STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335674	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Hamlet Rehabilitation and Healthcare Center At	100 Southern Boulevard Nesconset, NY 11767

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49245 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/12/2025 and completed on 2/20/2025, the facility did not ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practices, to promote healing and prevent infections. This was identified for one (Resident #11) of four residents reviewed for Pressure Ulcer/Injury. Specifically, Resident #11 had a Stage 4 Pressure Ulcer (full-thickness tissue loss that exposes bone, tendon, or muscle) on the left buttock and sacrum (bottom of the spine). Resident #11 had a Physician's order to cleanse the wound with Dakin's solution (a diluted bleach solution, used as antiseptic to clean and treat wounds); however, the Wound Care Nurse used sodium chloride solution (normal saline) to clean Resident #11's left buttock wound during the wound care observation. The wound care team recommended to cleanse the wound with normal saline instead of Dakin's solution on 2/14/2025; hoewever, there was no documented evidence the recommendation was implemented until 2/18/2025. The finding is: The facility's policy titled Pressure Injury, last revised on 6/2024, documented the medical provider will authorize pertinent orders related to wound care treatments, including wound cleansing and debridement approaches, dressings (occlusive, Absorptive, etc.), and application of topical agents if indicated for the type of skin alteration. Upon written receipt of recommendations made by the wound care provider/consultants, the primary care providers will review and address the recommendations within 48 hours. Resident #11 was admitted with diagnoses including Multiple Sclerosis (a disease that causes a breakdown of the protective covering of nerves), Stage 4 Pressure Ulcer of the Left Buttock and Sacrum (bottom of the spine), and Osteoarthritis. The Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 8, which indicated Resident #11 had moderately impaired cognition. Resident #11 had unhealed pressure ulcers and used a pressure-reducing device for the chair and bed. A Comprehensive Care Plan titled Left Buttock and Sacrum Unstageable Wound last revised on 2/15/2024 documented interventions including the use of a pressure reduction bed mattress, a cushion to wheelchair, administration of pain medication 60 minutes before treatment, turning and positioning every 2 hours, wound care consultations, and treatments as per the Physician's orders. (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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's order dated 1/30/2025 documented to apply Santyl (medication that removes damaged tissue from skin ulcers) External Ointment of 250 units per gram to the left gluteus (buttock) and sacral wound topically every day shift for wound care. Clean with quarter-strength Dakin's solution (a diluted bleach solution used as an antiseptic to clean and treat wounds), pat dry, apply Santyl followed by normal saline moistened gauze, Zinc Oxide to peri-wound, and cover with a silicone foam dressing daily and as needed. A wound care consultation progress note dated 2/14/2025, written by the Wound Care Nurse Practitioner, documented the left buttock Stage 4 pressure ulcer measuring 5.7 centimeters in length, 10.2 centimeters in width, and 0.2 centimeters in depth. The recommendations included cleansing the wound with normal saline, applying Santyl to the wound, and loosely packing it with saline moist gauze covered with bordered gauze daily and as needed. The Sacral Stage 4 pressure ulcer measurements were 1.2 centimeters in length, 1.2 centimeters in width, and 1 centimeter in depth. The recommendations included cleansing the wound with normal saline, protecting the peri-wound with zinc oxide, applying Santyl to the wound, and loosely packing the wound with saline moist gauze covered with bordered gauze daily and as needed. The Physician's order for the left buttock wound and sacral wound was not changed to indicate the wound care team's recommendation on 2/14/2025 to cleanse the wound with normal saline instead of Dakin's solution. During a wound care observation on 2/18/2025 at 1:15 PM, the Wound Care Nurse was assisted by Licensed Practical Nurse #3 and the Nurse Manager for positioning Resident #11 during the wound care treatment. The Wound Care Nurse started cleaning Resident #11's left buttock wound with 0.9 percent sodium chloride (normal saline). Upon inquiry by the surveyor, the Wound Care Nurse stopped and reviewed the Physician's order for Resident #11 and stated the Physician's order indicated that the wound should be cleansed with a quarter-strength Dakin's solution. During an interview on 2/18/2025 at 1:22 PM, the Wound Care Nurse stated that on 2/14/2025, the Wound Care Nurse Practitioner recommended discontinuing the use of the quarter-strength Dakin's solution and using the normal saline for cleansing the left buttock and sacral wounds. The Wound Care Nurse stated that they (the Wound Care Nurse) should have discontinued the quarter-strength Dakin's solution and started normal saline for cleaning as per the recommendations because there were no signs of wound infection. The Wound Care Nurse further stated they should have checked the Physician's orders prior to the start of the treatment and should have obtained a Physician's order prior to use the normal saline. During an interview on 2/18/2025 at 2:48 PM, Licensed Practical Nurse #1 stated when they provided wound care treatment for Resident #11, they followed the Physician's orders and used the quarter-strength Dakin's solution for cleaning the wound. Licensed Practical Nurse #1 stated they had never received any order to change Dakin's solution to normal saline. During an interview on 2/19/2025 at 9:10 AM, Licensed Practical Nurse #2 stated they provided wound care treatment on 2/13/2025 and 2/14/2025 for Resident #11. Licensed Practical Nurse #2 stated the Wound Care Nurse Practitioner was present and assessed the wounds with the Wound Care Nurse on 2/14/2025, but they (Licensed Practical Nurse #2) did not receive any orders to change the quarter-strength Dakin's solution to normal saline for cleaning Resident #11's wounds. Licensed Practical Nurse #2 stated they were using Dakin's solution to cleanse Resident #11's wound per the Physician's order. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/19/2025 at 9:22 AM, the Wound Care Nurse Practitioner stated they assessed Resident #11 on 2/14/2025. The Wound Care Nurse Practitioner stated Resident #11's wounds had no sign of infection. The Wound Care Nurse Practitioner stated they recommended discontinuing the quarter-strength Dakin's solution and using normal saline to cleanse Resident #11's wounds instead. The Wound Care Nurse Practitioner stated prolonged use of Dakin's solution can damage skin. The Wound Care Nurse Practitioner further stated they expected the nurses to relay recommendations to the primary Physicians within 24-48 hours. During an interview on 2/19/2025 at 1:27 PM, the Nurse Practitioner stated they were notified of the recommendation to discontinue the Dakin's solution for Resident #11's wound care by the Wound Care Nurse on 2/18/2025. The Nurse Practitioner stated they expected to be notified of recommendations within 24-48 hours of any consultation. The Nurse Practitioner stated they agreed with the Wound Care Nurse Practitioner's recommendation and the Physician's order was updated on 2/18/2025. During an interview on 2/19/2025 at 2:01 PM, the Director of Nursing Services stated they (the Director of Nursing Services) did not know why the Wound Care Nurse did not document the new treatment order for Resident #11 until 2/18/2025. 10 NYCRR 415.12(c)(1)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28670 Based on observation, record review and interview during the Recertification Survey initiated on 2/12/2025 and completed on 2/20/2025, the facility did not ensure care and services for the provision of parenteral fluids were consistent with the professional standard of practice for each resident. This was identified for one (Resident #323) of two residents reviewed for Hydration. Specifically, Resident #323 was admitted on [DATE] with a Peripherally Inserted Central Catheter (a thin flexible tube inserted into a vein in the upper arm and threaded into a large vein near the heart) inserted to the left upper arm. There was no documented evidence the external length of the catheter was routinely measured to prevent migration and the care plan was not updated to include the measurement of the external length of the catheter. The Physician's order did not include monitoring the catheter site for signs and symptoms of infection and measuring the external length of the catheter with each dressing change The finding is: The facility policy titled Peripherally Inserted Central Catheter and revised on 6/2024 documented to measure the length of the external access device with each dressing change or, if catheter dislodgement is suspected, compare with the length documented on initial assessment upon insertion. Healthcare providers should regularly assess the site for signs of infection, complications or dislodgement. Resident #323 was admitted with diagnoses that included Malignant Neoplasm (Cancer) of the Bone, Anemia, and Malignant Neoplasm of the Kidney. A Minimum Data Set assessment was not available because the resident was recently admitted . The hospital record dated 2/4/2025 documented a Peripherally Inserted Central Catheter was inserted into Resident #323's left Basilic vein. A Physician's order dated 2/6/2025 documented to change the catheter site dressing for Resident #323's Peripherally Inserted Central Catheter to the left upper extremity every 72 hours and as needed with transparent dressing, on the day shift every Monday and Thursday. The Physician's order also included to flush the Peripherally Inserted Central Catheter with 10 milliliters of Normal Saline before and after every intravenous medication use. The Physician's order did not include monitoring the catheter site for signs and symptoms of infection and measuring the external length of the catheter with each dressing change. A review of the resident Medication Administration Record and Treatment Administration Record for February 2025 revealed there was no documented evidence of external length measurements of the catheter or monitoring the catheter site for signs and symptoms of infection from 2/6/2025 to 2/14/2025 and 2/18/2025 to 2/19/2025. The resident was hospitalized from 2/14/2025 to 2/18/2025. During an observation on 2/12/2025 at 9:30 AM, Resident #323 was observed resting in bed with a Peripherally Inserted Central Catheter in the left upper arm. The site appeared to be intact. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Comprehensive Care Plan dated 2/13/2025 documented the resident had a Peripherally Inserted Central Catheter for the administration of medication. Interventions included assessing the insertion site of the Peripherally Inserted Central Catheter for any redness, tenderness, or swelling, as well as checking that the dressing is clean, dry, and intact. The Nursing Re-Admission Evaluation dated 2/18/2025 documented the dressing for the Peripherally Inserted Central Catheter line to the left upper arm was clean, dry and intact. The resident denied pain at the site. The evaluation did not include the external length measurement of the catheter. During an interview on 2/19/2025 at 4:22 PM, the Assistant Director of Nursing Services stated the Registered Nurses were responsible for flushing the Peripherally Inserted Central catheter and monitoring for blood return, pain, and signs of infection at the catheter site. The Assistant Director of Nursing Services stated they did not know if the facility policy included monitoring the catheter for migration and to measure the external length of the catheter. During an interview on 2/20/2025 at 9:45 AM, Registered Nurse #1 stated during each shift, the Peripherally Inserted Central Catheter line should be monitored to ensure the circumference of the resident's arm does not increase in size. The catheter should also be flushed and the external length should be measured with every dressing change. Registered Nurse #1 stated the Registered Nurses should document their assessment of the site and measurement of the catheter in the Medication Administration Record. Registered Nurse #1 stated upon admission and readmission, the Registered Nurse who completed the assessments should have obtained orders to monitor for signs and symptoms of infection and measure the external length of the catheter. During an interview on 2/20/2025 at 10:09 AM, the Director of Nursing Services stated the medical team, including the resident's medical provider, was responsible for entering and reconciling the orders in the Electronic Medical Record upon admission. The Director of Nursing Services stated after the Physician enters the orders in the medical record, the admitting nurse should ensure all orders are correct. The Director of Nursing Services stated the Registered Nurses were responsible for the dressing change of the Peripherally Inserted Central Catheter, which included measuring the external length of the catheter and checking for signs and symptoms of infection at the catheter site. The Director of Nursing Services stated there were no Physician's orders in place that addressed assessing the site for signs of infection and measurement of the external length of the catheter. The Director of Nursing Services further stated there should have been Physician's orders to monitor Resident #323's catheter for migration and to measure the external length of the catheter. During an interview on 2/20/2025 at 12:28 PM, Physician #1 stated upon admission, the medical team should have ensured that orders were in place for the care of the Peripherally Inserted Central Catheter, including to measure the external length of the catheter. 10 NYCRR 415.12(k)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44925 Based on observation, record review, and interviews during the Recertification Survey initiated on 2/12/2025 and completed on 2/20/2025, the facility did not ensure that each resident who needs respiratory care is provided such care consistent with professional standards of practice and the comprehensive person-centered care plan. This was identified for one (Resident #7) of three residents reviewed for Respiratory care. Specifically, Resident #7, with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD), had a Physician's Order to administer oxygen therapy at 2 liters per minute via a nasal cannula (tubing used to deliver supplemental oxygen) as needed. The resident complained of feeling short of breath and was trying to place the nasal cannula to receive supplemental oxygen from the oxygen tank; however, the oxygen tank was empty. The finding is: The Oxygen Administration Policy dated 1/28/2025 documented oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. The Policy did not include who was responsible for maintaining and/or monitoring the oxygen tanks. Resident #7 was admitted with the diagnoses of Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and Hypertension. The Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status score of 13, which indicated the resident had intact cognition. The Minimum Data Set documented the resident utilized oxygen therapy. The Physician's Order dated 1/7/2025 documented to administer Oxygen therapy via nasal cannula at 2 liters per minute as needed for shortness of breath. The Comprehensive Care Plan for cardiac decompensation related to Hypertension dated 10/16/2024 documented interventions including administering oxygen therapy as ordered by the Physician. During an observation on 2/12/2025 at 11:35 AM, Resident #7 was observed in their bed and was attempting to put the nasal cannula in their nose. The resident stated they felt short of breath and were trying to fix the tubing. The oxygen tubing was attached to the oxygen tank which was placed by the door. The gauge needle was at the red line indicating the tank was empty. The Director of Nursing Services was alerted to check the resident's oxygen saturation level. The Director of Nursing Services came to the resident's room and checked the resident's oxygen saturation level, which was between 88 percent to 91 percent (normal range above 95 percent). The Director of Nursing Services stated the oxygen tank was empty. A new oxygen tank was subsequently connected, and the resident's oxygen saturation level went up to 92 percent. During an interview on 2/12/2025 at 11:48 AM, the Director of Nursing Services stated the resident should use a concentrator for oxygen; however, when the concentrator was broken, the staff used an oxygen tank to administer oxygen therapy. The Director of Nursing Services stated the oxygen tank should have enough oxygen available. Resident #7 is alert and can use the call bell to call for staff assistance. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/13/2025 at 1:38 PM, Licensed Practical Nurse #4 stated Resident #7 has a Physician's Order for oxygen therapy as needed. Licensed Practical Nurse #4 stated the resident had been utilizing an oxygen tank since the morning. At 9:00 AM, there was a quarter full of oxygen remaining in the tank. The resident made their needs known and had no concerns. Licensed Practical Nurse #4 stated they got busy and did not check the oxygen tank after 9:00 AM. Licensed Practical Nurse #4 stated they should have checked the oxygen tank to ensure there was enough oxygen available. During an interview on 2/20/2025 at 11:57 AM, Nurse Practitioner #1 stated they expected the nursing staff to follow the Physician's Orders related to oxygen therapy. Resident #7 has significant Chronic Obstructive Pulmonary Disease, and if they did not receive oxygen therapy as needed, there could be a risk of respiratory distress and Hypoxia (lack of oxygen to body tissues). 10 NYCRR 415.12(k)(6)