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	08/15/2025

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure sufficient support personnel to safely carry out the functions of the food and nutrition services for the main kitchen and for 3 of 4 units (Units A1, B2, and C1) reviewed. Specifically, meal trays for Units A1, B2, and C1 were delivered an hour after the scheduled mealtimes, and concerns were identified with the effectiveness of meal preparation and other foot and nutrition services. Additionally, deficiencies related to food and nutrition services were identified in the areas of: Menus Meet Resident Needs/ Prepare in Advance/ Followed (F 803); Nutritive Value/ Appearance, Palatable/ Prefer Temperature (F804); and Food Procurement, Store/ Prepare Serve-Sanitary (F 812).Findings include:The facility policy, Food and Nutrition Services, revised 12/2024, documented meals and/or nutritional supplements would be provided within 45 minutes of either the resident request or scheduled mealtime, and in accordance with the resident's medication requirements. Meals were scheduled at regular times to assure that each resident received at least 3 meals per day. Breakfast downstairs began at 7:30 AM, upstairs at 8:00 AM; lunch downstairs began at 11:45 AM, upstairs at 12:15 PM; dinner downstairs began at 5:15 PM and upstairs at 5:45 PM. The Resident Listing Report, dated 8/10/2025, documented the facility's resident census was 138 residents. The facility dietary employee schedule documented the scheduled staff including staff who called off work the week of 8/11/2025-8/15/2025. The schedule documented the following day shift staffing:-On 8/11/2025 there were 5 staff including the cook and there was one call off.-On 8/12/2025 there were 5 staff including the cook and there was one call off.-On 8/13/2025 there were 3 staff including the cook and one staff who left at 9:00 AM.-On 8/14/2025 there was 1 staff, no cook and one staff who left at 10:00 AM. -On 8/15/2025 there was 4 staff including the cook. The following meal delivery time observations were made:-On 8/11/2025 at 12:44 PM, Unit C1 hallway trays arrived and were passed.-On 8/11/2025 at 1:03 PM, Unit A1 lunch trays arrived in the dining room.-On 8/13/2025 during a kitchen observation, lunch trays left the kitchen for Unit A1 at 1:24 PM and Unit C1at 1:36 PM, dining room cart for A1 and C1 left the kitchen at 1:50 PM. -On 8/14/2025 at 8:57 AM, there was an overhead page Unit B2 breakfast trays arrived.-On 8/14/2025 at 1:05 PM, there was an overhead page Unit A1 lunch trays arrived.-On 8/14/2025 at 1:24 PM, there was an overhead page Unit C1 trays arrived.During an interview on 8/13/2025 at 11:18 AM, Dietary Aide #42 stated they were behind with service because of call ins.During an interview on 8/13/2025 at 11:23 AM, [NAME] #41 stated they were running behind with meal service because of call ins. They stated the kitchen should function with six staff, but they usually ran it with three.During an interview on 8/13/2025 at 1:55 PM, Dietary Aide #31 stated lunch was behind because they were short staffed. During an interview on 8/13/2025 at 2:18 PM, the Food Service Director stated lunch was very slow today. There were call ins and new staff that were not quite up to par. During a follow up interview on 8/14/2025 at 10:08 AM, the Food Service Director stated the cook called in, so they were cooking today and there were only two dietary aides due to call ins. There was an activities aide helping and another staff member who they were not sure of their normal role in the facility. During an interview on 8/14/2025 at 11:55 AM, Certified Nurse Aide #35 stated they informed Licensed Practical Nurse (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
	335592	A. Building B. Wing	08/15/2025

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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#10 they called down to the kitchen and the kitchen was behind. They did not know if they could get a lunch tray to Resident #63 before their appointment. During an interview on 8/15/2025 at 11:13 AM, Registered Nurse Unit Manager #26 stated the past few days meals were late. They thought it may have to do with kitchen call ins. They stated residents deserved to have their meals on time; it caused disruptions to their schedule and throws them off. 10NYCRR 415.14(b)(1)(2)

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	08/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025- 8/15/2025, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for one (1) of (1) main kitchen reviewed. Specifically, the main kitchen had unclean floors, walls, and equipment, uncovered food, the sanitizer solution in the 3-bay sink was not tested, recipes were not followed for pureed items, a food scoop was left in a thickening agent bag, there was ice buildup in the walk in freezer, there were missing ceiling tiles, hand hygiene was not performed between dish washing and food services, there were no temperature logs for the tray line or the dishwasher, no kitchen cleaning logs, or sanitization logs. Findings include:The facility policy Kitchen Sanitization, revised 6/2025, documented the food service area was maintained clean and in a sanitary manner. All kitchens, kitchen areas, and dining areas were kept clean. All utensils, counters, shelves, and equipment were kept clean, maintained in good repair and were free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. All equipment, food contact surfaces and utensils were washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/ or chemical sanitizing solutions. Between uses, cloths and towels were used to wipe kitchen surfaces and soaked in containers filled with approved sanitizing solution. Cutting boards were washed and sanitized between uses. Kitchen surfaces not in contact with food were cleaned on a regular schedule and frequently enough to prevent the accumulation of grime. The Food Service Manager was responsible for scheduling staff for regular cleaning of kitchen and dining areas. There was documented evidence of completed kitchen cleaning logs, food temperature logs, dishwasher temperature logs, and sanitizer logs.On 8/11/2025 between 9:58 AM and 10:11 AM, the following was observed in the main kitchen area:-a pan of blueberry cobbler on a wheeled cart unattended and uncovered.-the kitchen walls were not clean. -the fryers had grease build up on the sides.-the ovens had built up grime on the sides.-the stove top had built up grime on the burners and the sides. -the floors underneath the stove, ovens, and fryers had built up grime. -the freezer condenser was dripping on the left side and there was a 2-foot by 2-foot area with ice buildup on the freezer floor dripping in between two metal racks containing frozen food in boxes.On 8/12/2025 between 1:32 PM and 2:10 PM, the following was observed in the main kitchen area:-standing water and food debris between the dish machine and the drying racks. -a mouse trap under the 3-bay sink.-the wall behind the 3-bay sink was dirty. -standing pink liquid in the prep sink.-stove top had burnt crusty debris on the top and sides. -the oven and the fryer had crusted on debris.-walls behind the large kitchen equipment had food debris.-there was caked on debris on the floor underneath the large kitchen equipment.-the steam table contained food that was left unattended and uncovered after the meal service was done.-the freezer condenser was leaking on the left side and there was a 2-foot by 2-foot area a few inches thick of ice buildup on the freezer floor dripping in between two metal racks with frozen food in boxes.-there were six missing ceiling tiles in between the dishwasher and drying racks with exposed wires hanging down below the level of the ceiling. During an interview on 8/12/2025 at 2:10 PM, the Food Service Director stated they were not sure if the chemical concentration in the 3-bay sink was checked or even where the strips were located. They asked Dietary Aide #47 who was actively washing dishes in the 3-bay sink, and they stated they never checked the chemical concentration and did not know where the test strips were located. The kitchen had years of buildup. The cleanliness was a lot better but there was still a long way to go. The walls were dirty, the kitchen equipment was dirty, the floors under the cooking equipment were sticky, there should not be standing water on the floor, but it happened especially after dishes were cleaned if they did not squeegee it. Everything should be clean. They were coming up with a cleaning list for the staff. They had purchased many items for a big clean of the kitchen but were waiting on casters to move the big (continued on next page)

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	08/15/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment. The ice buildup was a battle they had been fighting. The condenser needed a part and was fixed but had been broken again for about 4 weeks. They had not seen any evidence of pests. They needed more time and equipment to adequately clean the kitchen. During an observation and interview on 8/12/2025 at 2:40 PM, the Food Service Director found test strips for the 3-bay sink. They dipped the strip in the soapy water bay that contained pot and pan detergent and not the sanitizer bay sink. The blue color on the strip was not a color on the indicator key of the strip container. They stated that did not make any sense and the strips came from the company that supplied the chemicals, and the test strip did not really tell them anything about the chemical concentration. On 8/13/2025 the following was observed during the lunch meal preparation and service:-at 11:23 AM, Dietary Aide #56 was washing dishes. They took a plastic pitcher to scoop the standing water with food debris from the garbage disposable sink to the drain of the dish machine. There was a large area with white/ grayish frothy liquid with food debris on the floor underneath the dish machine. They stated the garbage disposal sink did not work and the dish machine ran constantly. -at 11:59 AM, [NAME] #41 was washing the dishes in the 3-bay sink while waiting on baked beans to cook. They were wearing the same gloves they had on during the food preparation. At 12:00 PM, they took their gloves off and washed the prep surfaces and blender with a cloth that was pulled from a red bucket containing liquid. At 12:06 PM, they turned off the alarm on the oven and went back to washing dishes. At 12:13 PM, they pulled the baked beans out of the oven. At 12:15 PM, they put on disposable gloves, obtained a spoon, stirred the baked beans, opened the oven door and put the beans back in. At 12:22 PM, they pulled the baked beans from the oven and put them in the steam table for service. There was no hand hygiene performed in between food service and dish services. -at 12:28 PM, [NAME] #41 spooned baked beans into the blender and stated they were making the pureed baked beans. The amount was not measured. At 12:29 PM, they dispensed hot water from the machine into a clear plastic pitcher. The amount of water was not measured. At 12:30 PM, they opened a black plastic tub under the prep sink and scooped out a white granulated substance they called thickener, out of a plastic bag with a paper cup that was left in the bag. There was also a blue plastic coffee mug in the plastic bag. At 12:31 PM, they used the paper cup to scoop some more thickener out. The thickener was not measured. They stated approximately a cup went into the pureed items until it looked like the right consistency.During a follow up interview on 8/14/2025 at 10:08 AM, the Food Service Director stated there was a recipe for each pureed item, and they all required different amounts of thickener, so it needed to be measured. The cook was expected to follow the recipes. Scoops, whether they were disposable cups or the blue coffee mug that was in the thickener container, were not supposed to be there, it was a cleanliness issue. Staff should also be washing their hands as it was also a cleanliness issue. 10NYCRR 415.14(h)

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	08/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **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 (continued on next page)

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	08/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 resident walked in and stated it was hot in there. At 4:22 PM, in the hallway outside room [ROOM NUMBER] the temperature was 82.7 degrees Fahrenheit; and at 4:24 PM, in the hallway outside room [ROOM NUMBER] the temperature was 83.3 degrees Fahrenheit.During an interview on 8/11/2025 at 12:24 PM, Resident #9's representative stated the air conditioning had not worked in the hallways or the atrium all summer. During an interview on 8/12/2025 at 12:29 PM, Certified Nurse Aide #30 stated the dining room was always hot. There used to be fans, but they did not know where they went. They stated Resident #144 often complained that it was hot but many of the residents on unit A2 were unable to voice their complaints. During an interview on 8/12/2025 at 1:28 PM, Dietary Aide #31 stated the air conditioner was always broken. It was broken a while ago and they were told it was fixed but the past two weeks it did not seem like it was working. It was so hot in the facility. During an interview on 8/12/2025 at 1:58 PM, Licensed Practical Nurse #10 stated they were told to take Resident #40's blood sugar because the resident was sweating profusely in the dining room. The resident's blood sugar was fine, and they thought they were probably sweaty because it was so hot on the unit. During an interview on 8/12/2025 at 4:16 PM, the Director of Nursing stated the air conditioning company came out earlier today and stated the air conditioning was fixed. They called them again because the temperatures were not getting cooler. The company was on their way. The dining room for the A2 unit was warm today when they were up there. They stated the dining room was going to be closed until the temperature was cooler. They were going to let residents eat in the atrium if they wanted to. During the bingo activity today, that was held in the dining room, they walked around and told the residents they could leave if the area was too warm. During an interview on 8/15/2025 at 2:36 PM, Maintenance Technician #2 stated there was a heating ventilation and air conditioning (HVAC) unit in each resident room. They were aware of a broken one on A1 and a broken one on A2. They thought new units were on order but had not arrived yet. All the units were fed from a unit on the roof. On Monday (8/11/2025) they went onto the roof and noticed the system that controlled the air conditioning was set to 77 degrees Fahrenheit, so it was not kicking on and that was why the building was warm. They changed this setting to 70 degrees but then they realized a fuse was blown and the air conditioning company was called and came out the same day. On Tuesday night, they noticed another fuse was broken and again the air conditioning company was called and came out. They stated they checked temperatures in the common areas and the highest temperature they got was 80 degrees Fahrenheit. They were not sure if the residents were being monitored. Areas Unclean and in Disrepair:The following observations were made on Unit A1:-On 8/11/2025 at 12:51 PM, the bathroom sink in room [ROOM NUMBER] was one third full of standing water with black flecks. Resident #116 stated staff knew the sink was clogged and nothing was done about it. -On 8/11/2025 at 4:16 PM, room [ROOM NUMBER] had sticky floors, and the bathroom sink was half full of standing water with black flecks. Resident #9's representative stated the sink was that way for a week or longer and the floors were always dirty. They stated staff filled a basin in that sink to provide hygiene care to Resident #9. -On 8/12/2025 at 11:26 AM, the bathroom sink in room [ROOM NUMBER] was half full of standing water with black flecks. Resident #116 stated staff used the sink to fill a basin for hygiene purposes. They asked to speak with maintenance, but they had not been in. -On 8/12/2025 at 11:41 AM, room [ROOM NUMBER]'s floors were sticky and had black scruff marks. The bathroom sink was half full of standing water with black flecks. -On (continued on next page)

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	08/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/12/2025 at 2:30 PM, in the kitchenette the drawer labeled lids had coffee grounds and coffee stains in it, the ice machine had a locked-out tag on it, the face of the cabinet doors had brown streaks, and the cabinet door under the drawer labeled lids was not secured to the hinges. -On 8/13/2025 at 9:10 AM in the high side hallway shower room the shower handle only moved down to the dependent position so there was no way to add cold water. The water temperature measured at 113 degrees Fahrenheit in the presence of Certified Nurse Aide #4. Certified Nurse Aide #4 stated the whirlpool tub in that shower room also did not work and the reservoir did not fill.-On 8/14/2025 at 11:21 AM, the headboard of the bed in room [ROOM NUMBER] was bent towards the mattress at a 45-degree angle. During an interview on 8/13/2025 at 8:37 AM, Certified Nurse Aide #33 stated the sinks in rooms [ROOM NUMBERS] had standing water in them the past week and a half. They told the Regional Director of Nursing about it and was told to put an electronic request in the system, but they did not have access. They had also told Registered Nurse Unit Manager #26. Both Residents #9 and #116 were dependent for hygiene needs and they filled a basin in the sink and then dumped it in the toilet. There was not a housekeeper assigned to the unit. The floors were not really mopped, and it had probably been a week or more since room [ROOM NUMBER] was mopped. The sinks and the floor were not clean. During an interview on 8/13/2025 at 8:57 AM, Certified Nurse Aide #32 stated the sinks in room [ROOM NUMBER] and 134 were disgusting. Everyone knew about it, but nothing was being done. During an interview on 8/13/2025 at 9:13 AM, Environmental Services Aide #28 stated former Director of Maintenance #17 quit and so did the housekeeper for the unit. They cleaned rooms [ROOM NUMBERS] today and called a plumber because the sinks did not work and were disgusting. Resident rooms and bathrooms should be clean because it was the residents' home. Resident rooms should be cleaned every day. They did not know there was nobody covering Unit A1 until they were made aware on 8/11/2025. During an interview on 8/13/2025 at 9:55 AM, Licensed Practical Nurse #27 stated the resident rooms should be clean for their well-being and to prevent infection. They stated they barely had room above the standing water in the sink to rinse Resident #116's urinal after it was emptied. During an interview on 8/15/2025 at 10:57 AM, Registered Nurse Unit Manager #26 stated the housekeeper had quit. Even before the housekeeper quit there were dirty floors because they only worked part time. They were not sure how long the sinks were clogged in rooms [ROOM NUMBERS] but it was brought to their attention on 8/11/2025 and they put in an electronic maintenance request. The residents should have a clean environment as it was their home. The kitchenette was a shared responsibility between housekeeping and maintenance. They knew the kitchenette was dirty with coffee stains. The ice machine had been down for a least 3 months and they had to go to the kitchen to get ice. Broken headboards were also maintenance's responsibility. They should be in good repair to prevent injury. The following observations were made on Unit A2:-On 8/11/2025 10:05 AM the floor across from the nurses' station had various debris including pieces of crackers, other wrappers and various debris that continued down the hall. -On 8/11/2025 at 10:12 AM room [ROOM NUMBER]-B's bed footboard was dangling on one side. -On 8/11/2025 at 10:15 AM room [ROOM NUMBER]-B's bed footboard was tilted outward and not attached tightly.-On 8/11/2025 at 10:36 AM room [ROOM NUMBER]-A had no bed footboard. -On 8/11/2025 at 11:04 AM Resident #35 was seated in their wheelchair in the television room. The left armrest of the wheelchair was peeling with exposed foam underneath.-On 8/11/2025 at 11:20 AM there was brown [NAME] debris in the hall in the upper 20's rooms. -On 8/11/2025 at 11:22 AM room [ROOM NUMBER]-B's footboard was not on the bed and was resting up against the dresser. A nut and bolt were on the floor under the foot of the bed. There was a moderate amount of brown food like debris on the floor. -On 8/11/2025 at 11:31 AM room [ROOM NUMBER]-A there were pieces of donut scattered on the floor with a large area of dried fluid under the bed and a large area of yellow dried material at the foot of the bed.-On 8/11/2025 at 11:45 AM room [ROOM NUMBER]-A the top drawer of the nightstand was on the floor near the foot of the bed, and the face of the drawer was on the floor in front of nightstand. There was dried on brown debris on the floor between the bed and wall.-On 8/11/2025 at 1:45 PM room [ROOM NUMBER]-A (continued on next page)

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	08/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there the metal strip on the door was lifted from the bottom of the door frame creating a sharp edge. The heater pulled away from the wall about 6 inches. -On 8/12/2025 at 11:16 AM the floors had brown debris at the start of the hall for higher number rooms. -On 8/12/2025 at 11:46 AM room [ROOM NUMBER]-B's bed footboard was loose. -On 8/13/2025 at 1:19 PM room [ROOM NUMBER]-B's footboard was flat on the floor. There was food debris on the left side of the bed.-On 8/14/2025 at 11:47 AM room [ROOM NUMBER]-A the room smelled of urine and the floor was slippery.-On 8/14/2025 at 11:48 AM room [ROOM NUMBER]-B had food debris (crackers) and brown scattered debris on the floor. The left enabler bar had dried crusty debris on it.During an interview on 8/13/2025 at 9:13 AM, Environmental Services Aide #28 stated resident rooms and units were cleaned every day. This was the residents' home, and it should be clean. During a follow up interview on 8/14/2025 at 12:01 PM, they stated it was common for the headboards and footboards to be bent or broken because staff leaned on them. There should be an electronic request so maintenance could repair or replace the items. There should be routine bed checks. During an interview on 8/14/2025 at 1:52 PM, Certified Nurse Aide #21 stated some footboards were missing and they reported it. They were also aware of some that were not yet reported. Footboards should not be missing or loose. During an interview on 8/14/2025 at 2:26 PM Licensed Practical Nurse #20 stated they went through the unit and wrote down all the missing footboards and gave them to Registered Nurse Unit Manager #19 who was currently on vacation. The following observations were made on Unit B2:-On 8/12/2025 at 11:06 AM, there were 5 discolored and cracked floor tiles across from the nurse's station.-On 8/12/2025 at 11:30 AM, the soffit across from room [ROOM NUMBER] had an area approximately 18 inches long that was peeling off. There were 3 ceiling tiles missing from this area. During an interview on 8/13/2025 at 10:37 AM, Certified Nurse Aide #29 stated maintenance was called for discolored floor or ceiling tiles. The archway where the soffit was peeling off had a leak about a month ago. Maintenance was aware and they did not know why it was not fixed. During an interview on 8/14/2025 at 2:21 PM, Registered Nurse #11 stated maintenance looked at the soffit last week and said they were working on it. It was not a homelike environment for the residents. The following observations were made on Unit C1:-On 8/11/2025 at 12:15 PM room [ROOM NUMBER]-A, there was a hole in the wall about upper shin height to the right of the head of the bed frame.-On 8/12/2025 at 10:58 AM the kitchenette had a sign documenting the ice machine was broken.-On 8/14/2025 at 10:07 AM there were food crumbs/particles on the floor under the overbed table and stationary chair parallel to the nurses' station outside the patient lounge.-On 8/14/2025 at 12:49 PM there was food debris in front of the chair parallel with the nurse's station. The following observations were made in the main lobby area:-On 8/12/2025 at 11:00 AM there was an alarm sounding coming from the stairwell. -On 8/13/2025 at 8:00 AM, to the left of the front entrance sliding door, the panel was broken and in a position that allowed entry. The water fountain was leaking with a red bucket underneath to catch the water.-On 8/13/2025 at 5:15 PM, the entrance door was broken and ajar. The water fountain was leaking and had a red bucket underneath. The alarm in the stairwell was sounding while an unidentified resident and visitor were conversing in the main lobby. -On 8/14/2025 at 12:14 PM, the alarm was sounding in the stairwell in the main lobby. During an interview on 8/15/2025 at 11:50 AM, Maintenance Technician #2 stated their boss quit on Friday, and they were the only person working in the maintenance department. Their job was to respond to broken items. They did not have access to the electronic maintenance request system, so they only knew if something needed fixed if it was verbalized to them. They were aware of broken headboards and footboards throughout the facility, but they were not easy to replace as it took a long time to get replacement parts. They were unaware of the metal coming out of the doorframe in room [ROOM NUMBER] or any holes in the walls in the facility. There was a water leak in the soffit, and they just replaced the ceiling tiles on B2. They were not aware of cracked floor tiles. They were made aware of the broken sinks in rooms [ROOM NUMBERS] on 8/8/2025 but did not know who to call but apparently Environmental Services Aide #28 had called a plumber a couple days ago. They did not know the shower handle, or the whirlpool tub (continued on next page)

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	08/15/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed repair. The ice machines were a known issue and to their understanding corporate had ordered new units, but they were waiting for them to come in. They fixed the alarm in the stairwell yesterday as a staff from another facility had come to help them. They did not know how to fix the front entrance. The water fountain was out of order because the drain needed to be snaked. They fixed wheelchairs if it was reported to them but again, the staff entered requests into the electronic system they did not have access to. Everything in the facility should be in good repair as it was the residents' right to feel at home. During an interview on 8/15/2025 at 12:23 PM the Administrator stated the Maintenance Director walked off the job the previous Friday. Maintenance Technician #2 did not have access to the electronic work orders, and they were working on that. They stated the floor scrubber was broken. They just stripped and waxed all the common areas. Some of the tiles were replaced and not pretreated. The floors had not been maintained. They stated the housekeeper quit last week on A1 after being educated on how to properly clean. 10NYCRR 415.29(j)(1)

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	08/15/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure prompt grievance resolution for one (1) of one (1) resident (Resident #138) or provide information on how to file a grievance or complaint for six (6) of seven (7) anonymous residents present at the group meeting. Specifically, Resident #138 had missing dentures and did not receive timely follow up on their grievance; and 6 residents present at the group meeting did not know how to file a grievance, grievance forms were not available to residents, and the facility lacked a process for residents to file an anonymous grievance. Findings include:The facility policy Grievances, revised December 2024, documented residents were afforded the right to voice grievances without fear of discrimination or reprisal. The Director of Social Work Services, designee, or resident social worker was identified as the grievance official and was responsible for acting as the resident advocate. A copy of the grievance policy was to be provided to residents upon admission.The facility policy Missing Items and Ruling Out Misappropriation of Personal Property, revised 12/15/24, documented staff must immediately report any resident complaint of a missing item to the Charge Nurse or Supervisor. A missing items report was to be completed; the resident and staff interviewed and determine if misappropriation was a reasonable suspicion. Items were to be returned to the resident and document the return. If the item remained missing, assist with an insurance claim as appropriate. Updates were to be provided the resident and the responsible party.The facility Policy Resident Rights, revised 3/2025 documented the residents had the right to have received contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, which had included, suspected abuse, neglect, exploitation, misappropriation of funds, or resident property.Resident #138 had diagnoses including stroke and anxiety disorder. The 6/6/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition and had no natural teeth or tooth fragments. The 6/12/2024 comprehensive care plan documented the resident had a self-care performance deficit and limited physical mobility. Interventions included the resident had upper dentures and staff were to brush the resident's teeth, rinse their dentures, clean gums with a toothette, and rinse the resident's mouth with wash. Changes were to be reported to the nurse.The 6/14/24 personal inventory record documented the resident was admitted to the facility with top dentures.The 5/16/2025 missing item report documented on 5/15/2025 Resident #138 reported their dentures were missing. The certified nurse aides were told to be on the lookout for the dentures. The Registered Nurse Unit Manager put the resident on the dentist list to be seen as soon as possible, and they would check back at the end of August 2025 after the resident was seen.During an interview on 8/11/2025 at 12:15 PM, Resident #138 stated the facility lost her dentures. Resident #138 spoke to the social worker but had not gotten anywhere and did not know the status of finding or replacing their dentures. They were upset as they had paid for their dentures.The 8/15/2025 missing item report for the missing dentures documented Resident #138 did not want to go to an outside dentist and had no issues eating. The dentures were found in their room on 8/15/2025 (3 months after the initial missing item was reported). During an interview on 8/15/2025 at 8:41 AM the Administrator provided a grievance log that included five entries for both 2024 and 2025. The Administrator stated they implemented the log when they started and reinstated the grievance process as the facility had not been using it. Missing items were on a separate report which was also re-implemented.During an interview on 8/15/2025 at 10:07 AM, Certified Nurse Aide #34 stated someone found the residents dentures in their nightstand that morning. The dentures were reported missing for over a month, and they previously thoroughly searched the resident's room looking for them. Certified Nurse Aide #34 stated they initially reported them missing to Licensed Practical Nurse #10.During an interview on 8/15/2025 at 10:29 AM, Social Service Director #35 stated they were responsible for grievances and missing items. If a resident was (continued on next page)

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	08/15/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interested in filing a grievance they would have to report it directly to them. Residents who wanted to file an anonymous grievance would have to reach out to the Ombudsman. Grievances and missing items should be resolved within 24 hours; however, that was not always feasible. Resident #138's dentures had been searched for by multiple staff and were unable to be located. The Unit Manager was to put the resident on the dentist list. They stated they did not update the resident on being put on the dentist list as they thought the Unit Manager did.During an interview on 8/15/2025 12:00 PM, Licensed Practical Nurse #10 stated the resident's dentures were found in their drawer that morning. The resident and staff had been unable to find them after searching for them after the resident moved rooms and then moved back. They stated the dentures had been missing for more than a month.10NYCRR 415.3(C)(1)(ii)

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	08/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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	08/15/2025

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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 used 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 Nuse Aide #21 stated enabler bars were zip tied if the resident was not care planned to have them. Resident #30's rails were positioned such that they were not in use. If they were in use, they would not be zip tied and would be positioned lower on the bed. They stated the resident did not use the bed rails and after checking the care card, stated the resident was care planned for 2 enablers.3) Resident #126 had diagnoses including stroke with left sided weakness. The 5/11/2025 Minimum Data Set assessment documented the resident had moderately impaired cognition, a functional range of motion impairment on one side, required moderate assistance for bed mobility, and did not use bed rails.The Comprehensive Care Plan initiated 9/12/2019 and revised 2/25/2020 documented an activity of daily living deficit. Interventions included extensive assistance of one for turning and repositioning, a specialized air mattress, and 2 bed enablers.The 10/16/2024 physician order documented enabler bars to enhance mobility.The 4/23/2025 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 documentation for the recommendation for bed rail use.There was no documented evidence of a bed rail assessment or a consent for use of the rails.During an interview on 8/14/2025 at 11:54 AM Certified Nurse Aide #4 stated Resident #126 could move themselves in bed and did not use the bed rails. Their rails were supposed to be strapped but they were not, so the mattress moved all over.During an interview on 8/15/2025 11:42 AM Maintenance Technician #2 stated they installed bed rails if physical therapy told them to. They checked beds for rusty bolts, made sure nothing was broken, and checked the condition of the bed rails. They did not know about entrapment zones, what entrapment meant, and had not had any related training.During an interview on 8/14/2025 at 2:26 PM Licensed Practical Nurse #20 stated bed rails should be listed in the care plan and be zip tied. They thought if there was not a zip tie then the resident could use the bar as an enabler. They were unsure why a bed with two bars only had one with a zip tie.During an interview on 8/15/2025 at 11:34 AM the Rehabilitation Director stated if a resident needed bed rails, they completed the device form and updated the care plan. They would also update the care plan with any changes. There should not be a rail on a bed if there was no recommendation for it or if it had not been cared planned for. Zip ties were put in place so the bars could not be put down. If they were down, then they were considered siderails. Zip ties prevented them from becoming a siderail. Any rail that was on a bed should be zip tied.10NYCRR 415.12(h)(1)(2)

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	08/15/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for one (3) of four (4) medication carts (Units A2, B2 and C1) and two (2) of two (2) medication rooms (Units A and C) reviewed. Specifically, the Unit A2 medication cart had opened and undated eye drops and multiple prefilled medication cups; the Unit C1 medication cart had opened and undated eye drops and an inhaler; the Unit B2 medication cart was left unattended and unlocked; and the medication refrigerator temperatures on Units A and C were not consistently monitored.Findings include:The facility policy Storage and Maintenance of Medications, revised 10/2017, documented medications were stored safely, securely, and properly following the manufacturer's recommendation or those of the supplier under proper temperature. The refrigerator must maintain a proper temperature of 36-46 degrees Fahrenheit. Medications were checked regularly for expiration dates and deterioration. Expired medications were removed from use. The August 2025 medication refrigerator temperature logs had the following missing temperatures: -Unit A2 day shift on 8/2/2025, 8/3/2025, 8/7/2025, and 8/9/2025.-Unit C1 night shift on 8/6/2025 and 8/7/22025.During an observation of the Unit A2 medication room and medication cart on 8/11/2025 at 4:27 PM, the medication refrigerator had ice built up in the freezer, registered a temperature of 50 degrees Fahrenheit, and the August 2025 medication refrigerator log was missing documentation of temperature readings for the day shift on 8/2/2025, 8/3/22025, 8/7/2025, and 8/9/2025. There were multiple medication cups in the top drawer of the medication cart containing both whole and crushed medications. One cup contained a small piece of white paper with a resident name and time on it. Latanoprost eye drops for Resident #11 were dated as opened 6/1/2025 and expired 7/1/2025. During an interview on 8/11/2025 at 4:27 PM, Registered Nurse #9 stated they were trained on the medication cart but was not sure what the refrigerator temperature was supposed to be. The refrigerator temperature was reviewed and documented on the day and night shift to ensure medications were stored at the proper temperatures. If medications were not stored at the proper temperatures, they were discarded. They were not sure why temperatures were not reviewed or recorded but they should have been. They stated they were slow with their medication pass and used the time from 2:30 to 4:00 to put all the resident's medications in a cup in the medication cart. They put their name on a piece of paper and what time the medications were scheduled to be administered. They were not trained to do this, however, did not feel it was a safety concern because the cart was locked. Once they got a little faster, they were going to stop this process. Resident #11 eye drops should have been discarded on 7/1/2025. They were not sure why they remained in the cart or when they were last administered. During an observation of the Unit C1 medication room and medication cart on 8/12/2025 at 7:51 AM, the August 2025 medication refrigerator log was missing documentation of temperature readings for the night shift on 8/6/2025 and 8/7/22025. The medication cart contained Lumigan 0.01% eye drops for Resident #85 that were not labeled when opened and an Arnuity inhaler for Resident #103 opened on 7/1/2025 and did not have a documented expiration date. During an interview on 8/12/2025 at 7:51 AM, Licensed Practical Nurse #10 stated all eye drops and inhalers were dated when opened and with an expiration date. Eye drops and inhalers were good for 30-60 days depending on the medication. Resident #85 received eye drops in the evening and those drops should be labeled when opened to ensure efficacy of the medication. They were not sure why the medication was not labeled because they had not worked for several days. They were not sure the last time the medication was administered but it should have been labeled when it was opened. The Arnuity inhaler for Resident #103 had an open date of 7/1/2025 and per the manufacturer it was good for 6 weeks after opening so it expired on 8/12/2025. The medication (continued on next page)

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	08/15/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	refrigerator temperature was reviewed and documented twice a day to ensure medications did not get too cold or too warm for proper efficacy when administered. They were not sure why the night shift did not take or document the temperatures, but they should have. During an observation on 8/14/2025 at 10:41 AM, the Unit B2 medication care was across from the nurse's station and unlocked. A resident was sitting nearby in their wheelchair, a second resident wheeled past the cart, and a third resident exited their room and wheeled toward the unlocked medication cart. At 10:46 AM Registered Nurse #11 exited a resident room and walked toward the unlocked medication cart. During an interview on 8/14/2025 at 2:21 PM, Registered Nurse #11 stated the medication carts should be locked at all times when unattended for the safety of all residents. They left the medication cart unlocked and unattended earlier in the day because a resident's family member asked for assistance, and they forgot to lock the cart. Several residents wheeled themselves independently around the unit and the cart should be locked for resident safety. During an interview on 8/15/2025 at 12:11 PM, The Director of Nursing stated medication carts should be locked at all times when not in use for resident safety. Eye drops and inhalers were dated when opened and expired in 30 days. Medications should be discarded after 30 days to ensure they were effective. They completed new employee training on the process for administering medications and medications were never prepared in a cup ahead of time for safety reasons. The medication refrigerator temperatures should be monitored twice daily by the day and night shift nurse to ensure the medications inside were safe to administer. If the temperatures were missed by the day or night shift nurse the evening nurse should document the temperatures. 10NYCRR 415.18(d)

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	08/15/2025

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two (2) of two (2) meals reviewed (lunch meals on 8/12/2025 and 8/13/2025). Specifically, food was not served at palatable and appetizing temperatures during the lunch meals on 8/12/2025 and 8/13/2025. Findings include:The facility policy Food and Nutritional Services, effective 5/2019 documented each resident was provided with a nourishing, palatable, well-balanced diet that met their daily nutritional and special dietary needs, taking in the preferences of each resident. The undated facility policy Temperature Maintaining Equipment, documented the facility would hold and maintain the temperature of hot and cold food items during meal service inside the dietary department, dining rooms, and during transportation to resident units. During an interview on 8/11/2025 at 10:44 AM, Resident #98 stated the food was not good, the portions were too small, they were often missing items, and the food was never hot.During an observation on 8/11/2025 at 12:29 PM, Resident #49's meal tray was tested (a replacement was provided) in the presence of Certified Nurse Aide #39. Food temperatures were measured as follows: hot pork sandwich with gravy 122.4 degrees Fahrenheit, milk 63.3 degrees Fahrenheit, and mashed potatoes with gravy 117.8 degrees Fahrenheit. The pork and potatoes were bland and not hot, and the milk was warm.During a meal observation on 8/13/2025 at 12:51 PM, Resident #98's meal tray was tested (a replacement was provided) in the presence of Minimum Data Set Coordinator #45. Food temperatures were measured as follows: cheeseburger on bun 110.5 degrees Fahrenheit, milk 65.8 degrees Fahrenheit, baked beans 127.9 degrees Fahrenheit, and coffee 127.6 degrees Fahrenheit. Minimum Data Set Coordinator #45 stated the cheeseburger did not look appetizing. The burger was missing cheese and was half brown and half dark brown and crispy looking. The burger was crunchy, the oatmeal cookie was too hard to bite, and the milk was warm. During an interview on 8/13/2025 at 10:37 AM, Certified Nurse Aide #29 stated residents complained about the food all the time saying it does not taste good and was tough to chew. During an interview on 8/14/2025 at 12:19 PM, Certified Nurse Aide #24 stated residents complained about the food all the time stating it was cold, did not taste good, and was hard to chew.During an interview on 8/14/2025 at 2:21 PM, Registered Nurse #11 stated residents were always complaining about the food saying it was cold and tough to chew.During an interview on 8/13/2025 at 2:07 PM Dietary Aide #47 stated the hamburger was 116.4 degrees Fahrenheit and should be 169 degrees or above. Cold food should be served above 32 degrees Fahrenheit. It was important for hot foods to be hot and cold foods to be cold because residents wanted a good meal. During an interview on 8/14/2025 at 10:08 AM, The Food Service Director stated they did not document temperatures of the food. The cook called out sick, so they were cooking. Hot food should be over 145 degrees Fahrenheit. 10NYCRR 415.14(d)(1)(2)

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	08/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 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: 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. The following observations were made in the Unit A2 dining room: -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? -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.” 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. 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 (continued on next page)

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	08/15/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 10 NYCRR 415.5(d)(1)(i)

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	08/15/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure all residents were fully informed of and participated in their treatment, including the right to be fully informed in a language that they can understand of their total health status, including but not limited to, their medical condition, and the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternatives or the option they prefer for one (1) of two (2) residents (Residents #53) reviewed. Specifically, Resident #53 was not informed of a medical order for a chest x-ray nor of the results of the x-ray. Findings include:The facility policy Resident Rights, revised 3/2025, documented residents had a right to be informed and make their own decisions. Residents had the right to be fully informed about their total health status, medical condition, and participate in decisions that affected their care. Resident #53 had diagnoses including atrial fibrillation (irregular heartbeat), high blood pressure, and heart failure. The 5/26/2025 Minimum Data Set assessment documented the resident was cognitively intact, was able to make themself understood and understood others. The 6/25/2021 Health Care Proxy form documented the resident appointed their child as their health care agent to make health care decisions for them effective only when and if they became unable to make their own health care decisions. The 5/20/2025 Capacity Evaluation documented the resident had decisional capacity regarding medical decisions. The 8/10/2025 at 12:14 PM Registered Nurse #19 progress note documented they were called to the unit due to Resident #53 sustaining a fall. Resident had sutures to their right eyebrow that had re-opened and there was a new order to apply steri-strips to reinforce the sutures. The resident's oxygen saturation (amount of oxygen in blood) was 88 percent, and the resident was not wearing oxygen. Nurse Practitioner #37 was made aware and a new order for a chest x-ray for desaturation was given. The resident's child was unavailable for a call. The 8/10/2025 physician order documented chest x-ray one time only. The 8/11/2025 at 7:03 AM, Registered Nurse Unit Manager #26 progress note documented the resident was seen by the provider. The designated representative was updated on the fall and the order for the chest x-ray and agreed with the current plan of care. The 8/11/2025 Nurse Practitioner #37 progress note documented the resident was seen after a fall on 8/10/2025. The resident was noted to have stable vital signs except for the oxygen saturation of 88 percent without wearing oxygen. The resident had a recent fall with a head laceration requiring suture repair and they hit that site during the fall and the area was reinforced with steri-strips. The oxygen saturation had been waxing and waning, and there were no other respiratory symptoms. An order was given to obtain a chest x-ray today and they were awaiting results. During an observation on 8/11/2025 at 10:23 AM, a portable x-ray machine was taken into the resident's room. The resident asked the technician why they were doing a chest x-ray. The resident stated they did not know they were getting a chest x-ray. (continued on next page)

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	08/15/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 8/11/2025 radiology report for the chest x-ray documented the exam was at 10:20 AM, signed by the radiologist, and results were provided to the facility at 11:11 AM. The report was initialed and dated 8/11/2025 by Nurse Practitioner #37 and Registered Nurse Unit Manager #26. During an observation on 8/13/2025 at 3:33 PM (2 days after the x-ray was ordered and after results were available), Registered Nurse Unit Manager #26 was in Resident #53's room to complete a new Medical Orders for Life-Sustaining Treatment form. The resident asked about the chest x-ray and why it was done. Registered Nurse Unit Manger #26 stated it was to make sure they did not have pneumonia because they were short of breath and needed oxygen a couple of days ago. The resident asked if the results were ok and was told they were. There was no documented evidence the resident was made aware of the chest x-ray order or the results of the testing prior to 8/13/2025. During an interview on 8/15/2025 at 10:43 AM, Registered Nurse Unit Manager #26 stated x-rays were ordered by Nurse Practitioner #37. Registered Nurse Unit Manager #26 entered them in the computer and called the imaging company. The resident's family was notified before the testing was completed and then again with the results. If the resident had a health care proxy they called them, or if the resident was their own health care proxy they told the resident directly. Resident #53 had a health care proxy, so they always notified them. The resident was asking about it when they went over the Medical Orders for Life-Sustaining Treatment form. They often deferred decisions to the resident's health care proxy, but the resident could make their own decisions and had capacity and should have been told about the reasons for the x-ray, and the results. 10NYCRR 415.3(e)(1)(i)

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	08/15/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents have reasonable access to and privacy in their use of communication methods. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure residents had the right to have reasonable access to the use of a telephone and a place in the facility where calls can be made without being overheard for two (2) of four (4) residents (Residents #69 and #126) reviewed. Specifically, Resident #69 did not have access to a telephone and Resident #126 had to make phone calls at the nurse's station where others could overhear their conversations. Findings include: The facility policy Resident Right to Forms of Communication/Privacy, effective 4/7/2023, documented the facility protected and facilitated the resident's right to communicate with individuals and entities within and external to the facility. Resident's had easy access to telephones and a place in the facility where calls could be made without being overheard. 1) Resident #69 had diagnoses including fractured left arm and anxiety. The 8/2/2025 Minimum Data Set assessment documented the resident had intact cognition; felt it was very important to have their family involved in their care; required partial/moderate assistance with most activities of daily living; had functional limitation of one arm; and used a manual wheelchair for mobility with partial/moderate assistance.The Comprehensive Care Plan initiated 7/31/2025, documented the resident was dependent on staff for meeting emotional, intellectual, physical, and social needs. Interventions included support for socialization and stimulation and to respect the residents right to refuse. The resident had an activity of daily living self-care performance deficit related to limited mobility. Interventions included limited assistance of one for locomotion using the wheelchair. During an interview and observation on 8/11/2025 at 12:38 PM there was a phone in the resident's room without a dial tone. The resident stated they were upset they were unable to reach their family. They stated they were told to go to a different room to use a telephone, but they were unable to use their wheelchair to get to another room as their arm was in a cast. On 8/12/2025 at 11:09 AM the resident stated calling their family made them feel better and when they could not call their family, they felt depressed. During an interview on 8/12/2025 at 11:14 AM, Maintenance Technician #2 stated the wall jack for the telephone in the resident's room was dead and they requested a splitter from the Director of Maintenance a week or so ago.During an observation and interview on 8/14/2025 at 12:17 PM the resident was wheeled by the Director of Nursing to room [ROOM NUMBER] to use the phone. The Director of nursing offered the resident to move to that room as it had a working phone. The Director of Nursing stated they called the resident's #69 family to notify them of an x ray. During the phone call the family stated they were more concerned they were not able to reach the resident by phone. The Director of Nursing offered the resident a new room and they accepted. During an interview on 8/14/2025 at 12:19 PM, Certified Nurse Aide #24 stated everyone had a phone in their room, but it was not working. They believed maintenance was notified and they did not know why it was not fixed.2) Resident #126 had diagnoses including anxiety and major depressive disorder. The 5/11/2025 Minimum Data Set assessment documented the resident had moderate cognitive impairment; was able to make themself understood; understand others; and felt down, depressed, or helpless 2-6 of 7 days. During an observation and interview on 8/11/2025 at 11:35 AM, the resident was in their room and stated they did not have a phone and could not have private telephone conversations with their family. They had to use the telephone at the nurse's station and talk in front of staff. There was no telephone observed in their room.During an interview on 8/13/2025 at 9:39 AM, Certified Nurse Aide #33 stated all residents should have a phone in their room. Resident #126 did not have a phone in their room and used the desk phone at the nurse's station to call their family. Staff could walk away but there were always other residents outside the nurse's station who could hear the conversations. The resident had the right to have private telephone conversations. During an interview on 8/13/2025 at 9:55 AM, Licensed Practical Nurse #27 stated Resident #126 did not have a phone in their room and came out to the nurse's station to call their (continued on next page)

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	08/15/2025

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 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	family. The resident could not have a private conversation because there were always people around the nurse's station. The resident should be able to have a private conversation. During an interview on 8/15/2025 at 11:14 AM, Registered Nurse Unit Manager #26 stated all resident had a land line phone or some had cellular phones. Residents had the right to have private conversations. They could not have private conversations at the nurse's station because it was a very busy, high traffic area and people were nosey. During an interview on 8/15/2025 at 11:42 AM, Maintenance Technician #2 stated every resident room was supposed to have a phone, but they were not sure if every room did. They were not aware Resident #126 did not have a phone and was unaware of a broken jack in that room. 10NYCRR 415.3(d)(3)

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	08/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not ensure that each resident received adequate supervision and assistance devices to prevent accidents for two (3) of seven (7) residents (Residents #22, and #83) reviewed. Specifically, Resident #22 did not have an enabler bar on their bed as care planned; and Resident #83 was transferred with assistance of one and not two as care planned.Findings include: The facility policy Comprehensive Care Planning, revised 12/15/2025, documented the Comprehensive Care Plan included measurable objectives to meet the resident's medical, nursing and psychosocial needs identified from admission assessments, the comprehensive assessment, and application of the Resident Assessment Protocols. Other problems, strengths or needs identified by the Interdisciplinary Team were included in the Comprehensive Care Plan as appropriate. Types of problems which should be included were, risk for falls and activities of daily living. The facility policy Sit to Stand Mechanical Lift, revised 3/2025, documented a minimum of one caregiver was to be present and assisting at all times during a sit to stand mechanical lift transfer of residents. The caregiver was to refer to the resident's transfer status prior to transfer to determine the exact number of staff required to perform the sit to stand mechanical lift transfer for the specific resident. The facility policy Hoyer Lift, prepared 3/2019, documented residents were transferred safely to/from bed to chair and/or toilet via Hoyer lift when ordered by either the physician and/or therapy department. The procedure was carried out by two nursing assistants/nurses, or physical therapy/occupational therapy always; there were no exceptions. The facility policy Siderail and Enabler, revised 10/16/2024, documented enablers (bar attached to the bed to assist with bed mobility) promoted independent movement in bed and provided a handhold for getting into or out of bed. The use of side rails was to only be utilized for the purposes intended and when they assisted the resident to maintain their highest practicable level of physical or psychosocial well-being. A side rail assessment was completed by the Rehabilitation Department and decisions to use or discontinue were made in the context of an individualized resident assessment using an interdisciplinary team approach. Recommendations for side rails were discussed with the resident's physician and orders were placed. Updates to the resident's activities of daily living were added to the care plan to outline the medical factors necessitating the side rail. The facility policy Falls and Fall Risk, Managing, prepared 12/10/2024, documented staff identified interventions related to the resident's specific risks and causes to prevent the resident from falls and to minimize complications from falls. Staff implemented a resident-centered fall prevention plan to reduce specific risk factors of falls for each resident at risk or with a history of falls. 1) Resident #22 had diagnoses including right below the knee amputation and diabetes. The 8/4/2025 Minimum Data Set assessment documented the resident had intact cognition, had limitation in functional mobility of one leg, and was dependent for transfers. Incident Reports for Resident #22 included: (continued on next page)

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	08/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on 8/1/2025 the resident was found sitting on the floor with their legs in front of them. The resident stated they were trying to get into the chair and was educated on using the call bell when they required assistance. -on 8/4/2025 the resident was found sitting on the floor with their buttocks against the bed. The resident stated they were repositioning themselves in bed and an enabler bar for the left side of the bed was issued. -on 8/7/2025 the resident was attempting to self-transfer when they fell landing on their back in front of their dresser. -on 8/9/2025 the resident was found on the floor in front of the bathroom door. The Comprehensive Care Plan initiated 7/31/2025, and revised 8/7/2025, documented the resident was at risk to falls related to deconditioning, right below the knee amputation and medication use. Interventions included fall protocol, call bell in reach and an enabler bar for positioning. The device rail assessment completed on 8/7/2025 by the Director of Nursing, Rehabilitation Director #3, and Social Worker #13 documented Resident #22 had a right below the knee amputation and required extensive assistance of 1 for transfers. A left enabler bar was implemented for enhanced bed mobility. The undated care instructions documented Resident #22 required assistance of 1 for bed mobility and had a left sided enabler bar. During observations on 8/11/2025 at 11:34 AM, and 8/12/2025 at 10:40 AM and 1:50 PM, there was no enabler bar on Resident #22's bed. During an observation and interview on 8/12/2025 at 2:36 PM, Resident #22 was in bed and stated they fell several times because staff did not come timely when they rang their call bell. There was no enabler bar on the bed. The resident stated they were told on 8/8/2025 by the Director of Nursing an enabler bar was going to be placed on their bed, but it never was. During an interview on 8/13/2025 at 2:41 PM, Certified Nurse Aide #23 stated enabler bars were not used in the facility because they were considered a restraint. During an interview on 8/14/2025 at 12:19 PM, Certified Nurse Aide #24 stated Resident #22 fell several times. Interventions implemented for falls were documented on the care plan and should be followed. The facility did not use enabler bars because they were considered a restraint. During an interview on 8/14/2025 at 2:21 PM, Registered Nurse #11 stated if a resident frequently fell, interventions would be documented on the care plan. Care planned interventions should be followed. They were not sure if Resident #22 had a care plan for enabler bars and if they did, the enabler bar should be on the bed. They stated Resident #22 did not have enabler bars on the bed, and they were not sure why. During an interview on 8/15/2025 at 8:05 AM, Registered Nurse Unit Manager #6 stated they were responsible for updating the nursing section of the care plan. The care plan directed staff on the individual care required for each resident. Resident #22 was care planned for enabler bars. They were (continued on next page)

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	08/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not sure why the enabler bar was not on the bed as recommended but should have been. During an interview on 8/15/2025 at 8:33 AM, Rehabilitation Director #3 stated their department was notified after every fall and they completed an evaluation. Interventions recommended included cushion devices, physical therapy for strengthening, and enabler bars. When enabler bars were recommended, they completed a device form and updated the care plan. The Director of Maintenance was emailed and put the bars on the bed. They recommended a left sided enabler bar for Resident #22 on 8/7/2025 and emailed the Director of Maintenance the same day. The Director of Maintenance quit without notice on 8/8/2025 and they were not aware until 8/11/2025. They expected the enabler bars to be on the bed for Resident #22 because they had balance issues from their amputated leg. 2) Resident #83 had diagnoses including morbid obesity, difficulty walking, and right sided paralysis after a stroke. The 7/20/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment, had limitations in functional mobility on one side of both upper and lower extremities, and was dependent for transfers. The Comprehensive Care Plan initiated 7/27/2021, and revised 2/25/2025, documented the resident had an activity of daily living self-care performance deficit and decreased mobility related to activity intolerance, dementia, fatigue, and hemiplegia (paralysis on one side of the body). Interventions included extensive assistance of 2 with standing Hoyer (mechanical lift) for toileting and transfers. The resident care instructions documented the resident required extensive assistance of 2 staff and standing Hoyer for toileting and transfers. During an observation on 8/11/2025 at 11:07 AM, Resident #83 was seated in their wheelchair outside the nurse's station and verbalized the word bathroom. Certified Nurse Aide #32 addressed the resident and stated they needed to get the mechanical lift. At 11:11 AM Certified Nurse Aide #32 entered the room with the resident and closed the door. At 11:13 AM, the resident said ow which was heard in the hallway outside the room. At 11:16 AM, Certified Nurse Aide #32 opened the door to the resident's room and told the resident to put the call light on when they were done and exited the room with a trash bag. There were no additional staff present in the resident's room. At 11:17 AM the resident's wheelchair in their room was empty and the bathroom door was closed. At 11:23 AM, Certified Nurse Aide #32 stated she was going to lunch and told Certified Nurse #33 Resident #83 was in the bathroom. Certified Nurse Aide #49 said they worked on a different unit but came down to cover for a break. At 11:27 AM, Certified Nurse Aide #33 and Certified Nurse Aide #49 entered the room. During an observation on 8/12/2025 at 11:05 AM, the resident was in their room in their wheelchair. They verbalized the word bathroom repeatedly and was heard from the hallway. Certified Nurse Aide #50 entered the room with the mechanical lift and closed the door. There were no additional staff present in the resident's room. At 11:18 AM, Certified Nurse Aide #50 wheeled the resident out of their room to just outside the nurse's station, went back into the resident's room and exited the room with the mechanical lift. During an interview on 8/12/2025 at 11:44 AM, Certified Nurse Aide #50 stated they put the resident on and off the toilet. They used the stand Hoyer to transfer them. They did both transfers by themself. During an interview on 8/13/2025 at 8:51 AM, Certified Nurse Aide #32 stated Resident #83 used the standup Hoyer for transfers. They transferred the resident by themself on 8/11/2025 and they knew they were not supposed to, but they were short staffed that day. There were only 2 certified nurse (continued on next page)

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	08/15/2025

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aides on the floor because the third was out with a resident on an appointment. The resident was heavy to lift to hook up the pad because one side of their body was paralyzed. The resident should be assisted by two for all transfers. During an interview on 8/13/2025 at 9:55 AM, Licensed Practical Nurse #27 stated the stand Hoyer required assistance of two if they were care planned that way. Resident #83 required assistance of two because they could not use one side of their body. The resident could only hang on with one arm and probably should be a full Hoyer with transfers. They had seen certified nurse aides transfer the resident with just one and not two. During an interview 8/15/2025 at 11:18 AM, Registered Nurse Unit Manger #26 stated all residents who required a mechanical lift were an assist of 2. This was for safety of the residents and the staff. Resident #83 used the stand Hoyer and required assistance of 2. Appointment days were Monday and Tuesday, and they tried to have extra staff scheduled on those days but there were call ins this week. They were not aware of staff transferring with only one, but it probably depended on the staffing ratios. 10 NYCRR 415.12(h)(1)(2)

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	08/15/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025 the facility did not ensure each resident received and the facility provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for two (2) of two (2) residents (Residents #18 and #6) reviewed. Specifically, Resident #18 had an emergency department visit due to suicidal ideations, did not receive follow up from social services or psychology services upon return, did not receive psychotherapy services timely as requested and did not have a person-centered care plan and interventions in place to address their mental health; and Resident #6 did not have person-centered care plan interventions in place to address their mental health. Findings include: The facility policy Comprehensive Care Planning, revised 12/15/2024 documented comprehensive care plans would include measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs identified by the admission assessments, comprehensive assessments, Resident Assessment Protocols, and additional problems, strengths, or needs identified by the interdisciplinary team. All residents had the right to participate in the development and implementation of their person-centered plan of care. The facility policy Behavioral Health Services, revised 12/2024 documented the facility would provide residents with behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral health services were provided to residents as needed as part of the interdisciplinary, person-centered approach to care. Residents who exhibited signs of emotional/psychosocial distress were to receive services and support that addressed their individual needs and goals for care. Staff were trained regarding behavioral health services to recognize changes in behavior, implementing and monitoring care plan interventions, reporting changes in condition, and protocols and guidelines related to the treatment of mental disorders. Behavioral health services were provided by staff who were qualified and competent in behavioral health and trauma-informed care.1) Resident #18 had diagnoses including recurrent severe major depressive disorder, stroke, and congestive heart failure. The 6/4/2025 Minimum Data Set documented the resident has moderately impaired cognition, had no symptoms of depression, and had no behavioral symptoms.The 9/28/2023 Comprehensive Care Plan, revised 7/14/2025, documented the resident used psychotropic medications related to depression, insomnia, and migraines. Interventions included administer psychotropic medications as ordered by the physician, monitor for side effects and effectiveness, discuss with the physician and family the ongoing need for use of medication, review behaviors, interventions, and alternate therapies attempted and their effectiveness, consult with the pharmacy with the physician to consider dosage reduction when clinically appropriate, and monitor, document, and report any adverse reactions of psychotropic medications.There was no documented evidence the care plan addressed the resident's mental health diagnoses, history and any nonpharmacological interventions.The 12/26/24 Psychiatric Nurse Practitioner #55 progress note documented the resident was hospitalized for multiple medical problems. The resident's only concern was still wanting to see their former therapist and resume mental health counseling. Nurse Practitioner #55 planned to inquire about the status of the referral for the psychotherapist and request staff update the resident on the status and timeline of the referral.The 1/22/2025 Psychiatric Nurse Practitioner #55 progress note documented the resident wanted an update on the status of their referral to resume psychotherapy as they felt it would be helpful to talk to someone. They informed the resident they would request another update on the referral from the facility staff. Nurse Practitioner #55 recommended the facility staff should seek an update on the status of the resident's psychotherapy referral and provide an update to the resident and to them.The 4/9/2025 Psychiatric Nurse Practitioner #55 progress note documented 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
	335592	A. Building B. Wing	08/15/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wanted to know the status of their referral for psychotherapy. They stated they needed it as they had broken down crying the day before and their mood was low. They denied suicidal ideations, but they did not want to get to that point again. They were getting very depressed and wanted to stay ahead of the depression. They did not feel it would be helpful to adjust their medications; they just wanted to speak with a counselor. Nurse Practitioner #55 documented they would check with the staff on the status of the referral and advised the resident to alert the staff if they felt unsafe or developed suicidal ideations. Nurse Practitioner #55 had inquired with the facility regarding the counseling referral and requested they update the resident.There was no documented evidence of follow-up regarding Resident #18 request to resume therapy with their previous counselor. The 6/24/2025 Emergency Department after visit summary documented the resident had experienced situational problems due to being unhappy about the nursing home they were at as they felt they were not getting the mental health support they needed and was feeling depressed and suicidal but no longer had suicidal ideation. The resident previously had suicidal ideations.The 6/30/2025 unsigned Social Service Initial Evaluation documented the resident had a suicide risk assessment. The resident had a weak suicide plan with past threats, had a controlled but depressed mood, had a barely adequate idea with means (e.g. method used), and had suicidal thoughts and self-harm. The plan was to continue with the current plan of care.There were no physician orders for psychotherapy consultation, and no documented psychiatric nurse practitioner, psychotherapy, or social work follow up following the resident's emergency department visit for suicidal ideations. There was no documented care plan addressing the resident's suicidal ideation. During an interview on 8/11/2025 at 10:47 AM, Resident #18 stated their depression was bad and it had reached the point where they did not want to live. The facility just watched them, and someone had talked to them about it, but they did not know who it was. The facility was supposed to be working on counseling services for them.During a follow up interview on 8/13/20245 at 11:19 AM, Resident #18 stated they were on a waitlist for the previous place they went for psychotherapy. The facility had not asked if the resident wanted to go to a different counselor or offered to send a referral somewhere else. They stated they just wanted to get into psychotherapy as soon as possible as the practitioner at the facility did not sit down and talk to the resident.During an interview on 8/14/2025 at 2:16 PM, Certified Nurse Aide #57 stated interventions and strategies on how to prevent resident behaviors were on the resident's care plan. Resident #18 expressed wanting counseling services several times and they continued to report the information to the nurse. Resident #18 had not had an appointment with psychotherapy they were aware of. Resident #18 was sent out for a psychiatric evaluation as the resident told them they wanted to harm themself, and they told the Unit Manager. Nurse Practitioner #37 wanted the resident to be sent to hospital as the resident was still waiting on counseling services.During an interview on 8/15/2025 at 12:00 PM, Licensed Practical Nurse #10 stated some of the care plans had interventions for resident behaviors such as how to calm a resident down. Resident #118 had expressed to them they wanted counseling and was supposed to be going. They stated it had taken a while for the resident to get into counseling as the resident did not want to talk to anyone in the facility. They were unaware of who was covering the psychology services in the facility while Psychiatric Nurse Practitioner #55 was out.During an interview on 8/15/2025 at 10:29 AM, the Social Services Director stated they were responsible for the social and emotional wellness of the residents and advocating for residents and their family. The Social Services Assistant was responsible for doing a lot of paperwork and forms but did not have a caseload in the facility. They stated they sometimes set up behavior plans or if there were issues with a resident's behavior, they would look to see what needed to be added to the care plan. Prior to the current Administrator, they were not involved in care plans, it was mainly the nurses who did the care plans. Care plans were reviewed every quarter. They were unaware of how the staff addressed a resident's behavior with non-pharmacological interventions if they were not on the care plan. They would get the non-pharmacological interventions from the psychiatric practitioner and from the Pre-admission Screening and Resident Review Level II (continued on next page)

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	08/15/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment. They did review the psychiatric nurse practitioner's notes and if there were recommendations, the nurses implemented them, even if they were not medication related. Resident #18 stated they wanted to go to psychotherapy but did not want to go in-house which the psychiatric nurse practitioner provided but it had taken a while to set up an outside consult. The Unit Managers sent all referrals and set up all appointments, including mental health appointments. It likely took a while as the unit has had at least four different Unit Managers since December of 2024, and staff thought the resident was getting therapy through the psychiatric nurse practitioner. They would talk to the resident to support their emotional wellbeing but would not document it if it was too personal in nature. Resident #18 did not have a care plan for their mental health. The resident should have a care plan in place with their history of mental health issues. There was no documented follow up from social services after the resident returned from the emergency department visit for suicidal ideations and there should have been. Psychiatric Nurse Practitioner #55 had been out on leave from June to the end of August, and they were unaware if anyone was covering for them at this time.During a phone interview on 8/15/2025 at 12:39 PM, Nurse Practitioner #37 stated they had been managing the building's psychiatric services while Nurse Practitioner #55 was out. They had sent Resident #18 out to the emergency department due to suicidal ideations where they could have a psychiatric evaluation. When the resident came back from the emergency department they started an antidepressant for the resident. They were unaware of why there was a delay in getting the resident into psychotherapy. They did not believe getting the resident into psychotherapy would have stopped the resident from going to the emergency department because the resident had variable moods. Resident #18 had been on a regimented schedule with Nurse Practitioner #55 prior to going out to the hospital. They expected social services to have followed up with the resident after their emergency department visit related to their mental health to follow up on what the resident's needs and wants were after their return.2) Resident #6 had diagnosis including schizophrenia, bipolar, and recurrent severe major depressive disorder without psychotic features. The 6/10/2025 Minimum Data Set documented the resident had moderately impaired cognition, had no behavioral symptoms, and had little interest or pleasure in doing things and feeling down, depressed, or hopeless two to six of seven days.The 9/19/2022 Comprehensive Care Plan, revised 8/4/2025, documented the resident utilized psychotropic medication related to behavior management, insomnia, depression, and anxiety. Interventions included administer the psychotropic medications as ordered by the physician and monitor for side effects and effectiveness every shift, consult with the pharmacy and medical provider to consider dosage reductions when clinically appropriate, and monitor, document, and report any adverse reactions of the psychotropic medications.There was no documented care plan to address the resident's mental health diagnoses, history and nonpharmacological interventions.The resident had a Level I Screen dated 9/19/2022 that documented the resident had a Level II Pre-admission Screening and Resident Review Level II assessment completed.There was no documented Pre-admission Screening and Resident Review Level II assessment (evaluation for serious mental illness) in the resident's record and no documented care plan to reflect their Level II resident review for mental illness.During an interview on 8/15/2025 at 11:43 AM, Certified Nurse Aide #44 stated a resident's care plan should have interventions for a resident who had behaviors. Resident #6 did not have behaviors except for some episodes of making false allegations. They did not see anything in the resident's care plan related to behaviors.During an interview on 8/15/2025 at 10:29 AM, the Social Services Director stated they only followed up with the resident about what was in the psychiatric nurse practitioner notes if the resident brought it up to them when they inquired how the resident was. They had never put in a care plan for the resident's mental health, but they had some mentions of their anxiety and depression and psychotropic medications. The only non-pharmacological intervention was to reduce psychotropic medications. Resident #6 was not seeing anyone while Nurse Practitioner #55 was on leave, but Nurse Practitioner #37 was managing their medications. During a follow up interview at 11:40 AM, the Social Services Director stated they (continued on next page)

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	08/15/2025

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were unaware Resident #6 had a Pre-admission Screening and Resident Review Level II when they were admitted in 2022. They did not have one on file for the resident and would have to reach out to obtain a copy.During an interview on 8/15/2025 at 12:14 PM, Registered Nurse Unit Manager #36 stated they had never been made aware nursing was responsible for putting in mood and behavior care plans for the facility. Resident #6 should have mental health care plans related to their mental diagnosis and histories.During a phone interview on 8/15/2025 at 12:39 PM, Nurse Practitioner #37 stated Resident #6 should have a care plan addressing their mental health history and/or their behaviors. 10 NYCRR 415.12

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	08/15/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, record review, and interviews during the recertification survey conducted 8/112/2025-8/15/2025, the facility did not ensure planned menus were followed for three (4) of thirteen (13) residents (Residents #8, #69, #98, and #148) reviewed. Specifically, Residents #69, #98, #148 did not receive Mighty Shakes (nutritional supplement) as planned; Resident #148 was missing multiple items listed on their meal ticket; and Resident #8 received bread at meals when care planned for no bread. Findings include: The facility policy Food and Nutritional Services, effective 5/2019, documented each resident was provided with a nourishing, palatable, well-balanced diet that met their daily nutritional and special dietary needs, taking in the preferences of each resident. 1) During a lunch meal observation on 8/11/2025 at 12:14 PM, Resident #98's lunch meal ticket documented the resident was to receive a Mighty Shake. The meal tray did not include a Mighty Shake. During a lunch meal observation and interview on 8/13/2025 at 12:51 PM, Resident #98's lunch meal ticket documented the resident was to receive a Mighty Shake. Resident #98's tray was missing the Mighty Shake. Resident #98 stated they trays were always wrong and they never received Mighty Shakes. They would have drunk the Mighty Shake if they received it. During a lunch meal observation on 8/13/2025 at 12:57 PM, Resident #69's lunch meal ticket documented the resident was to receive a Mighty Shake. Resident #69's tray was missing their mighty shake. During an observation and interview on 8/13/2025 at 1:10 PM, Resident #148 did not have their Mighty Shake, egg salad in a bowl, boiled egg, cheeseburger on a bun, or tomato soup. They stated if they had the egg salad, boiled egg, and soup they would have eaten it. During an observation and interview on 8/14/2025 at 12:57 PM, Resident #148 did not have a boiled egg, vegetable soup, or sweet potato fries on their meal tray and had regular French fries. The resident stated they did not eat white foods like French fries, however, would have liked the sweet potato fries and the soup. They did not have much of an appetite and had soup earlier in the week and it tasted good. During an interview on 8/14/2025 at 2:21 PM Registered Nurse #11 stated it was the kitchen's responsibility to make sure all items on the meal ticket were on the resident's tray and they had seen items missing from trays. Mighty shakes were ordered for residents who were nutritionally deprived or had wounds. Resident #98 had a wound. During an interview on 8/15/2025 at 8:05 AM Registered Nurse Unit Manager #6 stated the kitchen staff was initially responsible for making sure all items on the meal ticket were on the tray. Staff passing the trays double checked the trays to make sure there were no missing items. Mighty shakes were offered for weight loss, poor intake or extra supplements. Resident #148 had a poor intake and would benefit from Mighty Shakes. If the dietitian recommended Mighty Shakes, it was documented on the care plan and residents should get them. After looking at the care plan for Residents #69, #98, and #148, all were recommended to have Mighty Shakes for lunch and dinner. During an interview on 8/15/2025 at 10:42 AM, Registered Dietitian #8 stated they recommended Mighty Shakes when estimated protein needs were not being met or they had higher protein requirements for wounds or poor intake. Resident #148 had an assessment with their preferences and was expected to get their preferences as listed on their meal ticket. Resident #148 had Mighty Shakes added to their lunch and dinner trays because of poor intakes. Resident #69 had Mighty Shakes on their lunch and dinner tray because they were under weight and had a decline in their weight. Resident #98 had Mighty Shakes on their lunch and dinner trays because they had a wound. They expected Mighty Shakes to be on the resident trays if recommended and were not sure why the kitchen did not put them on the trays. During an interview on 8/15/2025 at 11:55 AM, Dietary Aide #42 stated food was prepared and set up in the kitchen by dietary aides. The dietary aides were responsible for making sure trays were accurate. Mighty shakes were used for residents that required additional calories. There were times when mighty shakes were not available because they did not arrive on the delivery truck, and they had been out of mighty shakes for approximately one week. If a resident asked for soup, they should (continued on next page)

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	08/15/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have received it and were not sure why the resident did not get the soup. They had sweet potato fries on the meal ticket, however had never seen sweet potato fries in the building and did not feel they should have been on the meal ticket since they were not available. During an interview on 8/15/2025 at 12:04 PM, the Food Service Director stated kitchen staff working the tray line made sure all items on the meal ticket were on the tray. Mighty shakes were ordered for residents to gain weight. Mighty shakes were not on resident trays this week because staff did not know where to locate them. They should have been on the tray. Sweet potato fries were listed on the meal tickets but not available from the vendor and they were working with the dietitian to get them removed. The cook called in sick on 8/14/2025 and they had stepped in to cook. They did not have time to make soup, therefore Resident #148 did not get their soup as requested. 2) Resident #8 had diagnoses including dysphagia (difficulty swallowing) and a gastrostomy (a feeding tube). The 7/2/2025 Minimum Data Set assessment documented the resident was cognitively intact, required setup or clean-up assistance for eating, did not have a swallowing disorder, received a mechanically altered diet, and previously received nutrition via gastrostomy tube.The Comprehensive Care Plan initiated 6/30/2025, and revised 8/11/2025, documented the resident had a nutritional problem related to mechanically altered diet of mechanical soft with thin liquids and relied on a tube feeding to meet estimated nutrient needs. Interventions included provide and serve mechanical soft diet with ground meats and no bread, thin liquids diet as ordered. During a lunch meal observation on 8/13/2025 at 12:50 PM, Resident #8's lunch meal ticket documented the resident was to receive cheeseburger on a bun-ground, baked beans, oatmeal cookie, tossed salad, water, whole milk, and coffee. Serve nothing on bread or biscuits. Meats must be ground. The ground meat was observed on a bun. Resident #8 told Licensed Practical Nurse #20 they were not allowed to have bread acknowledged the resident and left the room leaving the bun on the tray. During a lunch meal observation on 8/14/2025 at 12:46 PM, Resident #8's lunch meal ticket documented the resident was to receive glazed chicken fritters, sweet potato fries, coleslaw, chocolate peanut butter cake, coffee, whole milk, and water. Serve nothing on bread or biscuits. Meats must be ground. The ground meat was observed on a bun. During an observation and interview on 8/14/2025 at 12:48 PM Resident #8 told Certified Nurse Aide #39 they were not allowed to have the bun that was on their tray. Certified Nurse Aide #39 removed the bun from the tray. During an interview on 8/14/2025 at 2:21 PM, Registered Nurse #11 stated most residents that were at risk for choking were on an altered consistency diet. Resident #8 was at risk for choking on a thickened liquid only diet and on 8/11/2025 was changed to a mechanical soft diet with no bread. The kitchen was responsible for making sure all trays were accurate, so resident got the protein and calories required and did not choke. Resident #8 could not have buns and had one on their tray earlier today. They notified the Director of Nursing. During an interview on 8/14/2025 at 2:53 PM, Licensed Practical Nurse #20 stated Resident #8 was at risk for choking because they had swallowing difficulties. They had an appointment on 8/11/2025 with speech and language pathology for a swallowing evaluation and was upgraded to mechanical soft foods, ground meet, and no bread. They had a bun on their tray on 8/13/2025 and they did not remove it because the resident was oriented enough not to eat it. They should have removed the bun. During an interview on 8/15/2025 at 10:30 AM, Speech Language Pathologist #7 stated Resident #8 had Parkinson's disease with difficulty swallowing and received feeding through a gastrostomy tube. They were evaluated on 8/11/2025 and upgraded mechanical soft and thin liquids, no straws, no bread with ground meats. The recommendations were sent to the facility the same day. There was no bread because it was fluffy and got stuck in the back of the resident's throat. A bun was considered bread and Resident #8 should not have it. During an interview on 8/15/2025 at 11:55 AM, Dietary Aide #42 stated trays were prepared in the kitchen by staff on the tray line. The tray line staff was responsible for making sure the trays were accurate. If a meal ticket said no bread or biscuits, they should not get a bun. They were not sure why Resident #8 had buns on their lunch tray two days. During an interview on 8/15/2025 at 12:04 PM, the Food Service Director stated the tray line staff was responsible for (continued on next page)

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	08/15/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	preparing trays and making sure the items on the tray matched the meal ticket. They did not have any formal process for ensuring trays were accurate. If a ticket said no bread, they should not have the bun. They believed staff was not reading the meal ticket which was the reason for the bun on the tray. 10NYCRR 415.14(c)(1-3)

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	08/15/2025

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on record review and interviews during the recertification survey conducted on 8/11/2025 to 8/15/2025 the facility did not provide specific services outside the facility when the facility did not employ a qualified professional to furnish the specific service for one (1) of five (5) residents (Resident #1) reviewed. Specifically, Resident #1 was referred to Urology and was supposed to have dental and podiatry follow ups the facility did not follow up on in a timely manner. Findings include:The facility policy Consults-Outside Facility, revised 11/18/2024, documented the provider ordered all medical appointments and clinic visits. The Nurse Manager/designee initiated the consult form and filled out the name of the medical provider requesting the appointment, the medical clinic, the phone number, and the reason for the consult. The appointment was to be made in a timely manner, and they were to inform the provider if they were unable to do so. The resident/resident representative of the appointment were notified of the appointment, and the consult packet was made. Upon the residents' return from an outside appointment the Nurse Manager/designee was to follow-up with the physician to discuss any new consult recommendations.The facility policy Dental Services, revised 12/2024 documented routine and emergency dental services were available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Routine and 24-hour emergency dental services were provided to residents through a contract agreement with a licensed dentist that came to the facility monthly, a referral to the resident's personal dentist, community dentist, or health care organizations that provide dental services. Social services representatives were to assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan if eligible. All dental services provided were recorded in the resident's medical record. The facility policy Podiatry Consultations, revised 12/2024, documented podiatry services were provided to each resident. Podiatry services were available to all residents requiring routine and emergency podiatric care. The podiatrist would conduct a comprehensive foot examination, assess for any deformities, wounds, lesions, pain, or functional limitations during consultation. Based on the assessment findings, the podiatrist would develop a personalized treatment plan tailored to the residents' needs and goals. Resident #1 has diagnoses including peripheral vascular disease (poor circulation), obstructive and reflux uropathy (urine is blocked or flows backwards), and diabetes. The 7/18/2025 Minimum Data Set documented the resident had severely impaired cognition, had an indwelling urinary catheter, had no broken teeth or inflamed gums, and received insulin. The Comprehensive Care Plan initiated 9/21/2023, and revised 7/9/2025, documented the resident had diabetes and was at risk for altered blood sugars due to non-compliance with diet and snacking. Interventions included to refer to podiatrist/foot care nurse to monitor/document foot care needs and to cut long nails.There was no documented evidence of a care plan addressing the use of a urinary catheter.The 4/27/2024 Dental Consult documented the resident was previously seen on 6/7/2023 and had a loose tooth but did not want extraction. The resident was not seen on 4/27/2024 due to refusal but there were no reported concerns. The resident was to be seen on the next annual visit or as needed. There were no documented dental consults from 4/27/2024 through 8/15/2025. The 5/18/2024 Podiatry Consultation documented the resident was seen for evaluation and treatment. The resident had all ten toenails debrided (removal of thickened or deformed toenails) and trimmed. Recommendations included application of daily moisturizer. The resident was to be seen again in two to four months. There was no documented podiatry follow up after 5/18/2024. The 12/3/2024 Urology progress note documented the resident was planned to have a cystoscopy evaluation (examination of urinary tract using a thin camera tube) of their urinary retention and recurrent urinary tract infections. The resident refused the cystoscopy, and the recommendation was to leave the urinary catheter in and reschedule the resident in four weeks, around 12/31/2024, for another cystoscopy.There was no documented evidence a follow up for (continued on next page)

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	08/15/2025

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 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	urology was rescheduled. The 4/23/2025 hospital discharge summary documented a referral was sent to urology for follow up due to the resident's recurrent urinary tract infections. There was no documented evidence of a urology follow up as recommended. During a phone interview on 8/11/2025 at 4:41 PM, Resident #1's Health Care Proxy stated the resident was not seen by the dentist or podiatrist as recommended, and the resident was not seen by a urologist. The resident had a lot of issues with their catheter and the kept getting sores, sepsis, and urinary tract infections from it. During an interview on 8/15/2025 at 12:00 PM, Licensed Practical Nurse #10 stated for the podiatrist and dentist visits, the certified nurse aides would talk to the residents regarding who needed be seen. The certified nurse aides would let them know and they would tell the Unit Manager or Medical Records/Transportation who would send the list to the podiatrist or the dentist. Unfortunately, there had been a lot of turn over for Unit Managers. Resident #1 had a lot of issues with their catheter. The resident had it removed for a while but then they had a hospital stay where it was put back in. The family had wanted the catheter removed again but the urologist felt it was necessary. During a phone interview on 8/15/2025 at 12:14 PM, Registered Nurse Unit Manager #6 stated a lot of the follow up appointments were not put in when they took over as the Unit Manager. When a resident came back from an appointment the Unit Manager should put the follow up appointments into the computer under orders, let the provider know, and let the transportation person know. They stated they started to review each resident to see what specialist the residents saw as there were a lot of appointments they were not aware of. They were not aware of who set up the dentist appointments. Licensed Practical Nurse #10 was helping to identify who saw podiatry and who needed to be seen. They were unaware Resident #1 was supposed to have follow ups with both podiatry and the dentist. Resident #1 had frequent urinary tract infections in the past and a trial removal of the catheter occurred previously but was ultimately unsuccessful. During a phone interview on 8/15/2025 at 12:39 PM, Nurse Practitioner #37 stated Resident #1 had their catheter replaced in the hospital in June 2025. The resident had a couple different unsuccessful trial removals of the catheter. Urology wanted to follow up with the resident and wanted the catheter to remain in place until the follow up. They were unsure of when the urology follow up was, but the resident should have one. The original cystoscopy the resident refused and then had several hospitalizations, so the urology follow up fell through the cracks. They would defer to urology if the resident still needed the procedure. During an interview on 8/15/2025 at 1:24 PM, Medical Record and Transportation Aide #38 stated when a resident came back from an appointment, nursing reviewed the paperwork from the appointment, scheduled any needed appointments and emailed them to schedule transportation. The dentist usually came every Saturday but was on vacation this month. The dentist had a running list, and they printed out the reports for the Unit Managers to add to or remove from. The same thing occurred with podiatry. Resident #1 did not have a urology appointment scheduled. They were unaware of why the resident did not have their cystoscopy rescheduled from December 2024. 10NYCRR 415.26(e)

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	08/15/2025

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 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** Based on observations, record review, and interviews during the recertification survey conducted 8/11/2025-8/15/2025, the facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of three (3) residents (Resident #8) reviewed. Specifically, Resident #8 was on contact precautions (used to prevent transmission of pathogens that are spread by direct person-to-person or indirect contact with the resident or environment) and Licensed Practical Nurse #20 changed a gastrostomy tube dressing (a tube inserted in the stomach through the abdomen) without wearing required personal protective equipment. Additionally, the facility Infection Prevention and Control policies and standards were not reviewed annually to ensure effectiveness and were in accordance with current standards of practice for preventing and controlling infections. Findings include:The facility policy Policies and Practices-Infection Control, effective 3/2021, documented infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment to help prevent and manage transmission of disease and infection. All personnel were trained on infection control practices upon hire and periodically thereafter. The facility policy Monitoring Compliance with Infection Control, revised 3/2021, documented routine monitoring and surveillance of the workplace was conducted to determine compliance with infection prevention and control policies and practices.The undated facility policy Contact Precautions for Infection Control, documented all personnel, including visitors that had direct contact with a resident on contact precautions shall be required to follow all procedures as outlined within the policy in addition to standard precautions and general isolation precaution guidelines. Contact precautions were used for specific residents known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Gloves were worn when entering the resident room. Gowns were worn when it was anticipated that it will have substantial contact with the resident or wound drainage not covered by a dressing. Resident #8 had diagnoses including gastrostomy status (a feeding tube inserted in the stomach through the abdomen). The 7/2/2025 Minimum Data Set assessment documented the resident was cognitively intact, required partial/ moderate assistance with most activities of daily living, did not have [NAME]-drug resistant organisms, and had a feeding tube.The 7/27/2025 wound culture from the gastrostomy site documented the wound was positive for methicillin-resistant staphylococcus aureus (an antibiotic-resistant bacteria).The Comprehensive Care Plan initiated 7/31/2025, and revised 8/12/2025, documented the resident had methicillin-resistant staphylococcus aureus at their gastrostomy tube site. Interventions included contact precautions, wear gown and gloves when changing contaminated linens, placing linens in a biohazard bag, and antibiotic therapy as ordered. The 8/1/2025 physician order documented contact precautions for methicillin-resistant staphylococcus aureus in the gastrostomy site. During an observation on 8/13/2025 at 10:26 AM, the door to Resident #8's room had an enhanced barrier precaution sign next to Residents #8's name. The sign documented to see the nurse before entering and wear gloves and a gown. Licensed Practical Nurse # 20 entered Resident #8 room to perform care to the resident's gastrostomy tube site. They approached the resident's bed, put on gloves, removed the dressing containing brown drainage, cleansed the area with wound cleanser, and wiped the area. After cleaning the area, they removed their gloves and disposed of them in a trash bin inside the resident's room. They washed their hands and left the room. They did not wear a gown while performing gastrostomy care. During an interview on 8/14/2025 at 2:53 PM, Licensed Practical Nurse #20 stated if a resident was on isolation precautions it would be documented in the care plan. The Infection Control Nurse put a sign outside the door noting the type of precautions to be maintained and (continued on next page)

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	08/15/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a cart outside the door filled with gowns, masks, gloves, and face shields. There were not any residents on contact precautions on the unit at this time and no one with methicillin-resistant staphylococcus aureus. Resident #8 was on enhanced barrier precautions because they had a gastrostomy tube. After looking in the electronic record they stated Resident #8 had methicillin-resistant staphylococcus aureus and they should have worn a gown when they completed wound care to the gastrostomy site because it was draining. They stated they did not wear a gown because the sign outside the door was incorrect. During an interview on 8/15/2025 at 8:05 AM, Registered Nurse Unit Manager #6 stated if a resident was on isolation precautions the Unit Manager placed a bin of personal protective equipment outside the resident's door, placed the sign documenting the type of precaution and required personal protective equipment, and updated the care plan. They expected staff to follow posted signage. Resident #8 was on contact precautions for methicillin-resistant staphylococcus aureus. They changed the sign on 8/14/2025, when Licensed Practical Nurse #20 told them the incorrect sign was posted. They did not know why the Contact Precautions sign was not previously posted when the order was changed.During an interview on 8/15/2025 at 12:11 PM, the Director of Nursing, formerly the Infection Preventionist, stated isolation precautions were implemented based on the order from the provider. All staff were trained on infection control practices and were required to follow the posted signage. Signs should be accurate. Staff should wear a gown and gloves when they completed a dressing change to prevent the spread of infection. 10NYCRR 415.19(a)(b)