

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Huntington Hills Ctr for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 400 South Service Road Melville, NY 11747	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48827</p> <p>Based on record review and interviews during the Recertification Survey and Abbreviated Survey (NY 00331241) initiated on 11/06/2024 and completed on 11/15/2024 the facility did not ensure that all alleged violations, including injuries of unknown source, were reported not later than 24 hours if the events that cause the allegation do not include abuse or do not result in a serious bodily injury, to the New York State Department of Health. This was identified for one (Resident #54) of five residents reviewed for Abuse. Specifically, Resident #54 reported that a nurse erroneously administered an injectable medication to the resident's abdominal area. Upon assessment, the resident had a bruise on the lower left side of the abdomen. The facility investigation documented there was inconclusive evidence to determine if the resident erroneously received an injectable and the cause of the bruise was unknown. The facility did not report the injury of unknown origin incident to the New York State Department of Health.</p> <p>The finding is:</p> <p>The facility's policy titled Accident/Incident revised on 6/2024 documented the Licensed Nurse or Nurse Supervisor will complete and document the evaluation of the resident's condition including vital signs, type of injury, location on the body, and skin tear or bruise measurements. If the occurrence is an injury of unknown origin i.e., skin tear or bruise, statements from staff members on the unit will be taken to try and determine the cause of the injury. The results of the investigation will be reported to the New York State Department of Health by the Administrator or Director of Nursing Services.</p> <p>Resident #54 was admitted with diagnoses including Anxiety Disorder, Chronic Obstructive Pulmonary Disease, and Dementia. The Admission Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 10, indicating the resident had moderate cognitive impairment. The Minimum Data Set documented no Behavioral Symptoms.</p> <p>The Total Body Skin assessment dated [DATE] documented skin color normal for the ethnic group, with no wounds.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 335818	Facility ID: 335818 If continuation sheet Page 1 of 21

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility Complaint Form dated 12/08/2023 at 8:00 PM documented the family member reported Resident #54 told them a nurse took Resident #54 away from Bingo activity and administered an injection to the resident's abdomen. Resident #54 was alert with a Brief Interview for Mental Status score of 15 (indicating intact cognition). On 12/9/2023, the Infection Preventionist assessed the resident and noted an ecchymotic area on the left lower quadrant of the abdomen.</p> <p>A document entitled Grievance documented on 12/8/2023 Resident #54 reported by Licensed Practical Nurse #2 that they received an injection to their abdomen on 12/8/2023 between 2:30 PM and 2:45 PM and wanted to know what it was for. The Director of Nursing Services was notified, and a Grievance form was initiated. On 12/9/2023, the Infection Preventionist reviewed the Grievance form, assessed the resident, and noted a small 2.5 x 2.5 (no unit of measurement) discoloration on the left lower quadrant of the resident's abdomen, with no open area and no swelling.</p> <p>The Investigation Statement written by Licensed Practical Nurse #2 dated 12/11/2023 documented on 12/8/2023 Resident #54 stated they received an injection to their stomach and wanted to know the name of the medication. The resident did not have an order for an injectable medication. The resident's abdomen was noted with an old site with multiple colors of yellow, purple, and blue.</p> <p>A review of the medical record revealed there were no nursing progress notes, evaluations, or skin checks that documented Licensed Practical Nurse #2's or the Infection Preventionist's observation of a bruise to Resident #54's left lower quadrant.</p> <p>A Nurse Practitioner's note dated 12/09/2023 at 4:51 PM written by Nurse Practitioner #1 documented the resident was seen and examined today due to the nursing staff's request as the resident has a bruise on the left side of the abdomen, the resident denies and fall or injury. The note did not document any clinical factors that may have caused the identified bruise.</p> <p>The undated Investigative Summary, signed by the former Director of Nursing Services, documented that the investigation could not conclusively determine if any injectable was administered to the resident at this time.</p> <p>During an interview on 11/12/2024 at 11:08 AM, Licensed Practical Nurse #3 stated they were the assigned medication nurse on 12/08/2023 on the day shift when Resident #54 alleged they received an injection to their abdomen. Licensed Practical Nurse #3 stated Resident #54 did not have orders for injectable medications. Licensed Practical Nurse #3 stated they went to the Bingo room and administered Tylenol to Resident #54. Licensed Practical Nurse #3 stated the resident is alert and always asks what medication is being administered to them, before taking their medications.</p> <p>During an interview on 11/12/2024 at 1:06 PM, the Infection Preventionist stated they were the Nurse Supervisor on 12/09/2023 when they were called to assess Resident #54. The Infection Preventionist stated the resident had a bruise to the left lower abdomen. The Infection Preventionist stated they did not where the bruise came from.</p> <p>During an interview on 11/12/2024 at 1:13 PM, Licensed Practical Nurse #2 stated during the medication pass on 12/8/2023, the resident stated they got an injection that afternoon and wanted to know what it was. Licensed Practical Nurse #2 read through the orders and looked at the Medication Administration Record; they could not find any injectable medications that this resident may have received. Licensed Practical Nurse #2 did not know why the resident had bruising on the abdomen.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/24 at 10:30 AM, the former Director of Nursing Services stated the bruise to the resident's abdomen was small, and they did not think the bruise was from an injection. The former Director of Nursing Services stated they were focused on the resident saying they received an injection and they did not think of the bruise as an injury. The former Director of Nursing Services stated the incident should have been reported to the New York State Department of Health as an injury of unknown origin. The Director of Nursing Services or the Assistant Director of Nursing Services was responsible for reporting the Accident and Incident to the New York State Department of Health.</p> <p>During a re-interview on 11/13/2024 at 11:04 AM, the Infection Preventionist Nurse stated they did not write a progress note in the medical record after they observed Resident #54's bruise on 12/9/2024.</p> <p>During an interview on 11/13/2024 at 12:11 PM, the Director of Nursing Services stated Resident #54's grievance was reviewed with the former Director of Nursing Services, and after the investigation, they were able to determine that the individual did not get an injection. The Director of Nursing Services stated if the facility cannot conclude where the bruise came from, then the facility should report an injury of unknown origin to the New York State Department of Health. The Director of Nursing Services stated that based on the definition of injury of unknown origin, the bruise identified on Resident #54's abdomen was an injury of unknown origin that should have been reported to the New York State Department of Health.</p> <p>10 NYCRR 415.4(b)(2)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585</p> <p>Based on observations, record review, and interviews during the Recertification Survey initiated on 11/6/2024 and completed on 11/15/2023, the facility did not ensure that Residents who needed respiratory care were provided such care consistent with professional standards of practice. This was identified for one (Resident #236) of two residents reviewed for Respiratory care. Specifically, Resident #236 had a physician's order to receive 4 liters per minute of supplemental oxygen. The resident was observed receiving oxygen at a liter flow less than the current physician's order.</p> <p>The finding is:</p> <p>The facility's policy for Oxygen, revised on 2/2022, documented that oxygen is administered by licensed staff under a physician's order to oxygenate and provide comfort to residents' acute or chronic respiratory difficulties. The procedure includes checking the physician's orders for oxygen administration, the prescribed liter flow rate, and the frequency of oxygen administration.</p> <p>Resident # 236 was admitted with diagnosis that includes Chronic Obstructive Pulmonary Disease. The Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status score of 11, which indicated Resident#236 had moderately impaired cognition. Resident#236 did not have any behavior concerns. The Minimum Data Set indicated Resident#236 received continuous oxygen therapy. Resident#236 required substantial/maximal assistance (Staff does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort).</p> <p>The Comprehensive Care Plan dated 6/13/2024 documented altered respiratory status/difficulty breathing related to oxygen use. The Interventions included oxygen therapy via nasal cannula at 4 liters per minute.</p> <p>The physician orders dated 10/21/2024 documented to administer oxygen at 4 liters per minute via a nasal cannula (tubing used to provide external oxygen through the nose) continuously for shortness of breath.</p> <p>During an observation on 11/07/2024 at 01:27 PM, Resident #236 was sitting in the wheelchair in the hallway and was receiving supplemental oxygen at 2 liters per minute via a nasal cannula from a portable tank.</p> <p>During an observation and interview on 11/13/24 at 9:55 AM, Resident #236 was observed sitting in the wheelchair in the hallway and was receiving supplemental oxygen at 2 liters per minute via a nasal cannula from a portable tank. Resident #236 stated Certified Nursing Assistant # 6 put the oxygen on for them when they were transferred this morning to the wheelchair.</p> <p>During an interview on 11/13/2024 at 10:00 AM, Registered Nurse # 4 stated the resident should be receiving 4 liters of oxygen as per the physician's orders. The resident's oxygen was not checked by themselves this morning when they were transferred from the bed into the wheelchair.</p> <p>During an interview on 11/13/2024 at 10:05 AM, Certified Nursing Assistant # 6 stated they transferred the resident into the wheelchair; however, they did not touch the resident's oxygen.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2024 at 01:13 PM the Director of Nursing Services stated that Certified Nurse Assistants cannot touch the residents' oxygen or adjust the flow rate. When the resident's oxygen source was changed from their oxygen concentrator to the portable oxygen canister, the Registered Nurse should have ensured the oxygen was set to the correct flow rate.</p> <p>10 NYCRR 415.12(k)(6)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963</p> <p>Based on interviews and record review conducted during a Recertification Survey and Abbreviated Survey (NY 00350913) initiated on 11/6/2024 and completed on 11/15/2024, the facility did not ensure the Physician reviewed the resident's total program of care at each visit. This was identified for one (Resident #187) of two residents reviewed for Mood and Behavior. Specifically, Resident #187 with a diagnosis of Dementia but no prior history of physical aggression, punched another resident on 5/15/2024 and was ordered for psychiatric evaluation on 5/15/2024. The psychiatric consult was never completed. There is no documented evidence that the Physician followed up on the resident's psychiatric evaluation during their monthly visit in June 2024 and July 2024. Resident #187 subsequently bit another resident on 8/9/2024. The Psychiatrist assessed and evaluated the resident on 8/20/2024 and recommended Lexapro (Medication to treat Anxiety and Depression) 2.5 milligrams once a day.</p> <p>The finding is:</p> <p>The policy and procedure titled Attending Physician provided by the facility was issued by the National Health Care Associates dated 5/2002. The policy documented that the attending Physician shall be responsible for overseeing the medical care and treatment rendered to each resident under their direct supervision. The attending Physician will ensure that each resident's care plan identifies the individual's needs and provides for multi-disciplinary interventions to maximize resident functions.</p> <p>Resident #187 was admitted with diagnoses including Dementia, Hyperlipidemia, and Hypertension. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented the resident did not exhibit any physical behavioral symptoms directed toward others.</p> <p>A review of an Accident and Incident report dated 5/15/2024 documented that on 5/15/2024 at 4:45 PM, the Recreation Therapist witnessed Resident #187 punching another resident on their left arm. When interviewed, Resident #187 could not recall the incident. Resident #187 did not have any behaviors and the incident seemed spontaneous and unprovoked. The care plan was revised to include safety checks every 15 minutes for 24 hours, social work follow-up, psychiatric consult, and to keep both residents separated from each other during activities.</p> <p>A physician's order dated 5/15/2024 documented a psychiatric consult for physical aggression.</p> <p>The Comprehensive Care Plan for Behavior Problems dated 5/20/2024 documented the resident punched another resident on 5/15/2024. The resident has never displayed behavior previously. Interventions included but were not limited to monitoring behavior episodes and attempts to determine the underlying cause.</p> <p>A review of the Physician's monthly progress note dated 5/25/2024, signed by Attending Physician #1, documented that Resident #187 was doing well at baseline cognitively. No other acute issues and concerns were offered by the nursing staff. The progress note did not include documentation related to the resident's recent incident on 5/15/2024 and pending psychiatric consultation.</p> <p>(continued on next page)</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Physician's monthly progress note dated 7/7/2024 and 7/25/2024, signed by Attending Physician #1, documented that Resident #187 was doing well at baseline cognitively. No other acute issues and concerns were offered by the nursing staff. The progress note did not include documentation related to a follow-up on Resident #187's psychiatric evaluation ordered on 5/15/2024.</p> <p>A review of an Accident and Incident report dated 8/9/2024 documented that on 8/9/2024 at 11:30 AM, Resident #187 was witnessed [by Activity staff] biting another resident's right palm. Resident #187 could not recall the incident. There were no untoward/unusual incidents, or changes in behaviors in both residents before the incident.</p> <p>A review of the Physician's progress note dated 8/9/2024 documented that Resident #187 was examined for an incident with another resident. Resident #187 had a history of Dementia and was a poor historian. A psychiatry consult was ordered to evaluate and treat secondary to the biting incident.</p> <p>A physician's order dated 8/9/2024 documented a psychiatric consult for evaluation and treatment as indicated secondary to the biting incident.</p> <p>A review of Resident #187's medical record from 5/15/2024 to 8/20/2024 was conducted. There was no documented evidence that Resident #187 was seen and evaluated by a Psychiatrist until 8/20/2024.</p> <p>A Psychiatric assessment dated [DATE] documented Resident #187's agitation appeared to be secondary to Delirium. The Psychiatrist documented to consider Lexapro 2.5 milligrams once a day and explore the use of Namenda (medication used to treat Dementia associated with Alzheimer's Disease) as needed.</p> <p>The Comprehensive Care Plan for Psychosocial Well-being Potential related to Dementia, dated 9/3/2021 and revised 8/12/2024 documented the resident had behavioral concerns and had two incidents with other residents. The resident had mental health needs and required psychiatric evaluation as needed. Interventions included but were not limited to psychiatric/psychological consult as requested or indicated.</p> <p>During an interview on 11/13/2024 at 12:31 PM, Physician Assistant #1 stated they worked with Physician #1 and oversaw Resident #187's medical care. Physician Assistant #1 stated they were notified about Resident #187's altercation with another resident in May 2024 and they ordered psychiatric consultation. Physician Assistant #1 stated that it slipped their mind to follow up on Resident #187's psychiatric consult as no other behavioral problems were brought to their (Physician Assistant #1) attention after the incident in May. Physician Assistant #1 stated the psychiatric evaluation should have been completed and they (Physician Assistant #1) should have followed up on whether any recommendations were made by the Psychiatrist.</p> <p>During an interview on 11/13/2024 at 2:40 PM, Physician #1, who was Resident #187's attending Physician, stated they did not recall Resident #187's resident-to-resident altercation incident in May and whether a psychiatric consult was ordered. Physician #1 stated they expected to be informed if a consult was not completed. Physician #1 stated they have never observed Resident #187 exhibiting undesired behaviors. A psychiatric evaluation would be beneficial to assess the resident's sudden change in behaviors after the incident. Physician #1 stated they had not personally discussed Resident #187's condition with the Psychiatrist since they (Physician #1) never observed any behavior.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/13/2024 at 3:40 PM, the Medical Director stated a psychiatrist consultation was a standard intervention for all incidents involving resident-to-resident altercations. The Medical Director stated that the medical provider forgot to follow up on the result of Resident #187's psychiatric consult and they should have.</p> <p>10 NYCRR 415.15(b)(2)(iii)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>17585</p> <p>Based on record review and interviews during the Recertification Survey and Abbreviated Survey (Complaint # NY 00356442) initiated on 11/6/2024 and completed on 11/15/2024, the facility did not ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident. This was identified for eight of eight nursing units during the Sufficient Staffing Task. Specifically, 1) a review of the Payroll-Based Journal (PBJ) Staffing Data Report Quarter three, 2024 (April 1st- June 30th) and the weekend of 11/9/2024 to 11/10/2024 indicated excessively low weekend staffing; 2) a review of the daily staffing sheets revealed the facility did not provide sufficient number of Licensed Nurses as indicated in the Facility Assessment; 3) during the Resident Council meeting dated 11/7/2024, three of thirteen resident attendees verbalized concerns regarding short staffing on weekends.</p> <p>This is a repeat deficiency.</p> <p>Cross Reference:</p> <p>F 835 Administration</p> <p>F 838 Facility Assessment</p> <p>The findings are:</p> <p>The Facility does not have a Staffing Policy.</p> <p>1) The Payroll-Based Journal Daily Nurse Staffing Data Report dated for Fiscal Year (FY) Quarter three 2024 (April 1st- June 30th) documented the facility triggered for the Metric of excessively low weekend staffing.</p> <p>The Facility Assessment, dated 2/25/2024 and last reviewed 8/2/2024 documented based on data from several sources including multiple nursing home associations, census-based staffing levels would be approximately one nurse (Registered Nurse or Licensed Practical Nurse) assigned to eight to ten residents and approximately one aide (Certified Nursing Assistant) assigned to ten to fifteen residents.</p> <p>The Facility Assessment further documented:</p> <p>-For a Census of 20 residents with low acuity, there should be two Nurses and three Certified Nurse Assistants; with medium acuity, there should be three Nurses and four Certified Nurse Assistants; and with high acuity, there should be three Nurses and five Certified Nurse Assistants assigned for the 20 residents.</p> <p>-For a census of 30 residents with low acuity, there should be three Nurses and four Certified Nursing Assistants; with medium acuity, there should be four Nurses and five Certified Nurse Assistants; and with high acuity, there should be five Nurses and six Certified Nurse Assistants for the 30 residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-For a census of 40 residents with low acuity there should be four Nurses and five Certified Nursing Assistants; with medium acuity, there should be five Nurses and six Certified Nurse Assistants; and with high acuity, there should be six Nurses and seven Certified Nurse Assistants for the 40 residents.</p> <p>The Facility Assessment did not include a breakdown of staffing needs for each of the facility's eight units.</p> <p>2) A review of the facility's Daily Census Reports from 4/1/2024 to 6/30/2024 revealed the following:</p> <p>Unit 1A maintained a census between 31 and 38 on the weekends</p> <p>Unit 1B maintained a census between 26 and 39 on the weekends</p> <p>Unit 1C maintained a census between 22 and 37 on the weekends</p> <p>Unit 1D maintained a census between 38 and 40 on the weekends</p> <p>Unit 2A maintained a census between 38 and 40 on the weekends</p> <p>Unit 2B maintained a census between 34 and 40 on the weekends</p> <p>Unit 2C maintained a census between 39 and 40 on the weekends</p> <p>Unit 2D maintained a census between 37 and 40 on the weekends</p> <p>A review of the daily staffing sheets from 4/1/2024 to 6/30/2024 revealed the following:</p> <p>During the 6:30 AM to 2:30 PM Shift:</p> <p>Unit 1A had one licensed nurse assigned on 5/12/2024.</p> <p>Unit 1B had one licensed nurse assigned on 5/5/2024 and 5/12/2024.</p> <p>Unit 1C had one licensed nurse assigned on 4/13/2024, 4/20/2024, 4/28/2024, 5/12/2024, and 6/9/2024.</p> <p>Unit 1D had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2A had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Huntington Hills Ctr for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 400 South Service Road Melville, NY 11747	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Unit 2B had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2C had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2D had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>During the 2:30 PM to 10:30 PM Shift:</p> <p>Unit 1C had one licensed nurse assigned on 5/12/2024 and 6/8/2024.</p> <p>Unit 1D had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2A had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2B had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2C had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>Unit 2D had one licensed nurse assigned on 4/6/2024, 4/7/2024, 4/13/2024, 4/14/2024, 4/20/2024, 4/21/2024, 4/27/2024, 4/28/2024, 5/4/2024, 5/5/2024, 5/11/2024, 5/12/2024, 5/18/2024, 5/19/2024, 5/25/2024, 5/26/2024, 6/1/2024, 6/2/2024, 6/8/2024, 6/9/2024, 6/15/2024, 6/16/2024, 6/22/2024, 6/23/2024, 6/29/2024, and 6/30/2024.</p> <p>3) A Resident Council meeting was held on 11/7/2024 with 13 residents in attendance. 3 of the 13 residents complained about staffing shortage and stated that the nursing staff members were overburdened and therefore, the call bell responses were delayed:</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Resident #143 stated the facility had been short-staffed, especially on Sundays, and because of the short staffing, they had to wait for 40 minutes to get assistance to use the bathroom.</p> <p>-Resident # 157 stated when they ring their call bell, the staff turns off the call bell without responding to them.</p> <p>-Resident # 145 stated the facility is short-staffed on the weekends and holidays, especially the morning shift. It takes a very long time for them to receive their morning care. Resident #145 stated to use the bathroom, they must wait because they are at the mercy of the staff and this makes them feel very indignified. Resident #145 stated they are awake at 6:00 AM but must wait until 10 AM-10:30 AM to receive their morning care.</p> <p>During an interview on 11/06/2024 at 10:45 AM, the facility Ombudsman stated the facility has low staffing on the weekends. Staffing concern was shared with the facility Administrator and the Director of Nursing Services and they said the facility was hiring and training new staff and the administration will provide enhanced weekend supervision. Low staffing has been a consistent issue since the last survey. The Ombudsman stated the residents have reported they had to wait over two hours to receive incontinence care and the staff members do not respond to call bells in a timely manner.</p> <p>During an interview on 11/15/2024 at 11:09 AM, an anonymous Certified Nursing Assistant # 8 stated the facility has a staffing shortage, especially on the weekends and it is hard to provide necessary care to residents on time. There are a lot of call-outs on the weekends and there is no coverage for those call-outs.</p> <p>During an interview on 11/15/2024 at 11:37 AM, an anonymous Certified Nursing Assistant # 9 stated over the summer, the facility was short-staffed on weekends during the day shift. There were a lot of call-outs and the facility was not able to get staff to cover for the call-outs.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/14/2024 at 10:44 AM, the Staffing Coordinator stated they use the Par (set staffing) levels to staff each unit each shift. The Staffing Coordinator stated that the nursing par levels are not documented anywhere. The Staffing Coordinator stated on the morning shift (6:30 AM- 2:30 PM) Unit 1A and Unit 1B should have four Nurses (Registered Nurses and Licensed Practical Nurses) and five Certified Nursing Aides; Unit 1C should have three to four Nurses (Registered Nurses and Licensed Practical Nurses) and five Certified Nursing Assistants; Unit 1D should have two Nurses (Registered Nurses and Licensed Practical Nurses) and six Certified Nursing Assistants; Unit 2A, 2B, 2C, and 2D should have two Nurses (Registered Nurses and Licensed Practical Nurses) and five Certified Nursing Assistants. On the evening shift (2:30 PM to 10:30 PM) Units 1A, 1B, and 1C should have two Nurses and 4 Certified Nursing Assistants; Unit 1D should have one Nurse and five Certified Nursing Assistants; Units 2A, 2B, 2C, and 2D should have one Nurse and four Certified Nursing Assistants. The Staffing Coordinator stated the staffing on the weekend is lower than the staffing during the weekdays. On the day shift there should be two nurses and five Certified Nursing Assistants for the Unit 1A, 1B, and 1C. Unit 1D should have one Nurse and six Certified Nursing Assistants. Unit 2 A, 2B, 2C, and 2D should have one Nurse and five Certified Nursing Assistants. On the evening shift for Units 1A, 1B, and 1C there should be two Nurses and four Certified Nursing Assistants. Unit 1D should have one Nurse and five Certified Nursing Assistants and Units 2 A, 2B, 2C, and 2D should have one Nurse and four Certified Nursing Assistants. The Staffing Coordinator stated they only work from Monday to Friday and there is no Staffing Coordinator on the weekends. The Nursing Supervisors are supposed to find staff on the weekends when Certified Nursing Assistants or Nurses call out. The facility does not use staffing agencies for Certified Nursing Assistants; however, have contracts with staffing agencies for licensed nurses. The Staffing Coordinator stated they were not told about the required staffing levels documented in the Facility Assessments.</p> <p>During an interview on 11/15/2024 at 2:59 PM, the Administrator stated that the facility Ombudsman had brought staffing concerns to their attention in June 2024. The Administrator met with the Director of Nursing Services and adjusted the staffing levels. The Administrator stated the Facility Assessment does not break down the facility staffing needs per unit per shift. The Administrator stated that the Facility Assessment indicated there should be one Nurse assigned for every 8 to 10 residents and the units should be staffed as per the Facility Assessment. The number of nursing staff assigned on the weekend did not match the number of nursing staff required in the Facility Assessment and they were not aware that on the weekends the facility was staffed with fewer nursing staff than on the weekdays. The administrator stated that the facility was cited for insufficient staffing on the previous survey and therefore, staffing should have been looked into more closely in the Facility Assessment. The Administrator stated the facility does not have a policy on staffing and should be staffed based on the staffing levels documented in the Facility Assessment. The Administrator stated the Staffing Coordinator and the Director of Nursing Services should have been aware of the required staffing levels documented in the Facility Assessment.</p> <p>During an interview on 11/15/2024 at 3:24 PM, the Director of Nursing Services stated they were not aware of staffing levels that were documented in the Facility Assessment (one nurse for 8 to 10 residents) and were not involved in reviewing or revising the staffing portion of the Facility Assessment. The Director of Nursing Services stated that the facility Administrator was made aware of less nursing staff assigned on the weekends than on the weekdays when they discussed the adjusted staffing levels. The Director of Nursing Services stated in the summer, it was difficult to obtain staff on the weekends when the scheduled staff members called out.</p> <p>10 NYCRR-415.13(a)(1)(i-iii)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17585</p> <p>Based on observations, record review, and interviews during the Recertification Survey and Abbreviated Survey (Complaint # NY 00356442) initiated on 11/6/2024 and completed on 11/15/2024, the facility was not administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility was not effectively administered to ensure sufficient staffing was provided to promote the highest practicable physical mental, and psychosocial well-being of each resident. The Facility Assessment did not include the overall number of facility staff needed to ensure that each resident's needs were being met. Additionally, the Administrator did not monitor and enhance the quality of care and services by repeating the same deficiencies: F 695 Respiratory/Tracheostomy Care and Suctioning, F 725 Sufficient Nursing Staff, and F 838 Facility Assessment.</p> <p>Cross Reference:</p> <p>F 725 Sufficient Nursing Staff</p> <p>F 838 Facility Assessment</p> <p>The finding is:</p> <p>The Facility assessment dated [DATE] revealed that the assessment did not include a breakdown of Registered Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nursing Assistant (CNA) levels by unit and by nursing shifts to ensure that each resident's needs were being met.</p> <p>During an interview on 11/15/2024 at 2:59 PM, the Administrator stated that the facility Ombudsman had brought staffing concerns to their attention in June 2024. The Administrator met with the Director of Nursing Services and adjusted the staffing levels. The Administrator stated the Facility Assessment does not break down the facility staffing needs per unit per shift. The Administrator stated that the Facility Assessment indicated there should be one Nurse assigned for every 8 to 10 residents and the units should be staffed as per the Facility Assessment. The number of nursing staff assigned on the weekend did not match the number of nursing staff required in the Facility Assessment and they were not aware that on the weekends the facility was staffed with fewer nursing staff than on the weekdays. The administrator stated that the facility was cited for insufficient staffing on the previous survey and therefore, staffing should have been looked into more closely in the Facility Assessment. The Administrator stated the facility does not have a policy on staffing and should be staffed based on the staffing levels documented in the Facility Assessment. The Administrator stated the Staffing Coordinator and the Director of Nursing Services should have been aware of the required staffing levels documented in the Facility Assessment.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/2024 at 3:24 PM, the Director of Nursing Services stated they were not aware of staffing levels that were documented in the Facility Assessment (one nurse for 8 to 10 residents) and were not involved in reviewing or revising the staffing portion of the Facility Assessment. The Director of Nursing Services stated that the facility Administrator was made aware of less nursing staff assigned on the weekends than on the weekdays when they discussed the adjusted staffing levels. The Director of Nursing Services stated in the summer, it was difficult to obtain staff on the weekends when the scheduled staff members called out.</p> <p>10 NYCRR 415.26</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies.</p> <p>17585</p> <p>Based on record review and staff interviews during the Recertification Survey initiated on 11/6/2024 and completed on 11/15/2024, the facility did not ensure its Facility Assessment considered specific staffing needs for each shift and each resident unit (first floor and second floor) in the facility. Specifically, the Facility Assessment, last updated in February 2024, did not include a breakdown of staffing needs for each of the facility's eight units for each shift.</p> <p>Cross Reference:</p> <p>F 725 Sufficient Nursing Staff</p> <p>F 835 Administration</p> <p>The finding is:</p> <p>The Facility Assessment, dated 2/25/2024, documented based on data from several sources including multiple nursing home associations, census-based staffing levels would be approximately one nurse (Registered Nurse or Licensed Practical Nurse) assigned to eight to ten residents and approximately one aide (Certified Nursing Aide) assigned to ten to fifteen residents.</p> <p>The Facility Assessment further explained:</p> <p>-For a Census of 20 residents with low acuity, there should be two Nurses and three Certified Nurse Assistants; with medium acuity, there should be three Nurses and four Certified Nurse Assistants; and with high acuity, there should be three Nurses and five Certified Nurse Assistants assigned for the 20 residents.</p> <p>-For a census of 30 residents with low acuity, there should be three Nurses and four Certified Nursing Assistants; with medium acuity, there should be four Nurses and five Certified Nurse Assistants; and with high acuity, there should be five Nurses and six Certified Nurse Assistants for the 30 residents.</p> <p>-For a census of 40 residents with low acuity there should be four Nurses and five Certified Nursing Assistants; with medium acuity, there should be five Nurses and six Certified Nurse Assistants; and with high acuity, there should be six Nurses and seven Certified Nurse Assistants for the 40 residents.</p> <p>The Facility Assessment did not include a breakdown of staffing needs for each of the facility's two units for each shift.</p> <p>(continued on next page)</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 11/15/2024 at 2:59 PM, the Administrator stated the Facility Assessment does not break down the facility staffing needs per unit per shift. The Administrator stated that the Facility Assessment indicated there should be one Nurse assigned for every 8 to 10 residents and the units should be staffed as per the Facility Assessment. The administrator stated that the facility was cited for insufficient staffing on the previous survey and therefore, in the Facility Assessment, nursing staffing should have been reviewed closely. The Administrator stated the facility does not have a policy on staffing and should be staffed as per the Facility Assessment. The Administrator stated the Staffing Coordinator and the Director of Nursing Services should have been aware of the required staffing levels documented in the Facility Assessment.</p> <p>During an interview on 11/15/2024 at 3:24 PM, the Director of Nursing Services stated they were not aware of staffing levels that were documented in the Facility Assessment (one nurse for 8 to 10 residents) and were not involved in reviewing or revising the staffing portion of the Facility Assessment.</p> <p>10 NYCRR 415.26</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44963</p> <p>Based on interviews, observations, and record review conducted during a Recertification Survey and Abbreviated Survey (NY 00350913) initiated on 11/6/2024 and completed on 11/15/2024, the facility did not ensure that timely arrangements were made for outside services that met professional standards. This was identified for one (Resident #187) of two residents reviewed for Mood and Behavior. Specifically, Resident #187 with a diagnosis of Dementia but no prior history of physical aggression, punched another resident on 5/15/2024 and was ordered for psychiatric evaluation on 5/15/2024. There is no documented evidence that the psychiatric consult was completed until 8/20/2024 after Resident #187 bit another resident on 8/9/2024.</p> <p>The finding is:</p> <p>The facility did not develop policy and procedures related to outside consultant.</p> <p>Resident #187 was admitted with diagnoses including Dementia, Hyperlipidemia, and Hypertension. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, which indicated the resident had moderately impaired cognition. The Minimum Data Set documented the resident did not exhibit any physical behavioral symptoms directed toward others.</p> <p>A review of an Accident and Incident report dated 5/15/2024 documented that on 5/15/2024 at 4:45 PM, the Recreation Therapist witnessed Resident #187 punching another resident on their left arm. When interviewed, Resident #187 could not recall the incident. Resident #187 did not have any behaviors and the incident seemed spontaneous and unprovoked. The care plan was revised to include safety checks every 15 minutes for 24 hours, social work follow-up, psychiatric consult, and to keep both residents separated from each other during activities.</p> <p>A physician's order dated 5/15/2024 documented to refer a psychiatric consult for physical aggression.</p> <p>The Comprehensive Care Plan for Behavior Problem dated 5/20/2024 documented the resident punched another resident on 5/15/2024. Resident has never displayed any liked-behavior previously. Interventions included but were not limited to monitor behavior episode and attempt to determine underlying cause.</p> <p>A review of an Accident and Incident report dated 8/9/2024 documented that on 8/9/2024 at 11:30 AM, Resident #187 was witnessed [by Activity staff] biting another resident's right palm. Resident #187 could not recall the incident. There were no untoward/unusual incidents, or changes in behaviors in both residents before the incident.</p> <p>A physician's order dated 8/9/2024 documented a psychiatric consult for evaluation and treatment as indicated secondary to the biting incident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335818	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Huntington Hills Ctr for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 400 South Service Road Melville, NY 11747	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0840</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #187's medical record from 5/15/2024 to 8/9/2024 was conducted. There was no documented evidence that Resident #187 was seen and evaluated by a Psychiatrist during this period. There was no further documentation in the medical record regarding Psychiatric consultation arrangements or cancellations.</p> <p>A Psychiatrist assessment dated [DATE] documented Resident #187's agitation appeared to be secondary to Delirium. The Psychiatrist documented to consider Lexapro 2.5 milligrams once a day and explore the use of Namenda (medication used to treat Dementia associated with Alzheimer's Disease) as needed.</p> <p>During an interview on 11/13/2024 at 9:20 AM, Unit Clerk #1 stated they were responsible for arranging all outside consultation services as per the physician's orders. Unit Clerk #1 stated that they kept a Psychiatry appointment book at the nursing station and updated the list of residents on the appointment book. Unit Clerk #1 stated that the Psychiatrist visited every Tuesday and checked the appointment book for names of residents to be seen. Unit Clerk #1 was not unable provide documented evidence that Resident #187 was on the list to be seen by the Psychiatrist because Unit Clerk #1 did not save the data for May 2024.</p> <p>During an interview on 11/13/2024 at 11:51 AM, Registered Nurse Supervisor #2 stated they ordered the psychiatry consult for Resident #187 on 5/15/2024. Registered Nurse Supervisor #2 stated that the unit clerk should be informed during the day shift nursing report and complete the referral for Psychiatric consultation.</p> <p>During an interview on 11/13/2024 at 12:31 PM, Physician Assistant #1 stated they had ordered a psychiatric consultation for Resident #187 after a resident-to-resident altercation on 5/15/2024. Physician Assistant #1 stated Resident #187 should have been seen by the Psychiatrist no more than two weeks from the day the consultation order was placed.</p> <p>During an interview on 11/13/2024 at 3:40 PM, the Medical Director stated that a psychiatrist consultation was a standard intervention for all incidents involving resident-to-resident altercations. The Medical Director stated that Resident #187 should have been seen by the Psychiatrist as per the physician's order in May 2024.</p> <p>During an interview on 11/13/2024 at 4:14 PM, Psychiatrist #1 stated they visited the facility every Tuesday for the past 6 months including May 2024. Psychiatrist #1 stated they were not aware of the 5/15/2024 consultation order for Resident #187 and would have evaluated the resident if they had been informed by the facility.</p> <p>During an interview on 11/15/2024 at 10:45 AM, the Director of Nursing Services stated the facility did not have a policy and procedures for outside consultation services including psychiatry. The Director of Nursing Services stated they expected the unit manager or unit clerk to place a consultation referral for Resident #187 in May 2024 and follow up to ensure that the consultation was completed.</p> <p>10 NYCRR 415.15(b)(2)(iii)</p>		

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NAME OF PROVIDER OR SUPPLIER Huntington Hills Ctr for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 400 South Service Road Melville, NY 11747	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245</p> <p>Based on observation, record review, and interviews during the Recertification Survey initiated on 11/6/2024 and completed on 11/15/2024, the facility did not establish and maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections. This was identified for two (Resident #627 and Resident #625) of three residents reviewed for Transmission Based Precautions. Specifically, during observation of Resident #627 and Resident #625's shared room, an Isolation Droplet/Contact Precaution sign was observed outside the door for positive COVID-19 (Coronavirus-2019) infection. The precaution signage included instructions for the use of Personal Protective Equipment (PPE) including N95 respirator mask, gloves, a gown, and eye protection (face shield or goggles). Certified Nursing Assistant #1 was observed inside the room and was not wearing appropriate Personal Protective Equipment as indicated on the precaution signage.</p> <p>The finding is:</p> <p>The facility's policy titled Infection Prevention and Control last revised on 6/2024 documented that Contact Precautions are intended to prevent transmission of infectious agents including microorganisms that are spread by direct or indirect contact with the resident or the resident's environment. Donning (putting on) Personal Protective Equipment (PPE) upon entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been associated with transmission through environmental contamination.</p> <p>-Resident #627 was admitted with Diagnoses including Pulmonary Hypertension, COVID-19 infection, and Dementia. A Minimum Data Set (MDS) assessment dated [DATE] had not been completed.</p> <p>The Brief Interview for Mental Status (BIMS) dated 11/5/2024 documented that Resident #627 had a score of 3, which indicated Resident #627 was cognitively impaired.</p> <p>A Comprehensive Care Plan (CCP) dated 11/5/2024 for COVID-19 infection documented interventions that included assisting residents with hand hygiene, respiratory hygiene, and cough etiquette; implementing standard, contact, and droplet precautions, and notifying healthcare providers as needed for worsening conditions.</p> <p>A physician order dated 11/4/2024 documented Droplet/Contact Precautions: Isolation for positive COVID-19 infection every shift for infection control measures for 10 days.</p> <p>-Resident #625 was admitted with Diagnoses including Parkinson's Disease, Acute Pulmonary Edema, and COVID-2019 infection. A Comprehensive Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, indicating Resident #625 had moderately impaired cognition. The Minimum Data Set documented Isolation/Quarantine for active infectious disease.</p> <p>A Comprehensive Care Plan (CCP) dated 11/5/2024 documented confirmed COVID-19 infection with interventions that included Contact/Droplet Precaution and assisting residents with hand hygiene as needed.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Huntington Hills Ctr for Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 400 South Service Road Melville, NY 11747	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A physician order dated 11/5/2024 documented Droplet/Contact Precautions: Isolation for positive COVID-19 infection every shift for infection control measures for 10 days.</p> <p>During an observation on 11/6/2024 at 12:29 PM, a precautions sign was posted outside Resident #627 and Resident #625's shared room. The signage read: Contact/Droplet Isolation Precautions; everyone must perform hand hygiene before and after entering the room. Use Personal Protective Equipment (PPE) including a gown, N95 respirator, eye protection (face shield or goggles), and gloves before entering. Discard the gown, gloves, N95 respirator, and eye protection before exiting the room. Keep the room door closed (if not on a dedicated and physically separated unit). The room door was open and Certified Nursing Assistant #1 was observed inside the room without a gown, an N95 respirator mask, eye protection, or gloves. Certified Nursing Assistant #1 was wearing a surgical mask.</p> <p>During an interview on 11/6/2024 at 12:40 PM, Certified Nursing Assistant #1 stated they went to Resident #627 and Resident #625's shared room to pick up the meal trays after the residents completed their meals and forgot to put the Personal Protective Equipment (PPE). Certified Nursing Assistant #1 stated they should have put on, a gown, an N95 respirator mask, a face shield, and gloves when they entered Resident #627 and Resident #625's room.</p> <p>During an interview on 11/6/2024 at 1:00 PM, Registered Nurse #1 (the Unit Supervisor) stated that Certified Nursing Assistant #1 should have used appropriate Personal Protective Equipment as directed on the precautions signage and the resident's room door should also be kept closed; staff must have forgotten to close the door.</p> <p>During an interview on 11/7/2024 at 8:53 AM, the Infection Preventionist stated staff should wear appropriate Personal Protective Equipment (PPE) when entering the isolation rooms. The Infection Preventionist stated that Certified Nursing Assistant #1 did not follow the facility's infection control procedure.</p> <p>During an interview on 11/7/2024 at 3:07 PM, the Director of Nursing Services stated that Certified Nursing Assistant #1 should have put on Personal Protective Equipment (PPE) when they entered Resident #627 and Resident #625's room. The Director of Nursing Services stated their expectation included staff following proper infection control guidelines to prevent further transmission of infection.</p> <p>10 NYCRR 415.19(a) (1-3)</p>		