STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335761	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Luxor Nursing and Rehabilitation at Sayville	300 Broadway Avenue Sayville, NY 11782

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review during an abbreviated survey (Complaint Number: NY00371931), the facility did not ensure resident rights to be free from neglect. Specifically, one (Resident #2) of three residents reviewed for neglect, required two-person assistance for mechanical lift (Hoyer) for transfers as documented in the Comprehensive Care Plan (CCP). A Certified Nursing Assistant (CNA #2) neglected to implement the Comprehensive Care Plan. Certified Nursing Assistant #2 placed a Hoyer sling under Resident #2 by themselves and proceeded to transfer Resident #2 alone. This negligence resulted in Resident #2 's being lowered to the floor. Resident #2 was transferred to the hospital and diagnosed with a contusion. The Findings are: The Review of the facility policy dated 8/2029 entitled Lift, Mechanical documented at least two nursing assistants are needed to safely move a resident with a mechanical lift. The policy and procedure titled Resident Abuse, Mistreatment, Neglect and Exploitation revised 12/2022 defined neglect as failing to provide timely, consistent, safe, adequate and appropriate services, treatment and/or care to a resident of a residential care facility while resident is under the supervision of the facility. The policy also documented a federal definition of neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Resident # 2 was admitted to the facility on [DATE] with diagnoses that included, anemia, (low blood count), peripheral vascular disease (circulation problems) and dementia(confusion). The review of the Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 99 indicating severe impairment for decision making and is dependent on staff for chair to bed transfer. The review of the Comprehensive Care Plan (CCP) titled Risk for Falls dated 11/24/2024 documented at risk for falls, actual fall, mechanical Hoyer lift, the interventions documented bilateral floor mats at bedside bed. Perimeter mattress, yellow star program identified as frequent faller. The review of the [NAME] dated 4/9/2024 documented interventions including chair/bed chair transfer: 2-person mechanical lift, shower transfer: two-person mechanical lift. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The review of the progress notes dated 2/3/2025 at 2:00 PM documented the Registered Nurse was called to resident's room. Resident #2 was observed on floor next to bed lying on right side. Certified Nurse's Aide in room and stated, during transfer from bed to wheelchair via Hoyer Resident started to slide out of Hoyer out of Hoyer pad and slid to floor. The Resident complained severe pain to right shoulder and right hip. Resident maintained in same position and 911 was called. 911 responded and placed resident into stretcher from floor. Resident transferred to the hospital. The facility's Investigative Summary dated 2/3/2025 documented on 2/3/2025, the Registered Nurse was called to evaluate Resident #2. Resident #2 was lowered to the floor. The nurse observed Resident#2 on the floor with the Hoyer pad underneath the Resident, the nurse aid was standing beside the Resident. The Resident #2 was lying on right side, alert and awake. The nursing supervisor conducted a full body assessment. The neurological assessment was at baseline, there was no Loss of consciousness noted by the nurse's aide. Vital signs were stable, the Resident was complaining of right hip and right shoulder pain. The primary care physician ordered to send Resident #2 to the emergency room via 911 to rule out any injury. Emergency Medical Services responded to the facility and transferred the Resident to the hospital. The investigation conclusion documented no cause to believe any abuse, mistreatment or neglect. The Facility Investigative Summary also documented that the Certified Nursing Assistant (CNA)#2 was interviewed and ascertained the resident required an assist of two for transfer per plan of care and resident's [NAME]. The caregiver was suspended pending investigation due to the break in resident's plan of care. The Certified Nurse's Aide was given an in-service on the need to follow the comprehensive care plan and resident [NAME] and need to use an assist of 2 when placing on Hoyer pad to transfer with the Hoyer. The review of the Hospital after visit summary dated 2/3/2025 documented CT Brain dated 2/3/2025 no acute intracranial hemorrhage, no acute fracture; CAT scan of spine dated 2/3/2025 vertebral body heights are maintained, no acute fracture; The x-ray of the right knee dated 2/3/2025 documented no acute fracture with degenerative changes and the resident was returned to the facility with diagnosis of urinary tract infection. During the telephone interview dated 4/29/2025 at 2:20PM, with the unit 7:00 AM -3:00 PM shift Certified Nurse's Aide # 2 who was on duty 2/3/2025 and the Certified Nurse's Aide for Resident #2 they stated they were assigned to Resident #2. Resident #2 was trying to stand up on own and they wanted to put the resident into the wheelchair. The Resident is a Hoyer transfer, supposed to have 2 people. The stated the other Certified Nurse's Assistant were busy, and they started to put resident in sling while still in bed, putting feet on the floor, but while lifting the resident the sling broke. Certified Nurses Aid #2 stated they held the resident and lowered the resident to the floor slowly. They called for the Registered Nurse, all the nurses came in. The nurses called 911 and took the resident out of the facility. During the interview dated 4/15/2025 at 11:37AM, with the unit 7:00 AM -3:00 PM per diem, Registered Nurse Supervisor (Nurse) # 3 who was on duty 2/3/2025 Registered Nurse they stated at about 10:30AM, they were called to Resident #2's room by Certified Nurse's Aide, that Resident # 2 slid out of the Hoyer. They stated they assessed the resident and called 911. They started during an investigation they identified the Hoyer pad loop was broken, and the Certified Nurse's Aide stated resident was slid to floor. Does not recalled if the Certified Nurse's Aide examined the loop prior to using the Hoyer. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The telephone interview dated 4/15/2025 at 3:30PM with Director of Nursing, they stated the resident was sent via 911 to the hospital. No fractures were identified for the Resident. An investigation was completed for the Certified Nurse's Aide transferring a resident via Hoyer with only one person present. There should have been two staff present to transfer Resident #2 with the Hoyer. 483.12(a)[1]