STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335837	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maria Regina Rehabilitation and Nursing	1725 Brentwood Road Brentwood, NY 11717

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20757 Based on observation, record review, and interviews during the abbreviated survey (Complaint # NY000330281) the facility did not ensure that each resident received adequate supervision to prevent accidents for 1 (Resident #1) of 3 residents reviewed for accidents. Specifically, Resident #1, who has a diagnosis of dementia, was observed by Certified Nurse's Aide #1 sitting in their reclining wheelchair next to the nursing station drinking from a brown bottle labeled Wella Color Charm hair color which had been left unattended at the nursing station. Subsequently, Resident #1 was transferred to the hospital for swelling to the lips and tongue via 911 and admitted to the hospital on 12/19/2023. This resulted in actual harm that is not immediate jeopardy. The findings are: Resident #1 was admitted on [DATE] with diagnoses that included Anemia (low blood count), Dementia (confusion), and High Blood Pressure. The review of the Quarterly Minimum Data Set assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 3, indicating severe impairment for decision making, eating-maximum help, no identified issues with swallowing. The review of the Comprehensive Care Plan dated 7/12/2023 documented end stage dementia, with interventions documented including monitor for changes in mental status. The review of the Safety Data sheet for Wella Color Charm Permanent Liquid Hair color dated 7/29/2020 documented after swallowing: consult a doctor. The Review of the facility policy dated 11/2023 titled Hazard Communication documented all hazardous substances will be locked in a secure location. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335837	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maria Regina Rehabilitation and Nursing	1725 Brentwood Road Brentwood, NY 11717

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 - Actual harm Residents Affected - Few	Review of the facility investigation dated 12/19/2023 documented at 2:50PM, Nursing Supervisor #1 was called to the unit by Charge Nurse #2, who reported Resident #1 ingested Wella 9N/911 light blonde hair dye. Resident #1 was sitting in reclining wheelchair at the nursing station, the ingestion was observed by Certified Nurse's Aide #1. Nursing Supervisor #1's assessment documented Resident #1's tongue was red, slightly edematous (swollen), lips red also with some edema. The Medical Doctor #1 was notified, ordered to administer steroid 40mg IM stat (immediately) the medication was given and 911 for emergency treatment was initiated. Resident #1 was transported via Emergency Medical Services to South Shore Hospital. The investigation further documented that on 12/15/2023 as per Licensed Practical Nurse #4, the hair dye for Resident #2 was given to Volunteer #1 who was transporting Resident #2 to the beauty parlor. Resident #2 never came to the beauty parlor to get their hair done on 12/15/2023. Certified Nurse's Aide #2 took the box containing the hair dye from the beauty parlor to the unit, informed Charge Nurse #2 that Resident #2 did not color their hair and left the bottle of Wella hair dye at the nursing station. The review of the Resident Progress Notes dated 12/19/2023 at 3:20PM documented Nursing Supervisor #1 was called to unit by Charge Nurse #2, Resident #1 had ingested Wella 9N/911 blonde hair dye, Physician aware and ordered solumedrol 40 mg intramuscular (injection into the muscle) stat (immediately). Nursing Supervisor #1 assessed Resident #1 and documented tongue was red, scant (small amount) edema, lips were also red with edema. Resident #1 was transported to the hospital. The review of the Hospital Documents Review Report dated 12/19/2023 at 9:14PM documented Toxicology was consulted, and patient admitted for management of angioedema (swelling under the skin) in the setting of accidental ingestion of foreign substance. During the interview conducted with Certified Nurse's Aide #1 on 4/11/2024 at 11:30AM, they stated Resident #1 was seated in reclining wheelchair, and Resident #1 was facing the entrance/exit to the unit. Resident #1 was calling out for water, and Certified Nurse's Aide #1 stopped and saw a small brown bottle on the tray over the reclining wheelchair of Resident #1. Certified Nurse's Aide #1 stated you can't drink that from the brown bottle, and took the bottle away from the resident. The Certified Nurse's Aide #1 stated, they saw Wella on the label and immediately brought it to Charge Nurse #2. During the interview with Licensed Practical Nurse #1 on 4/11/2024 at 11:30AM they stated prior to the incident dated 12/19/2023, hair color was kept in the closet of the medication room. Resident #1 was seated in front of the nursing station in a reclining wheelchair at the nursing desk area, facing the entrance/exit hallway. They further stated Resident #1 started to call out give me water. Licensed Practical Nurse #1 stated Certified Nurse's Aide #1 brought water to Resident #1 and saw Resident #1 drinking from a small brown bottle. The Certified Nurse's Aide #1 immediately removed the bottle from Resident #1 and brought the brown bottle to Charge Nurse #2. The brown bottle was labeled Wella. Charge Nurse #2 stated they called for the Nursing Supervisor #1, who came to the unit. The Medical Doctor #1 was called and ordered Resident #1 to be transported to the hospital, 911 was called, and the resident was transported to the hospital. Charge Nurse #2 was not available for an interview despite multiple telephone attempts. During an interview with the Director of Nursing on 4/11/2024 at 3:40PM, they stated they were not working at the facility 12/19/2023 when the incident occurred. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335837	A. Building B. Wing	04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maria Regina Rehabilitation and Nursing	1725 Brentwood Road Brentwood, NY 11717

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 - Actual harm Residents Affected - Few	During an interview with the Administrator on 4/12/2024 at 1:30PM, the Administrator stated Resident #1 was observed drinking Wella hair color from the bottle. The Administrator stated the policies for storage of hair care items for residents and securing hazardous items were reviewed and revised and the staff was retrained. The Administrator stated Charge Nurse #2 was disciplined and was no longer employed at the facility. The Administrator stated that hazardous items should not be unlocked or unsecured. During the telephone interview with the Medical Doctor #1 on 4/19/2024 at 11:09AM, they stated they were covering on 12/19/2023 when staff reported that Resident #1 drank hair dye. Medical Doctor #1 stated they ordered steroids and stomach calming medication right away and ordered Resident #1 to be transferred to the hospital. Medical Doctor #1 stated there was no delay in response, the staff called 911 who responded immediately. Medical Doctor #1 stated hair dye and other hazardous substances should be kept away from all residents and should be in a locked area. During the telephone interview with the Medical Director on 4/19/2024 at 4:00PM, they stated on 12/19/2023 Resident #1 drank hair dye. The Medical Director stated they reviewed the case, and this incident was an isolated incident. The Medical Director stated all staff were trained not leave hazardous or potentially hazardous items of any type within the reach of or near any residents. The Medical Director stated hair dye should not have been left on the nursing station in an unsecured area, and instead should have been placed in a locked, secured, and supervised area. 10 NYCRR 415.12(h)(1)