| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335082 | A. Building<br>B. Wing | 09/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue<br>Rochester, NY 14612 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey and complaint investigation (#NY00343916) from 07/08/2024 to 09/17/2024, for five (Resident #55, #92 #106, #140, and Resident #457) of seven residents reviewed, the facility did not ensure that the residents were treated in a respectful and dignified manner. Specifically, Resident #55 was observed in the dining room wearing only a t-shirt and an incontinence brief. Resident #92 was observed to be asleep in their bed and the bed was bare, with no sheets in place. Resident #106 was observed laying on a urine soiled incontinence pad. Resident #140 was observed lying on a mattress without sheets. Resident #457 was observed lying on wet linens over an extended period of time. Additionally, there were multiple observations of residents using paper plates and plastic utensils for meals. This was evidenced by the following:<br><br>Review of the facility policy, Quality of Life-Dignity, dated January 2024, documented each resident shall be treated with respect and dignity at all times, and shall be assisted to dress in their own clothes.<br><br>Review of the facility policy, Resident Care with Activities of Daily Living, dated January 2024, documented the facility would provide resident(s) with adequate toileting to maintain the maximum level of toileting and continence.<br><br>Review of the facility policy, Resident Rights, dated January 2024, documented federal and state laws guaranteed certain basic rights to all residents in the facility which included (but not limited to) equal access to quality care.<br><br>Review of the facility policy, Dining Atmosphere, dated January 2024, documented dishware and flatware used for meals should be non-disposable.<br><br>Review of Resident Council (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care and quality of life) meeting minutes from April 2024 through June 2024 included (but not limited to) concerns about a linen shortage, the use of blankets in the place of incontinence pads, bed linens not being changed, and staff cutting up linens to use as wash cloths. Each month, documentation included that past concerns were addressed, but the residents had not seen improvement.<br><br>(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: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE: 425 Beach Avenue Rochester, NY 14612 | |

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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 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | 1. Resident #457 had diagnoses of respiratory failure, requirement of supplemental oxygen, and diabetes. A Nursing Admission Note, dated 07/02/2024, included the resident was cognitively intact, was incontinent of bladder, wore an incontinence brief, and had requested the use of a bedside commode.<br><br>Review of the current Comprehensive Care Plan and Kardex (care plan used by Certified Nursing Assistants to guide care) revealed Resident #457 was incontinent of urine and stool, required supervision or touch assist for toilet transfers, used a bedside commode, and required incontinence briefs with checks and changes every three to four hours, or as needed.<br><br>During an interview on 07/08/2024 at 9:41 AM, Resident #457 said they were not able to use the bathroom in their four-person room because the toilet was too low for them, and they used a commode (currently placed at the head of their bed). Resident #457 stated they are not provided proper care in that some days they only got assistance and/or changed (incontinence care) once a day.<br><br>During an observation on 07/09/2024 at 10:30 AM, Resident #457 was in bed. The bed linens were visibly wet from their left thigh to their upper right shoulder and the room smelled of urine. Resident #457 said staff had delivered their breakfast tray earlier and knew the sheet was wet as it was visible over their shoulder.<br><br>During an observation and interview on 07/10/2024 at 12:56 PM, Resident #457 was sitting on the side of their bed and stated that they could not use the bathroom toilet because they had arthritis, and it was too low for them. Resident #457 said they could not use the commode independently and when they called for assistance, staff did not come so they had to urinate in their brief.<br><br>During an observation and interview on 07/10/2024 at 2:18 PM, Resident #457's bathroom had two toilets, both with the seats at about knee height (approximately one and a half to two feet in height). Certified Nursing Assistant #8 stated currently none of the four residents in the room used the bathroom because they were all dependent on staff for toileting.<br><br>During an interview on 07/15/2024 at 11:00 AM, Certified Nursing Assistant #6 said if a resident was continent of urine, they would wait for the resident to call for assistance to use the bathroom or commode. If a resident was incontinent, incontinence care was provided after morning care and incontinence rounds were supposed to be done every two hours, which was hard to complete when the unit was short staffed. Certified Nursing Assistant #6 said they thought Resident #457 did know when they needed to use the bathroom and had only seen the resident use the commode for bowel movements. Certified Nursing Assistant #6 said residents should not have to void (urine or stool) in their brief if they were continent.<br><br>During an interview on 07/15/2024 at 11:33 AM, Licensed Practical Nurse #5 said nursing staff should provide residents assistance with toileting either when the resident's call light was on or during rounding. Licensed Practical Nurse #5 said if a resident was continent, they should get up (to go to the bathroom). Licensed Practical Nurse #5 said Resident #457 was continent of urine and could get up but did not. Resident #457 preferred to have their soiled brief changed or to use the commode. Licensed Practical Nurse #5 said when they asked Resident #457 why they did not get up to go to the bathroom, the resident said it was due to their oxygen, so longer oxygen tubing had been offered (not observed in the resident's room at the time).<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manager #2 said Resident #457 received incontinence care because they were non-weight bearing and therapy was using the commode with the resident. Licensed Practical Nurse Manager #2 said a resident should not have to sit in urine or stool during meals as it was undignified.<br><br>2. Resident #55 had diagnoses including vascular dementia, anxiety disorder, and obsessive-compulsive disorder (a disease where a person experiences uncontrollable and recurring thoughts and/or engaged in repetitive behaviors). The Minimum Data Set Resident Assessment, dated 05/17/2024, documented that Resident #55 was dependent on staff for toileting and hygiene and needed assistance with lower body dressing.<br><br>Review of Resident #55's current Kardex documented that Resident #55 needed to be toileted before meals.<br><br>During an observation on 07/10/2024 at 4:55 PM, Resident #55 was in the dining room in a wheelchair wearing only a shirt and an incontinence brief. Resident #55 did not have any shoes or pants on and was uncovered from the waist down. Four residents and one staff member were also in the dining room.<br><br>During an interview on 07/10/2024 at 5:00 PM, Certified Nursing Assistant #10 stated residents should be dressed and presentable when out of their room and if they saw a resident who was not dressed appropriately, they would remove them from the common area and get them dressed.<br><br>During an interview on 07/10/2024 at 5:10 PM, Licensed Practical Nurse #6 stated a resident should not be in a common area in just a shirt and brief. They stated that Resident #55 was known to take their clothes off and staff should re-dress the resident or at least cover them up for their privacy.<br><br>3. Resident #106 had diagnoses that included a stage 4 (full thickness tissue damage) healing pressure ulcer (bed sore), depression, and hemiplegia (paralysis on one side of the body). The Minimum Data Set Resident Assessment, dated 05/02/2024, documented that Resident #106 was cognitively intact, did not exhibit behaviors or rejection of care, required assistance with transfers and toileting hygiene, and was always incontinent of bladder and bowel.<br><br>Review of the current Comprehensive Care Plan and the current Kardex revealed Resident #106 required assistance with activities of daily living, had bladder and bowel incontinence, and was at risk for impaired skin integrity. Interventions included, but were not limited to, check for needed assist with toileting every two hours and/or check and change incontinence brief as needed every three to four hours. Provide peri-care (private areas) after each incontinent episode and keep skin clean and dry with prompt removal of wet or damp clothing or sheets.<br><br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | During observations and interview on 07/08/2024 at 10:24 AM, Resident #106 was sitting upright in bed. There was an odor of urine and yellow and brown stains on the incontinence pad underneath the resident. Resident #106 stated they were soaked, had already eaten breakfast and had not been changed out of their wet incontinence brief since the previous night at bedtime. They said they put their call bell on for assistance and a nurse responded that the Certified Nursing Assistants were working their way down the hall. At 11:54 AM, Resident #106 remained in bed and stated they still had not been assisted with incontinence care. The room continued to have an odor of urine and the incontinence pad had not been changed.<br><br>During an observation and interview on 07/11/2024 at 9:11 AM and again at 10:56 AM, Resident #106 remained in bed and stated they were again soaked and had not been changed since the previous night at bedtime. The incontinence pad placed underneath the resident was stained yellow extending from the incontinence brief and smelled of urine. Resident #106 stated they had not received care on 07/08/2024 until after they had eaten their lunch.<br><br>During an interview on 07/11/2024 at 1:30 PM, Resident #106 stated they have requested repeatedly that they get changed prior to breakfast and lunch, but it is not being done and it makes them feel terrible (like a piece of crap), like they are not worthy of being given any service.<br><br>4. Resident #92 was admitted with diagnoses that included dementia, visual hallucinations, and anxiety. The Minimum Data Set Resident Assessment, dated 06/05/2024, documented Resident #92 was severely cognitively impaired.<br><br>During an observation on 07/11/2024 at 10:24 AM on the South 2 Unit, Resident #92 was asleep in their bed. The bed was bare, with no sheets in place. The linen cart on the unit had no pillowcases, fitted sheets, flat sheets, or blankets.<br><br>During an interview on 07/11/2024 at 1:40 PM, Licensed Practical Nurse #3 stated that often there was no linen available, and residents and family members would get upset when staff could not assist with care before breakfast. The laundry staff were only available on day shift and had to wash linen from the previous day before delivering it to the units which was sometimes during the late morning or afternoon. Licensed Practical Nurse #3 stated when the cart was delivered, there was usually only six washcloths for 40 residents, and staff had to cut up towels to use as washcloths or use disposable dry wipes.<br><br>5. Resident #140 had diagnoses that included cerebral infarction (stroke), malignant neoplasm of breast (breast cancer), and type 2 diabetes mellitus. The Minimum Data Set Resident Assessment, dated 05/30/2024, documented Resident #140 was cognitively intact.<br><br>During an observation and interview on 07/09/2024 at 10:42 AM on the South 1 Unit, Resident #140 was lying in bed. There were no sheets in place and the resident was wrapped in what appeared to be a personal fleece blanket. When interviewed Resident #140 stated staff were too busy to put sheets on their bed the previous night and no one had come to offer assistance yet that morning.<br><br>(continued on next page) |

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| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue Rochester, NY 14612 |

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| F 0550<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | During an interview on 07/10/2024 at 11:36 AM, Certified Nursing Assistant #12 stated there was not an adequate supply of linen to care for the residents. When linen was delivered to the unit, there were usually six towels and five washcloths for 40 residents. Certified Nursing Assistant #12 stated they often had to improvise when giving residents care, including cutting a bath sheet to make washcloths.<br><br>6. During observations at breakfast and/or lunch on 07/10/2024 at 1:16 PM, 07/11/2024 at 9:31 AM, and 07/11/2024 at 1:25 PM in the dining room, the majority of residents (up to 22 on one observation) in the dining room were served meals on paper plates and were using plastic utensils.<br><br>During an interview on 07/11/2024 at 1:38 PM, Certified Nursing Assistant #5 stated the facility had been using plastic utensils for meals for a couple of weeks.<br><br>During an interview on 07/12/2024 at 8:41 AM, the Assistant Director of Rehabilitation stated that a resident using plastic utensils could result in spillage of food and dropping the plastic utensils while eating.<br><br>During an interview on 07/12/2024 at 9:34 AM, the Diet Technician stated the facility's current number of plates and utensils was not enough, and the facility was using plastic utensils and paper plates to replace what was missing.<br><br>During an interview on 07/12/2024 at 11:27 AM and again on 07/15/2024 at 8:44 AM, the Director of Food Service stated the facility did not have enough dishware in stock for all resident's meals and the last two units delivered to had to use paper plates and plastic utensils for meals. The Director of Food Service stated the Assistant Director of Food Service did the ordering for the dining supplies, but the corporate office could change or decrease the amount ordered.<br><br>During an interview on 07/11/2024 at 2:02 PM and again on 07/15/2024 at 8:50 AM, the Assistant Director of Food Service stated they order supplies the facility needed, but the corporate office controlled the amount ordered.<br><br>During an interview on 07/15/2024 at 9:55 AM, the Administrator stated the facility should not be using plastic utensils and paper plates for meals because it was a dignity issue. The Administrator said the best solution would be to obtain the adequate amount of dining products.<br><br>During an interview on 07/15/2024 at 10:00 AM, the Regional Administrator stated the facility should have a par (inventory control system in place to determine the levels of non-disposable dishware, glassware, and utensils the facility should have to meet resident care needs) level for dining products that the kitchen staff should be monitoring. The Regional Administrator said ordering should be done weekly to maintain the par level.<br><br>10 NYCRR 415.5 |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to organize and participate in resident/family groups in the facility.<br><br>20765<br><br>Based on interviews and record reviews conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for six (Residents #4, #24, #80, #105, #201, and #613) of six residents, the facility did not ensure that grievances and recommendations of the Resident Council (resident group) concerning issues of resident care and life in the facility were acted on promptly. Specifically, during a special Resident Council meeting, the six residents voiced care concerns and a review of the previous six months of meeting minutes included issues such as long call bell wait times, residents not being provided personal care or receiving medications when scheduled, a shortage of linens, and a lack of staffing that were not investigated and/or addressed in a timely manner. This is evidenced by the following:<br><br>During a special Resident Council meeting held on 07/10/2024 at 11:30 AM with six residents present, it was reported that call lights did not get answered in a timely manner especially on weekends, medications were not given on time, there was a lack of linens, and residents did not receive assistance with activities of daily living including bathing and showering. Residents also reported that the facility did not act promptly upon their concerns and there was no follow up from facility staff regarding their complaints/grievances.<br><br>Review of the Resident Council meeting minutes for January 2024, March 2024, April 2024, May 2024, and June 2024 revealed the resident's reported care concerns including, but not limited to, not receiving showers regularly, nails not being trimmed and cleaned, call lights not being answered timely, bed linens not being changed, a lack of linens, and medications not being administered timely. Each of the meeting minutes included an old business section that documented that the concerns from last month were discussed and that residents stated that they did not see any improvement in those areas. The meeting minutes did not include any follow up done by staff regarding their concerns.<br><br>During an interview on 07/15/2024 at 9:33 AM with the Director of Social Work and the Director of Nursing, the Director of Social Work stated they attended the monthly Resident Council meetings with the Director of Activities and sent the meeting minutes to the Administrator, Director of Nursing, and Assistant Directors of Nursing. The Director of Nursing stated resident concerns brought forth during the Resident Council meeting were discussed in morning report. The Director of Nursing stated that old business was reviewed before new business was discussed at each Resident Council meeting, and there was verbal discussion of any updates during the meeting. The Director of Social Work stated that the updates are not documented on the meeting minutes and if there was a resident specific concern, they would ask the resident to come to their office to complete a grievance form.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Assistant Administrator stated the Quality Assurance Committee was not aware that complaints and/or grievances discussed in Resident Council meetings were not being addressed promptly. The Regional Administrator stated that any issues or grievances should be documented on a grievance form, monitored weekly, and a copy of the grievance form (dependent on the issue) was sent to the Administrator, Nurse Managers, and Assistant Directors of Nursing. The Regional Administrator stated it was determined that the previous Administrator had not been following up on resident grievances.<br><br>(continued on next page) |

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| F 0565<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 10 NYCRR 415.5 (c)(6) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey and complaint investigation (#NY00343730) from 07/08/2024 to 09/17/2024, for four (South 1, South 2, South 3, and [NAME] 2) of seven residential units reviewed, the facility did not ensure residents had a safe, clean, comfortable, and homelike environment. Specifically, there was not an adequate supply of clean bed and bath linens and linens that were available, were not in good condition preventing residents from receiving assistance with their activities of daily living in a timely manner. For Resident #106 they were given a bottom sheet for a top sheet and were observed laying on a urine soiled pink pad. Residents #92 and #140 were observed lying on their bare mattresses without sheets. Resident #457 was observed lying on wet linens over an extended period of time. There was a dirty fan in use in Resident #153's room and multiple dining room chairs that were in poor repair. This is evidenced by the following:<br><br>Review of the facility policy, Resident Rights, dated January 2024 revealed that federal and state laws guarantee certain basic rights to all resident in the facility which included (but not limited to) equal access to quality care.<br><br>Review of the facility policy and procedure, Resident Care with Activities of Daily Living, dated January 2024 revealed when assisting residents with activities of daily living, such as toileting, perineal (the area between the genitalia and the anus) care, personal hygiene, showers or a bed bath, staff were expected to gather the necessary supplies that included, but were not limited to, a towel, wash cloth, and clean bed linens. After assisting the resident with care, soiled towels, wash cloths, and bed linens were to be discarded in the soiled laundry container.<br><br>Review of Resident Council (an organized group of residents who meet regularly to discuss and address concerns about their rights, quality of care and quality of life) meeting minutes from April 2024 through June 2024 included (but not limited to) concerns about a linen shortage, the use of blankets in the place of incontinence pads, bed linens not being changed, and staff cutting up linens to use as wash cloths. Each month, documentation included that past concerns were addressed, but the residents had not seen improvement.<br><br>During an observation and interview on 07/08/2024 at 11:54 AM on the South 1 Unit, Resident #106, whose cognition was intact, was lying in bed and stated they still had not been assisted with incontinence care since the previous night. The room had a strong odor of urine, and the incontinence pad was stained brown and yellow.<br><br>During an interview on 07/08/2024 at 12:18 PM, Unit Secretary #1 stated they were sent to South 3 to assist with resident care but there were no washcloths or towels available on the unit to care for the residents. The Unit Secretary #1 stated, they made the supervisor aware.<br><br>During an observation on 07/08/2024 at 12:29 PM on South 3 Unit Activity Aide #3 left the unit to attempt to locate washcloths, towels or disposable wipes that were needed to complete resident care for residents on the unit.<br><br>(continued on next page) |

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|---|---|
| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an observation and interview on 07/09/2024 at 10:42 AM on South 1 Unit Resident #140 was asleep in bed. There were no sheets in place and the resident was wrapped in what appeared to be a personal fleece blanket. During an immediate interview Resident #140 stated that staff were too busy to put sheets on their bed the previous night and no one had come to offer assist yet.<br><br>During an interview on 07/10/2024 at 11:36 AM, Certified Nursing Assistant #12 stated there was not an adequate supply of linen to care for the residents. When linen was delivered to the unit, there were usually six towels and five washcloths for 40 residents. Certified Nursing Assistant #12 stated they often had to improvise when giving residents care, including cutting a bath sheet to make washcloths. The Certified Nursing Assistant stated, they did not feel they could adequately do their job without having the necessary supplies.<br><br>During an interview on 07/10/2024 at 1:35 PM, a family member expressed concerns about placement of the incontinence pad underneath the resident they were visiting. The family member stated the pink pad was supposed to keep the bed from getting soiled. If the fitted sheet did get soiled, the facility did not have any linen available to change it. The family member stated It had been an on-going concern that soiled linens would go unchanged for four or more days. They stated, there was not enough linen to care for the number of residents that lived in the facility.<br><br>During an observation on 07/10/2024 at 1:47 PM [NAME] 2 Unit, the linen cart had no towels or washcloths. At 1:57 PM, a Resident Assistant (resident helper who does not do hands on care) arrived on the unit with a linen cart that did not include any towels or wash cloths.<br><br>During an observation and interview on 07/10/2024 at 2:05 PM on South 1 Unit Certified Nursing Assistant #17 informed the Assistant Administrator that the unit had been waiting for linen to be sent up from laundry for over an hour. At 2:11 PM, a linen cart was delivered to the unit and did not include any towels or washcloths. During an immediate interview, Certified Nursing Assistant #17 stated the availability of linen had been limited for a while.<br><br>During an observation on 07/11/2024 at 10:24 AM on South 2 Unit, Resident #92 was asleep in their bed and the bed was bare, with no sheets on the mattress. The linen cart on the unit had no pillowcases, fitted sheets, flat sheets, or blankets.<br><br>During an interview on 07/11/2023 at 1:40 PM, Licensed Practical Nurse #3 stated often there was no linen available, and residents and family members were often upset when staff could not assist with personal and incontinent care before breakfast. The laundry staff were only available on day shift and had to wash linen from the previous day before delivering it to the unit which was sometimes during the late morning or afternoon. Licensed Practical Nurse #3 stated when the cart was delivered there were usually only six washcloths for 40 residents and staff would have to cut up towels to use as washcloths or were expected to use disposable wipes which were not good for washing residents.<br><br>During an interview on 07/11/2023 at 4:03 PM, Resident #78 stated staff used disposable wipes when there were no washcloths or towels available but did not feel the wipes cleaned them well enough and would prefer washcloths.<br><br>During an interview on 07/12/2024 at 9:50 AM, Certified Nursing Assistant #7 stated only six towels had been delivered the previous evening and the expectation was for staff to wash residents with paper cloths, but they would have to use a half pack to wash one person.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE: 425 Beach Avenue Rochester, NY 14612 | |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 07/12/2024 at 12:08 PM, the Registered Nurse Staff Educator stated that the disposable dry wipes should only be used for peri-care and not for showering or bathing a resident. Staff should use the dry wipes to manage bowel incontinence followed by cleansing the resident with a washcloth.<br><br>During an interview on 07/12/2024 at 1:34 PM, Registered Nurse Manager #1 stated there were times when linen was not delivered to the unit until after breakfast and staff were unable to assist residents with care until late morning.<br><br>During an interview on 07/12/2024 at 2:20 PM with the Regional Administrator and Administrator, the Regional Administrator stated that staff should be using washcloths and towels for bathing and showering residents and dry disposable wipes should be used for peri-care only. The Regional Administrator stated they were not aware that resident care had been delayed due to the limited availability of washcloths and towels. There had been a lot of money spent on linen, there was a par (inventory control system in place to determine the levels of linen the facility should have to meet resident care needs) system in place to track the linen supply and would expect washcloths to be available.<br><br>During an interview of 07/15/2024 at 9:12 AM, the Laundry Supervisor stated there was no par system in place for linen and that there were only 10 washcloths available to go to South 2 and five washcloths available to go to South 3 at that time. Both units had 40 residents.<br><br>During observations (West 2) on 07/08/2024 at 8:56 AM and 07/09/2024 at 10:06 AM, a box fan in Resident #153's room was blowing directly on them with streams of dust and debris blowing from it. It had been identified that Resident #153 was non-verbal and immobile, and they would not have been able to notify facility staff of the blowing debris.<br><br>During an observation on 07/09/2024 at 10:16 AM, there were four straight back chairs throughout the dining room at tables intended for resident use. The vinyl was torn across the seats exposing cloth and foam.<br><br>During an observation and interview on 07/15/2024 at 8:45 AM, the Assistant Administrator stated the box fan needed to be cleaned and staff on the unit could clean the fans but should also make maintenance aware. The Assistant Administrator stated the four chairs in the dining room should be cleaned, repaired, or replaced.<br><br>10 NYCRR 415.5(h)(3) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>46880<br><br>Based on interviews, observations, and record reviews conducted during the extended Recertification Survey and complaint investigation (#NY00341657) from 07/08/2024 to 09/17/2024, the facility failed to ensure residents right to be free from abuse, mistreatment, or neglect for seven (Residents #70, #92, #106, #134, #140, #177, and #182) of eight residents reviewed for abuse. Specifically, for Residents #92, #134, #177, and #182, the facility did not implement interventions to protect the residents from sexual abuse. For Resident #70 who had reported to several staff members, ongoing abuse from their roommate, the facility failed to investigate the allegations. For Resident #106, the facility did not ensure incontinence care was received in a timely manner when the resident was left soiled for several hours on multiple occasions. For Resident #140, the facility did not ensure clean bed linens were supplied and the resident was observed sleeping on a bare mattress. These issues resulted in the likelihood of serious injury, serious harm, or death for all of the residents in the facility (census 213), which resulted in Immediate Jeopardy. This is evidenced by the following:<br><br>The facility's policy Abuse Prohibition Protocol, Types of Abuse, Response/ Reporting, dated January 2021, includes it is the facility policy that every resident has the right to be free from abuse, mistreatment, neglect, and misappropriation of property. All personnel must attempt to immediately stop the abuse, then promptly report any incident or suspected incident of resident abuse.<br><br>1. Resident #92 had diagnoses which included dementia, visual hallucinations, and anxiety. The Minimum Data Set Resident Assessment, dated 03/12/2024, documented the resident had severely impaired cognition.<br><br>Review of the current Comprehensive Care Plan did not include Resident #92 had a history of sexual-related behaviors or person-centered interventions to address the behaviors. The current Kardex (care plan used by Certified Nursing Assistants to guide care) included to provide the resident with a safe and secure, clutter free environment.<br><br>Resident #177 had diagnoses which included dementia, diabetes, and adult failure to thrive. The Minimum Data Set Resident Assessment, dated 06/28/2024, included the resident had severely impaired cognition and no verbal or physical behaviors directed toward others.<br><br>Resident #177's current Comprehensive Care Plan did not include the resident had a history of sexual-related behaviors.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of an undated Facility Investigation revealed on 05/07/2024 at 5:30 PM, Resident #92 entered the room of two residents (Resident #166 and #177). Resident #92 removed their clothes and climbed into Resident #166's bed (near the door) and made a sexual advance towards Resident #166. Resident #166 got off the bed, alerted nursing staff and Resident #92 was removed from the room. Resident #92 was redressed by nursing staff and was escorted to the dining room. At approximately 6:45 PM, Resident #166 alerted staff that Resident #92 and Resident #177 were in the room, engaging in sexual behaviors. Upon entry, Certified Nursing Assistant #5 observed Resident #92 standing without pants on and Resident #177 was touching Resident #92's private area. Staff immediately removed Resident #92 from the room and Registered Nurse Supervisor #5 was made aware. The facility investigation included Residents #92 and #177 were considered non-consenting adults due to their impaired cognitive status, poor judgement and insight, and the inability to understand the consequences of their actions. Resident #177 was subsequently moved to a different unit.<br><br>During an interview on 07/12/2023 at approximately 1:00 PM, Resident #92 said they got along with some residents and never had issues with any residents.<br><br>During an interview on 07/15/2024 at 9:55 AM, Certified Nursing Assistant #5 said if a resident had a history of certain behaviors, such as behaviors that were sexual in nature, the information should be in the resident's chart. If a resident required supervision, the information should be listed on the Kardex. Certified Nursing Assistant #5 said on 5/7/2024 Resident #166 notified them Resident #92 was in their room. Certified Nursing Assistant #5 said they removed Resident #92, walked the resident to their room and got the resident dressed. Certified Nursing Assistant #5 said Resident #166 later alerted them Resident #92 was in the room with Resident #177. When Certified Nursing Assistant #5 walked into the room, Resident #177's hand was touching Resident #92's private area They said after the incident with Resident #166, no one told them to stay with Resident #92.<br><br>During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manager #2 said Resident #177 was moved from another unit due to a previous incident (sexual behavior in nature). Licensed Practical Nurse Manager #2 said a history of resident-to-resident sexual behaviors should be included on the resident's care plan.<br><br>During an interview on 07/15/2024 at 4:23 PM, Assistant Director of Nursing #1 said they would expect to see a history of resident-to-resident sexual behaviors included on a resident's care plan. Assistant Director of Nursing #1 was familiar with the incident involving Resident #92 and Resident #177 and said after Resident #92's sexual behaviors were directed at Resident #166; staff should have been watching the resident (in an effort to prevent further incidences).<br><br>During an interview on 08/06/2024 at 1:06 PM, Certified Nursing Assistant #5 said after learning Resident #92 had a history of inappropriate behaviors they kept an eye on the resident. Certified Nursing Assistant #5 said even on days the resident was not on their assignment, they would still monitor them because the resident had a history of wandering into other resident rooms.<br><br>2. Resident #134 had diagnoses which included dementia with agitation, delirium, and diabetes. The Minimum Data Set Resident Assessment, dated 12/06/2023, documented the resident had severely impaired cognition and no history of behaviors directed toward others.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the current Comprehensive Care Plan and Kardex revealed that Resident #134 was at risk for being a victim due to inability to understand their surroundings. Neither care plan included a history of any inappropriate behavior directed towards other residents.<br><br>Resident #182 had diagnoses including dementia, anxiety, and depression. The Minimum Data Set Resident Assessment, dated of 04/30/2024, included the resident had severely impaired cognition.<br><br>Review of the current Comprehensive Care Plan and Kardex did not include any behaviors directed toward other residents or staff.<br><br>During an observation on 07/08/2024 at 8:59 AM, Resident #134 was walking up and down the hallway behind Resident #182. While standing at the nurse's station, Resident #134 placed their arm around Resident #182 and began kissing them repeatedly on the cheek. Resident #182 was making whimpering noises and walked away. At 9:07AM, Resident #182 was in front of the nurse's station when Resident #134 placed their hand on Resident #182's lower back and attempted to kiss them on the cheek. Resident #182 put their hand up, said stop, and walked away.<br><br>During an interview on 07/12/2024 at 9:50 AM, Certified Nursing Assistant #7 stated Resident #134 wanders all day long and does have behaviors directed towards multiple residents (including Resident #182) which included touching them in passing, kissing, and hugging them. Certified Nursing Assistant #7 stated they try to intervene if they observe the interactions, but they had not told anyone because they felt the interactions were innocent in nature.<br><br>During an interview on 07/15/2024 at 8:45AM, the Assistant Administrator stated staff should separate the two residents, report these interactions to the Nurse Manager, who should initiate an investigation and report it to administration.<br><br>During an interview on 07/15/2024 at 10:25AM, Assistant Director of Nursing #1 stated Resident #134 does have behaviors, but they had not seen or been told that Resident #134 touched or kissed other residents. They stated staff should have reported these interactions so the behaviors could be care planned for with interventions. The Director of Nursing joined the interview and stated Resident #134 had rubbed their back and kissed their cheek, but they did not feel there was any malice to these interactions with staff or residents.<br><br>3. Resident #106 had diagnoses that included a stage 4 (full thickness tissue damage) healing pressure ulcer (bed sore), depression, and hemiplegia (paralysis on one side of the body). The Minimum Data Set Resident Assessment, dated 05/03/2024. revealed the resident was cognitively intact, did not exhibit behaviors or rejection of care, required assistance with transfers and toileting hygiene, and was always incontinent of bladder and bowel.<br><br>Review of the current Comprehensive Care Plan and the current Kardex revealed Resident #106 required assistance with activities of daily of living, had bladder and bowel incontinence, and was at risk for impaired skin integrity. Interventions included, but were not limited to, check for needed assist with toileting every two hours and/or check and change incontinence brief as needed every three to four hours; provide peri-care (private areas) after each incontinent episode; keep skin clean and dry with prompt removal of wet or damp clothing or sheets, and encourage the resident to use their call bell for assistance.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During observations and interview on 07/08/2024 at 10: 30 AM, Resident #106 was sitting upright in bed. There was the odor of urine with yellow and brown stains on the incontinence pad underneath the resident. Resident #106 stated they were soaked, had already eaten breakfast and had not been changed out of their wet incontinence brief since the previous night at bedtime. They said they put their call bell on for assistance and a nurse responded that the Certified Nursing Assistants were working their way down the hall. At 11:54 AM, Resident #106 remained in bed and stated they still had not been assisted with incontinence care. The room continued to have an odor of urine and the incontinence pad had not been changed.<br><br>During an observation and interview on 07/11/2024 at 9:11 AM and again at 10:56 AM, Resident #106 remained in bed and stated they were again soaked and had not been changed since the previous night at bedtime. The incontinence pad placed underneath the resident was stained yellow extending from their incontinence brief and smelled of urine. Resident #106 stated they had not received care on 07/08/2024 until after they had eaten their lunch.<br><br>During an interview on 07/11/2024 at 1:30 PM, Resident #106 stated they have requested repeatedly that they get changed prior to breakfast and lunch, but it is not being done and it makes them feel terrible (like a piece of crap), like they were not worthy of being given any service.<br><br>During an interview on 07/11/2024 at 1:40 PM, Licensed Practical Nurse #3 stated there was often no linens available, and residents and family members were often upset when staff could not assist with care before breakfast. The laundry staff were only available on day shift and had to wash linen from the previous day before delivering it to the unit which was sometimes during the late morning or afternoon. Licensed Practical Nurse #3 stated when the cart was delivered there were usually only six washcloths for 40 residents and staff had to cut up towels to use as washcloths or were expected to use disposable wipes, which were not good for washing residents.<br><br>During an interview on 07/12/2024 at 1:34 PM, Registered Nurse Manager #1 stated they had not received any complaints from residents about not receiving assistance with incontinence care from night shift until late morning. They said sometimes staffing was not good, and the facility was working on the issue. Registered Nurse Manager #1 stated they try to assist as much as possible and sometimes the linen cart does not get delivered to the unit until after breakfast which also affects care.<br><br>During an interview on 07/12/2024 at 1:45 PM, Certified Nursing Assistant #13 stated the unit was understaffed most of the time and they feel unable to get everything done timely, including nail care, incontinence care, passing meal trays, and documentation. Certified Nursing Assistant #13 stated most times staff were unable to provide morning care until after breakfast due to not having linens, which often did not arrive until 10:30 AM or later and then not enough linen was provided, such as six towels and six incontinence pads for 40 residents.<br><br>4. Resident #70 had diagnoses that included hemiplegia (paralysis on one side of the body), end stage renal disease (kidney failure) requiring dialysis, and respiratory failure with dependence on supplemental oxygen. The Minimum Data Set Resident Assessment, dated 06/03/2024, documented the resident was cognitively intact.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the current Comprehensive Care Plan revealed that Resident #70 was at risk for adjustment issues related to the resident's recent placement in a nursing home, with staff interventions to provide the resident emotional support and allow opportunities for the resident to express themselves. The resident was also taking psychotropic medication to treat depression.<br><br>During an interview on 07/08/2024 at 9:41 AM, Resident #70 said they were frustrated with their roommate (Resident #88) who was rude, mean, yelled at them, shouted curse words at them, and blasted their television purposely so that Resident #70 could not hear their own television. The resident said they had reported these behaviors to staff on countless occasions, and the staff would talk with the roommate, but the behaviors continued.<br><br>During an interview on 07/10/2024 at 4:30 PM, Social Worker #2 and the Director of Social Work both said the unit staff had not made them aware Resident #70 was having problems with their roommate. Social Worker #2 said they would have talked with nursing and admissions to move the resident had they known.<br><br>During an interview on 07/10/2024 at 4:59 PM, Certified Nursing Assistant #9 said Resident #70 reported the abuse to them, and they had reported the resident's concerns to Licensed Practical Nurse Manager #2, Licensed Practical Nurse #11, and Registered Nurse Supervisor #2. Certified Nursing Assistant #9 said the resident had asked to be moved to a different room. Certified Nursing Assistant #9 said after Resident #88 had sprayed Resident #70 with air freshener, they had brought Resident #70 into the hall to separate them from their roommate. Certified Nursing Assistant #9 then removed the air freshener from Resident #88 and notified Licensed Practical Nurse Manager #2.<br><br>During an interview on 07/10/2024 at 5:08 PM, the Director of Nursing said the allegations of abuse had not been brought to their attention and that it should have been immediately.<br><br>During an interview on 07/12/2024 at 9:56 AM, Licensed Practical Nurse Manager #2 said Resident #70's roommate (Resident #88) had four roommates in the last year who all asked to be moved away from them. Licensed Practical Nurse Manager #2 said they knew Resident #88 was being mean and rude to Resident #70 and these occurrences were often related to Resident #70 being incontinent, which was a trigger for Resident #88 based on statements they had made to Resident #70 in the past. Licensed Practical Nurse Manager #2 said they did not report Resident #70's concerns to Social Worker #2, the Director of Nursing, or the Administrator because they did not consider it abuse.<br><br>5. Resident #140 had diagnoses which included schizophrenia, major depressive disorder, and cerebral infarction (stroke). The Minimum Data Set Resident Assessment, dated 6/30/2024, documented the resident was cognitively intact, and had no history of behaviors.<br><br>During an observation and interview on 07/09/2024 at 10:42 AM on the South 1 Unit, Resident #140 was lying in bed. There were no sheets in place and the resident was wrapped in what appeared to be a personal fleece blanket. When interviewed, Resident #140 stated staff were too busy to put sheets on their bed the previous night and no one had come to offer assistance yet.<br><br>On 08/02/2024, the New York State Department of Health survey team identified and declared Immediate Jeopardy. The facility administrator was notified at 5:10 PM.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | On 08/04/2024 at 2:00 PM, the New York State Department of Health survey team declared the Immediate Jeopardy was removed based on the following corrective actions taken by the facility:<br><br>-100% of staff working at the time of removal had received education on abuse, neglect, mistreatment and proper reporting and notifications.<br><br>- Interviews completed with multiple staff, including licensed nursing staff, direct care staff and environmental services staff on seven of seven resident care units, revealed appropriate knowledge of abuse, neglect, mistreatment, and proper reporting and notifications.<br><br>-Approximately 41% of all non-licensed staff were educated regarding abuse, neglect, mistreatment, and proper reporting and notifications.<br><br>-Approximately 61% of all licensed nursing staff were educated regarding abuse, neglect, mistreatment, and proper reporting and notifications.<br><br>-The corrective action included a plan to educate all staff (including licensed, certified, and non-medical staff), agency staff, and staff on vacation and/or leave prior to the start of their next shift and would be tracked by the administrative team to ensure 100% compliance.<br><br>10 NYCRR 415.4 (b)(1)(i) |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>49447<br><br>Based on interviews and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for eight (Residents #13, #45, #70, #112, #149, #186, #559, and #607) of eight residents reviewed, the facility did not ensure that a written Baseline Care Plan summary was provided to the residents and/or resident representatives. Specifically, the facility was unable to provide evidence that a Baseline Care Plan (developed within 48 hours of admission and included minimum healthcare information necessary to properly care for the immediate needs of the residents, that they were able to understand) had been completed within 48 hours and a written summary of the plan had been provided to any of the residents and/or their representatives. This is evidenced by, but not limited to the following:<br><br>The facility policy Care Plans - Baseline, dated as reviewed January 2024, included a baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48) hours of admission and that the resident and their representative will be provided a summary of the baseline care plan.<br><br>1. Resident #45 was admitted with diagnoses that included urinary tract infection, neuromuscular dysfunction of the bladder (the bladder was unable to empty on its own) and enlarged prostate. The admission Minimum Data Set Resident Assessment, dated 02/11/2024, documented the resident was cognitively intact and participated in assessment and goal setting.<br><br>2. Resident #149 was admitted with diagnoses that included stroke, high blood pressure, and diabetes. The admission Minimum Data Set Resident Assessment, dated 01/15/2024, documented the resident was cognitively intact and participated in assessment and goal setting.<br><br>3. Resident #112 was admitted with diagnoses that included chronic obstructive lung disease (a lung disease that effects breathing), anxiety disorder, and epilepsy (a brain disease that causes seizures). The admission Minimum Data Set Resident Assessment, dated 04/27/2024, documented the resident was cognitively intact and participated in assessment and goal setting.<br><br>When requested, the facility was unable to provide evidence that a Baseline Care Plan had been completed within 48 hours or that a written summary of their Baseline Care Plan had been reviewed with them or provided to them prior to their Comprehensive Care Plan meeting for all the residents.<br><br>During an interview on 07/12/2024 at 12:20 PM, the Director of Social Work stated the Baseline Care Plan is reviewed with the resident and/or their resident representative when the admission care plan meeting is held usually 14-21 days after admission. The Director of Social Work stated that some information is added to the Comprehensive Care Plan in the first 48 hours, but not everything, and everything should be added prior to the admission care plan meeting.<br><br>(continued on next page) |

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| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue<br>Rochester, NY 14612 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 07/12/2024 at 1:56 PM, Assistant Director of Nursing #2 stated the Baseline Care Plan should be implemented in the first 48 hours after admission and should be reviewed with the resident or their representative. Assistant Director of Nursing #2 stated they were unsure of who does the review (summary) with the resident or their representative, when it was done or how the review was documented.<br><br>During an interview on 07/15/2024 at 10:05 AM, the Director of Nursing stated Baseline Care Plans and a review with the resident or resident representative should be completed before the admission care plan meeting.<br><br>10 NYCRR 415.11 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE: 425 Beach Avenue Rochester, NY 14612 | |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>49368<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for seven (Residents #45, #92, #134, #139, #177, #182 and #559) of nine residents reviewed, the facility did not develop and/or implement comprehensive person-centered care plans that included measurable goals and interventions to meet the residents' medical, nursing, and psychosocial needs as identified in their comprehensive assessments. Specifically, the comprehensive care plan for Resident #45 did not include catheter care. For Residents #92 and #177, the comprehensive care plans did not include a history of sexual-related behavior. For Residents #134 and #182, the comprehensive care plans did not include a history of any inappropriate behaviors towards other residents and/or staff. For Residents #139 and #559, the comprehensive care plans did not have interventions to prevent skin breakdown. This is evidenced by the following:<br><br>Review of the facility policy, Care Plans-Comprehensive Person-Centered, dated January 2024, revealed the care plan would describe the services that were to be provided to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, incorporate identified problem areas and associated risk factors, and aid in preventing and reducing decline in the resident's functional status. Additionally, the resident had the right to refuse to participate in development of their care plan and medical and nursing treatments. Refusals would be documented in the resident's clinical record.<br><br>1. Resident #559 had diagnoses including Stage 3 (full-thickness tissue loss) pressure ulcer (bed sores) to the sacrum (area at base of spine), pulmonary embolism (blood clot in the lungs) and a deep vein thrombosis (blood clot) of the lower extremity. The Minimum Data Set Resident Assessment, dated 06/21/2024, documented the resident had severe cognitive impairment, did not exhibit behaviors including rejection of care, was dependent on staff for dressing, had one or more unhealed pressure ulcers, and had pressure reducing devices in place.<br><br>Review of the current Comprehensive Care Plan and Kardex (care plan used by Certified Nursing Assistants to guide care) revealed the resident had an alteration in skin integrity. Interventions included, but were not limited to, ensure heel protection boots (positioning devices used to prevent skin breakdown) were on both feet when in bed.<br><br>Review of an Occupational Therapy evaluation and treatment plan, dated 06/18/2024, the Assistant Director of Rehabilitation documented that Resident #559 had skin discoloration on their right heel, a protective boot was placed on the resident's foot, and the resident required Occupational Therapy to develop and instruct a positioning program to reduce the risk for further skin breakdown.<br><br>Review of an Occupational Therapy discharge summary, dated 07/10/2024, the Assistant Director of Rehabilitation documented that Resident #559 was tolerating the protective boots well and visual and written instructions for the positioning devices were posted on the wall.<br><br>During observations on 07/08/2024 at 9:41 AM, 07/10/2024 at 9:17 AM, 07/11/2024 at 4:09 PM, and 07/12/2024 at 10:22 AM, Resident #559 was in bed with both heels resting on the mattress. The protective boots were on a shelf in the resident's room.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/12/2024 at 10:06 AM, the Assistant Director of Rehabilitation stated the protective boots were intended to alleviate pressure as a preventative measure (against skin breakdown) and Resident #559 should be wearing them as recommended.<br><br>During an interview on 07/12/2024 at 1:00 PM, Certified Nursing Assistant #14 stated Resident #559 was supposed to have protective boots on when in bed but had refused them and they had notified the nurse. Review of the resident's electronic health record for the prior three months did not include any documented evidence Resident #559 had refused the boots.<br><br>2. Resident #139 had diagnoses including malnutrition, diabetes mellitus, and a history of pressure injuries to their sacrum and bilateral ankles. The Minimum Data Set Resident Assessment, dated 05/24/2024, documented that the resident had moderately impaired cognition, did not exhibit behaviors including rejection of care, was dependent on staff for lower extremity dressing, was at risk for developing pressures ulcers and had pressure reducing devices in place.<br><br>Review the current Comprehensive Care Plan and Kardex revealed the resident required assistance with activities of daily living and was at risk for pressure ulcer development. Interventions included, but were not limited to, protective boots on at all times when in bed.<br><br>Review of current physician orders included to offload (relieve pressure) both heels while in bed or chair, apply protective heel boots daily and as needed, and to elevate both lower extremities on two pillows while in bed as tolerated.<br><br>During observations on 07/10/2024 at 9:20 AM and 1:33 PM, on 07/11/2024 at 10:20 AM and 4:12 PM, and on 07/15/2024 at 8:10 AM, Resident #139 was in bed with their heels resting directly on the mattress. Protective boots were not on the resident's heels or visible in the room, and the lower extremities were not elevated on pillows.<br><br>During an interview on 07/12/2024 at 10:28 AM, Certified Nursing Assistant #12 stated Resident #139 was care planned to have protective boots on while in bed, but there were no boots in the residents' room, and they had never seen them.<br><br>During an interview on 07/15/2024 at 3:37 PM, Assistant Director of Nursing #2 stated pressure relieving devices, including protective boots, should be put on residents who required them, and would expect Certified Nursing Assistants to report to the nurse if a resident refused placement, or if the devices were unavailable.<br><br>3. Resident #45 had diagnoses that included urinary tract infection, neuromuscular dysfunction of the bladder (the bladder was unable to empty on its own) and enlarged prostate. The Minimum Data Set Resident Assessment, dated 05/13/2024, documented the resident was cognitively intact, had a urinary catheter, and had a urinary tract infection in the last 30 days (requiring hospitalization ).<br><br>Review of the current Comprehensive Care Plan and Kardex revealed no measurable goals or interventions that addressed Resident #45's urinary issues or the care of the catheter.<br><br>Review of a hospital discharge summary, dated 04/25/2024, revealed Resident #45 had been hospitalized and treated for a urinary tract infection that required intravenous (via a catheter inserted into a vein) antibiotics.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of current physician orders included urinary catheter care every shift.<br><br>Review of a medical progress note, dated 05/22/2024, Nurse Practitioner #1 documented that Resident #45 was started on intravenous antibiotics in the facility for another urinary tract infection.<br><br>Review of a medical progress note, dated 06/14/2024, Nurse Practitioner #1 documented that Resident #45's urinary catheter was occluded and required replacement, and the resident was started on antibiotics for a urinary tract infection.<br><br>During an interview on 07/12/2024 at 10:57 AM, Licensed Practical Nurse #5 stated they would look in the care plan for specific interventions or needs related to a urinary catheter and that the drainage bag should never be on the floor or above the level of the bladder. Licensed Practical Nurse #5 stated the drainage bag was kept off the floor and below the bladder to prevent contamination and urinary tract infections.<br><br>During an interview on 07/12/2024 at 1:56 PM, Assistant Director of Nursing #2 stated staff should look at the Comprehensive Care Plan and the Kardex to direct care for each resident. They said if a resident had a urinary catheter, the care plan and Kardex should include information about the catheter and interventions specific to that resident.<br><br>4. Resident #92 had diagnoses that included dementia, visual hallucinations, and anxiety. The Minimum Data Set Resident Assessment, dated 06/05/2024, documented Resident #92 had severely impaired cognition and had no behaviors.<br><br>Review of the current Comprehensive Care Plan did not include Resident #92 had a history of sexual-related behaviors. The current Kardex included to provide the resident with a safe, secure, and clutter free environment.<br><br>Resident #177 had diagnoses that included dementia, diabetes, and adult failure to thrive. The Minimum Data Set Resident Assessment, dated 06/28/2024, documented that Resident #177 had severely impaired cognition and had no behaviors.<br><br>Review of the current Comprehensive Care Plan did not include that Resident #177 had a history of sexual-related behaviors.<br><br>Review of an undated Facility Investigation revealed that on 05/07/2024 at 5:30 PM, Resident #92 entered the room of two residents (Residents #166 and #177), Resident #92 removed their clothes and climbed into Resident #166's bed (near the door) and made a sexual advance towards Resident #166. Resident #166 got off the bed, alerted nursing staff and Resident #92 was removed from the room. Resident #92 was redressed by nursing staff and was escorted to the dining room. At approximately 6:45 PM, Resident #166 alerted staff that Resident #92 and Resident #177 were in the room and engaging in sexual behaviors. Staff immediately removed Resident #92 from the room and the Registered Nurse Supervisor was notified. The facility investigation noted that Residents #92 and #177 were considered non-consenting adults due to their impaired cognitive status, poor judgement and insight, and the inability to understand the consequences of their actions. Resident #177 was subsequently moved to a different unit.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/15/2024 at 9:55 AM, Certified Nursing Assistant #5 said if a resident had a history of certain behaviors, such as behaviors that were sexual in nature, the information should be in the resident's chart. If a resident required supervision, the information should be listed on the Kardex. Certified Nursing Assistant #5 said they had heard that Resident #92 had sexual behaviors towards other residents in the past.<br><br>During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manager #2 said Resident #177 was moved from another unit due to an incident that was sexual in nature. They said a history of resident-to-resident sexual behaviors should be included on the resident's care plan.<br><br>During an interview on 07/15/2024 at 4:23 PM, Assistant Director of Nursing #1 stated they were familiar with the incident involving Resident #92 and Resident #177 and that a history of resident-to-resident sexual behaviors should be included on a resident's care plan.<br><br>5. Resident #134 had diagnoses including dementia with agitation, delirium, and diabetes. The Minimum Data Set Resident Assessment, dated 12/06/2023, documented the resident had severely impaired cognition and no history of behaviors towards others.<br><br>Review of the current Comprehensive Care Plan and Kardex revealed Resident #134 was at risk for being a victim due to inability to understand their surroundings. Neither care plan included a history of any inappropriate behavior directed towards other residents.<br><br>Resident #182 had diagnoses including dementia, anxiety, and depression. The Minimum Data Set Resident Assessment, dated 04/30/2024, documented the resident had severely impaired cognition.<br><br>A review of the current Comprehensive Care Plan and Kardex did not include any behaviors directed toward other residents or staff.<br><br>During an observation on 07/08/2024 at 8:59 AM, Resident #134 was walking up and down the hallway behind Resident #182. While standing at the nurse's station, Resident #134 placed their arm around Resident #182 and began kissing Resident #182 repeatedly on the cheek. Resident #182 was making whimpering noises and walked away. At 9:07 AM, Resident #182 was in front of the nurse's station when Resident #134 placed their hand on Resident #182's lower back and attempted to kiss them on the cheek. Resident #182 put their hand up, said stop, and walked away.<br><br>During an interview on 07/12/2024 at 9:50 AM, Certified Nursing Assistant #7 stated Resident #134 wanders all day long and does have behaviors directed towards multiple residents (including Resident #182) touching them in passing, kissing, and hugging them.<br><br>During an interview on 07/15/2024 at 10:25AM, Assistant Director of Nursing #1 stated Resident #134 does have behaviors, but they had not seen or been told that Resident #134 touched or kissed other residents. They stated staff should have reported these interactions so the behaviors could be care planned for with interventions.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator, and Regional Clinical Director, the Regional Clinical Director stated the clinical team had been reviewing care plans and working to ensure they were complete but was not aware the care plans were not being implemented.<br><br>(continued on next page) |

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| | 335082 | A. Building<br>B. Wing | 09/17/2024 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 10 NYCRR 415.11 (c)(1) |

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| F 0677<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>20765<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey and complaint investigations (#s NY00339393, NY00343730, and NY00343916) from 07/08/2024 to 09/17/2024, for ten (Residents #69, #98, #106, #116, #122, #134, #140, #182, #456, and #457) of 13 residents reviewed, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene. Specifically, Resident #69 was lying in bed with no clothes on, there was a brown substance observed on their body, as well as, on the fitted sheet and the hospital gown that was underneath the resident's bottom. Resident #98 was in a wheelchair partially in the bathroom with their pants on the floor. There was stool on the floor near their bed and on the bed sheets with no staff in sight. Resident #106 was observed on several occasions with lack of incontinent care. Resident #116 was in bed and the incontinent pad underneath the resident was soiled and had a large brown stain that extended toward their mid-back with an odor of urine. Residents' #134 and #182 did not receive nail care over the course of several days. Resident #456 stated there was no aide on the overnight shift and they did not receive assistance with incontinence care until 4:00 AM. Resident #457 was observed lying in bed on wet linens and stated they required assistance with toileting, but staff did not come when they called for assistance, so they urinated in their brief. Resident #140 was observed sleeping in a bed that had no sheets in place and the resident was wrapped in what appeared to be a personal fleece blanket. Resident #122 was observed on several occasions with unwashed hair and long unshaven facial hair. This resulted in actual harm to Resident #106. This is evidenced by but not limited to the following:<br><br>1. Resident #106 had diagnoses that included a stage 4 (full thickness tissue damage) healing pressure ulcer (bed sore), depression, and hemiplegia (paralysis on one side of the body). The Minimum Data Set Resident Assessment, dated 05/02/2024, revealed the resident was cognitively intact, did not exhibit behaviors or rejection of care, required assistance with transfers and toileting hygiene, and was always incontinent of bladder and bowel.<br><br>Review of the current Comprehensive Care Plan and the current Kardex (care plan used by Certified Nursing Assistants to guide care) revealed that Resident #106 required assistance with activities of daily of living, had bladder and bowel incontinence, and was at risk for impaired skin integrity. Interventions included, but were not limited to, check for needed assist with toileting every two hours and/or check and change incontinence brief as needed every three to four hours. Provide peri-care (private areas) after each incontinent episode and keep skin clean and dry with prompt removal of wet or damp clothing or sheets.<br><br>During observations and interview on 07/08/2024 at 10:24 AM, Resident #106 was sitting upright in bed. There was the odor of urine and yellow and brown stains on the incontinence pad underneath the resident. Resident #106 stated they were soaked, had already eaten breakfast and had not been changed out of their wet incontinence brief since the previous night at bedtime. They said they put their call bell on for assistance and a nurse responded that the Certified Nursing Assistants were working their way down the hall. At 11:54 AM, Resident #106 remained in bed and stated they still had not been assisted with incontinence care. The room continued to have an odor of urine and the incontinence pad had not been changed.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an observation and interview on 07/11/2024 at 9:11 AM and again at 10:56 AM, Resident #106 remained in bed and stated they were again soaked and had not been changed since the previous night at bedtime. The incontinence pad placed underneath the resident was stained yellow extending from the incontinence brief and smelled of urine. Resident #106 stated they had not received care on 07/08/2024 until after they had eaten their lunch.<br><br>During an interview on 07/11/2024 at 1:30 PM, Resident #106 stated they have requested repeatedly that they get changed prior to breakfast and lunch, but it is not being done and it makes them feel terrible (like a piece of crap), like they are not worthy of being given any service.<br><br>During an interview on 07/12/2024 at 1:34 PM, Registered Nurse Manager #1 stated they had not received any complaints from residents about not receiving assistance with incontinence care from night shift until late morning. They said sometimes staffing was not good, and the facility was working on the issue, that they try to assist as much as possible and sometimes the linen cart does not get delivered to the unit until after breakfast which also affects care.<br><br>During an interview on 07/12/2024 at 1:45 PM, Certified Nursing Assistant #13 stated the unit was understaffed most of the time and they feel unable to get everything done timely, including nail care, incontinence care, passing meal trays, and documentation. Certified Nursing Assistant #13 stated most times staff were unable to provide morning care until after breakfast due to no linen which often did not arrive until 10:30 AM or later and then not enough linen was provided, such as six towels and six incontinence pads for 40 residents.<br><br>2.Resident #69 had diagnoses that included cerebral infarction (stroke), muscle weakness, and adult failure to thrive. The Minimum Data Set Resident Assessment, dated 06/30/2024, revealed the resident had severe cognitive impairment and required assistance from staff for personal hygiene, dressing and bathing.<br><br>Review of the current Comprehensive Care Plan revealed that Resident #69 required assistance with activities of daily of living and was incontinent of bladder and bowel. Interventions included, but were not limited to, check for needed assistance with toileting every two hours and/or check and change incontinence brief as needed every three to four hours. Provide peri-care after each incontinent episode.<br><br>Review of the current Kardex revealed that Resident #69 could not be transferred to the toilet due to a medical condition or safety concern, used a high back chair, and were dependent on staff for toileting hygiene in bed.<br><br>During an observation on 07/08/2024 at 9:55 AM, Resident #69 was lying in bed with no clothes on. There was a brown substance on their right heel, left hip, on the fitted sheet, and on the hospital gown that was underneath the resident's bottom. The resident's call bell was on the floor and not within reach.<br><br>During an observation on 07/10/2024 at 12:40 PM, Resident #69 was in bed eating independently, the resident's sweatpants were on the bed next to the resident, and they were asking for someone to put their pants on them. At approximately 12:45 pm, Resident Assistant #2 (unit helper that does not provide direct resident care) entered the room, Resident #69 asked for assistance with their pants and Resident Assistant #2 stated they would assist them after lunch.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an observation and interview on 07/10/2024 at 2:18 PM, Resident #69 was observed in bed wearing their sweatpants, there was a brown pudding like substance on their shirt. Certified Nursing Assistant #8 stated they did not put the resident's pants on, and they were not sure who did. Certified Nursing Assistant #8 stated they usually did not put Resident #69's pants on until after meals due to the resident urinating.<br><br>3. Resident #116 had diagnoses including a history of subdural hemorrhage (pool of blood covering the brain), muscle weakness, and type 2 diabetes mellitus. The Minimum Data Set Resident Assessment, dated 05/24/2024, revealed the resident had severe cognitive impairment and was dependent on staff for personal hygiene and bathing.<br><br>Review of the current Comprehensive Care Plan revealed Resident #116 required assistance with activities of daily of living and was incontinent of bladder and bowel. Interventions included, but were not limited to, check for needed assistance with toileting every two hours and/or check and change incontinence brief as needed every three to four hours. Provide peri-care after each incontinent episode.<br><br>Review of the current Kardex revealed Resident #116 could not be transferred to the toilet due to a medical condition or safety concern and was dependent on staff for toileting hygiene in bed.<br><br>During an observation on 07/08/2024 at 11:12 AM, Resident #116 was in bed and the incontinence pad underneath the resident was soiled with a large brown stain that extended toward their mid-back and there was an odor of urine in the room.<br><br>During an interview on 07/15/2024 at 8:42 AM, Certified Nursing Assistant #11 stated they were the only aide on the unit that shift and was not sure if additional staff were coming. They stated they would not be able to assist all residents with morning care, turning and positioning, and feeding.<br><br>During an interview on 07/15/2024 at 12:51 PM, Assistant Director of Nursing #2 stated they were not aware that South 3 (a 40-bed unit) only had one Certified Nursing Assistant on the unit on 07/08/2024, and the unit should have more than one aide on the day and evening shift.<br><br>4.Resident #98 had diagnoses that included dementia, muscle weakness and difficulty walking. The Minimum Data Set Resident Assessment, dated 04/08/2024, revealed the resident had moderately impaired cognition and required staff assistance for personal hygiene, toileting, and bathing.<br><br>Review of the current Comprehensive Care Plan and the current Kardex revealed that Resident #98 required assistance with activities of daily of living and was incontinent of bladder and bowel. Interventions included, but were not limited to, check for needed assistance with toileting every two hours and/or check and change incontinence brief as needed every three to four hours. Provide peri-care after each incontinent episode.<br><br>During an observation on 07/08/2024 at 11:17 AM, Resident #98 was in a wheelchair partially in the bathroom with their pants on the floor. There was stool on the floor near their bed and on the bed sheets, and there were no staff in sight.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | 5. Resident #457 had diagnoses including respiratory failure with supplemental oxygen and diabetes. A Nursing Admission Note, dated 07/02/2024, documented that Resident #457 was cognitively intact, incontinent of bladder, wore an incontinence brief, and had requested use of a bedside commode.<br><br>Review of the Comprehensive Care Plan and Kardex revealed Resident #457 was incontinent of urine and stool, required supervision or touch assist for toilet transfers using a walker, used a bedside commode, and required incontinence briefs with checks and changes every three to four hours, or as needed.<br><br>During an interview on 07/08/2024 at 9:41 AM, Resident #457 said they were not able to use the bathroom in their four-person room because the toilet was too low for them, and they used a commode (currently placed at the head of their bed). Resident #457 stated they are not provided proper care in that on some days they only got assistance and/or changed (incontinence care) once a day.<br><br>During an observation on 07/09/2024 at 10:30 AM, Resident #457 was in bed. The bed linens were visibly wet from their left thigh to their upper right shoulder and the room smelled of urine. Resident #457 said staff had delivered their breakfast tray earlier and knew the sheet was wet as it was visible over their shoulder.<br><br>During an observation and interview on 07/10/2024 at 12:56 PM, Resident #457 was sitting on the side of their bed and stated they could not use the bathroom toilet because they had arthritis, and it was too low for them. Resident #457 said they could not use the commode independently and when they called for assistance, staff did not come so they had to urinate in their brief.<br><br>During an observation and interview on 07/10/2024 at 2:18 PM, Resident #457's bathroom had two toilets, both with the seats at about knee height (approximately one and a half to two feet in height). Certified Nursing Assistant #8 stated currently none of the four residents in the room used the bathroom because they were all dependent on staff for toileting.<br><br>During an interview on 07/15/2024 at 11:00 AM, Certified Nursing Assistant #6 said if a resident was continent of urine, they would wait for the resident to call for assistance to use the bathroom or commode. If a resident was incontinent, incontinence care was provided after morning care and incontinence rounds were supposed to be done every two hours, which was hard to complete when the unit was short staffed. Certified Nursing Assistant #6 said they thought Resident #457 did know when they needed to use the bathroom and had only seen the resident use the commode for bowel movements. Certified Nursing Assistant #6 said residents should not have to void (urine or stool) in their brief if they were continent.<br><br>During an interview on 07/15/2024 at 11:33 AM, Licensed Practical Nurse #5 said nursing staff should provide residents assistance with toileting either when the resident's call light was on or during rounding. Licensed Practical Nurse #5 said if a resident was continent, they should get up (to go to the bathroom). Licensed Practical Nurse #5 said Resident #457 was continent of urine and could get up but did not. Resident #457 preferred to have their soiled brief changed or to use the commode. Licensed Practical Nurse #5 said when they asked Resident #457 why they did not get up to go to the bathroom, the resident said it was due to their oxygen, so longer oxygen tubing had been offered (not observed in the resident's room at the time).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335082 | A. Building<br>B. Wing | 09/17/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue<br>Rochester, NY 14612 |

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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|---|---|
| F 0677<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Some | During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manager #2 said Resident #457 received incontinence care because they were non-weight bearing and therapy was using the commode with the resident. Licensed Practical Nurse Manager #2 said a resident should not have to sit in urine or stool during meals as it was undignified.<br><br>6. Resident #182 had diagnoses including dementia, anxiety, and depression. The Minimum Data Set Resident Assessment, dated 04/30/2024, documented the resident had severely impaired cognition, required assistance with personal hygiene and had not refused care.<br><br>Review of the current Comprehensive Care Plan and Kardex revealed Resident #182 required assistance with personal hygiene.<br><br>During an observation on 07/08/2024 at 10:26 AM, Resident #182's fingernails were approximately one-half inch long on both hands and some nails had sharp, jagged edges.<br><br>During an observation on 07/09/2024 at 9:31 AM, Resident #182's fingernails remained uncut, and several had sharp jagged edges.<br><br>During an observation on 07/12/2024 at 10:50 AM, Resident #182 was dressed and walking in the hallway. Their nails remained long, broken, and had brown debris under them. When interviewed at that time, Certified Nursing Assistant #7 stated Resident #182's fingernails needed to be cut and although the resident was not on their assignment, they would cut them.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Assistant Administrator stated the Quality Assurance Committee was aware of concerns related to assistance with activities of daily living and resident care audits were on-going.<br><br>10 NYCRR 415.12(a)(3) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for two (Resident #122 and #182) of 13 residents reviewed for Activities of Daily Living, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice. Specifically, Resident #122 was observed on several occasions with unwashed hair and long unshaven facial hair and Resident #182 did not receive nail care. In addition, the facility did not assist Resident #122 with an appointment with a stylist for a wash and cut as requested. This is evidenced by, but not limited to, the following:<br><br>Review of the facility policy, Resident Care with Activities of Daily Living, dated January 2024, revealed staff should review the resident's care plan to assess for any special needs of the resident when providing assistance with scalp or hair care and shaving, follow general guidelines for each activity of daily living, and document the date and time the procedure was performed or if the resident refused treatment. Additionally, the supervisor was to be notified of any refusals of care.<br><br>1. Resident #122 had diagnoses including cerebral infarction (stroke), malnutrition, and anxiety. The Minimum Data Set Resident Assessment, dated 05/31/2024, documented the resident was cognitively intact and had no refusals of care.<br><br>Review of the current Comprehensive Care Plan revealed that Resident #122 required supervision with bathing or showering. The current Kardex (care plan used by Certified Nursing Assistants to guide care) included the resident's shower day was once weekly on Wednesday evening.<br><br>During an observation and interview on 07/08/2024 at 10:12 AM, Resident #122 was observed with long facial hair on their chin and upper lip and unwashed hair. Resident #122 said their hair was last washed a few weeks ago, was sometimes itchy, and they were waiting for a haircut.<br><br>During an observation and interview on 07/09/2024 at 10:07 AM, Resident #122's hair appeared greasy. The resident said they wanted their hair washed and was waiting for an appointment with the hairdresser. Resident #122's facial hair on their chin and upper lip remained long.<br><br>During an observation and interview on 07/12/2024 at 12:45 PM, Resident #122's hair remained unwashed and facial hair unchanged. Resident #122 said they asked the unit secretary about a month ago to make an appointment with the hairdresser but had not been scheduled yet. Resident #122 said their hair felt greasy and they needed their chin hairs to be shaved.<br><br>Review of Resident #122's Task Care Records (documentation used by the Certified Nursing Assistants to record care provided) revealed their last shower was on 06/26/2024. Review of Task Care Records and Interdisciplinary Progress Notes from 06/26/2024 to 07/15/2024 revealed no documented evidence the resident had been offered, received, or refused getting their hair washed or facial hair shaved. Additionally, there was no documented evidence Resident #122 had been assisted with scheduling an appointment with a hairdresser.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue Rochester, NY 14612 |

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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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/12/2024 at 1:06 PM, Resident Assistant #2 said the hairdresser was usually in house every Wednesday and the unit secretaries add the residents to the list if a resident (or representative) requests an appointment. During an interview on 07/15/2024 at 11:00 AM, Certified Nursing Assistant #6 said they assist residents with bathing, showers, hair washing and shaving (if requested), on their shower day or with morning care if needed. Certified Nursing Assistant #6 said they documented the care provided in the electronic medical record but could not recall if the electronic medical record specified shaving or hair washing. Certified Nursing Assistant #6 said Resident #122 had not asked for their hair to be washed and they had not noticed any facial hair.<br><br>During an interview on 07/15/2024 at 11:33 AM, Licensed Practical Nurse #5 said they were not sure when Resident #122 last had their hair washed. The unit had been short staffed, and they did not know when staff would have been able to wash Resident #122's hair.<br><br>During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manager #2 said residents' baths, showers and hair washing should be completed as scheduled and shaving facial hair was per the resident's preference. Licensed Practical Nurse Manager #2 said they had not seen the hairdresser at the facility.<br><br>2. Resident #182 had diagnoses including dementia, anxiety, and depression. The Minimum Data Set Resident Assessment, dated 04/30/2024, documented the resident had severely impaired cognition, required assistance with personal hygiene and had not refused care.<br><br>Review of the current Comprehensive Care Plan and Kardex revealed Resident #182 required assistance with personal hygiene.<br><br>During an observation on 07/08/2024 at 10:26 AM, Resident #182's fingernails were approximately one-half inch long on both hands and some nails had sharp, jagged edges.<br><br>During an observation on 07/09/2024 at 9:31 AM, Resident #182's fingernails remained uncut, and several had sharp jagged edges.<br><br>During an observation on 07/12/2024 at 10:50 AM, Resident #182 was dressed and walking in the hallway. Their nails remained long, broken, and had brown debris under them. When interviewed at that time, Certified Nursing Assistant #7 stated Resident #182's fingernails needed to be cut and although the resident was not on their assignment, they would cut them.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Assistant Administrator stated the Quality Assurance Committee was aware of concerns related to assistance with activities of daily living and resident care audits were on-going.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Assistant Administrator stated the Quality Assurance Committee was aware of concerns related to assistance with activities of daily living and resident care audits were on-going.<br><br>10 NYCRR 415.12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, the facility failed to ensure the resident received the necessary care, treatment, and services, consistent with professional standards of practice, to promote healing, prevent new pressure ulcers from developing, and/or prevent existing pressure ulcers from worsening for one (Resident #106) of five residents reviewed. Specifically, the facility did not ensure that wound treatments recommended by the Wound Care Physician were accurately and timely transcribed and implemented, that wound treatments were provided as ordered, and Resident #106 was observed on several occasions with lack of incontinence care. These issues resulted in the potential likelihood of serious injury for all the residents in the facility (census 216) that was Immediate Jeopardy.<br><br>Review of the facility policy, Prevention of Pressure Ulcers/Injuries, dated January 2024, included to keep skin clean and free of exposure to urine and fecal matter, and to wash the skin after any episode of incontinence.<br><br>Review of the facility policy, Pressure Ulcers/Skin Breakdown - Clinical Protocol, dated January 2024, included the physician would authorize pertinent orders related to wound treatments, including wound cleansing, and debridement (the removal of dead or infected skin tissue) approaches, dressings, and the application of topical agents if indicated for the type of skin alteration. During resident visits, the physician would evaluate and document the progress of wound healing, especially for residents with complicated, extensive, or non-healing wounds.<br><br>Resident #106 had diagnoses that included a stage 4 (full thickness tissue damage) pressure ulcer (bed sore), depression, and hemiplegia (paralysis on one side of the body). The Minimum Data Set Resident Assessment, dated 05/03/2024, revealed the resident was cognitively intact, was always incontinent of bladder and bowel, required assistance with toileting hygiene, had a Stage 4 pressure ulcer and moisture associated skin damage (inflammation or skin breakdown caused by prolonged exposure to a source of moisture such as urine or stool), and received pressure ulcer care.<br><br>Review of the current Comprehensive Care Plan documented Resident #106 had a stage 4 pressure ulcer to the sacrum (area of skin at base of spine) and was incontinent of urine and bowel. Interventions included, but were not limited to, apply treatment creams and dressings per physician's orders and to check and change incontinence briefs every three to four hours and as needed.<br><br>Review of a Wound Assessment and Plan note, dated 02/26/2024, the Wound Care Physician documented wound healing had stalled and ordered a wound treatment that included to cleanse with normal saline, apply collagen particles (powder-like wound treatment to promote healing) to wound bed, loosely pack with alginate AG (type of wound dressing with antibacterial properties) and cover with ABD pad (highly absorbent wound dressing) every day and as needed. Review of medical orders did not include evidence the Wound Care Physician's orders had been transcribed into the electronic medical record until 03/05/2024.<br><br>(continued on next page) |

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|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of a Wound Assessment and Plan note, dated 03/11/2024, the Wound Care Physician documented wound healing had declined related to critical contamination and ordered a wound treatment that included to cleanse with normal saline, apply collagen particles to wound bed, loosely pack with alginate AG and cover with ABD pad every day and as needed. Review of medical orders did not include evidence the Wound Care Physician's orders had been transcribed into the electronic medical record.<br><br>Review of a Wound Assessment and Plan note, dated 03/18/2024, revealed the Wound Care Physician's treatment orders made on 03/11/2024 were never implemented. Review of the Treatment Administration Record from 03/11/2024 to 03/20/2024 revealed Resident #106 continued to receive skin barrier film to the skin surrounding the wound for six days (despite the Wound Care Physician's treatment order changes on 03/11/2024).<br><br>In a Wound Assessment and Plan note, dated 04/15/2024, the Wound Care Physician documented wound healing had declined related to peri care and the skin surrounding the wound was macerated (skin that has softened and broken down due to prolonged exposure to moisture). Treatment orders included to cleanse the wound with normal saline, apply skin barrier film to skin surrounding wound, loosely pack with iodoform (a sterile dressing that is used to treat draining or infected wounds) gauze and cover with ABD pad every day and as needed.<br><br>Review of medical orders did not include evidence the Wound Care Physician's orders had been transcribed into the electronic medical record.<br><br>Review of Wound Assessment and Plan notes, dated 04/22/2024, 04/29/2024 and 05/06/2024, revealed treatment orders to cleanse with normal saline, loosely pack with iodoform gauze and cover with ABD pad daily and as needed. Review of medical orders did not include evidence the Wound Care Physician's orders had been transcribed into the electronic medical record.<br><br>In a Wound Assessment and Plan note, dated 05/13/2024, the Wound Care Physician documented wound healing had declined related to dermatitis and included treatment orders to cleanse with sterile water, apply triamcinolone/ nystatin (Mycolog II cream) (a steroid cream used to treat fungal infections) to the skin surrounding the wound, loosely pack with iodoform gauze and cover with ABD pad daily and as needed.<br><br>Review of the Treatment Administration Record from 04/15/2024 to 05/15/2024 revealed Resident #106 received wound treatments that included collagen particles (despite the Wound Care Physician's treatment order changes on 04/15/2024).<br><br>Review of a Provider Progress Note, dated 06/19/2024, Nurse Practitioner #1 revealed the resident was seen to review a wound culture of the sacral wound obtained on 6/3/2024 and reports of green drainage from and redness surrounding the wound. The wound culture was positive for Staphylococcus Aureus (bacteria that causes skin infections) and Nurse Practitioner #1 ordered Bactrim (antibiotic medication used to treat infections) to be administered for seven days.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Wound Assessment and Plan notes, dated 07/01/2024, 07/08/2024, 07/15/2024, and 07/22/2024, revealed wound treatment orders that included to cleanse with sterile water, apply Miconazole 2% cream (an antifungal cream used to treat skin infections) to the skin surrounding the wound, loosely pack with iodoform gauze and cover with a non-adherent super absorbent dressing daily and as needed. Review of medical orders did not include evidence the Wound Care Physician's orders had been transcribed into the electronic medical record.<br><br>Review of the Treatment Administration Record from 07/01/2024 to 07/27/2024 revealed Resident #106 received Mycolog II cream to the skin surrounding the wound for 26 days (despite the Wound Care Physician's treatment order changes on 07/01/2024).<br><br>Review of Treatment Administration Records from January 2024 through July 2024 revealed missing documentation (blank boxes) for 21 out of 218 total opportunities for wound care.<br><br>During observations and interview on 07/08/2024 at 10:24 AM, Resident #106 was sitting upright in bed. There was the odor of urine and yellow and brown stains on the incontinence pad underneath the resident. Resident #106 stated they were soaked and had not been changed out of their wet incontinence brief since the previous night at bedtime. At 11:54 AM, Resident #106 remained in bed and stated they still had not been assisted with incontinence care. The room continued to have an odor of urine and the incontinence pad had not been changed. Additionally, an Enhanced Barrier Precautions (an infection control strategy) sign was observed on the door outside the resident's room. Instructions on the sign included, but were not limited to, everyone must clean their hands before entering and when leaving the room, staff must wear a gown and gloves for high contact resident care activities that included transferring, providing hygiene, changing briefs, or assisting with toileting, and wound care (any skin opening requiring a dressing).<br><br>During an observation and interview on 07/11/2024 at 9:11 AM, Resident #106 remained in bed and stated they were soaked and had not been changed since the previous night at bedtime. The incontinence pad placed underneath the resident was stained yellow extending from the incontinence brief and smelled of urine. Additionally, the resident stated they had not received care on 07/08/2024 until after they had eaten their lunch.<br><br>During an observation and interview on 07/11/2024 at 1:40 PM, Licensed Practical Nurse #3 entered Resident #106's room to provide wound care, at which time Resident #106 reported to the nurse that they were wet (incontinent of urine). Licensed Practical Nurse #3 proceeded to perform wound care to Resident #106's sacral pressure ulcer. Licensed Practical Nurse #3 was not wearing a gown during the procedure and did not change their gloves or perform hand hygiene after removing the old dressing (containing wound drainage), cleaning the wound, and before applying the new dressing (which included the application of collagen particles that had not been ordered by the Wound Care Physician since 04/15/2024). During an interview, Licensed Practical Nurse #3 stated they had not changed gloves or performed hand hygiene during and immediately following wound care but should have.<br><br>During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manger #2 said a blank box on the Medication Administration Record or Treatment Administration Record would indicate the something was not given (or done).<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 08/05/2024 at 1:22 PM, the Wound Care Physician explained their role involved the assessment of residents' wounds, prescribing wound treatments, evaluating if ordered treatments were still appropriate, performing minor procedures, and ordering labs or tests if necessary. The Wound Care Physician said they are in the facility one day a week (to assess residents wounds) and the Wound (and Infection Control) Nurse was responsible for reviewing the Wound Care Physician's notes to update the wound treatment orders into the electronic medical record. The Wound Care Physician stated there were times they evaluated Resident #106's wound and the surrounding skin was deteriorating, which the resident attributed to not being provided incontinence care. The Wound Care Physician stated they frequently observed residents being heavily soiled (incontinent of urine or stool) when they would assess them during wound rounds.<br><br>During an interview on 08/06/2024 at 11:04 AM, the Wound and Infection Control Nurse said they perform wound rounds on Mondays with the Wound Care Physician and would review their visit notes the following day (if available). The Wound and Infection Control Nurse stated they would change the wound treatment orders in the electronic medical record based on what the Wound Care Physician wrote in their notes. The Wound and Infection Control Nurse said they started in their role in May 2024, and they were told that prior to their arrival, the Director of Nursing and Assistant Director of Nursing #1 were transcribing the wound treatment orders into the electronic medical record. The Wound and Infection Control Nurse could not speak to why the correct wound treatments orders were not entered into the electronic medical record as indicated by the Wound Care Providers' notes dated 02/26/2024, 03/11/2024, 04/15/2024, 04/22/2024, 04/29/2024, and 05/06/2024. Upon reviewing the Wound Assessment and Plan note dated 7/1/2024 and current medical orders, the Wound and Infection Control Nurse said the Wound Care Physician included a treatment order for Miconazole cream, but the current order was for triamcinolone/nystatin (Mycolog II cream). They were not sure how the error occurred, but it was possible they got the creams mixed up.<br><br>During an interview on 08/06/2024 at 12:24 PM, Assistant Director of Nursing #2 said they would expect the nurses to perform wound treatments as ordered by the provider. Assistant Director of Nursing #2 said they would expect the nurse transcribing the wound treatment orders into the electronic medical record to review the Wound Care Provider's notes to ensure accuracy.<br><br>During an interview on 08/07/2024 at 9:11 AM, the Wound Care Physician stated they had been informed by nursing staff about inconsistencies between the Wound Care Physician's visit notes and the treatment orders entered into the electronic medical record. The Wound Care Physician said there was a time when the facility did not have a wound nurse and they did not know who was transcribing the treatment orders into the electronic health record. The Wound Care Physician said that orders not being transcribed into the electronic medical record timely, dressings not being changed (as ordered) and the resident not being assisted with incontinence care frequently and timely could all have an impact on the resident's (lack of) wound healing.<br><br>The Director of Nursing did not return calls made on 08/07/2024 and 08/08/2024 requesting an interview.<br><br>On 08/22/2024, the New York State Department of Health survey team identified and declared Immediate Jeopardy. The facility administrator was notified at 12:00 PM.<br><br>On 08/22/2024 at 6:00 PM, the survey team declared that the IJ was removed based on the following corrective actions taken by the facility:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 1. 100% of licensed staff working on the day and evening shifts at the time of removal had received education on the following:<br><br>a. Appropriate Personal Protective Equipment and hand hygiene for wound care (including incontinence care).<br><br>b. Appropriate weekly, post admission/readmission skin assessments on all residents.<br><br>c. Accurately transcribing and implementing Physician orders, including hospital discharge instructions and wound care medical consultants, for wound care treatments and ensuring treatment orders match Physician orders and consultant recommendations (unless otherwise indicated). Additionally notifying the medical team for unclear orders or no orders for existing skin issues.<br><br>d. Accurate and timely documentation of wound care.<br><br>e. Care Plan interventions for all existing skin issues.<br><br>2. Interviews completed with licensed staff on all six facility resident units to verify content of education completed and understanding of.<br><br>3. Review of a facility wide audit conducted for all residents consisting of head-to-toe skin assessments to ensure all skin issues addressed with medical and orders were correctly transcribed and implemented.<br><br>4. Medical record review of sample group of residents with current wounds/skin issues to ensure all Physician orders and consultant recommendations matched the treatment administration records to verify the correct treatments were being provided.<br><br>5. The correction action included a plan to educate all licensed staff, agency staff and any staff on vacation/leave prior to next working shift and tracked by Administration team to ensure 100% compliance.<br><br>10 NYCRR 415.12 (c)(1) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>49447<br><br>Based on observations, interviews, and record reviews conducted during the extended Recertification Survey and complaint investigation (#NY00345239) from 07/08/2024 to 09/17/2024, the facility did not ensure a resident with an indwelling urinary catheter received the treatment and care necessary to prevent urinary tract infections to the extent possible for one (Resident #45) of two residents reviewed. Specifically, Resident #45's urinary catheter and drainage bag were observed on the floor with no protective barrier on several occasions, were observed above the level of the bladder, and the facility did not develop a care plan to address the resident's urinary issues and care of their urinary catheter. This is evidenced by the following:<br><br>The facility policy Catheter Care, dated January 2024, documented that staff should review the resident care plan to assess for any special needs of the resident, that the urinary catheter and drainage bag should be kept below the level of the bladder at all times, and to be sure the catheter tubing and drainage bag are kept off of the floor.<br><br>Resident #45 was admitted with diagnoses that included urinary tract infection, neuromuscular dysfunction of the bladder (the bladder was unable to empty on its own), and an enlarged prostate. The Minimum Data Set Resident Assessment, dated 05/13/2024, documented the resident was cognitively intact, had a urinary catheter, and had a urinary tract infection in the last 30 days (requiring hospitalization ).<br><br>The Comprehensive Care Plan and Kardex (care plan used by the Certified Nursing Assistants for daily care) did not include any information, goals, or interventions for Resident #45's urinary issues or the care of the catheter.<br><br>A hospital discharge summary, dated 04/25/2024, documented Resident #45 had been hospitalized and treated for a urinary tract infection that required intravenous (via a catheter inserted into a vein) antibiotics.<br><br>Current Physician orders included urinary catheter care every shift.<br><br>In a medical progress note dated 5/22/2024 Nurse Practitioner #1 documented Resident #45 was started on intravenous antibiotics in the facility for another urinary tract infection.<br><br>In a medical progress note, dated 06/14/2024, Nurse Practitioner #1 documented Resident #45's urinary catheter was occluded, was replaced, and the resident started on antibiotics for a urinary tract infection.<br><br>During observations on 07/09/2024 at 9:52 AM and on 07/10/2024 at 10:00 AM and again at 4:34 PM, Resident #45 was sitting in their wheelchair. The urinary catheter and drainage bag were on the floor without a protective covering.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/10/2024 at 1:45 PM, Certified Nursing Assistant #6 stated they were responsible for making sure the drainage bag was off the floor, emptied during their shift, and not above the level of the bladder and that they usually find this information in the Kardex.<br><br>During an observation on 07/11/2024 at 9:12 AM, the urinary catheter and the drainage bag were sitting on Resident #45's lap above the level of the bladder. During an interview at this time, Resident #45 stated staff had not attached the drainage bag to their wheelchair so they were carrying it so it would not get stuck under the wheelchair wheel.<br><br>During an observation and interview on 07/11/2024 at 12:35 PM, Resident #45's urinary catheter and the drainage bag were on the floor next to the tray table. Resident Assistant #1 (a staff member who does not provide hands on resident care) placed the lunch tray on the tray table and moved the tray table around the catheter drainage bag to get it closer to the resident. When interviewed Resident Assistant #1 stated they could not move the drainage bag and would inform one of the Certified Nursing Assistants.<br><br>During an interview on 07/12/2024 at 10:57 AM, Licensed Practical Nurse #5 stated they would look in the care plan to know if a resident had specific interventions or needs related to a urinary catheter and that the drainage bag should never be on the floor or above the level of the bladder. Licensed Practical Nurse #5 stated that the drainage bag is kept off the floor and below the bladder to ensure infection control and prevent urinary tract infections.<br><br>During an interview on 07/12/2024 at 1:56 PM, the Assistant Director of Nursing #2 stated that staff should look at the Comprehensive Care Plan and the Kardex to know how to take care of each resident's needs. The Assistant Director of Nursing #2 said the Comprehensive Care Plan and the Kardex should include if a resident has a urinary catheter and have interventions specific to that resident.<br><br>In a progress note, dated 07/12/2024, Licensed Practical Nurse #10 documented Resident #45 had been sent to the hospital for further evaluation due to blood in the urine and pain from their catheter.<br><br>10 NYCRR 415.12(d)(1) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>49368<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for one (#66) of one resident reviewed, the facility did not ensure that a resident being fed by enteral means (a feeding tube placed in the stomach to receive nutrition) received the appropriate care and services to prevent complications. Specifically, Resident #66's tube feedings were not consistently labeled to ensure the physician orders were being followed with the correct formula, when the feeding was intiated or by whom and had no resident identifyers on the tube feedings. This is evidenced by the following:<br><br>Resident #66 had diagnoses including dysphagia (difficulty swallowing) that required a feeding tube, malnutrition, and diabetes mellitus. The Minimum Data Set Resident Assessment, dated 05/23/2024, revealed the resident was moderately impaired cognitively and received 51% or more of total calories via the feeding tube.<br><br>The current Comprehensive Care Plan included the resident required tube feeding related to a digestive disorder with a goal that the resident was adequately nourished and hydrated. Interventions included, but were not limited to, administer tube feeding and water flushes per Registered Dietitian recommendation and medical orders.<br><br>Current physician's orders included Diabetisource AC 1.2 (may use Glucerna 1.2) via a feeding tube at 95 milliliters per hour for 18 hours for a total volume of 1750 milliliters (per day) and 200 milliliters of water every 6 hours four times a day via the feeding tube for hydration.<br><br>During an observation on 07/08/2024 at 9:30 AM, Resident #66 had two bags of fluid hanging infusing into their feeding tube. One unlabeled bag contained a brown fluid and the other bag contained what appeared to be water. Both bags were labeled with 07/07/2024 on the bag. The bags were not labeled with what was in the bag, the resident's name, the start time, or the initials of the staff who started the feedings.<br><br>During an observation on 07/11/2024 at 8:10 AM, Resident #66 had a bag of fluid infusing. The bag again had no information to verify the contents, the date it was hung, the resident's name, the time started, or initials of the nurse who initiated the feeding. The water flush bag was not labeled with anything. Next to the resident's bed were three 33.8 fluid ounce bottles of Glucerna 1.5, one 33.8 fluid ounce bottle of Jevity 1.5, and a case (containing twenty-four 8 fluid ounce cartons) of Glucerna 1.5, in which one carton was sitting on top of Resident #66's tray table. None of which were the formula ordered by the physician.<br><br>During an interview on 07/11/2024 at 8:31 AM, Licensed Practical Nurse #15 stated the formula, the date (hung), resident's name, and rate should be on the label. Licensed Practical Nurse #15 stated they could not identify what formula was infusing because there was no label on the bag. Licensed Practical Nurse #15 stated Resident #66 usually gets Diabetisource in premade bags and then the bags should be initialed with the start time (to ensure the proper amount infused). Licensed Practical Nurse #15 said when they run out of Glucerna the dietitian sometimes substitutes Jevity, but they would need an order to administer Jevity.<br><br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 07/11/2024 at 8:36 AM, the Regional Dietitian stated Jevity enteral feeding formula was not an equivalent substitution for Glucerna and Resident #66's current enteral feeding order was for Diabetisource AC with Glucerna 1.2 as a substitute. The Regional Dietitian stated they would not allow Glucerna 1.5 as a substitute for Diabetisource AC before staff had a discussion with them to ensure the resident's enteral formula could be adjusted properly to provide the needed calories. The Regional Dietitian said they were not made aware of any changes in Resident #66's orders.<br><br>During an interview on 07/15/2024 at 7:49 PM, the Corporate Administrator stated they were not aware until surveyor intervention that a resident did not receive the ordered tube feed formula with multiple observations of the resident's tube feed bottles and water flush bags were not labeled appropriately, including name, date, time, and rate.<br><br>10 NYCRR 415.12(g)(2) |

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| F 0725<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for six (South 1, South 2, South 3, North 1, North 2, and [NAME] 2) of seven resident units, the facility did not ensure sufficient staffing to provide nursing services to attain or maintain the highest practical physical, mental, and psychosocial well-being for residents in the facility. Specifically, there were several observations of residents who were incontinent and had not received timely assistance with care, and several residents had not received significant medications on 07/04/2024, 07/05/2024, and 07/29/2024 due to no nurse being available to administer the medications. This resulted in actual psychosocial harm to Resident #106 that was not immediate jeopardy. The findings included but not limited to the following:<br><br>For additional information see Centers for Medicare/Medicaid Services Form 2567: F677 Activities of Daily Care Provided for Dependent Residents; F760 Residents Are Free of Significant Medication Errors.<br><br>Review of the Facility Assessment, dated 06/21/2024, revealed the facility was licensed for 228 beds with an average daily census of 180 residents. Resident care and services included, but were not limited to, assistance with activities of daily living, incontinence prevention and care, and medication administration. The staffing plan included that nursing staff was evaluated at the beginning of each shift and adjusted as needed to meet the care needs and acuity of the resident population. The facility's Full Time Equivalents (measurement that compares the amount of time worked by each employee to that of a full-time employee) were as follows: Registered Nurses: Three full-time and three per diem (employees who work when the need arises); Licensed Practical Nurses: 28 full-time and 17 per diem; Certified Nursing Assistants 32 full-time, 22 part-time and 22 per diem.<br><br>Review of the facility policy Emergency Nurse Staffing Plan, dated January 2023, revealed the Staffing Coordinator would discuss with the Director of Nursing staffing levels daily and in the event of critically low staffing, the Mandation Policy would be strictly followed. The Staffing Coordinator was expected to follow daily staffing practices which included, but were not limited to, evaluating nurse staffing, and adjusting at least every eight hours and more if needed based on patient census and acuity level (the level of care that was required), and confirming the number of staff on duty was sufficient to ensure nursing care needs of each resident was met.<br><br>During the entrance conference on 07/08/2024 at 8:56 AM with the Administrator, Assistant Administrator and Director of Nursing, the Director of Nursing stated the facility census was 213 residents.<br><br>1. Observations and interviews on the South 3 Unit (40 residents) included:<br><br>a. On 07/08/2024 at 8:52 AM, Licensed Practical Nurse #14 stated there were two Licensed Practical Nurses and one certified Nursing Assistant on the unit for day shift. The resident census was 40.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | b. On 07/08/2024 at 10:01 AM, Certified Nursing Assistant #12 was passing a breakfast tray to a resident room who was incontinent of bowel and on a soiled sheet. Certified Nursing Assistant #12 asked Licensed Practical Nurse #14 for assistance due to the resident requiring the assist of two staff for care. Licensed Practical Nurse #14 stated that assisting the aide with the resident's care would cause them to be late passing medications and it was often difficult to get their medication administration done when the staffing was short.<br><br>c. On 07/08/2024 at 11:12 AM, Resident #116 was in bed and the incontinence pad underneath the resident was soiled and had a large brown stain that extended toward their mid-back and there was an odor of urine.<br><br>d. On 07/15/2024 at 8:42 AM, Certified Nursing Assistant #11 stated they were the only aide on the unit that shift and was not sure if additional staff were coming. They stated they would not be able to assist all residents with morning care, turning and positioning and feeding.<br><br>e. On 07/15/2024 at 12:51 PM, Assistant Director of Nursing #2 stated they were not aware that South 3 only had one Certified Nursing Assistant on the unit on 07/08/2024, and the unit should have more than one aide on the day and evening shift.<br><br>2. Observations and interviews on the North 2 Unit included:<br><br>a. On 07/08/2024 at 9:24 AM, Resident #456 stated there was no aide on the overnight shift and they did not receive assistance with incontinence care until 4:00 AM.<br><br>b. On 07/08/2024 at 9:55 AM Resident #69 was lying in bed with no clothes on. There was a brown substance on their right heel, left hip, on the fitted sheet, and on the hospital gown that was underneath the resident's bottom. The call bell was on the floor and not within reach. When interviewed Licensed Practical Nurse #5 stated the North 1 and North 2 Units had a total of 36 residents and there was two Licensed Practical Nurses and three Certified Nursing Assistants (one was a new hire in training).<br><br>c. On 07/08/2024 at 10:12 AM, Resident #122 was observed with long facial hair on their chin and upper lip and unwashed, greasy hair. Resident #122 said their hair was last washed a few weeks ago, was sometimes itchy, and that they were waiting for a haircut.<br><br>d. On 07/08/2024 at 10:21 AM, Resident #199 said they had received their medications late the previous night because there was only one nurse on the unit.<br><br>e. On 07/09/2024 at 10:30 AM, Resident #457 was in bed. The bed linens were visibly wet from their left thigh to their upper right shoulder and the room smelled of urine. Resident #457 said staff had delivered their breakfast tray earlier and knew the sheets were wet as it was visible over their shoulder.<br><br>f. On 07/10/2024 at 12:56 PM, Resident #457 was sitting on the side of their bed and stated they cannot use the commode independently, but when they call for assistance, staff do not come so they urinate in their brief.<br><br>3. Observations and interview on the South 2 Unit (40 beds) included:<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | a. On 07/08/2024 at 9:04 AM, Licensed Practical Nurse Manager #1 stated there was one other Licensed Practical Nurse (beside themselves) who was assigned to medications and two Certified Nursing Assistants for 37 residents.<br><br>b. On 07/08/2024 at 11:17 AM, Resident #98 was in a wheelchair partially in the bathroom with their pants on the floor. There was stool on the floor near their bed and on the bed sheets. There were no staff in sight.<br><br>4. Observations and interview on South 1 Unit (40 residents) included:<br><br>a. On 07/08/2024 at 10:24 AM, Resident #106 was in bed. There was the odor of urine and yellow and brown stains on the incontinence pad underneath the resident. Resident #106 stated they were soaked, had already eaten breakfast and had not been changed out of their wet incontinence brief since the previous night at bedtime. They had put their call bell on for assistance and a nurse responded that Certified Nursing Assistants were working their way down the hall. At 11:54 AM, Resident #106 was in bed and stated they still had not been assisted with incontinence care. The room continued to have an odor of urine and the incontinence pad did not appear to have been changed. During an interview on 07/11/2024 at 1:30 PM, Resident #106 stated they have requested repeatedly that they get changed prior to breakfast and lunch, but it is not being done and it makes them feel terrible (like a piece of crap), like they were not worthy of being given any service.<br><br>b. On 07/08/2024 at 1:25 PM, Resident #60 stated there was no nurse on the unit this past weekend to give medications and they had not received their insulin. Review of Resident #60's July 2024 Medication Administration Record revealed apixaban (scheduled for 6:00 PM) and Lantus insulin (scheduled for 9:00 PM) were documented as not administered on 07/04/2024 and 07/05/2024.<br><br>c. On 07/09/2024 at 10:42 AM, Resident #140 was lying in bed. There were no sheets in place and the resident was wrapped in what appeared to be a personal fleece blanket. When interviewed, Resident #140 stated that staff were too busy to put sheets on their bed the previous night and no one had come to offer assistance yet this morning.<br><br>d. On 07/12/2024 at 1:34 PM, Registered Nurse Manager #1 stated they were aware that some residents on the unit missed medications the previous week as the nursing supervisor had called them to report being short of nurses.<br><br>e. On 07/12/2024 at 1:55 PM, Licensed Practical Nurse #3 stated they had worked as the only nurse on the unit for the evening shift on 07/03/2024, 07/04/2024, and 07/05/2024. On 07/04/2024 there was one Certified Nursing Assistant scheduled with them and they were responsible for administering medications for all residents on the unit and assisting with passing meal trays, feeding residents, and incontinence care (making it difficult to get everything done).<br><br>5. Observations and interview on [NAME] 2 Unit (31 residents) included:<br><br>a. On 07/08/2024 at 10:26 AM, Resident #182's fingernails were approximately one-half inch long on both hands and some nails had sharp jagged edges.<br><br>b. On 07/12/2024 at 1:34 PM, Resident #134's fingernails were approximately one-half inch long with debris underneath.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | Review of the daily punches (staff signed in to work) for Licensed Nursing Staff on 07/04/2024, evening shift revealed there was one Registered Nurse (3:00 PM to 9:00 PM), two Registered Nurse Supervisors (3:00 PM to 11:00 PM), and one Licensed Practical Nurse (3:00 PM to 7:00 PM). The resident census was approximately 206 residents. The nurse to resident ratio from 9:00 PM to 11:00 PM was one nurse to approximately 103 residents.<br><br>Review of the actual staffing sheets for 07/07/2024 revealed one Licensed Practical Nurse and one Registered Nurse Supervisor in the facility for night shift for 206 residents resulting in a nurse to resident ratio of one nurse to 103 residents. Additionally, there was one Certified Nursing Assistant assigned to both North 1 and North 2 during the 07/07/2024 night shift for 36 residents.<br><br>Review of the Certified Nurse Aide Staffing sheet for 07/08/2024 revealed there were 12 Certified Nursing Assistants during the day shift for 213 residents or one aide per 18 residents.<br><br>During an interview on 07/10/2024 at 1:35 PM, a family member stated the facility never had enough help and that there were several residents who required assistance with feeding but not enough staff to assist them all, so they tried to be at the facility daily to ensure their family member got fed.<br><br>During an interview on 07/11/2024 at 12:18 PM, a second family member stated they had witnessed residents lying in stool for extended periods of time and not being changed timely and that the facility was short staffed on the weekends, sometimes with only two staff members on the unit (40 residents). The family member stated they had to wash the resident they were visiting that day.<br><br>During an interview on 07/15/2024 at 2:58 PM, the Staffing Coordinator stated that on each unit there should be a minimum of three Certified Nursing Assistants and two Licensed Practical Nurses on the day and evening shift, and two Certified Nursing Assistants and one Licensed Practical Nurse on the night shift. When the staffing is under the minimum, all staff are contacted to attempt to fill the open shift and if unable to fill the shift other certified and/or licensed staff in the building will assist as needed.<br><br>During an interview on 07/15/2024 at 4:26 PM, Nurse Practitioner #1 stated they were made aware about a week prior that medications had not been given for entire shifts due to not having a nurse available to administer the medications.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Regional Administrator stated leadership had not been notified of the staffing concerns on 07/04/2024 and 07/05/2024. The Regional Administrator stated there was a recruiter specifically assigned to the facility and they felt there had been a lot of staff hired. The Regional Clinical Director stated several changes had been made which included posting open shifts, making schedule changes to accommodate staff, meetings held before the weekend to ensure there was enough staff, holding staff accountable for call-offs, and holding weekly general orientations to prevent delays in new staff starting.<br><br>(continued on next page) |

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| F 0725<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Many | 6. During an interview on 08/01/2024 at 2:11 PM, Licensed Practical Nurse Manager #2 said residents on the South 1 unit did not receive their evening medications on 07/29/2024 because there was no nurse on the unit. Licensed Practical Nurse Manager #2 said residents' finger sticks (blood glucose levels) were also not checked (as ordered) because there was no nurse on the unit. During a follow-up interview at 2:51 PM, Licensed Practical Nurse Manager #2 showed the Electronic Medication Administration Record for the evening shift on 07/29/2024 and 32 residents with medications scheduled to be given were highlighted red, indicating that they had not been given medications during the shift.<br><br>Review of the Medication Administration Audit Report for the South 1 unit residents from 07/24/2024 through 07/30/2024 revealed 28 residents were not administered their significant medications as scheduled during the evening shift on 07/29/2024. Medications included but were not limited to antiseizure medications, insulins, anticoagulants (blood thinners), antibiotics, blood pressure medications, analgesics (medications for pain), antipsychotics (medications that treat psychosis-related conditions and symptoms), antidepressants and medications for Parkinson's.<br><br>Review of the actual staffing sheets for 07/29/2024 revealed Licensed Practical Nurse #17 was assigned to South 1 unit from 3:00 PM to 11:00 PM (evening shift). However, review of the daily punches report, dated 07/29/2024, revealed Licensed Practical Nurse #17 did not punch in or out, indicating they did not work, and the Director of Nursing was in the facility for the duration of the evening shift (until 11:56 PM).<br><br>During an interview on 08/08/2024 at 11:57 AM, Nurse Practitioner #1 stated they were not in the building on 07/30/2024 and did not recall being notified that medications were not given to residents on South 1 during the evening shift on 07/29/2024. Nurse Practitioner #1 said they had heard of instances, usually once a week, in which medications were missed (not administered) and it was usually due to not having a nurse.<br><br>During an interview on 08/08/1024 at 2:18 PM, Medical Director #1 stated they had been the facility's Medical Director up until 08/03/2024. Medical Director #1 stated they would expect to be notified if residents were not receiving their medications and they did not recall being notified that residents on an entire unit were not administered medications.<br><br>The Director of Nursing did not return calls made on 08/07/2024 and 08/08/2024 requesting an interview.<br><br>10 NYCRR 415.13(a)(1)(i-iii) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue Rochester, NY 14612 |

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) |
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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>46526<br><br>Based on observations, interviews, and record reviews conducted during the extended Recertification Survey and complaint investigation (#NY00343730) from 07/08/2024 to 09/17/2024, for 32 (Residents #4, #17, #19, #33, #36, #40, #42, #44, #56, #59, #60, #68, #80, #83, #84, #85, #90, #104, #107, #114, #116, #117, #133, #140, #164, #167, #168, #179, #190, #358, #359, and #614) of 46 residents reviewed, the facility failed to ensure the residents were free from significant medication errors. Specifically, Resident #359 was not administered their anti-anxiety and respiratory medications (not available) and was sent to the hospital the following day. Residents #33, #60, #68, and #140, did not receive significant medications that included insulin, anticoagulant (a blood thinner that prevents or reduces the clotting of blood), anti-seizure medication, and anti-hypertensive (medication for high blood pressure) on 07/04/2024 and 07/05/2024 as prescribed due to nurse staffing concerns. Resident #83, who was prescribed an antibiotic for seven days received an extra dose of the medication without a physician's order. Resident #80 did not receive their insulin, anti-hypertensive, diuretic (water pill), or their pain medication prior to leaving the facility for an outing on 07/08/2024. Resident #164 received medications that included a muscle relaxant, anti-seizure, and anti-hypertensive approximately three hours after the scheduled administration time which the resident stated affected their ability to move. Additionally, Residents #4, #17, #19, #33, #36, #40, #42, #44, #56, #59, #60, #68, #84, #85, #90, #104, #107, #114, #116, #117, #133, #140, #167, #168, #179, #190, #358, and #614 on South 1 unit did not receive any of their scheduled medications during the evening shift (3:00pm - 11:00pm) on 07/29/2024 because there was no nurse on the unit. These issues resulted in the likelihood of serious injury, serious harm, or death for all the residents in the facility (census 205) that was Immediate Jeopardy and substandard quality of care.<br><br>This is evidenced by, but not limited to, the following:<br><br>The facility policy Administering Medications, dated January 2024, included medications must be administered in accordance with the orders, including any required timeframe. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication should document in the electronic medication administration record for the drug and dose. The person withholding, receiving the refusal, or administering the medication at a different time would notify the attending or covering provider.<br><br>1. Resident #359 had diagnoses that included emphysema (lung condition causing shortness of breath and reduces the amount of oxygen in the blood), chronic obstructive pulmonary disease (disease that prevents airflow to the lungs), and anxiety. Review of a Nursing Admission Note, dated 07/08/2024, revealed that Resident #359 was cognitively intact.<br><br>Review of the current Comprehensive Care Plan revealed Resident #359 received psychotropic medications for anxiety and depression and treatments for an alteration in respiratory status. Interventions included, but were not limited to, administration of treatments and medications per physician orders.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of Resident #359's physician orders, dated 07/08/2024, included alprazolam (anti-anxiety medication) every 12 hours as needed for anxiety, arformoterol tartrate inhaler (for chronic obstructive pulmonary disease to decrease shortness of breath) twice daily, budesonide inhaler (prevent asthma attacks) twice daily, and oxygen at three liters per minute continuous via nasal cannula.<br><br>During an interview on 07/11/2024 at 1:04 PM, a visitor stated on the day Resident #359 was admitted to the facility, they had not received their medications including their anti-anxiety or respiratory medications and were told by facility staff the medications had not been delivered by the pharmacy. The visitor stated Resident #359 called them (that evening) and told them they had not received any of their medications. The visitor stated the next morning (day after admission) they received a call from facility staff informing them the resident's oxygen level was low, they were given 12 liters of oxygen, and transferred back to the hospital.<br><br>Review of the July 2024 Medication Administration Record revealed Resident #359 did not receive the arformoterol tartrate and budesonide inhalers on 07/08/2024 and their alprazolam on 07/08/2024 or in the morning on 07/09/2024. All missing medications were coded as not available.<br><br>Review of a nursing progress note dated 07/08/2024 at 11:37 PM, Licensed Practical Nurse Manager #2 documented the arformoterol tartrate and budesonide were not administered because they were not received from the pharmacy. There was no documented evidence the medical provider was notified that the medications were not available.<br><br>Review of a nursing progress note dated 07/09/2024 at 9:49 AM, Assistant Director of Nursing #1 documented Resident #359 was transferred to the hospital due to increased anxiety and complaints of shortness of breath.<br><br>During an observation and interview on 07/12/2024 at 1:10 PM, Resident #359 was on three liters of oxygen via nasal cannula and said when they were first admitted to the facility, they did not have any of their medications and they requested to be sent to the hospital.<br><br>During an interview on 07/15/2024 at 3:14 PM, Licensed Practical Nurse Manager #2 stated when a new resident was admitted to the facility, the medication orders were entered into the electronic medical record and if entered after 11:00 AM, they would not receive the medications until 10:00 PM. Licensed Practical Nurse Manager #2 said if a medication was not available, staff should call the pharmacy to see when they would receive it, and if an administrator were in the building, they would authorize an immediate delivery. Licensed Practical Nurse Manager #2 said the nurse should also notify the provider that the medication was not available. Licensed Practical Nurse Manager #2 said on 07/08/2024 the medications did not arrive at 10:00 PM. Licensed Practical Nurse Manager #2 said they thought alprazolam was kept in the emergency box, but they did not have access to it due to no nursing supervisor in the building at the time and the arformoterol tartrate and budesonide would not have been in the emergency box. Licensed Practical Nurse Manager #2 said they did not notify the medical provider.<br><br>During an interview on 07/15/2024 at 4:23 PM, Assistant Director of Nursing #1 stated if a medication was due to be given but was not available, the nurse should call the pharmacy to get an immediate delivery and notify the Physician, but this did not occur. They said they were not aware a nursing supervisor had not been in the building on 07/08/2024 but there should have been someone in the facility at the time that had access to the emergency box.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | 2. Resident #60 had diagnoses that included diabetes, atrial fibrillation (irregular and often rapid heart rate), a stroke, and congestive heart failure. The Minimum Data Set Resident Assessment, dated 05/31/2024, revealed the resident was cognitively intact and received an anticoagulant (to prevent blood clots and strokes) medication and insulin.<br><br>Current Physician orders for Resident #60 included apixaban (an anticoagulant) twice daily for atrial fibrillation and Lantus (a long-acting insulin used to control blood sugar) once daily at bedtime for diabetes.<br><br>During an interview on 07/08/2024 at 1:25 PM, Resident #60 stated there was no nurse on the unit this past weekend to give medications and they had not received their insulin.<br><br>Review of the July 2024 Medication Administration Record revealed apixaban (scheduled for 6:00 PM) and Lantus insulin (scheduled for 9:00 PM) were documented as not administered on 07/04/2024 and 07/05/2024.<br><br>Review of interdisciplinary progress notes, dated 07/04/2024 to 07/12/2024, did not include any documented evidence that a provider had been notified of the missed medications.<br><br>During an interview on 07/12/2024 at 1:25 PM, Licensed Practical Nurse #12 stated Resident #60 had reported not receiving insulin on two days the previous week, but they had not been concerned because their blood sugar readings were within normal limits. Licensed Practical Nurse #12 reported Resident #60's concerns to Registered Nurse Manager #1.<br><br>During an interview on 07/12/2024 at 1:34 PM, Registered Nurse Manager #1 stated the Director of Social Work had reported Resident #60 had not received any medications on a couple of days the previous week, but Registered Nurse Manager #1 was not sure what was done to address the missed medications.<br><br>3. Resident #33 had diagnoses including epilepsy (a chronic neurological condition that causes recurrent seizures in the brain), heart disease, and mild intellectual disabilities. The Minimum Data Set Resident Assessment, dated 05/01/2024, revealed the resident had moderately impaired cognition and was on an anticoagulant medication.<br><br>Current Physician orders included apixaban twice daily for atrial fibrillation, hydralazine (a medication used to treat hypertension) once daily at bedtime and divalproex sodium (a medication used to treat epilepsy/seizures) once daily at bedtime.<br><br>Review of the July 2024 Medication Administration Record revealed apixaban and divalproex sodium (scheduled for 6:00 PM) and hydralazine (for 9:00 PM) were documented as not administered on 07/04/2024 and 07/05/2024.<br><br>Review of interdisciplinary progress notes, dated 07/04/2024 to 07/12/2024, did not include any documented evidence that a provider had been notified of the missed medications.<br><br>During an interview on 07/12/2024 at 1:25 PM, Licensed Practical Nurse #12 stated they thought some residents on the South 1 Unit had not received their medications on 07/04/2024 and 07/05/2024 but was unsure of the reason why.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 07/12/2024 at 1:34 PM, Registered Nurse Manager #1 stated they were aware some residents on the South 1 Unit missed medications the previous week. Registered Nurse Manager #1 stated the nursing supervisor had called them to report being short nurses, but they were out of town and unable to help. Registered Nurse Manager #1 stated blanks in the Medication Administration Record usually meant the medication was not given. If not given, the medical provider should be notified, and the notification documented.<br><br>During an interview on 07/12/2024 at 1:55 PM, Licensed Practical Nurse #3 stated they were the only nurse on South 1 from 3:00 PM to 7:00 PM on 07/04/2024, and 07/05/2024 with one Certified Nursing Assistant with them and they were responsible for administering medications for all residents on the unit (40) and assisting with passing meal trays, feeding residents, and incontinence care (making it difficult to get everything done). Licensed Practical Nurse #3 stated the medication keys were given to Registered Nurse Supervisor #3 on 07/04/2024 and to Licensed Practical Nurse #13 on 07/05/2024 at 7:00 PM.<br><br>Review of staffing schedules on 07/04/2024 revealed there were three nurses in the facility from 7:00 PM-9:00 PM and two nurses from 9:00 PM -11:00 PM for 206 residents.<br><br>Registered Nurse Supervisor #3 did not return calls made on 07/15/2024 and 07/16/2024 requesting an interview.<br><br>During an interview on 07/15/2024 at 4:26 PM, Nurse Practitioner #1 stated they would consider antipsychotics, psychotropics, blood pressure, anticoagulants, and seizure medications as significant medications and would expect to be notified if any of those medications were missed. Nurse Practitioner #1 stated the missed medications included anti-seizure and anticoagulant medications that required medical follow-up with the residents. Residents who missed anti-seizure medications required lab work to ensure their levels remained therapeutic and additional monitoring for symptoms and vital signs for residents who missed anticoagulants. Nurse Practitioner #1 stated they were made aware recently that medications had not been given to several residents for entire shifts due to not having nurses available to administer them.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Regional Administrator stated the Quality Assurance Committee was aware of concerns related to missed medications and they were not sure what happened. The Regional Administrator stated leadership had not been notified and was not aware of staffing concerns on 07/04/2024 and 07/05/2024.<br><br>4. During an interview on 08/01/2024 at 2:11 PM, Licensed Practical Nurse Manager #2 said residents on the South 1 unit did not receive their evening medications on 07/29/2024 because there was no nurse on the unit. Licensed Practical Nurse Manager #2 said residents' finger sticks (blood glucose levels) were also not checked (as ordered) because there was no nurse on the unit. During a follow-up interview at 2:51 PM, Licensed Practical Nurse Manager #2 showed the Electronic Medication Administration Record for the evening shift on 07/29/2024 and 32 residents with medications scheduled to be given were highlighted red, indicating they had not been given medications during the shift.<br><br>(continued on next page) |

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|---|---|
| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | Review of the Medication Administration Audit Report for the South 1 unit residents from 07/24/2024 through 07/30/2024 revealed 28 residents were not administered their significant medications as scheduled during the evening shift on 07/29/2024. Medications included but were not limited to antiseizure medications, insulins, anticoagulants (blood thinners), antibiotics, blood pressure medications, analgesics (medications for pain), antipsychotics (medications that treat psychosis-related conditions and symptoms), anti-depressants and medications for Parkinson's.<br><br>During an interview on 08/05/2024 at 1:27 PM, the Staffing Coordinator said on 07/29/2024, the Director of Nursing stayed during the evening shift to supervise the Licensed Practical Nurse Supervisor (Licensed Practical Nurse #13). The Staffing Coordinator said Licensed Practical Nurse #17 was assigned to South 1 during the evening shift on 07/29/2024.<br><br>Review of the Actual Nursing Staffing sheets for 07/29/2024 revealed Licensed Practical Nurse #17 was assigned to South 1 unit from 3:00 PM to 11:00 PM (evening shift). However, review of the Nursing Staff Daily Punches report dated 07/29/2024 revealed Licensed Practical Nurse #17 did not punch in or out, indicating they did not work, and the Director of Nursing was in the facility for the duration of the evening shift (until 11:56 PM).<br><br>During a follow-up interview on 08/05/2024 at 4:14 PM, the Staffing Coordinator said they had given the wrong information, and that Licensed Practical Nurse Supervisor #1 came in at 11:10 PM on 07/29/2024 to work the night shift. The Staffing Coordinator said if the punch report showed blanks (punch in and punch out), it meant the staff member did not work. The Staffing Coordinator said they made the Director of Nursing aware by 3:30 PM on 07/29/2024 that Licensed Practical Nurse #17 was not in the facility. The Staffing Coordinator said on 07/29/2024, their scheduling duties were done by 3:00 PM because they had to work as a Certified Nursing Assistant on the [NAME] 1 unit.<br><br>During an interview on 08/08/2024 at 11:14 AM, Physician #1 said if it was identified that residents were not administered medications, the medical providers would be notified during morning meetings (with facility leadership). Physician #1 stated they did not recall being made aware of South 1 residents not being administered medications during the evening shift on 07/29/2024. Physician #1 said they had heard that nurses would stay past the end of their shift to administer medications (due to no nurses available to relieve them).<br><br>During an interview on 08/08/2024 at 11:57 AM, Nurse Practitioner #1 said the nurses in the facility would contact the on-call medical providers during off shifts (typically after 4:30 PM). Nurse Practitioner #1 said during morning report, facility leadership would print and review the list of medications that were missed (not administered) and the nurse managers would be notified. Nurse Practitioner #1 stated they were not in the building on 07/30/2024 and did not recall being notified medications were not given to residents on South 1 during the evening shift on 07/29/2024. Nurse Practitioner #1 said they had heard of instances, usually once a week, in which medications were missed (not administered) and it was usually due to not having a nurse.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Some | During an interview on 08/08/2024 at 2:18 PM, Medical Director #1 stated they had been the facility's Medical Director up until 08/03/2024. Medical Director #1 said all medications could be significant, with anti-seizure, blood thinners and insulin especially important because they require closer monitoring and evaluation to prevent adverse reactions. Medical Director #1 stated they would expect to be notified if residents were not receiving their medications and they did not recall being notified residents on an entire unit were not administered medications. Medical Director #1 said if a medication could not be given, they would expect the nursing supervisor to be made aware and if needed, the issue be escalated to the nurse practitioner or the on-call medical provider, so they could tell the nurses what to do about the missed medications. Medical Director #1 stated the concern was never brought to the Quality Assurance and Performance Improvement Committee or facility leadership meetings.<br><br>The Director of Nursing did not return calls made on 08/07/2024 and 08/08/2024 requesting an interview.<br><br>On 09/17/2024 the survey team identified and declared Immediate Jeopardy. The facility Regional Administrator and the Assistant Administrator were notified at 5:20 PM.<br><br>On 09/17/2024 at 7:13 PM the survey team declared that the IJ was removed based on the following corrective actions taken by the facility:<br><br>-Immediate education regarding the medication administration policy and the medication error policy to include the medication error form, the medication error severity assessment tool, the missed medication daily review process to ensure compliance, and proper communication of staffing emergencies related to coverage was completed with all licensed nursing staff currently in the facility with an attestation that all 59 of the facility's licensed nursing staff will be educated prior to their next shift.<br><br>- a facility wide audit, with a lookback period of 30 days, to identify any residents with any missed or omitted medications and medical team notification of any missed medications.<br><br>-Interviews with licensed nursing staff on each resident unit to verify education completed and post test results related to medication errors, appropriate notifications (medical team, nursing supervisors) and documentation, missing medication reports, significant medication errors on severity and outcomes, and pharmacy process for missing medications.<br><br>10 NYCRR 415.12(m)(2) |

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| F 0761<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>49447<br><br>Based on observations, interviews, and record reviews conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, the facility did not ensure that all drugs and biologicals in the facility were properly stored in accordance with State and Federal Laws for eight (West Two Long Hall, South One Short Hall, North One Unit, North Two Unit, South Two Long Hall, South Two Short Hall, South Three Short Hall and South Three Long Hall) of nine medication carts and three (South One, North One, and [NAME] One) of four medication rooms reviewed. Specifically, medication carts contained expired medications, medications with no resident identifiers on them, open food for staff use, a medication with no pharmacy or manufacturer label, opened insulin pens that were in use and undated, and medications stored in containers with the wrong resident identifiers. Medication rooms contained expired medications and controlled medications that were not secured with two locks. Additionally, facility staff members did not follow the facilities medication storage policy or procedure. These issues resulted in the likelihood of serious injury, harm, and death for all the residents in the facility (census 216) that was Immediate Jeopardy. The findings are:<br><br>The facility policy Storage of Medications, dated January 2024, documented that drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received, the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals, medications must be stored separately from food, and all controlled substances will be stored in a double locked cabinet affixed to the wall in the medication room.<br><br>1. During an observation and interview on 07/11/2024 at 5:32 PM, the South Three Long Hall medication cart had an Admelog (fast-acting) insulin pen stored in a toothpaste container labeled with a resident name on it that was different than the label on the insulin pen. A plastic container labeled with a resident's name had three bottles of eye drops; two (Refresh tears and brimonidine) bottles that were not labeled with any information and one (latanoprost) bottle with different resident identifiers than were on the container's label. One plastic container label with a resident's name had one bottle of latanoprost eye drops that was not labeled with any resident identifiers. During an immediate interview, Licensed Practical Nurse #4 stated medications should be stored in the pharmacy packaging with resident information on them.<br><br>2. During an observation and interview on 07/12/2024 at 11:24 AM, the [NAME] One medication room held two narcotic cupboards. One cupboard's second (outer) door was open leaving multiple narcotic medications not secured or secured under a single lock (versus two). During an immediate interview, Licensed Practical Nurse #5 stated the narcotic cupboards should have both doors closed and locked. They forgot to lock it after taking medication from the cupboard.<br><br>3. During an observation and interview on 07/11/2024 at 1:48 PM, the [NAME] Two Long Hall medication cart had one vial of lispro (rapid-acting) insulin had no open or expiration date and a bottle of vitamin D3 in use that had an expiration date of June 2023. During and immediate interview, Licensed Practical Nurse #2 stated there should be no expired medications in the medication cart and insulin should be labeled with the open and expiration date.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | 4. During an observation and interview on 07/11/2024 at 4:14 PM, the South One Short Hall medication cart contained one small bag of Smart Food popcorn and one small bag of Doritos tortilla chips, opened in a drawer. During an immediate interview, Licensed Practical Nurse #3 stated staff food should never be stored in the medication cart.<br><br>5. During an observation and interview on 07/11/2024 at 4:47 PM, the North One Unit, the medication cart contained a bottle of ibuprofen (pain reliever) that was opened and in use; there was no expiration date on the medication. Three bottles of medications were expired including melatonin (a sleep aid) with an expiration date of April 2024, acidophilus (a probiotic) with an expiration date of June 2024, and magnesium with an expiration date November 2023. The North One medication room contained a bottle of medication that was not labeled with any pharmacy or manufacturer label and had no resident identifiers. During an immediate interview, Registered Nurse #1 stated they should never use any medication from a bottle without a pharmacy or manufacturer's label.<br><br>During an interview on 07/15/2024 at 10:05 AM, the Director of Nursing stated that all medications (including over the counter and prescribed, resident specific medications) should be labeled, have an expiration date on them, and resident specific information. All insulin pens should be labeled with open and expiration dates, and no food should be stored in the medication carts. The Director of Nursing said that all controlled medications (narcotic medications) should be kept in the controlled substance cabinet with both doors locked.<br><br>6. Additional observations and interviews conducted on 08/01/2024 revealed the following:<br><br>a. At 9:53 AM, the South Three Long Hall medication cart had one bottle of aspirin with an expiration date of December 2022 and one vial of Lantus (long-acting) insulin in use with no open or expiration dates. The vial of insulin was not labeled with any resident identifiers and was stored in a plastic bag with a resident's handwritten name.<br><br>b. At 10:29 AM, the South Three Short Hall medication cart had a staff member's Starbucks drink stored on top of the cart and an open cup of applesauce was on top of the cart with no open date. One vial of lispro insulin and one vial of Admelog insulin, both vials in use with no open or expiration dates, and no resident identifiers on the vials. One Lantus insulin pen was loose and stored in the cart (not stored in a bag or other container) and not labeled with open or expiration dates. The medication cart had approximately 24 loose, unlabeled medications in the bottom of the drawers. One drawer had a liquid spill of an unidentified substance that covered the bottom of the drawer and five of 10 medication bottles stored in the drawer. During an immediate interview, Licensed Practical Nurse #15 stated there should never be any loose pills in the cart or medication spills in the medication cart. All medications should be labeled with resident identifiers and stored in the pharmacy packaging. Insulin and eye drops should be labeled with the open and expiration dates.<br><br>c. At 10:58 AM, the South Two Long Hall medication cart had a vial of lispro insulin stored in a plastic bag with a resident's handwritten name and date. The date handwritten on the bag was illegible and the insulin vial was in use and not labeled with open or expiration dates.<br><br>d. At 11:06 AM, the South Two Short Hall medication cart had a basaglar (long-acting) insulin pen stored in a plastic bag labeled with resident identifiers and dated 07/26/2024 (did not indicate if this was the open or expiration date). The insulin pen was in use and was not labeled with any resident identifiers, an open or expiration date.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | e. At 11:17 AM, the North Two medication cart had a budesonide and Formoterol (used to treat chronic respiratory disease) inhaler stored in the drawer with no bag or box and was not labeled with any resident identifiers. An insulin glargine pen with one resident's identifiers, was not labeled with an open or expiration date, and was stored in a clear plastic bag labeled with another resident's identifiers.<br><br>On 08/02/2024, Immediate Jeopardy was declared. The facility administrator was notified at 5:14 PM.<br><br>On 08/04/2024 at 2:00 PM, Immediate Jeopardy was removed based on the following corrective actions taken by the facility:<br><br>a. 100% of the licensed nursing staff working at the time of removal had received education on the proper labeling of all medications with the date they were opened, discarding all medications with an expired medication date, improper labeling of medications manually, careful administration of medication using a blister pack, and the proper way to dispose of unused loose medications in both the medication cart and the medication rooms.<br><br>b. Interviews completed with multiple licensed nursing staff on seven of seven units revealed appropriate knowledge on the proper labeling of all medications with the date they were opened, discarding all medications with an expired medication date, improper labeling of medications manually, careful administration of medication using a blister pack, and the proper way to dispose of unused loose medications in both the medication cart and the medication rooms.<br><br>c. Approximately 61% of the licensed nurses were educated on appropriate proper labeling of all medications with the date they were opened, discarding all medications with an expired medication date, improper labeling of medications manually, careful administration of medication using a blister pack, and the proper way to dispose of unused loose medications in both the medication cart and the medication rooms.<br><br>d. The corrective action included a plan to educate all staff (including licensed, certified, and non-medical staff) and agency staff, staff on vacation and/or leave prior to the start of their next shift and would be tracked by the administrative team to ensure 100% compliance.<br><br>e. Observations on seven of seven resident units which included six medication carts and three medication rooms, revealed no concerns with proper labeling and storage of medications.<br><br>10 NYCRR 415.18(d)(e)(1-4) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide special eating equipment and utensils for residents who need them and appropriate assistance.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for two (Residents #18 and #134) of two residents reviewed, the facility did not provide special eating equipment for residents who need them to maintain or improve the resident's ability to eat and drink independently. Specifically, Resident #18 was observed on multiple occasions consuming food from flat plates or plastic bowls instead of a divided plate as recommended by Occupational Therapy. Resident #134 was observed on several occasions consuming food from plastic bowls or a paper plate instead of a divided plate as care planned for. This is evidenced by the following:<br><br>Review of the facility policy Rehabilitation/Adaptive Devices, dated January 2024, documented that the facility would issue and maintain all appropriate and necessary adaptive equipment per therapy evaluation.<br><br>1. Resident #18 had diagnoses including diabetes, chronic obstructive pulmonary disease (a chronic inflammatory lung disease), and schizoaffective disorder (a mental health condition). The Minimum Data Set Resident Assessment, dated 06/28/2024, documented that Resident #18 had moderately impaired cognition and required supervision for meals.<br><br>Resident #18's current Comprehensive Care Plan and Kardex (care plan used by Certified Nursing Assistants to guide daily care) included providing an adaptive divided plate with meals.<br><br>Review of Resident #18's Occupational Therapy evaluation, dated 1/10/2024, documented that Resident #18 required supervision during meals and a divided plate.<br><br>During an observation on 07/11/2024 at 12:39 PM, Resident #18 was eating lunch from several plastic bowls (containing what appeared to be pasta with red sauce). Review of the resident's meal ticket at this time included that Resident #18 was to have a divided plate for meals.<br><br>During an observation on 07/15/2024 at 9:01 AM, Resident #18's scrambled eggs were served on a flat plate. Review of the resident's meal ticket at this time included that Resident #18 should have a divided plate for meals.<br><br>2. Resident #134 had diagnoses including dementia with agitation, delirium, and diabetes. The Minimum Data Set Resident Assessment, dated 12/06/2023, documented that Resident #134 had severely impaired cognition and required supervision or touching assistance for eating.<br><br>Review of Resident #134's current Comprehensive Care Plan and Kardex revealed Resident #134 required a divided plate for eating.<br><br>During and observation on 07/10/2024 at 9:32 AM, Resident #134 was eating breakfast in the dining room. Their breakfast tray included several food items served on a paper plate. There was no divided plate for resident use.<br><br>(continued on next page) |

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| F 0810<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 07/12/2024 at 9:34 AM, Resident #134 was seated at the dining table. Their food (scrambled eggs, ground sausage, pureed coffee cake, and grits) were all served in bowls. There was no divided plate for resident use. The meal ticket included divided plate highlighted in yellow.<br><br>During an interview on 07/11/2024 at 1:38 PM, Certified Nursing Assistant #5 stated that Resident #18 had been getting their meals in separate bowls.<br><br>During an interview on 07/12/2024 at 9:50 AM, Certified Nursing Assistant #7 stated that the kitchen used to send divided plates but has stopped.<br><br>During an interview on 07/11/2024 at 1:50 PM, the Dietary Technician stated that the Occupational Therapist usually informs the Dietary Department of recommendations for residents that needed adaptive equipment and that they were waiting on an order of divided plates. The Dietary Technician stated the Assistant Director of Dietary did the ordering for adaptive equipment for meals.<br><br>During an interview on 07/11/2024 at 2:02 PM, the Assistant Director of Food Service stated their Corporate Office had previously ordered divided plates, but those divided dishes fell apart and broke after the first use at the facility. The Assistant Director of Food Service said that Corporate had control over what was ordered and could override the facility's request. The Assistant Director of Food Service said the facility was waiting on a new supply of divided plates to be delivered.<br><br>During an interview on 07/12/2024 at 8:41 AM, the Assistant Director of Rehabilitation stated they ordered adaptive equipment that was used by the Therapy Department, and recommendations for adaptive equipment with meals was sent via email to the Food Service Director to order. The Assistant Director of Rehabilitation said that they were not aware that the facility did not have enough divided plates for all the residents who needed them.<br><br>During an interview on 07/15/2024 8:45 AM, the Assistant Administrator stated a par level count of divided plates had been completed last week and an order for divided plates had been placed by the food director.<br><br>10 NYCRR 415.14(g) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>34459<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for one of one main kitchen the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, dishware was not properly air dried and stored, floors were soiled with food debris, a freezer was not properly maintained, and there was food spillage on a shelving unit. The findings are:<br><br>Record review of the facility policy and procedure, The Grand Rehabilitation and Nursing (Subject: Sanitization), dated January 2024 included that the food service area will be maintained in a clean and sanitary manner. All kitchen areas shall be kept clean, maintained in good repair, and all shelves and equipment shall be kept clean. Kitchen surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.<br><br>Observations on 07/08/2024 at 8:59 AM included several 6-inch stainless steel pans were stacked together on a storage rack adjacent to the cook line and there was moisture and water droplets on the inside of the pans. During an immediate interview, the Director of Food Service stated the drying area for dishware was at the end of the dish machine and all stored dishware and utensils should be properly sanitized and air dried before being stored.<br><br>Observations on 07/08/2024 at 9:00 AM included the floors within the main kitchen (in the dish wash area, under and behind the cooking equipment, and in the tray line area) were unclean and soiled with food debris. During an immediate interview, the Director of Food Service stated there were many challenges in the kitchen that needed to be addressed from prior directors, and many areas should be cleaned better and organized due to cluttered storage.<br><br>Observations on 07/08/2024 at 9:10 AM included liquid egg spillage on the top shelf on the right side of walk-in cooler #1. During an immediate interview, the Director of Food Service stated the spill was liquid eggs and should have been cleaned up.<br><br>Observations on 07/08/2024 at 9:11 AM included there was ice buildup on the floor and around the door of the walk-in freezer. During an immediate interview, the Director of Food Service stated that the freezer should be working fine but, the door was not always being closed tightly.<br><br>The daily census for the facility was reported to be 216 on 08/01/2024. During an interview on 08/01/2024 at 9:03 AM, the Director of Food Service stated that the facility prepares food for all residents. The Director of Food Service also stated that they have cleaning schedules daily and weekly for the kitchen including the Dietary Aides who are responsible for cleaning their work areas and the [NAME] mops after lunch daily.<br><br>Observations and interviews in the basement kitchen on 08/01/2024 beginning at 9:15 AM through 10:09 AM included the following:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | a. There was a T-shaped section of the kitchen floor that was approximately 12.5 tiles long and 5 tiles wide with black residue that felt like tar when touched and appeared to be old dirty grease. Another similar spot was observed to be a few feet away by the dietician's office that measured 4 tiles by 7 tiles. In an immediate interview, the Director of Food Service stated that they thought that maybe there had been some equipment over these areas in the past.<br><br>b. There was a build-up of grimy residue and empty containers on the floor under a Southbend brand 10-burner stove.<br><br>c. There was a build-up of grease and grime on the sides of a [NAME] Rite brand combination 6 burner/flattop grill.<br><br>d. There was grease, food debris, and a ladle on the floor beneath a Southbend brand double stacked oven.<br><br>e. There was food debris and grease on the floor underneath a stainless-steel cabinet with a microwave and a slicer on top.<br><br>f. There were frozen water droplets on two boxes of 16-ounce packages of bagged whipped cream and a 40-pound box of country style ribs located in the walk-in freezer. The droplets appeared to be coming from water that had accumulated on the ceiling of the freezer and dripped down.<br><br>g. There was two stacks of 6 plate covers on a cart that was ready for service and the lids (plate covers) had droplets of water on the surfaces (were not properly air dried). In an immediate interview, the Director of Food Service stated that they have told staff a thousand times to turn over the lids, so they dry. Further observations included a dishwasher rack with utensils ready for use by the serving line that were also wet (not properly air dried).<br><br>h. The drip pan under the food service tray line was dirty with food debris and residue.<br><br>10 NYCRR: 415.14(h), Subpart 14-1.95, 14-1.110(d), 14-1.116, 14-1.170, 14-1.171 |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>34459<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, the facility policy regarding use and storage of foods brought to residents by family and other visitors did not ensure safe and sanitary storage, handling, and consumption. Specifically, staff were not aware or educated on facility policies and procedures to label, date, and measure temperatures of resident food brought in from outside the facility, and items were not properly labeled and dated. The findings are:<br><br>The facility policy, Foods Brought by Families/Visitors, dated January 2024, documented that food brought by family/visitors that is left with the resident to be consumed later will be labeled and stored in a manner that is clearly distinguished from facility-prepared food. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential food borne danger (for example mold growth, foul odor, past due package expiration dates).<br><br>Observations on 07/11/2024 at 8:50 AM, included a container inside a large brown paper bag with a residents' left-over food including rice in the South first floor nourishment refrigerator behind the nurse's station. The container of food was not labeled with a resident name and was not marked with a date. Further observations included a memo taped to the outside of the refrigerator listing that all resident food should be labeled and dated, and to consume within 3 days or discard after that time. Additionally, there was no probe thermometer to measure the temperature of reheated food items within the room. During an immediate interview, Unit Secretary #1 stated they were not aware of any time frame for when resident food needed to be discarded. Unit Secretary #1 also stated that if food needed to be reheated for residents it would have to been brought downstairs to the kitchen to have that staff reheat the food, and then take the food back to the unit.<br><br>Observations on 07/11/2024 at 8:55 AM, included there were no probe thermometer available for staff use within the [NAME] first floor nourishment room behind the nurse's station, and there was no policy or memo available for review on how to label or reheat food for residents. During an immediate interview, Certified Nursing Assistant #1 on the [NAME] first floor unit stated that a resident's name and the date should be labeled on food that was brought in. Certified Nursing Assistant #1 also stated that there was no microwave on the unit and if residents wanted their food, staff were not trained to reheat food and would have to bring foods to the kitchen and have that staff heat up the food to bring back to the residents. Certified Nursing Assistant #1 also stated there was an incident seven to eight months ago where a resident got to a microwave and the facility had all the microwaves taken away on the units.<br><br>Observations on 07/11/2024 at 9:06 AM, included there was no probe thermometer available for staff use within the South second floor nourishment room behind the nurse's station, and there was no policy or memo was available for review on how to label or reheat food for residents. When interviewed at that time, Licensed Practical Nurse #1 stated there were no microwaves or thermometers available on the units anymore, they were not trained on how to reheat food for residents and were not sure if any nursing staff were trained to reheat food.<br><br>(continued on next page) |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During and interview on 07/11/2024 at 9:15 AM, the Director of Food Service stated that food service staff did not discard any resident food items or label resident foods, and that would have been up to nursing staff. The Director of Food Service also stated they could not take resident food from the outside in the kitchen as it would have been a cross contamination issue, and they would not want food service staff heating up food from the outside or bringing it into the kitchen. The Director of Food Service also stated that they were not sure how nursing staff heated up food for residents and did not believe they were trained on how to reheat foods and the appropriate temperatures they should be.<br><br>During an interview on 07/11/2024 at 12:43 PM, Resident #122 stated that staff did not offer to heat up their food as staff did not have a microwave to use because something had exploded in one.<br><br>During an interview on 08/01/2024 at 9:03 AM, the Director of Food Service stated that they do not know who gets meals brought in from outside and they do not accept any food brought in by residents or staff. The Director of Food Service also stated that no food from a unit would be re-heated in the kitchen, and they prepare food for all the residents.<br><br>During interviews on 08/01/2024 at 10:10 AM, the Regional Registered Dietician stated they were aware of the policy for food brought in from outside the facility but had not read it. During an immediate interview with the Diet Technician, they stated they also had not seen the policy.<br><br>During an interview on 08/01/2024 at 10:20 AM, the Regional Registered Dietician stated that they have no idea how much food is coming in from outside the facility.<br><br>During an interview on 08/01/2024 at 10:46 AM, the Licensed Practical Nurse #16 (North 1) stated that things (food items) can be in the fridge for three days and the dates on the packages represent when they are put in the refrigerator. Licensed Practical Nurse #16 also stated that with DoorDash (an external food ordering and meal service) residents order out more, but they try not to save things.<br><br>During an interview on 08/01/2024 at 11:20 AM, Registered Nurse Manager #1 (South 1) stated the policy for food items in the nourishment refrigerator is three days and that Dietary is usually in charge of getting rid of older food. Registered Nurse Manager #1 also stated that food being brought in must be labeled, and they have to see if it is okay for the resident.<br><br>Observations on 08/01/2024 at 11:45 AM included the following food items in the [NAME] first floor nourishment refrigerator: a square see thru 'to go' container of salad dated 07/31/2024 with no resident name and two black plastic bags with takeout food. One bag held a rectangular plastic container with an unknown meat and vegetable dish, an unknown roll or pastry, and another small round clear plastic container of what appeared to be macaroni salad. The other bag held a Denny's (restaurant) round plastic container with rice and an unknown orange food. Neither the bags or plastic containers were labeled with food contents, resident names, or dates. During an immediate interview, Licensed Practical Nurse #3 stated the bags should be labeled and dated, and food in the refrigerator is discarded in about two to three days if it is brought in and they discard it and when a resident wants their food reheated, staff takes the food to the staff cafeteria in the basement and heat it in the microwave.<br><br>10 NYCRR: 415.1(b)(1), 415.14(d), (h) |

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| F 0837<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.<br><br>39181<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, it was determined that the facility and governing body failed to assure that the resident received appropriate quality of care by allowing the following deficient practices to exist putting the resident at risk for harm and serious injury: F550, F600, F677, F686, F760, F761, and F837. Specifically, there was inconsistent communication with the facility Administrator to ensure management of the facility and regulatory compliance. Multiple deficiencies were identified during the Recertification Survey and extended survey, including but not limited to, Immediate Jeopardy, Harm, Substandard Quality of Care, and multiple repeat deficiencies. This resulted in the likelihood of serious injury, serious harm, or death for all the residents in the facility (census 205) that was Immediate Jeopardy.<br><br>This is evidenced by, but not limited to, the following:<br><br>For additional information see Centers for Medicare/Medicaid Services Form 2567, refer to F550 (Resident Rights/Exercise of Rights):<br><br>During observations in the unit dining room for breakfast and/or lunch on 07/10/2024 at 1:16 PM, 07/11/2024 at 9:31 AM, and 07/11/2024 at 1:25 PM, the majority of residents (up to 22 on one observation) in the dining room were served meals on paper plates and were using plastic utensils.<br><br>During an interview on 07/11/2024 at 1:38 PM, Certified Nursing Assistant #5 stated the facility had been using plastic utensils during meals for several weeks.<br><br>During an interview on 07/12/2024 at 9:34 AM, the Diet Technician stated the facility's current number of plates and utensils were not enough, so they were using plastic utensils and paper plates.<br><br>During interviews on 07/12/2024 at 11:27 AM and 07/15/2024 at 8:44 AM, the Director of Food Service stated the facility did not have enough stock for all residents and the last two units that meals were delivered to had to use paper plates and plastic utensils. The Director of Food Service stated the Assistant Director of Dietary did the ordering for the dining supplies, but the corporate controller could change or decrease the amount ordered.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator (governing body representative) and Regional Clinical Director (governing body representative), the Regional Administrator stated they were not aware of on-going concerns since the last plan of correction was cleared and audits had been stopped.<br><br>For additional information see Centers for Medicare/Medicaid Services Form 2567, refer to F565 (Resident/Family Group and Response):<br><br>(continued on next page) |

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| F 0837<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | During a special Resident's Council meeting held on 07/10/2024 at 11:30 AM with the state surveyor and six residents (from different units), residents reported call lights do not get answered in a timely manner especially on weekends, medications were not given on time, there was a lack of linens, and residents were not receiving assistance with activities of daily living including bathing and showering. Residents also reported the facility did not act promptly upon their concerns and there was no follow-up from facility staff regarding their complaints/grievances.<br><br>A review of the Resident Council meeting minutes for January 2024, March 2024, April 2024, May 2024, and June 2024 revealed the residents reported care concerns including but not limited to, not receiving showers regularly, nails not being trimmed and cleaned, call lights not being answered timely, bed linens not being changed, a lack of linens, and medications not being administered timely. Each of the meeting minutes included an old business section which included the concerns from last month had been discussed and residents stated they were not seeing any improvement in those areas. The meeting minutes did not include any follow-up done by staff regarding their concerns.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Regional Administrator stated they were not aware of concerns related to the follow-up of grievance brought by the Resident Council. The Regional Administrator stated all grievances should be placed on a grievance form and monitored weekly, but it appeared as though this was not being done. The Regional Administrator stated it had been determined the previous facility Administrator was not following up on resident grievances.<br><br>For additional information see Centers for Medicare/Medicaid Services Form 2567, refer to F584 (Safe/Clean/Comfortable/Homelike Environment):<br><br>During an interview on 07/08/2024 at 12:18 PM, Unit Secretary #1 stated there were no washcloths or towels available on the unit to care for the residents and the supervisor had been notified.<br><br>During an observation and interview on 07/09/2024 at 10:42 AM on the South 1 Unit, Resident #140 was lying in bed. There were no sheets in place.<br><br>During an interview on 07/10/2024 at 11:36 AM, Certified Nursing Assistant #12 stated there was not an adequate supply of linen to care for the residents and they did not feel they could adequately do their job without having the necessary supplies.<br><br>During an observation on 07/11/202424 at 10:24 AM on the South 2 Unit, Resident #92 was asleep in their bed that had no sheets on the mattress. The linen cart contained no sheets or blankets.<br><br>During an interview on 07/12/2024 at 2:20 PM with the Administrator and the Regional Administrator, the Regional Administrator stated staff should be using washcloths and towels for bathing and showering residents. The Regional Administrator stated they were not aware resident care had been delayed due to the limited availability of washcloths and towels. The Regional Administrator stated there had been a lot of money spent on linen, there was a par system (inventory control system to determine the levels of linen the facility should have to meet resident care needs) in place to track the linen supply, and washcloths should be available.<br><br>During an interview on 07/15/2024 at 9:12 AM, the Laundry Supervisor stated there was no par system in place for linens and there were currently only 15 washcloths to send to two, 40 bed units.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335082 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/17/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue Rochester, NY 14612 |

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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| F 0837<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | For additional information see Centers for Medicare/Medicaid Services Form 2567, refer to F600 (Free from Abuse and Neglect):<br><br>The facility did not ensure the residents' right to be free from abuse, mistreatment, or neglect. Specifically, Resident #70 reported ongoing abuse from their roommate that staff were aware of and for Residents #92, #134, #177 and #182, the facility did not implement interventions to protect the residents from sexual abuse. For Resident #106, the facility did not ensure the resident received incontinence care in a timely manner and they were left soiled for several hours on multiple occasions. For Resident #140, the facility did not ensure the resident received clean linen and they were observed sleeping on a bare mattress.<br><br>For additional information see Centers for Medicare/Medicaid Services Form 2567, refer to F725 (Sufficient Nurse Staff):<br><br>The facility did not ensure sufficient staffing to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents in the facility. Specifically, there were several observations of residents who were incontinent and had not received timely assistance with care, and several residents had not received significant medications on 07/04/2024, 07/05/2024, and 07/29/2024 due to no nurse being available to administer the medications.<br><br>During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Regional Administrator stated leadership had not been notified of the staffing issues on 07/4/2024 and 07/5/2024 (causing many residents to not get significant medications). The Regional Clinical Director stated several changes had been made which included posting open shifts, making schedule changes to accommodate staff, meetings held before the weekend to ensure there was enough staff, holding staff accountable for call-offs, and holding weekly general orientations to prevent delays in new staff starting.<br><br>On 09/17/2024, the survey team identified and declared Immediate Jeopardy. The facility Regional Administrator and Assistant Administrator were notified at 5:20 PM.<br><br>On 09/17/2024 at 7:13 PM the survey team declared that the IJ was removed based on the following corrective actions taken by the facility:<br><br>-Review of weekly recruitment audits of all new incoming and outgoing staff and the recent hiring of a recruitment officer.<br><br>-Education of the Assistant Administrator (Acting) and the current Administrator (prior to return from leave) regarding the role and duties of the Administration team, communication with governing body, involvement with QAPI team on an ongoing basis. Includes review of daily emails between current (new) Administrator and the Corporate Administrator involving current census, staffing issues, resident incidents requiring follow up, hospitalization s, discharges and/or deaths.<br><br>-Invoices for linen purchases (07/09/2024, 07/16/2024, 07/17/2024, 08/01/2024, 08/23/2024, 09/10/2024, 09/13/2024) and education to administration team regarding inventory controls<br><br>-Two additional contracts with agencies for Registered and Licensed Nurses<br><br>(continued on next page) |

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| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue<br>Rochester, NY 14612 |

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| F 0837<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Many | -Review of a revised Grievance process by the Administration team including the Grievance binder with all recent resident grievances, follow ups and outcomes.<br><br>-Updated Quality Assurance and Performance Improvement Plan Policy with goals and interventions.<br><br>-Updated Facility Assessment.<br><br>10 NYCRR 415.26(b)(3)(1) |

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| NAME OF PROVIDER OR SUPPLIER Waterview Heights Rehabilitation and Nursing Ctr | | STREET ADDRESS, CITY, STATE, ZIP CODE 425 Beach Avenue Rochester, NY 14612 | |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>49686<br><br>Based on observations, interviews, and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, for four (Residents #66, #83, #106, and #607) of 10 residents reviewed for enhanced barrier precautions, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Affected residents resided on four (South 1, South 2, [NAME] 1, and [NAME] 3) of seven units. Specifically, Resident #66 was on enhanced barrier precautions and staff did not wear appropriate personal protective equipment (including gown and gloves) while flushing a feeding tube (tube inserted directly into the stomach to receive nutrition) and changing the feeding tube dressing. For Resident #83, there were several observations of the urinary catheter and collection bag lying directly on the floor. For Resident #106, who was on enhanced barrier precautions (an infection control strategy), staff did not wear appropriate personal protective equipment while performing wound care and did not change gloves or perform hand hygiene during the wound care. Additionally, Resident #106's comprehensive care plan did not include the need for enhanced barrier precautions. Resident #607 was on enhanced barrier precautions due to a medically inserted medical device and staff did not wear appropriate personal protective equipment while assisting the resident in the bathroom. This is evidenced by, but not limited to, the following:<br><br>Review of the facility policy, Handwashing/Hand Hygiene, dated January 2024, included that hand hygiene should be performed before and after direct contact with residents, before handling clean or soiled dressings, after handling used dressings, and before moving from a contaminated body site to a clean body site during resident care.<br><br>Review of the facility policy, Barrier Enhanced Precautions, dated January 2024, documented Enhanced Barrier Precautions expands the use of personal protective equipment and designates the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multidrug resistant organisms (a germ that is resistant to many antibiotics) to staff hands and clothing. Hand hygiene should be performed, and new gown and gloves should be donned before caring for a different resident. High contact resident care activities included (but were not limited to) transferring residents, changing briefs, or assisting with toileting, medical device care or use, and wound care for chronic wounds.<br><br>1. Resident #106 had diagnoses including a stage 4 (full thickness tissue damage) pressure ulcer (healing) on the sacrum (area of skin at base of spine), pancytopenia (low levels of blood cells that may increase a person's risk for infection), and hemiplegia (paralysis on one side of the body). The Minimum Data Set Resident Assessment, dated 05/03/2024, revealed the resident was cognitively intact, had a stage 4 pressure ulcer, and received pressure ulcer care.<br><br>Review of the current Comprehensive Care Plan revealed Resident #106 had a stage 4 pressure ulcer and to provide dressing changes daily. The care plan did not address the need for enhanced barrier precautions.<br><br>Current Physician's orders included to clean the Stage 4 pressure ulcer and change the dressing daily and as needed.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an observation on 07/08/2024 at 10:53 AM, there was an enhanced barrier precautions sign posted on the outside of Resident #106's room door. Instructions on the sign included, but were not limited to, everyone must clean their hands before entering and when leaving the room, staff must wear a gown and gloves for high contact resident care activities that included transferring, providing hygiene, changing briefs, or assisting with toileting, and wound care (any skin opening requiring a dressing). Personal protective equipment was available near the resident's room.<br><br>During an observation and interview on 07/11/2024 at 1:40 PM, Licensed Practical Nurse #3 performed wound care to Resident #106's sacral healing pressure ulcer. Licensed Practical Nurse #3 was not wearing a gown during the procedure and did not change their gloves or perform hand hygiene after removing the old dressing (containing wound drainage), cleaning the wound, and before applying the new dressing. At the end of the procedure, they removed their gloves, opened the resident's room door, and proceeded down the hall to the clean utility room; opening the door and touching their hair before they washed their hands. When interviewed at that time, Licensed Practical Nurse #3 stated they had not changed gloves or performed hand hygiene during and immediately after wound care but should have and had not noticed the enhanced barrier precautions sign because it was new. Licensed Practical Nurse #3 stated Resident #106 was on precautions for their pressure wound and they should also have worn a gown.<br><br>2. Resident #83 had diagnoses that included bladder dysfunction, chronic kidney disease, and a urinary catheter. The Minimum Data Set Resident Assessment, dated 06/04/2024, included Resident #83 had moderately impaired cognition and an indwelling urinary catheter.<br><br>Review of the facility policy Catheter Care, Urinary, dated January 2024 included to be sure the catheter tubing and drainage bag were kept off the floor.<br><br>Review of the Comprehensive Care Plan revealed Resident #83 had an indwelling suprapubic catheter (a catheter inserted from the abdomen directly into the bladder to drain urine into a bag) and for the urine collection bag to be maintained below the level of the bladder.<br><br>During an observation on 07/09/2024 at 11:04 AM, Resident #83 was in bed and their urine collection bag was resting on the floor without a barrier. There was an enhanced barrier precautions sign posted on the outside of Resident #83's room door that stated personal protective equipment (gown and gloves) were required for high contact resident care activities.<br><br>During an observation on 07/10/2024 at 10:40 AM, Resident #83 was in bed and their urine collection bag (including the opening spout) was touching the floor.<br><br>During an interview on 07/15/2024 at 10:26 AM, Certified Nursing Assistant #15 said they would sometimes find Resident #83's urine collection bag on the floor because some staff did not hook it to the bed frame. Certified Nursing Assistant #15 said the resident was not known to put the bag on the floor and could not reach that far (to the end of the bed).<br><br>During an interview on 07/15/2024 at 1:31 PM, Licensed Practical Nurse #14 said urine collection bags should be in a lower position but not touching the floor.<br><br>During an interview on 07/15/2024 at 4:23 PM, Assistant Director of Nursing #1 said urine collection bags should be positioned hanging from the side of the bed and not observed on the floor.<br><br>(continued on next page) |

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| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue Rochester, NY 14612 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. Resident #66 had diagnoses including dysphagia (swallowing difficulties) with a feeding tube (a tube inserted directly into the stomach to provide nutrition), malnutrition, and gastroesophageal reflux disease. The Minimum Data Set Resident Assessment, dated 05/23/2024, revealed the resident had moderately impaired cognition and received nutrition via a feeding tube.<br><br>Review of the Comprehensive Care Plan, dated 07/11/2024, revealed Resident #66 was at risk for infection related to having a feeding tube. Interventions included to implement enhanced barrier precautions as indicated.<br><br>Review of current Physician orders included to clean the feeding tube site and apply a gauze dressing twice daily.<br><br>During an observation on 07/08/2024 at 9:27 AM, there was an enhanced barrier precautions sign posted on the outside of Resident #66's room door that stated personal protective equipment (gown and gloves) were required for high contact resident care activities that included transferring, providing hygiene, changing briefs, or assisting with toileting, and wound care (any skin opening requiring a dressing). Personal protective equipment was available outside of the resident's room.<br><br>During an observation on 07/11/2024 at 10:23 AM, Licensed Practical Nurse #15 wearing gloves and no gown flushed the feeding tube, cleansed the site, and applied a new dressing.<br><br>During an interview on 07/11/2024 at 8:31 AM, Licensed Practical Nurse #15 stated they should wear gloves when caring for a feeding tube.<br><br>4. Resident #607 had diagnoses including malignant neoplasm of the lower right lobe (lung cancer), diabetes mellitus, and history of respiratory failure. The Minimum Data Resident Assessment, dated 07/05/2024, documented the resident had moderate cognitive impairment, had a feeding tube, and required assistance with toileting.<br><br>There was an enhanced barrier precautions sign posted on the outside of Resident #607's room door. Instructions on the sign included, but were not limited to, everyone must clean their hands before entering and when leaving the room, staff must wear a gown and gloves for high contact resident care activities that included transferring, providing hygiene, changing briefs, or assisting with toileting.<br><br>During an observation on 07/11/2024 at 8:50 AM, Resident #607 was observed in their room, coming out of the bathroom with Certified Nursing Assistant #18 who was wearing gloves but not wearing a gown. Certified Nursing Assistant #18 assisted the resident with getting dressed and finishing in the bathroom.<br><br>During an interview on 07/11/2024 at 9:01 AM, Certified Nursing Assistant #18 stated the staff are continuously getting education on precautions and infection control. The type of precautions differs based on what they have. Certified Nursing Assistant #18 stated they did not know Resident #607 was on precautions even though the resident's door did have a precaution sign and they should have worn a gown while providing care. Certified Nursing Assistant #18 stated they provided hands on care while helping the resident finish up in the bathroom and getting dressed.<br><br>(continued on next page) |

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|---|---|---|---|
| | 335082 | A. Building<br>B. Wing | 09/17/2024 |

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| Waterview Heights Rehabilitation and Nursing Ctr | 425 Beach Avenue<br>Rochester, NY 14612 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 07/15/2024 at 7:49 PM with the Administrator, Assistant Administrator, Regional Administrator and Regional Clinical Director, the Regional Clinical Director stated staff had been educated and re-educated on appropriate infection control practices including enhanced barrier precautions. If a resident required enhanced barrier precautions, staff should wear appropriate personal protective equipment. The Regional Clinical Director stated enhanced barrier precautions were in place for residents with feeding tubes, wounds that required a dressing, transfers, toileting, and any care activities that required close contact. Nurses should also perform proper hand hygiene during wound care.<br><br>10 NYCRR 415.19(a)(1-3) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>49686<br><br>Based on interview and record review conducted during the extended Recertification Survey from 07/08/2024 to 09/17/2024, the facility did not ensure each resident received the pneumococcal immunizations for two (Residents #22 and #177) of five residents reviewed. Specifically, there was no documented evidence that either resident received the pneumococcal vaccine despite signing the consent forms requesting it. This is evidenced by the following:<br><br>Per facility policy, Infection Control, Pneumococcal Vaccine, dated January 2024, all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.<br><br>1. Resident #22 had diagnoses that included dementia with psychotic disturbance (dementia with features of delusions or hallucinations), adult failure to thrive, and atrial fibrillation (an irregular and often rapid heart rhythm). The Minimum Data Set Resident Assessment, dated 06/30/2024, documented that Resident #22 had severely impaired cognition and that Resident #22's Pneumococcal vaccination status was not up to date. There was no documented reason checked for the resident not receiving the pneumococcal vaccination.<br><br>Review of the facility's undated Resident Influenza/Pneumococcal Immunizations Consent Form revealed that Resident #22's representative had verbally requested, via a phone call, that Resident #22 receive the pneumococcal vaccine. The undated form was witness and signed by a facility staff signature. Review of Resident #22's electronic medical record and a paper medical record chart revealed no documented evidence that the vaccine had been ordered or administered to the resident.<br><br>2. Resident #177 had diagnoses that included dementia, diabetes, and adult failure of thrive. The Minimum Data Set Resident Assessment, dated 06/28/2024, documented that the resident had severely impaired cognition and that Resident #177's pneumococcal vaccination status was not up to date. There was no documented reason checked for the resident not receiving the pneumococcal vaccine.<br><br>Review of the facility's undated Resident Influenza/Pneumococcal Immunizations Consent Form revealed that Resident #177's representative had signed the consent form (undated) requesting that Resident #177 receive the pneumococcal vaccine. Review of Resident #22's electronic medical record revealed no documented evidence that the vaccine had been ordered or administered to the resident.<br><br>During an interview on 07/15/2024 at 12:33 PM, the Infection Preventionist stated that they were unable to find any documentation that the vaccines had been ordered or administered, was not sure why, and was not aware that of any issue with the vaccines.<br><br>During an interview on 07/15/2024 at 6:02 PM, the Assistant Director of Nursing #1 stated that they were unable to find any evidence that either resident received the pneumococcal vaccine after the consent forms were signed.<br><br>10 NYCRR 415.19(a)(1) |