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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335592	A. Building B. Wing	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Massena Rehabilitation & Nursing Center	89 Grove Street Massena, NY 13662

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 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. 34465 Based on record review and interviews during the abbreviated survey (NY00359676), the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care person-centered care plan, and the residents' choices for 1 of 3 residents (Resident #2) reviewed. Specifically, Resident #2's wound consultant recommended to start an antibiotic for a wound infection and the recommendation was not reviewed timely. Findings include: The facility policy, Consults-Outside Facility, effective 7/2023, documented upon return from an outside appointment, the Nurse Manager/designee followed up with the physician to discuss any new consult recommendations (this could be done by telephone or in-person if attending was in the facility at the same time resident returned from consultation). The attending physician might not agree with consultation recommendations which required documentation in the medical record by the Nurse Manager/designee. Resident #2 had diagnoses including diabetes, Stage 3 chronic kidney disease, and peripheral vascular disease (poor circulation). The 8/20/2024 Minimum Data Set assessment documented the resident's cognition was intact, they were dependent for bed mobility and transfers, and had 9 venous or arterial ulcers (wounds caused by poor circulation). The 1/14/2024 Comprehensive Care Plan documented the resident had wounds present due to limited mobility. Interventions included assess, record, and monitor wound healing, turn and position every 2-3 hours and an alternating air mattress for pressure relief. The 6/13/2024 outside Wound Consultant #8 note documented the resident was seen and had 13 arterial wounds on their right and left lower legs/feet. They spoke to the resident about the recommendation they received elsewhere for amputation and the resident indicated they did not want amputation at this time. A wound culture (test that identifies bacteria, viruses, or fungi) came back positive for methicillin-resistant Staphylococcus aureus (strong bacteria, resistant to some antibiotics) in 2 locations and a prescription was issued for doxycycline (antibiotic) 100 milligrams twice daily for 30 days. The consult documented it was printed by facility Nurse Practitioner #1 On 6/18/24. There was no documented evidence of a physician order for doxycycline and no documented rationale why the antibiotic was not ordered as recommended by the Wound Consultant. (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: 335592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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	The 6/17/2024 Nurse Practitioner #1 note documented a routine 30-day visit. The resident was followed by a local wound healing center for treatment of both lower leg wounds. The plan was to continue all medications. There was no documentation regarding the positive wound culture and doxycycline prescription issued during the 6/13/2024 Wound Consultant visit. The 6/18/2024 at 10:38 AM Registered Nurse #7 progress note documented the resident was seen by the nurse practitioner (unidentified) on 6/17/2024 for a routine visit with no new orders. The care plan was reviewed and found to be appropriate for the resident's needs. The 6/27/2024 Wound Consultant #8 note documented the resident was seen for their wounds and the plan was for doxycycline. The consult documented it was printed by Nurse Practitioner #1 on 7/2/2024. The 6/28/2024 at 3:01 PM late entry note written 7/2/2024 at 3:00 PM by Registered Nurse Manager #7 documented a new order for doxycycline 100 milligrams twice daily for 30 days. The 7/2/2024 physician order documented doxycycline 100 milligrams twice daily for 30 days for infection of both legs. There was no corresponding provider note. During a telephone interview on 11/13/2024 at 2:22 PM, former Registered Nurse Manager #7 stated consultants faxed their notes and recommendations and office staff placed the consult into the provider's mailbox. Once the provider reviewed the consult, orders were written if the provider agreed with the recommendations. They could not recall why there was a delay in reviewing the resident's wound consults or why the order for doxycycline was not obtained timely. During a telephone interview on 11/19/2024 at 8:11 AM, Nurse Practitioner #1 stated they became aware of consultant recommendations after the consultant sent their office notes or the consult form back with the resident. The notes were often faxed. If notes were not obtained timely, they expected nursing to follow up to obtain them. Nurse Practitioner #1 had access to an online portal through the hospital and could obtain notes in real time if the consultant was affiliated with that hospital. Once Nurse Practitioner #1 agreed with recommendations, they alerted nursing via email. On 6/13/2024 and 6/27/2024, they did not recall what happened or why the recommendation was missed, and the order was not written timely. There were no negative effects from the delay as the resident was not symptomatic at that time. 10NYCRR 415.12