

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 08/15/2025
NAME OF PROVIDER OR SUPPLIER Massena Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observations, record review, and interviews during the recertification and abbreviated (IQIES 525144 and 2582064) surveys conducted 8/11/2025-8/15/2025, the facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for six (6) of six (6) staff (Licensed Practical Nurse #12, and Certified Nurse Aides #22, #51, #52, #53, and #54) observed. Specifically, during meal service on Unit A2 residents were observed being fed by Licensed Practical Nurse #12, and Certified Nurse Aides #22 and #51 while standing; and Licensed Practical Nurse #12, and Certified Nurse Aides #52, #53, and #54 addressed residents as honey and feeders. Findings include:</p> <p>The facility policy Maintaining Resident Respect and Dignity, revised 5/27/2025, documented the facility provided loving care to all residents in a timely manner that best bespeaks dignity, respect, compassion, sensitivity, and concern. The care embraced the physical, emotional, and spiritual needs of all residents. They respected social status and created a dignified homelike environment respecting the resident's room and personal space. Clothing was clean, fit properly, and matched. Residents would be addressed by his/her given name in an adult manner. When feeding staff should be seated at eye level to promote socialization. The dining experience was pleasant, relaxing, and like that in a fine restaurant.</p> <p>The following observations were made in the Unit A2 dining room:</p> <ul style="list-style-type: none"> -on 8/11/2025 at 12:20 PM, Licensed Practical Nurse #12 was feeding a resident while standing. At 12:24 PM, Licensed Practical Nurse #12 moved and stood while feeding Resident #35. -on 8/11/2025 at 12:36 PM, Certified Nurse Aide #22 fed residents while standing. -on 8/12/2025 at 12:45 PM, Licensed Practical Nurse #12 was standing while feeding Resident #35. -on 8/12/2025 at 12:47 PM, Certified Nurse Aide #51 was standing while feeding Resident #48. -on 8/13/2025 at 9:34 AM, Licensed Practical Nurse #12 addressed multiple residents by the name "honey"; and not their preferred names. -on 8/13/2025 at 11:12 AM, Certified Nurse Aide #52 asked staff in the area Is this where the feeders are going? <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-on 8/13/2025 at 11:13 AM, Certified Nurse Aides #54 and #53 were at the nurse's station where multiple residents were sitting and asked where "the feeders were going";</p> <p>During an interview on 8/13/2025 at 12:07 PM, Certified Nurse Aide #53 stated they had many trainings on different topics including dignity and abuse training. They were not trained to refer to residents as "feeders". It was not professional to call residents "feeders" and they should not do it. They were trained not to address residents as "honey" but did it all the time because they felt it was welcoming.</p> <p>During an interview on 8/13/2025 at 12:18 PM, Licensed Practical Nurse #12 stated they tried to use the residents' last names but that they did use pet names. Residents should not be called honey or sweetie or labeled as a lift or a Hoyer because it was a dignity issue. Residents should be addressed in the way their parents named them. They stated they knew they should be sitting down when feeding a resident, but the chairs were locked up and they did not have access to them. They should not be standing when feeding because it intimidated residents into eating.</p> <p>During an interview on 8/13/2025 at 12:40 PM, Certified Nurse Aide #51 stated when feeding residents, staff should sit next to them and not stand over them. They stood when feeding Resident #48 because they did not know they were allowed to pull up a chair and there was not a lot of room for the chair.</p> <p>10 NYCRR 415.5(d)(1)(i)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification and abbreviated (NY00372537) surveys conducted 8/11/2025-8/15/2025, the facility did not ensure a safe, clean, comfortable, and homelike environment for the main lobby area, common areas, and four (4) of four (4) units (Units A1, A2, B2, and C1) reviewed. Specifically, the facility did not maintain comfortable temperatures on nursing units A1, A2, B2, and C1, A2 and B2 dining rooms, and the A1 and C1 atriums; and Units A1, A2, B2, and C1, and the main lobby were unclean and in disrepair. Findings include: The facility policy Quality of Life- Homelike Environment, revised 12/15/2025, documented residents were provided with a safe, clean, comfortable, and homelike environment. Characteristics that reflected a homelike setting included a clean, sanitary, and orderly environment; inviting colors and decor; comfortable and safe temperatures (71 degrees Fahrenheit- 81 degrees Fahrenheit); and comfortable noise levels. Temperatures: The resident council meeting minutes documented on 6/16/2025 the air conditioning was not working and on 7/28/2025 there were still issues with the air conditioning. The July 2025- August 2025 Maintenance log documented open requests for broken air conditioning units as follows: -On 7/14/2025 for B2 Unit rooms 214, 219, 226; and A2 Unit room [ROOM NUMBER]. -On 7/30/2025 B2 Unit rooms 206, 207, 214, 215, 219, 222, 226, and 245.-On 7/31/2025 A1 Unit rooms [ROOM NUMBERS]; and the second-floor dining room.-On 8/11/2025 Unit C1 room [ROOM NUMBER]. During an anonymous resident group meeting on 8/11/2025 at 1:35 PM, seven of seven residents stated the facility was too hot in the summer. The following temperature observations were made on 8/11/2025: -Unit A1 at 3:07 PM, the hallway outside room [ROOM NUMBER] was 82 degrees Fahrenheit; at 3:10 PM, the hallway outside room [ROOM NUMBER] was 81.5 degrees Fahrenheit; and at 3:18 PM, the atrium on the first floor by the couch in front of the television was 84 degrees Fahrenheit.-Unit A2 at 3:05 PM, the dining room was 88.9 degrees Fahrenheit. Resident #59 was in the dining room and stated they could not handle it; it was so hot. The nurse's station was 87.8 degrees Fahrenheit; the television/ laundry room was 85.5 degrees Fahrenheit; the hallway on the lower number side was 85.3 degrees Fahrenheit; and the hallway with the higher number side was 83.8 degrees Fahrenheit. -Unit B2 at 3:10 PM, the hallway outside room [ROOM NUMBER] was 83.7 degrees Fahrenheit; the hallway outside room [ROOM NUMBER] was 81.7 degrees Fahrenheit; the hallway outside room [ROOM NUMBER] was 82.4 degrees Fahrenheit; the hallway outside the therapy department was 83.1 degrees Fahrenheit; and the dining room was 86 degrees Fahrenheit. -Unit C1 at 3:03 PM, the hallway outside room [ROOM NUMBER] was 82.5 degrees Fahrenheit; at 3:04 PM, the hallway outside room [ROOM NUMBER] was 82 degrees Fahrenheit; at 3:10 PM, the shaded area of the atrium measured 83.4 degrees Fahrenheit and a sunny area in the middle of the atrium was 87.4 degrees Fahrenheit. The following temperature observations were made on 8/12/2025: -Unit A1 at 11:12 AM, the nurse's station was measured at 82.2 degrees Fahrenheit. At 11:54 AM, the dining room was 83.6 degrees Fahrenheit, and many residents were seated waiting on the lunch meal. Resident #62 stated it was hot in there and they did not want to fix it. At 4:16 PM, the hallway outside room [ROOM NUMBER] was 83.8 degrees Fahrenheit; the nurse's station was 82.8 degrees Fahrenheit; the temperature in the middle of the atrium was 90.0 degrees Fahrenheit; and the dining room was 88.7 degrees Fahrenheit where Resident #62 was seated.-Unit A2 at 11:05 AM, the dining room was 82.9 degrees Fahrenheit and the nurse's station was 81.7 degrees Fahrenheit. At 12:03 PM, residents were being brought to the dining room for lunch, and the temperature was 85.3 degrees Fahrenheit. At 1:51 PM, the dining room was empty, two wall vents were not blowing any air and two were blowing warm air. One vent's air exhaust was measured at 97.2 degrees Fahrenheit and the dining room measured at 90.1 degrees Fahrenheit. At 3:54 PM, the short hall was 82 degrees Fahrenheit, the long hall was 85.3 degrees Fahrenheit, and it was 85.8 degrees Fahrenheit across from the nurse's station. The television area was 88 degrees Fahrenheit, and the dining room was 91 degrees Fahrenheit. -Unit B2 at 4:07 PM, the dining room was 86.2 degrees Fahrenheit; the hallway outside room [ROOM NUMBER] was 82.2 degrees Fahrenheit; the hallway outside room [ROOM NUMBER] was 81.3 degrees Fahrenheit; and the hallway outside room [ROOM NUMBER] was 83.9 degrees Fahrenheit.-Unit C1 at 11:30 AM, the atrium was 82.4 degrees Fahrenheit, and five residents were seated there; the atrium measured 84.9 degrees in a sunny area; the hallway outside room [ROOM NUMBER] was 81.5 degrees Fahrenheit; and the hallway outside room [ROOM NUMBER] was 81.6 degrees Fahrenheit. At 4:16 PM the dining room was 84.2 degrees Fahrenheit and the atrium was 84.9 degrees Fahrenheit. At 4:17 PM a</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>(continued on next page)</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observations, record review, and interviews during the recertification and abbreviated (NY00357525) surveys conducted 8/11/2025-8/15/2025, the facility did not provide on-going assessment and monitoring of bed rails (side rails) for three (3) of three (3) residents (Residents #4, #30, and #126) reviewed. Specifically, Resident #4 had bilateral bed rails and did not have an order or a comprehensive care plan that included the use of bed rails, regular assessments to ensure the bed rails remained appropriate or documented evidence that risks and benefits were reviewed with the resident or resident representative or consents were obtained prior to bed rail use; Residents #30 and #126 had bilateral bed rails and did not have regular assessments to ensure the bed rails remained appropriate or documented evidence that risks and benefits were reviewed with the resident or resident representative or consents were obtained prior to bed rail use; and the facility did not have documented evidence of inspections of bed frames, mattress, and bed rails as part of a regular maintenance program. Findings include: The facility policy Siderail and Enabler, revised 10/16/2024, documented side rails were used as enablers to promote independent movement in bed; the side rail assessment would be completed by the rehabilitation department upon admission, readmission, quarterly, significant change, and as needed; maintenance would ensure if enabler bars were recommended they were secured in the upright enabler position to prevent them from being moved out of the enabler position; and the resident or designated representative would be educated on the benefits and risks of side rail use.1) Resident #4 had diagnoses including arthropathies (joint diseases). The 6/9/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, required supervision for bed mobility, and did not use bed rails. The following observations of Resident #4 were made: -on 8/11/2025 at 11:45 AM bed rails were zip tied in an upright position on the resident's bed. -on 8/14/2025 at 2:41 PM the bed rails were double looped p-shaped bed rails engaged in the enabler bar position. The Comprehensive Care Plan initiated 9/14/2023, and revised 9/13/2024, documented an activities of daily living self-care performance deficit. Interventions included extensive assistance of one for bed mobility and use of a concave mattress. There was no documented evidence of the use of bed rails/enabler bars. The physician orders did not document the use of enabler bars. There was no documented evidence of risk/benefits, an assessment, or a consent for the use of the rails. The 7/25/2025 Physical Therapist #43 discharge summary documented the resident required minimal assistance to perform bed mobility tasks without the use of side rails. There was no documented evidence of a recommendation for the use of side rails. During an interview on 8/14/2025 at 2:58 PM Resident #4 stated they needed the enabler bars and used them to get in and out of bed. During an interview on 8/15/2025 at 11:43 AM Certified Nurse Aide #44 stated if a resident was supposed to have mobility bars on their bed it would be listed on their care card. They stated Resident #4's mobility bars were taken off and the resident was really upset about it. They believed they were taken off on 8/14/2025 when there was a realization they were not in their care plan. The resident had since been reassessed and a bar was going to be put back on the bed. During an interview on 8/15/2025 at 12:00 PM Licensed Practical Nurse #10 stated if a resident had mobility bars on their bed, they should be care planned for it. Resident #4 told them their bars were removed, and they were upset about it. Physical therapy went in and talked to the resident and one small bar was put back on the bed. Zip ties were used so the residents could not pull down the bar and create a risk for entrapment. They did not think that prior to that day the resident was care planned for the bars but should have been. During an interview on 8/15/2025 at 12:14 PM Registered Nurse Unit Manager #36 stated if a resident had mobility bars on their bed, they should have a care plan. They were not aware that resident #4 had mobility bars. They should have had a related care plan prior to 8/15/2025 as well as a consent.2) Resident #30 had diagnoses of kidney disease. The 7/11/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, required supervision with most activities of daily living, and did not use bed rails. The 12/23/2022 Comprehensive Care Plan documented an activities of daily living self-care performance deficit. Interventions included concave mattress and 2 enabler bars. The 4/14/2025 physician order documented bilateral enabler bars to enhance mobility. There was no documented evidence of a bed rail assessment or a consent for use of the rails. During observations on 8/11/2025 at 10:15 AM and 8/14/2025 at 11:31 AM the resident had two mismatched bilateral bed rails, both zip tied in an up position at the head of the bed. During an observation on 8/14/2025 at 11:31 AM the resident sat on the edge of the bed and reclined to a lying position without using the bed rails. During an interview on 8/14/2025 at 1:33 AM Certified Nurse Aide #21 stated enabler bars were zip tied</p>		