was bleeding, a dressing was applied to the area. Licensed Practical Nurse #4 stated there are times when Bacitracin ointment was applied. Licensed Practical Nurse #4 stated the Nurse Practitioners were aware of the treatment. Licensed Practical Nurse #4 stated because the lesion was chronic, they used their Nursing judgment and applied treatment to the left forehead when the lesion was open and bleeding. During an interview on 12/5/2024 at 11:02 AM, Nurse Practitioner #2 stated the growth on Resident #120's forehead was chronic. Nurse Practitioner #2 stated the nurses updated them (Nurse Practitioner #2) about the lesion, but they (Nurse Practitioner #2) did not order a treatment because the lesion was chronic. During an interview on 12/9/2024 at 3:00 PM, Physician #3 stated Resident #120's forehead was chronic and the resident's family did not want further workup or consultations. Physician #3 stated they did not know Resident #120 had a behavior of scratching the lesion. During an interview on 12/10/2024 at 9:00 AM, the Director of Nursing Services stated a physician order is needed for all treatments. The Director of Nursing Services stated that Nurses cannot just use their judgment to apply treatments. The Director of Nursing Services stated a care plan for the chronic left-sided forehead lesion should have been in place with goals and interventions. 17732 2) The Consultation Policy and Procedure last reviewed in January 2024 documented residents will be evaluated by a Consultant as ordered by the Primary Medical Doctor (PMD). The Primary Medical Doctor will review the Consultant's recommendations and follow up accordingly. Resident #93 had diagnoses that included Status Post Corneal Repair and Hypertension. The Admission 5 Day Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognitive skills for daily decision-making. The Minimum Data Set documented the resident wore corrective lenses and the resident was able to see under adequate light. The Physician's Order dated 10/25/2024 documented for the resident to have an Optometry Consult. The Physician's Order dated 10/25/2024 documented for the resident to receive Polytrim eye drops (a prescription antibiotic for certain eye infections caused by bacteria) by ophthalmic (eye) route - place 1 drop to left eye 4 times daily for Unspecified Infectious Disease. This order was discontinued on 11/4/2024. (continued on next page)

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	335213	A. Building B. Wing	12/11/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order dated 10/26/2024 documented for the resident to wear a patch to their left eye for status post corneal repair. The Physician's Order dated 10/31/2024 documented the resident to go to an Eye Institute for a follow-up appointment on 11/4/2024. The Nursing Progress Note dated 11/4/2024 documented the resident returned from their eye appointment and recommendations included continuing the Polytrim eye drops 4 times per day and following up with the Eye Institute in one month. The Ophthalmology Report of Consultation 11/4/2024 documented as one of the recommendations for the resident to continue Polytrim eye drops four times daily. The Physician's Order dated 11/4/2024 for the resident to receive Polytrim eye drops by ophthalmic route for 7 days, place one drop to the left eye 4 times daily for Unspecified Infectious Disease. This order was discontinued on 11/11/2024. The Nursing Progress Note dated 11/12/2024 written by Registered Nurse #1 documented that Registered Nurse #1 spoke with the resident's (eye) Surgeon and the resident was to continue the Polytrim eye drops by ophthalmic route for 7 days. Place 1 drop to the left eye 4 times daily as per the Ophthalmology Medical Doctor (MD) with no stop date. The resident was to continue to receive the medication until further notice. The Physician's Order dated 11/12/2024 entered into the resident's Electronic Medical Record by Registered Nurse #1 documented Polytrim eye drops by ophthalmic (eye) route for 7 days place 1 drop to left eye 4 X [times] daily As per Ophth. M.D No stop date. Pt. [resident] to continue to receive medication until further Notice. This order was discontinued on 11/19/2024. A review of the resident's November 2024 Medication Administration Record revealed that the resident did not receive the Polytrim eye drops from the 11/19/2024 4:00 PM dose to the 11/25/2024 1:00 PM dose. The Physician's Order dated 11/25/2024 (last renewed on 12/4/2024), entered into the Electronic Medical Record by Licensed Practical Nurse #1, documented for the resident to receive Polytrim eye drops by ophthalmic (eye) route - place 1 drop to left eye 4 times daily for prophylactic measures. During an interview on 12/6/2024 at 9:40 AM, Registered Nurse #1 stated they should not have put a stop date for the Polytrim eye drop order when they entered the order into the Electronic Medical Record on 11/12/2024. Registered Nurse #1 stated that was an error because they knew the resident's eye drops needed to continue until they saw their eye doctor again. (continued on next page)

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	335213	A. Building B. Wing	12/11/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/6/2024 at 10:00 AM, Licensed Practical Nurse #1 stated they realized the resident's Polytrim eye drops had stopped when the resident told them (Licensed Practical Nurse #1) on 11/25/2024 that they (Resident #93) had not received their eye drops on 11/24/2024. Licensed Practical Nurse #1 stated that they called the resident's representative, who had taken the resident to her Ophthalmology appointment on 11/4/2024, and the representative told them that the Ophthalmologist did not want to stop the Polytrim eye drops. Licensed Practical Nurse #1 stated that Registered Nurse #1 had called the resident's Ophthalmologist on 11/12/2024 to clarify the order and was told that the resident's Polytrim eye drops should continue until they were seen by the eye doctor again. Licensed Practical Nurse #1 stated that was why they got a new Physician's Order for the resident's eye drops to start again on 11/25/2024. During an interview on 12/6/2024 at 11:15 AM, the Optometrist who works with the resident's Corneal Specialist stated that the resident was being seen at the Eye Institute for a perforated ulcer of their left eye. The Optometrist stated that the resident's visit on 11/4/2024 was a follow-up to examine the bandage contact lens placed in the resident's left eye to seal the perforation in the resident's cornea. The Optometrist stated that it was important for the resident to receive the Polytrim eye drops until their next visit to the Eye Institute because the drops were an antibiotic given to avoid infection with the bandage contact lens on the resident's left eye. The Optometrist stated that the resident had a very severe infection, possibly herpetic, and could have lost their eye. During an interview on 12/10/2024 at 9:50 AM, the Director of Nursing Services stated Registered Nurse #1 accidentally put the Physician's Order for the Polytrim eye drops into the resident's Electronic Medical Record on 11/12/2024 with a stop date. 10 NYCRR 415.12

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	335213	A. Building B. Wing	12/11/2024

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and staff interviews during the Recertification Survey initiated on 12/3/2024 and completed on 12/11/2024, the facility did not ensure that drugs and biologicals were stored in a locked compartment. This was identified for one (Resident #46) of one resident reviewed for Accident Hazards. Specifically, Resident #46 was observed with a Calcitonin (Salmon) spray bottle on their overbed table and there was no staff in the vicinity. Additionally, Resident #46 was not assessed to self-administer their medication. The finding is: The facility's policy and procedure titled, Medication Storage, last revised on 1/2024, documented that medications must be stored in accordance with the manufacturer's specifications and secured in locked storage areas in compliance with State and Federal requirements and accepted professional standards of practice. Storage areas may include, but are not limited to, drawers, cabinets, medication rooms, refrigerators, and carts. Resident #46 was admitted with Diagnoses including Legal Blindness, Osteoporosis, and Myelodysplastic Syndrome (a group of disorders caused by blood cells that are poorly formed or do not work properly). The Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #46 had intact cognition. The Minimum Data Set (MDS) assessment documented Resident #46 had an active diagnosis of Osteoporosis and severely impaired vision. The physician's order dated 10/3/2024 and last renewed on 11/18/2024 documented to administer Calcitonin (Salmon) Spray 200 units per actuation (mouthpiece). One spray by nasal route daily in one nostril, rotating nostrils every day for age-related Osteoporosis. The medical record review revealed no care plan for the use of Calcitonin spray for age-related osteoporosis. During an observation on 12/3/2024 at 10:28 AM, a Calcitonin spray bottle was lying flat on Resident #46's overbed table. Resident #46 was in bed and there was no staff in the vicinity. During an interview on 12/3/2024 at 11:00 AM, Licensed Practical Nurse #3 (Medication Nurse) stated they administered the Calcitonin nasal spray to Resident #46 at 9:00 AM today. Licensed Practical Nurse #3 stated they must have forgotten to take and place the nasal spray in the medication cart. Licensed Practical Nurse #3 stated that Resident #46 cannot self-administer any medications. Licensed Practical Nurse # 3 stated they should not have left the nasal spray unattended in the resident's room. (continued on next page)

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	335213	A. Building B. Wing	12/11/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/2024 at 11:15 AM, Licensed Practical Nurse #4 (Charge Nurse) stated Licensed Practical Nurse #3 should have taken the Calcitonin spray after administering the medication to Resident #46. Licensed Practical Nurse #4 stated that Resident #46 cannot self-administer any medications and all the nurses in the unit were aware that there should not be any medications left with Resident #46. During an interview on 12/9/2024 at 10:39 AM, Pharmacist #1 stated due to sedimentation, it is recommended the Calcitonin spray bottle should be kept in an upright position during storage and shaken before use. During an interview on 12/10/2024 at 8:58 AM, the Director of Nursing Services stated that the medication nurse should not have left the medication with the resident. The Director of Nursing Services stated that all medications should be kept in the medication carts unless the resident had an order for self-administration. The Director of Nursing Services stated that their expectation is for the Nurses to ensure that all medications are given and stored according to the facility's policy and procedure. 10NYCRR 415.18(e)(1-4)

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	335213	A. Building B. Wing	12/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963 Based on observation, record review, and interviews during the Recertification Survey initiated on 12/3/2024 and completed on 12/11/2024, the facility did not implement an ongoing infection prevention and control program to prevent, recognize, and control the onset and spread of infection to the extent possible. This was identified for one (Resident #14) of two residents reviewed for Skin Conditions. Specifically, there was no documented evidence that Resident #14, with a diagnosis of a chronic infected wound on the right hip, was placed on Enhance Barrier Precautions as per the facility's policy. The finding is: The facility's policy and procedure titled Enhanced Barrier Precaution, dated 4/1/2024 documented the facility will implement Enhanced Barrier Precaution to include any resident with chronic wounds (e.g. pressure injuries, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers) regardless of Multidrug Resistant Organisms colonization or infection status. Resident #46 was admitted with diagnoses of an Open Wound of the Right Hip, Infection due to Internal Right Hip Prosthesis, and Cellulitis. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 15, which indicated Resident #14 had intact cognition. The assessment documented that Resident #14 had a Multidrug-Resistant Organism, Wound Infection, and Infection due to an Internal Right Hip Prosthetic. The resident had a surgical wound that required wound care and received antibiotics on admission. The Comprehensive Care Plan titled Skin Integrity - Surgical Right Hip, dated 9/6/2024 documented the resident had chronic infected prosthetic hardware with an open area along the scar line. Resident #14 was hospitalized from 10/1/2024 to 10/8/2024 for a non-healing wound to the right hip. Interventions included but were not limited to the surgical incision site treatment per the Physician's order. Maintain precautions as per the physician's order; maintain single room isolation; wear Personal Protective Equipment (PPE); and monitor for signs and symptoms of infection. A physician's order dated 10/8/2024 documented Contact Precautions. The order was discontinued on 11/15/2024 due to the Contact Precautions no longer being necessary. The Comprehensive Care Plan titled Infection - Chronic Cellulitis of Right Hip, dated 10/8/2024 documented interventions that included but were not limited to administering medications and changing the dressing to [the surgical site] per physician orders. During an observation on 12/3/2024 at 10:13 AM, there was no signage observed indicating Resident #14 was placed on Enhanced Barrier Precautions. During an interview on 12/3/2024, immediately after the observation, Licensed Practical Nurse #5 stated residents on Enhanced Barrier Precautions should have an orange dot sticker placed next to their name by the door. Resident #14's name by the door did not have an orange dot sticker. (continued on next page)

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	335213	A. Building B. Wing	12/11/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 12/4/2024 at 11:28 AM, Resident #14's name by the door did not have an orange dot, no Enhance Barrier Precaution sign was posted, and no Personal Protective Equipment cart was observed in front of Resident #14's room. During an interview on 12/6/2024 at 1:32 PM, the Wound Care Nurse stated Resident #14 has a chronic open surgical wound on their right hip. The Wound Care Nurse stated that Resident #14 received daily wound treatments. During an interview on 12/6/2024 at 1:57 PM, the Infection Preventionist stated residents with chronic wounds should be placed on Enhanced Barrier Precautions. The Infection Preventionist stated Resident #14 had a chronic wound and they did not know why the resident was not placed on Enhanced Barrier Precaution. A review of the physician's orders on 12/6/2024 from 11/15/2024 to 12/5/2024 revealed no orders for Enhanced Barrier Precautions for Resident #14. A physician's order dated 12/6/2024 documented Enhanced Barrier Precautions due to a chronic wound. A review of the Comprehensive Care Plan on 12/6/2024 from 11/15/2024 to 12/5/2024 revealed no care plan for Enhanced Barrier Precautions for Resident #14. The Comprehensive Care Plan titled Enhanced Barrier Precaution dated 12/6/2024 documented the resident was placed on Enhance Barrier Precaution due to a chronic wound. Interventions included but were not limited to maintaining Enhanced Barrier Precautions during high-contact resident care activities. During an additional interview on 12/6/2024 at 3:17 PM, the Infection Preventionist stated they were responsible for tracking residents requiring Enhanced Barrier Precaution and other levels of isolation/precaution. The Infection Preventionist stated Resident #14 should have been placed on Enhanced Barrier Precautions because of an existing chronic wound, and it was an oversight. During an interview on 12/10/2024 at 9:38 AM, the Director of Nursing Services stated residents who had chronic wounds should be placed on Enhanced Barrier Precautions following Center for Disease Control and Prevention guidelines. The Director of Nursing Services stated that the Infection Preventionist is responsible for monitoring and ensuring residents are placed on appropriate precautions to prevent transmission of infections. 10 NYCRR 415.19(a) (1-3)