STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Ctr	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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641 Based on observations, interviews and record review conducted during the Extended Survey from 03/09/2025 to 05/09/2025 for five (5) (Residents #114, #148, #191, #462, and #463) of six (6) residents reviewed, the facility did not ensure each resident was treated with respect and dignity and cared for in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. Specifically, Residents #114 and #462 were seated in a designated resident space and staff were eating take-out pizza and breadsticks in the room. Resident #148 had a sign above the head of their bed that read 'I AM A FEEDER.' Resident #191 was observed in the hallway without pants on and their incontinence brief visible to other residents and visitors in the hallway. Residents #463 and #462 resided in a four (4) person room where Resident #463 had to move out of their chair to allow space for staff to assist Resident #462 with a mechanical lift transfer. Resident #462 was not allowed privacy during the transfer. The findings include: The facility policy Quality of Life - Dignity dated January 2025, included each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with respect and dignity at all times, signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room unless specifically requested by the resident or family member, and staff shall promote, maintain, and protect resident privacy, including bodily privacy during assistance with care. 1. Resident #191 had diagnoses including hemiparesis (muscle weakness on one side of the body) affecting the right dominant side, epilepsy (seizures), and high blood pressure. The Minimum Data Set (a resident assessment tool) dated 12/25/2024 included the resident had severely impaired cognition and was dependent on staff for all activities of daily living. Resident #191's current Certified Nursing Assistant Kardex (care plan) reviewed on 03/17/2025, included the resident was dependent on staff for all activities of daily living, including assistance with putting on clothing and wheelchair mobility. During an observation on 03/09/2025 at 4:24 PM, Registered Nurse Supervisor #3 assisted Resident #191, who was wearing only a brief and t-shirt, into a wheelchair and wheeled them into the hallway. At 4:48 PM, Resident #191 was in the hallway with a rolled-up sheet in their hands, their brief was visible, and other residents and visitors were in the hallway. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #148 had diagnoses including dementia, failure to thrive (insufficient nutrition), and ataxia (lack of muscle coordination making it difficult to walk). The Minimum Data Set, dated dated dated [DATE] included the resident had severe cognitive impairment and was dependent on staff for eating assistance. Resident #148's current Kardex, reviewed on 03/17/2025, included the resident was dependent on staff for eating. During observations on 03/09/2025 at 3:41 PM and 03/14/2025 at 2:49 PM, there was a sign posted on the wall above Resident #148's head of bed that read 'I AM A FEEDER.' During an interview on 03/18/2025 at 9:19 AM, Resident #148's family member stated a certified nursing assistant posted the sign to alert staff the resident needed assistance with eating, but felt the staff should have come up with something better than a sign that read 'I AM A FEEDER.' During an interview on 03/20/2025 at 10:03 AM, Licensed Practical Nurse Manager #1 stated the sign was there when they started working at the facility and they were not sure if the resident's family member wanted the sign there or not. They stated it was a dignity issue if the family did not want the sign posted, and it should not be displayed in the resident's room. 3. Resident #114 had diagnoses including anoxic brain damage (a severe condition that occurs when the brain is deprived of oxygen for an extended period), heart failure, and diabetes. The Minimum Data Set, dated dated dated [DATE] included the resident had severe cognitive impairment. Resident #114's current Kardex, reviewed on 03/19/2025, included the resident was non-verbal and to anticipate the resident's needs as able. 4. Resident #462 had diagnoses including schizophrenia (a mental health condition), chronic kidney disease and diabetes. The Minimum Data Set, dated dated dated [DATE] included the resident had severely impaired cognition. During an observation on 03/14/2025 at 12:42 PM, Residents #114 and #462 were seated in the sunroom, a designated resident space, eating their lunch with staff assistance. At 12:51 PM, Licensed Practical Nurse Manager #3 and two certified nursing assistants were observed at a nearby table in the sunroom eating take-out pizza and breadsticks while Residents #114 and #462 were still seated in the sunroom. 5. Resident #463 had diagnoses including diabetes, chronic kidney disease, and anxiety. The Minimum Data Set, dated dated dated [DATE] included the resident had moderately impaired cognition and required assistance with ambulating (walking) with a walker. During an observation on 03/14/2025 at 2:55 PM, Certified Nursing Assistant #11 was assisting Resident #462 with a mechanical lift transfer from their wheelchair to their bed with Licensed Practical Nurse #10 standing by watching. Resident #463 (who resided in the four (4) person room with Resident #462) was leaning on their walker watching Resident #462 being transferred. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/14/2025 at 02:59 PM, Licensed Practical Nurse #10 stated they were not able to be next to Resident #462 during the transfer, as the resident's bed was against the wall and there was not enough space in the four (4) person room. They stated Resident #463 had to be moved out of their chair to accommodate space for the mechanical lift to be used for their roommate. During an interview on 03/21/2025 at 2:50 PM the Director of Nursing stated residents should be dressed appropriately and covered at all times. They stated staff should not be eating in front of residents or in the sunroom, as that space was for residents only. The Director of Nursing stated there should not be any signs posted in a resident's room stating, 'I am a feeder,' as it was a dignity issue, and they expressed concerns about privacy with the four (4) person rooms. During an interview on 03/21/2025 at 6:31 PM, the Administrator stated they were currently doing a Performance Improvement Project that focused on quality of care and dignity. 10 NYCRR 415.5(a)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 33313 Based on interviews and record reviews conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025 for 15 residents reviewed for grievances, the facility did not ensure that grievances and/or 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, Residents #31, #37, #53, #93, #96, #107, #159, and #203 voiced care concerns. Residents #3, #38, #53, #62, #93, #96, #104, #110, #128, and #147 had filed grievances with the facility between 12/31/2024 to 02/06/2025 for care concerns. A review of previous meeting minutes included issues such as long call bell wait times, lack of personal care, not receiving medications timely, and lack of staffing and there is no documented evidence the grievances were investigated and/or addressed in a timely manner. The facility failed to demonstrate their response and rationale to the grievances. The findings include: The facility policy Filing Grievance Complaints dated January 2025 documented that upon receipt of a written grievance and/or complaint the Director of Social Services/designee will investigate the allegations within three (3) working days of receiving the grievance and/or complaint and take immediate action to prevent further potential violations of any resident rights while the investigation is ongoing. During a special Resident Council meeting held on 03/10/2025 at 11:30 AM with eight (8) 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, 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. Review of facility Grievances/Complaints for December 2024, January 2025, and February 2025 included Residents #3, #38, #53, #62, #93, #96, #104, #110, #128, and #147 had filed grievances regarding care concerns including the lack of showers, not being assisted out of bed, and lack of staffing. The Resident Council meeting minutes for December 2024, January 2025, and February 2025 documented the residents reported care concerns including, but not limited to, not receiving showers regularly, call lights not answered timely, lack of staffing, and medications not being administered timely. The December 2024 and January 2025 meeting minutes did not include evidence that the concerns from the previous month were discussed. The February 2025 meeting minutes included an old business section that documented the concerns and grievances filed from the previous month that were discussed but did not include any follow up done by staff regarding their concerns/grievances. During an interview on 03/17/25 at 1:11 PM, the Director of Social Work stated they attended the monthly Resident Council meeting. Grievances and concerns discussed at the meeting are written up after the meeting and distributed to the respective departments to address. The Director of Social Work stated prior to 03/01/2025, old business was not discussed at the meetings. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence that monthly grievances discussed, were addressed. During an interview on 03/19/2025 at 11:16 AM, the Director of Nursing stated the Director of Social Work was responsible to distribute the grievances and concerns discussed during the Resident Council meetings to the correct departments to address, but no audits had been completed to ensure grievances and concerns were resolved. 10 NYCRR 415.5(c)(6)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations and interviews conducted during the Extended Recertification Survey from 03/9/2025 to 05/09/2025 it was determined that for five (5) (North One, South One, South Three, [NAME] One, [NAME] Two) of seven (7) resident units and two (2) (West and South basements) of two (2) basements observed the facility did not provide housekeeping or maintenance services necessary to maintain a sanitary, orderly, comfortable, and homelike interior. Specifically: there were heavy urine and fecal odors on units, floors and walls were dirty and/or in disrepair, door frames were jagged, mechanical lifts and weight scales were dirty, a shower stretcher was soiled, plumbing fixtures had not been maintained and/or were not working properly, garbage cans were lacking lids, there was a dirty fan, resident items were stored on the floor in disarray, and resident rooms lacked hanging space for personal items. The findings include: Observations on 03/09/2025 at 9:45 AM included a heavy smell of urine in the north first floor lounge and nearby south first floor near the elevators. Observations on 03/09/2025 at 10:08 AM on the North One Unit (second floor) included a large sticky spill on the floor in the clean utility room and a small refrigerator on the floor was cracked, dirty, and had a large ice buildup within it. Observations on 03/09/2025 at 10:42 AM on the South Three Unit in resident room [ROOM NUMBER] included a corkboard leaning against the nightstand closest to the window that was not mounted to the wall. Observations on 03/09/2025 at 11:02 AM on South Unit included the surface of a scale in the corridor across from room [ROOM NUMBER] was heavily soiled with crumbs and debris. Observations on 03/09/2025 at 11:07 AM on the South One Unit in the soiled utility room included the hot water handle on the handwash sink was not functional. Observations on 03/09/2025 at 11:29 AM on the South One Unit in resident room [ROOM NUMBER] included the bathroom sink was leaking and there was a soiled brief on top of the paper towel dispenser. Observations on 03/09/2025 at 11:38 AM on the South One Unit outside room [ROOM NUMBER] included the footrest of an assistive stand device (marked G7) was soiled with crumbs, hair, dust, and debris. Observations on 03/09/2025 at 12:23 PM on the [NAME] Two Unit in the dining room included a red plastic bin for medical waste that did not open when the foot pedal for the lid was pressed. Observations on 03/09/2025 at 2:25 PM on the North Two Unit in room [ROOM NUMBER] (a four-person room) included the bathroom door that measured two feet six inches wide using a [NAME] Professional GLM-20 laser measuring device leaving little room for wheelchair access. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 03/09/2025 at 2:30 PM on the North Two Unit in room [ROOM NUMBER] (a four-person room), the pathway leading to the bathroom was reduced to two feet eight inches by a bed placed near the wall and radiator. Additionally, there was a large, chipped area of the laminate on the wardrobe and a fall mat was on the floor near the side of the bed leaving a limited narrow pathway to the bathroom. Observations on 03/09/2025 at 2:45 PM on the North Two Unit in room [ROOM NUMBER] (a four-person room) included a privacy curtain on the left side that was dirty with brown stains. The privacy curtain for the right-side bed closest to the door did not extend along the rail for full visual privacy from the hallway leaving an approximately 6-foot-long open section. Additionally, the pathway leading to the bathroom was reduced to one and one-half foot wide by a bed placed near the wall and storage of a tray table and boxes of personal items. During an observation on 03/09/25 at 4:29 PM on the South Two Unit in room [ROOM NUMBER] Resident #178 stated they were not wearing any clothes and only had a sheet over them because their room was too hot. The temperature in the room, using the surveyor's thermometer, measured 83.4 degrees Fahrenheit. There were no pictures or decorations on the walls, and a bare bulletin board above Resident #178's television was falling off the wall. Observations on 03/10/2025 at 10:22 AM on the North Two Unit in room [ROOM NUMBER] (a four-person room) included no outside window within the room. There was an approximately four feet by three feet cutout in the wall approximately six feet above the floor leading to an adjacent sunporch with outside windows. Additionally, access to the bathroom within the room was reduced to 29 inches due to placement of a bed and nightstand making it accessible to ambulatory residents but not wheelchair bound residents. The residents were unable to access the sunporch from their room. Observations on 03/10/2025 at 11:08 AM on the South One Unit included a shower stretcher with a blue mat that was stored in the hallway outside room [ROOM NUMBER] with a soiled washcloth and brown debris in the catch basin beneath. Observations on 03/10/2025 at 11:55 AM on the North Two Unit included there were no cork boards or other method for hanging pictures or personal items in room [ROOM NUMBER] (a four-person room). In an immediate interview Resident #147 stated the room was made for three people but a while back they (staff) came in and took some measurements and told them they were getting someone else. Resident #147 stated that they do not like to have to share a closet with someone else. Each resident did not have their own closet space, rather, there were three freestanding wardrobes for the four (4) residents in this room and one of the wardrobes was shared for resident #147. Additionally, the privacy curtain for Resident #147 did not extend all the way around the bed for full visual privacy from the other residents within the room. Observations on 03/11/2025 at 10:26 AM on the [NAME] One Unit included an approximately one inch by two inches jagged rusted section of the metal door frame at the floor level of the shower room across from the nurse's station. Observations on 03/11/2025 at 10:35 AM on the [NAME] Two Unit included an approximately 1 inch wide by 12 inches long cracked and damaged section of wall creating a hole in the wall in the dining room next to the ice machine. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 03/11/2025 at 10:40 AM on the [NAME] Two U included an approximately 4 inches by 12 inches section of the floor tile around the mop sink in the janitor closet that had damaged and missing pieces of tile with debris on the floor nearby. Observations on 03/11/2025 at 10:56 AM included a large accumulation of bags, boxes, resident personal items, shoes, decorations, ripped open bags of clothes, briefs, masks, blankets, wheelchairs, therapy equipment, siderails, opened mail, a resident's Medical Orders for Life-Sustaining Treatment (MOLST) form, and other various items stored in piles on the floor of the [NAME] building basement. Observations on 03/12/2025 at 9:05 AM included a trash can at the end of the corridor by stairwell G1 (west one) that was mostly full of garbage, the plastic trash receptable was cracked, and the flip-top lid was missing. Additionally, there were three large bags of garbage left on the floor in the hallway near the exit. Observations on 03/12/2025 at 9:05 AM in the [NAME] Two Unit dining room included a trash can and another trash receptacle nearby lacked their covers. Observations on 03/13/2025 at 11:06 AM in the South One Units' janitor closet included the metal base of the door frame at the floor level (near room [ROOM NUMBER]) was bent and jagged. Observations on 03/14/2025 at 9:47 AM in the North Unit's soiled utility room included the handwash sink had no valve handles to turn the water on and was taped over with plastic. In an immediate interview a housekeeper stated that it (the sink) does not work. 10NYCRR: 415.29, 415.29(c), 415.29(d), 415.29(h)(1), 415.29(i)(1,2), 415.29(j)(1)

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	335082	A. Building B. Wing	05/09/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 46526 Based on observations, interviews, and record review conducted during an Extended Recertification Survey from 03/09/2025 to 05/09/2025, for 13 (Residents #3, #4, #11, #32, #62, #83, #111, #148, #158, #178, #459, #461, #508) of 13 residents reviewed, the facility failed to ensure that residents were free from neglect when it failed to provide the required structures and processes in order to meet the needs of one or more residents. Specifically, the facility failed to ensure sufficient nursing staff to provide nursing services to meet the residents' needs including showers, assistance with eating, toileting, personal hygiene, skin care, application of devices to prevent loss of range of motion, receiving medications as ordered by the medical team and supervision of residents on aspiration precautions to prevent choking. For Resident #178, who was observed on several occasions not wearing recommended hand splints resulting in lost range of motion to their hands, which resulted in actual harm, that was not immediate jeopardy. For Resident #158 who was observed incontinent for extended periods of time, it can be determined that a reasonable person in the residents' position would have experienced serious psychosocial harm (such as anger, embarrassment, humiliation, anxiety), that was not immediate jeopardy. Additionally, Resident #158 was identified by staff to have skin breakdown to their buttocks and there was no documented evidence that a medical provider was notified, or treatments initiated until three days later, which resulted in actual harm, that was not immediate jeopardy. The findings include: Review of the facility policy Abuse Clinical Protocol dated January 2025 revealed the physician and staff would help to identify risk factors for abuse in the facility to include, but not limited to, deficiencies in the physical environment, problems related to adequate staffing, and staff burnout that might affect how the residents were being cared for. Along with other staff and management, the physician would help to identify situations that might constitute neglect to include, but not limited to, inadequate prevention or care of pressure ulcers and recurrent failure to provide incontinence care. The facility management and staff will institute measures to address the needs of residents and minimize the possibility of abuse and neglect. The medical director will advise facility management and staff about systems to ensure that basic medical, functional, and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately. For additional information see Centers for Medicare/Medicaid Services Form 2567: F677 - Activities of Daily Living Care for Dependent Residents Specifically, Residents #62 and #148 reported no showers for several weeks and were observed with unwashed hair, Resident #178 had no documented showers for several weeks, was observed with unwashed hair, long uncut nails and was unshaven over multiple days, and Resident #158 was observed incontinent for extended periods of time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	Resident #158 had diagnoses including failure to thrive, dementia and diabetes. The Minimum Data Set (a resident assessment tool) dated 03/01/2025 included the resident had severe impairment of cognitive function. The undated Comprehensive Care Plan reviewed on 03/18/2025 documented the resident was incontinent of urine and stool and required staff to check for incontinence and change as needed every three (3) to four (4) hours. During an observation on 03/09/2025 at 12:52 PM Resident #158 was incontinent of urine soaking through to their sweatpants in the groin area almost down to the knees with a strong odor of urine. When observed at 2:27 PM and again at 4:20 PM the residents' pants remained soiled with a strong odor of urine. During an observation and interview on 03/17/2025 at 10:14 AM Resident #158 was in bed. Their incontinence brief was half off and heavily soiled with a strong odor of urine. The linens were soiled with wet yellow and brown stains. Staff were notified, entered the room and Certified Nursing Assistant #8 stated that they could not remember when the resident had last received incontinence care but was sometime last night as they only had two aides on the unit (census of 38). In a follow-up interview at 11:56 AM Certified Nursing Assistant #8 stated they were unaware the resident had been so soiled, but the resident required two staff for cares due to being combative. During an interview on 03/21/2025 at 2:50 PM the Director of Nursing stated they would be very concerned if a resident were to go all day without incontinence care (Resident #158). The Director of Nursing stated staffing has been very challenging. F684 - Quality of Care Specifically, Resident #178 was observed on several occasions not wearing specially made hand splints as recommended by Occupational Therapy to maintain range of motion resulting in lost range of motion to their hands. F686 - Treatment/Services to Prevent/Heal Pressure Ulcers Specifically, Resident #158 was identified by staff to have skin breakdown to their buttocks on 03/14/2025. There was no documented evidence that a medical provider was notified, or treatments initiated until three days later and the resident had two (2) new stage two (2) pressure ulcers. F689 - Free of Accident Hazards/Supervision/Devices Specifically, for Residents #4, #11, #83, #461, and #508 the facility failed to ensure that residents received adequate supervision during meals to prevent accidents for residents that were on aspiration precautions. Additionally, Resident #461 was observed with the incorrect liquid consistency as ordered by the provider (to prevent choking). F760 - Residents are Free from Significant Medication Errors (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	Specifically, for Residents #3, #32, #111, and #459 the facility failed to ensure that residents were free of significant medication errors. Specifically, there was no documented evidence the residents received multiple significant medications over the course of several days including but not limited to insulin, antihypertensives (used to treat high blood pressure), antiplatelets (used to prevent blood platelets from forming clots), antidepressants, antipsychotics, antibiotics, antirejection medication (used for kidney transplants) and a medication used to treat kidney disease in dialysis patients. Additionally, review of full-house Medication Administration Audit Reports revealed no documented evidence that 193 residents from 02/13/2025 to 02/17/2025 and 213 residents from 03/21/2025 to 03/30/2025 had received multiple medications on multiple days which was verified by staff interviews and record review. F725 - Sufficient Nursing Staff The facility failed to ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents in the facility. Specifically, there was insufficient staff to meet all resident needs including showers, assistance with eating, toileting, personal hygiene, and receiving medications as ordered by the medical team due to lack of licensed nurses and certified nursing assistants. During an interview on 03/10/2025 at 9:40 AM Licensed Practical Nurse #2 stated that they did not have enough staff on 03/09/2025 day shift and that was the reason why residents were left wet for hours. During an interview on 03/13/2025 at 11:12 AM, Certified Nursing Assistant #4 stated they recalled working the weekend of 02/14/2025, and that they were the only Certified Nursing Assistant on the unit with one (1) nurse and approximately 40 residents. Certified Nursing Assistant #4 stated not much resident care was completed besides feeding the residents and each resident got changed or taken to the bathroom once. Residents who required two staff and a mechanical lift for transfers did not get out of their bed. They said the nurse could not help them with resident care as they were trying to pass all the medications, and it was impossible to get to everyone. During an interview on 03/13/2025 at 11:13 AM, the Certified Nursing Assistant Staffing Coordinator stated that the facility was budgeted for four (4) Certified Nursing Assistants and two (2) nurses a shift for days and evenings, and two (2) Certified Nursing Assistants and one (1) nurse for night shift for each of the six (6) units. They were told minimal staffing included two (2) Certified Nursing Assistants and one (1) nurse per unit. They said when staffing was at critical levels residents could not get out of bed especially if they required two assist and showers did not happen unless a resident was covered in stool. The Certified Nursing Assistant Staffing Coordinator stated staff complain daily about not having enough staff on the units to care for the residents. Residents and family members have complained there was not enough staff and their complaints were valid. At times the facility has had only six (6) to seven (7) staff total in the building for the night shift. During an interview on 03/13/2025 at 11:51 AM, Certified Nursing Assistant #5 stated they often worked by themselves with one (1) nurse on a unit (40 bed unit). They said when it was just them and a nurse it was impossible to get to all residents and they would have to pick who needed the most care. For a resident who required two (2) staff assist they would have to care for them on their own. (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 B. Wing	05/09/2025

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

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F 0600 Level of Harm - Actual harm Residents Affected - Many	During an interview on 03/13/2025 at 12:00 PM, the Director of Nursing stated their minimum staffing level was one (1) licensed nurse and one (1) certified nursing assistant for 40 residents, but they would then try to infuse other resources including therapy staff. The Director of Nursing stated one nurse passing medications to 40 residents would need help to finish. They said on the weekend of 02/14/2025 through 02/16/2025 they were aware of numerous staff calling in and more than 20 residents did not receive their medications because there was not enough nursing staff to give them. The Director of Nursing stated that they were aware of the concerns regarding one (1) nurse for 40 residents, but it was within their (the facility's) guidelines. During an interview on 03/16/2025 at 6:05 AM, Licensed Practical Nurse #14 stated that there were night shifts where there were only one (1) to three (3) nurses in the entire building and they could not get to all of the residents for care. They have begged the facility for help. During an interview on 03/21/2025 at 12:48 PM, the Medical Director stated that it was a well-known issue that residents did not receive their medications timely or at all and that it was likely due to lack of staffing. During interviews on 03/21/2025 at 2:50 PM and 6:31 PM, the Director of Nursing stated one (1) Certified Nursing Assistant for 40 resident was a lot, and if staff could not get to all the residents for care, they should say something. They are working on the staffing challenges and trying to hire more staff. During an interview on 03/21/2025 at 6:31 PM, the Administrator stated they were aware of issues with nurse staffing and have hired more agency nursing staff and an in-house recruiter. During an interview on 03/31/2025 at 3:28 PM, the Director of Nursing stated they have worked on the medication carts to ensure medications were passed but this does impact their Director of Nursing duties. The Director of Nursing stated low nurse staffing numbers could be why so many residents did not receive their medications. During an interview on 04/23/2025 at 10:03 AM, Licensed Practical Nurse #10 stated they worked on 04/20/2025 day shift and there was only one nurse and one aide on the unit. They stated there were 22 residents on the unit who all required the assistance of two staff for activities of daily living and four (4) residents who required supervision during meals due to aspiration precautions. Licensed Practical Nurse #10 stated the staffing scenario happens often and because they have to assist the aide with resident care, they often complete their medication passes late, including blood sugars and insulin administration. During an interview on 04/23/2025 at 10:10 AM, Certified Nursing Assistant #9 stated the residents on the North One Unit needed the assistance of two (2) staff for most of their care. At mealtimes there were a lot of trays to be passed, and some residents needed supervision due to aspiration precautions. Certified Nursing Assistant #9 stated when there was only one (1) aide on the unit, the only residents able to get out of bed were those with appointments and they do their best to ensure all residents are dressed and dry. They stated a lot of things do not get done with only one (1) aide and one (1) nurse, but we do the best we can. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Many	During observations on 04/24/2025 at 9:00 AM and 11:48 AM on the South Two Unit (resident census was 40) there was one (1) registered nurse, one (1) licensed practical nurse, and one (1) certified nursing assistant on the unit. During an interview on 04/24/2025 at 11:52 AM, Certified Nursing Assistant #19 stated the South Two Unit was supposed to get another certified nursing assistant to help but no one else had arrived. Certified Nursing Assistant #19 stated they passed breakfast meal trays on their own and the majority of the residents on the back hall (approximately 16 residents) and all residents that required the assistance of two staff had not received any care. During an interview on 04/24/2025 at 12:18 PM, the Administrator stated they were not aware until significantly later in the morning that all scheduled staff had not arrived on the South Two Unit. While the facility strives for higher, their minimum staffing for 40 residents is one (1) nurse and one (1) aide. 10 NYCRR 415.4 (b)(1)(i)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on interviews and record review conducted during the Extended Recertification Survey from [DATE] to [DATE] for 1 (Resident #308) of 12 residents reviewed, the facility did not ensure that an incident was thoroughly investigated to rule out abuse, neglect, mistreatment, or care plan violation. Specifically, Resident #308 had an unwitnessed fall on [DATE] and was found unresponsive in front of the nurse's station. The facility was unable to provide documented evidence (including statements from all involved staff members or potential witnesses) that the incident was thoroughly investigated to rule out abuse, neglect, mistreatment, or care plan violation. The findings include: The facility policy Abuse Prevention Program/Abuse and Neglect - Clinical Protocol/Abuse Investigation and Reporting, dated as reviewed [DATE], documented the facility will initiate a full investigation immediately of any potential abuse, neglect or mistreatment. The facility policy Accident and Incident - Investigating and Reporting - Reporting, dated as reviewed [DATE], documented the Nurse Supervisor/Charge Nurse and/or department director or supervisor shall promptly initiate and document the investigation of the accident or incident. The report should include the circumstances surrounding the accident or incident. Resident #308 had diagnoses which included diabetes (high blood sugar levels), depression, and high blood pressure. The Minimum Data Set (a resident assessment tool) dated [DATE] documented the resident was cognitively intact. Resident #308's current Comprehensive Care Plan, reviewed on [DATE], documented the resident was on a pureed diet with thin liquids and required supervision or touching assistance with eating and ambulation. Additionally, the resident had a history of behaviors such as putting foreign objects in their mouth ([DATE]). Physician's orders dated [DATE], documented a pureed diet with thin liquids. In a late entry nursing progress note dated [DATE] at 10:20 AM, Licensed Practical Nurse Manager #1 documented the floor nurse notified them Resident #308 was on the floor. The note included resident was observed on the floor in front of the nurse's station lying on their back with bilateral lower extremities extended in front of them, and hands at side. Resident was breathing but unresponsive. Writer turned resident to their right side and observed an excessive amount of soft, mushy substance coming from resident's oral cavity. Writer and floor nurse got resident off the floor. Writer began the Heimlich maneuver, as floor nurse called a code blue. Medical team responded immediately, 911 called, and provider took over the code blue. The progress note included that cardiopulmonary resuscitation continued until Emergency Medical Services arrived, cardiopulmonary resuscitation continued as well as attempted intubation without success and pronounced the resident deceased at 11:09 AM. The unsigned facility Accident/Incident Report dated [DATE] 9:00 AM, documented the resident name, sex, and location where incident occurred. There was no further documentation on the report. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Incident and Accident Statement Form dated [DATE] 9:00 AM and signed by Certified Nursing Assistant #2, documented they observed Resident #308 lying on the floor and the last time the resident was observed, the resident had been ambulating in the hallway. The facility Incident and Accident Statement Form dated [DATE] 9:30 AM and signed by Licensed Practical Nurse #2, documented they observed resident on floor at nurses station. The facility Incident and Accident Statement Form dated [DATE] 9:30 AM, reported by Licensed Practical Nurse Manager #1 and completed by the Director of Nursing documented, Resident had an unwitnessed fall, was observed prone on the floor in front of the nurses station. Resident was unresponsive but breathing. During an interview on [DATE] at 4:32 PM, Certified Nursing Assistant #9 stated Resident #308 recently passed away from choking on cereal. During an interview on [DATE] at 3:19 PM, Licensed Practical Nurse Manager #1 stated Resident #308 was found lying on the floor in front of the nurses' station and was breathing but unresponsive. Licensed Practical Nurse Manager #1 and Licensed Practical Nurse #2 utilized a mechanical lift to lift the resident off the floor, who appeared to be foaming from the mouth with a mushy substance coming out of their mouth. The Heimlich maneuver was performed, the resident became limp, and a code blue was initiated. Licensed Practical Nurse Manager #1 stated that it was not the statement they filled out but more a summary of what they said over the phone with the Director of Nursing. Licensed Practical Nurse Manager #1 said they had no idea what happened to Resident #308. During an interview on [DATE] at 2:48 PM, the Director of Nursing stated accident/incident investigations are completed to determine what occurred and to prevent further occurrences but not every incident required an investigation. The Director of Nursing stated if the Heimlich maneuver had to be performed by staff, it would be important to investigate and determine if choking was an issue or maybe a fall. After review of the investigation, the Director of Nursing stated possible choking was not part of their investigation. 10 NYCRR 415.4 (b)(3)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Honor each resident's preferences, choices, values and beliefs. 39181 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, the facility failed to provide an environment which supported and enhanced each resident's quality of life, which was the result of the cumulative effect of noncompliance cited for abuse/neglect, incontinence care, quality of care, pressure ulcers, accident hazards, sufficient staffing, significant medication errors, and infection prevention and control. This noncompliance was found to be pervasive and created an environment reflecting a complete disregard of one or more residents' well-being and quality of life, which has caused or is likely to cause serious harm that is Immediate Jeopardy, related to one or more residents' self-worth, self-esteem, and well-being. On 05/09/2025 the survey team identified and declared Immediate Jeopardy and the facility Administrator was notified at 2:03 PM. The findings include: For additional information see Centers for Medicare/Medicaid Services Form 2567: F689 - Free of Accident Hazards/Supervision/Devices Specifically, for Residents #4, #11, #83, #461, and #508 the facility failed to ensure that residents received adequate supervision during meals to prevent accidents for residents that were on aspiration precautions. Additionally, Resident #461 was observed with the incorrect liquid consistency as ordered by the provider (to prevent choking). This resulted in Immediate Jeopardy. F725 - Sufficient Nursing Staff The facility failed to ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents in the facility. Specifically, there was insufficient staff to meet all resident needs including showers, assistance with eating, toileting, personal hygiene, and receiving medications as ordered by the medical team due to lack of licensed nurses and certified nursing assistants. This resulted in Immediate Jeopardy. F760 - Residents are Free from Significant Medication Errors Specifically, for Residents #3, #32, #111, and #459 the facility failed to ensure that residents were free of significant medication errors. Specifically, there was no documented evidence the residents received multiple significant medications over the course of several days including but not limited to insulin, antihypertensives (used to treat high blood pressure), antiplatelets (used to prevent blood platelets from forming clots), antidepressants, antipsychotics, antibiotics, antirejection medication (used for kidney transplants) and a medication used to treat kidney disease in dialysis patients. Additionally, review of full-house Medication Administration Audit Reports revealed no documented evidence that 193 residents from 02/13/2025 to 02/17/2025 and 213 residents from 03/21/2025 to 03/30/2025 had received multiple medications on multiple days which was verified by staff interviews and record review. This resulted in Immediate Jeopardy F880 - Infection Prevention and Control (continued on next page)

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F 0675 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections for three (3) (Residents #82, #148, and #459) of 10 residents reviewed and one (1) of one (1) facility potable water systems (the collection, treatment, storage, and distribution of safe drinking water). Specifically, Issue one (1) includes: The facility failed to 1) provide further testing for Legionnaires' disease for residents diagnosed with pneumonia, 2) to ensure short-term water disinfection control measures were implemented for the potable water system after receipt of samples testing positive for Legionella, and 3) to report potable water system samples exceeding greater than 30% positivity for Legionella to the New York State Department of Health, which resulted in the likelihood of serious injury, serious harm, serious impairment or death to all 214 residents in the facility. This resulted in Immediate Jeopardy F600 - Free from Abuse and Neglect For 13 (Residents #3, #4, #11, #32, #62, #83, #111, #148, #158, #178, #459, #461, #508) of 13 residents reviewed, the facility failed to ensure that residents were free from neglect when it failed to provide the required structures and processes in order to meet the needs of one or more residents. Specifically, the facility failed to ensure sufficient nursing staff to provide nursing services to meet the residents' needs including showers, assistance with eating, toileting, personal hygiene, skin care, application of devices to prevent loss of range of motion, receiving medications as ordered by the medical team and supervision of residents on aspiration precautions to prevent choking. For Resident #178, who was observed on several occasions not wearing recommended hand splints resulting in lost range of motion to their hands, which resulted in actual harm, that was not immediate jeopardy. For Resident #158 who was observed incontinent for extended periods of time, it can be determined that a reasonable person in the residents' position would have experienced serious psychosocial harm (such as anger, embarrassment, humiliation, anxiety), that was not immediate jeopardy. Additionally, Resident #158 was identified by staff to have skin breakdown to their buttocks and there was no documented evidence that a medical provider was notified, or treatments initiated until three days later, which resulted in actual harm, that was not immediate jeopardy. F684 - Quality of Care Specifically, Resident #178 was observed on several occasions not wearing specially made hand splints as recommended by Occupational Therapy to maintain range of motion resulting in lost range of motion to their hands. This resulted in actual harm to Resident #178 that was not immediate jeopardy. F686 - Treatment/Services to Prevent/Heal Pressure Ulcers Specifically, Resident #158 was identified by staff to have skin breakdown to their buttocks on 03/14/2025. There was no documented evidence that a medical provider was notified, or treatments initiated until three days later and the resident had two (2) new stage two (2) pressure ulcers. This resulted in actual harm to Resident #158 that was not immediate jeopardy. 10 NYCRR 415.5

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews and record review conducted during an Extended Recertification Survey and complaint investigations (#NY00372404, #NY00372850, #NY00364319) from 03/09/2025 to 05/09/2025 the facility did not ensure that residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming and personal hygiene for four (4) (Residents' #62, #148, #158 and #178) of eight (8) residents reviewed. Specifically, Residents' #62 and #148 reported no showers for several weeks and were observed with unwashed hair, Resident #178 had no documented showers for several weeks, was observed with unwashed hair, long uncut nails and was unshaven over multiple days and Resident #158 was observed incontinent for extended periods of time. The findings include: The facility policy Resident Care with Activities of Daily Living dated as reviewed January 2025 documented that when a shower and/or tub bath was provided staff should document the date and time one was performed, the name and title of the staff who assisted, and how the resident tolerated the shower or tub bath. If the resident refused, the reason why and the intervention taken should be documented. The policy documented that staff are not to trim a resident's toenails or fingernails unless instructed by their supervisor. 1.Resident #158 had diagnoses including failure to thrive, dementia and diabetes (high blood sugar). The Minimum Data Set (a resident assessment tool) dated 03/01/2025 documented the resident had severe impairment of cognitive function. The undated Comprehensive Care Plan reviewed on 03/18/2025 documented the resident was incontinent of urine and stool and required staff to check for incontinence and change as needed every three (3) to four (4) hours. The resident was at risk for pressure ulcers from extended exposure to moisture and required prompt removal of wet or damp clothing and sheets. During an observation on 03/09/2025 at 12:52 PM Resident #158 was incontinent of urine, soaking through their sweatpants in the groin area almost down to the knees with a strong odor of urine. Their nails were long, some with jagged edges and all with dark debris underneath. When observed again at 2:27 PM and at 4:20 PM the residents' pants remained soiled with a strong odor of urine. During an observation and immediate interview on 03/17/2025 at 10:14 AM Resident #158 was in bed with their incontinence brief half off and heavily soiled with a strong odor of urine. The linens were soiled with wet, yellow and brown stains. Staff were notified, entered the room and Certified Nursing Assistant #8 stated that they could not remember when the resident had last received incontinence care, but was sometime last night as they only had two (2) aides on the unit (census of 38). In a follow-up interview at 11:56 AM Certified Nursing Assistant #8 stated they were unaware that the resident had been incontinent, but the resident required two (2) staff for care due to being combative. 2. Resident #62 had diagnoses including cardiomyopathy (diseases that affect the heart muscle causing weakness and multiple complications), paranoid personality disorder and tremors. The Minimum Data Set, dated dated dated [DATE] documented that the resident was cognitively intact. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #62's Comprehensive Care Plan dated 03/14/2025 and current Certified Nursing Assistant Kardex (care plan) documented the resident required supervision or touching assist for bathing and personal hygiene. During an observation and interview on 03/10/2025 at 10:07 AM Resident #62 stated they would like a shower, but no one has asked them if they wanted one and their last shower was three (3) weeks ago. The resident's hair was unwashed and stringy. During observations on 03/15/2025 at 11:14 AM Resident #62's hair remained unwashed, and the resident stated they had not yet received a shower that week as there was no one available to give them one. Review of the Certified Nursing Assistant task record (documentation of care received) revealed no documentation that Resident #62 had received a shower for the prior 30 days. During an interview on 03/20/2025 at 2:45 PM Certified Nursing Assistant #3 stated staff usually ask the resident on their designated shower day if they want one and then document in the electronic health record (task record) that the resident received a shower or had refused one. Certified Nursing Assistant #3 stated Resident #62 did not receive a shower on their shower day because there was not enough staff. 3. Resident #148 had diagnoses including dementia, failure to thrive and ataxia (lack of muscle coordination making it difficult to walk). The Minimum Data Set, dated dated dated [DATE] documented the resident had severe impairment of cognitive function. The Comprehensive Care Plan last revised on 05/08/2024 documented the resident was dependent on staff for bathing, toileting and personal hygiene. Resident #148's current Kardex dated as printed on 03/17/2025 documented the resident was dependent on staff for all activities of daily living, including bathing and was incontinent of bladder and bowel. The Kardex did not include a history of refusing care or interventions to follow if care was refused. During an observation and interview on 03/09/2025 at 3:41 PM a distraught visitor came into the hall to request help for Resident #148 who had been incontinent. In an immediate observation Resident #148 had a large amount of stool on their bottom, hip, hands, fingernails and their bed linens. Their hair was disheveled and greasy in appearance. The visitor stated that an aide had been in the room previously but left the resident soiled. The visitor said the resident was supposed to have a shower once a week and get their hair done once a week, but it had been weeks since a shower or since they had their hair washed and it is messy and greasy. During an observation on 03/11/2025 at 1:50 PM Resident #148's hair remained disheveled, greasy and stringy. In a progress note dated 03/14/2025 Licensed Practical Nurse #2 documented the resident refused their hair appointment as they did not want to get up. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/17/2025 at 11:19 AM Certified Nursing Assistant #2 stated showers are documented in the resident's electronic health record when complete. The facility was unable to provide documentation when Resident #148 had last received a shower. During an observation and interview on 03/18/2025 at 9:13 AM Resident #148's visitor stated the resident was soaked with urine, was wearing the same socks they put on them last week and has not had a shower for at least three to four weeks. During an interview on 03/19/2025 at 11:20 AM Licensed Practical Nurse #9 stated Resident #148's hair did not look clean, and did not know when the resident last had a shower or had their hair washed. Licensed Practical Nurse #9 said the resident sometimes refused a shower. 4. Resident #178 had diagnoses including rheumatoid arthritis (a chronic autoimmune disease that affects the joints causing pain, swelling, stiffness and a loss of function), spinal stenosis (narrowing of spinal canal [space that protects the spinal column]) and repeated falls. The Minimum Data Set, dated dated dated [DATE] included the resident had moderate impairment of cognitive function. The Comprehensive Care Plan dated 09/06/2024 included that Resident #178 was dependent on staff for all activities of daily living. Resident #178's current Certified Nursing Assistant Kardex reviewed on 03/18/2025 documented the resident was dependent on staff for all activities of daily living. During an observation and interview on 03/09/2025 at 4:24 PM Resident #178 stated they had not been changed since the morning and their brief was full of urine. Resident #178 had a full beard and mustache; their skin was dry, scaly and had a white crusty substance on their chest and shoulder. The resident said they did not like the facial hair and would like to be shaved, including their head as it was very itchy, but they had not been shaved or had a shower in a long time. Resident #178's nails were long and jagged, and the resident stated their palms hurt from the long nails. Both hands were contracted (a tightening of the muscles and tendons causing a deformity of the hand) and the skin slightly reddened but intact. During an observation on 03/17/2025 at 9:48 AM Resident #178's nails remained long, jagged and appeared to be cutting into the skin. The resident was unable to open their palm due to the contracture. The resident stated their nails needed to be cut and their head still itched. The white substance on the resident's shoulders and chest remained and they remained unshaven. Review of the resident's electronic medical record on 03/10/2025 revealed no documented evidence that the resident had obtained a shower for the previous 30 days. During an observation and interview on 03/17/2025 at 2:06 PM Registered Nurse Supervisor stated that Resident #178's nails were long and sharp and needed to be cut. During an interview on 03/20/204 Licensed Practical Nurse Unit Manager #1 stated Resident #178 should get a shower weekly, but they did not know when the resident last had a shower. (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 B. Wing	05/09/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/21/2025 at 2:50 PM the Director of Nursing stated residents should receive showers weekly and staff should let the nurses know if they cannot get to it. Nail care should be completed that day if needed, including getting them cut if too long. The Director of Nursing said they did not know when Resident #148 had a shower last but should have received a daily bed bath. Resident #178 got a shower recently (during survey) and had one about a month or two ago. Resident #178 does not always remember when they were last changed (incontinence care). The Director of Nursing said the Certified Nursing Assistants should be able to see when a resident's hair was uncut or dirty, or what care a resident required and ask them their preferences. They would be very concerned if a resident were to go all day without incontinence care (Resident #158). The Director of Nursing stated staffing has been very challenging. 10 NYCRR 415.12(a)(3) 47641

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641 Based on observations, interviews and record review conducted during an Extended Recertification Survey and complaint investigation (NY00372698) from 03/09/2025 to 05/09/2025, the facility failed to ensure that all residents received treatment and care in accordance with professional standards of practice for 2 (Residents #178 and #459) of 41 residents reviewed. Specifically, Resident #178 was observed on several occasions not wearing custom-made hand splints as recommended by Occupational Therapy to maintain range of motion, resulting in lost range of motion to their hands. Resident #459 did not have orders for care of their nephrostomy tube (tube inserted directly into the kidney through the skin to drain urine) for an extended period of time. This resulted in actual harm to Resident #178 that was not immediate jeopardy. The findings include: 1. Resident #178 had diagnoses including rheumatoid arthritis, spinal stenosis and a history of repeated falls. The Minimum Data Set (a resident assessment tool) dated 02/28/2025 included the resident had moderate impairment of cognitive function and was dependent on staff for all activities of daily living. In an Occupational Therapy progress note dated 12/04/2024, Occupational Therapist #1 documented they educated and trained Certified Nursing Assistant #2, Registered Nurse Unit Manager #2 and Licensed Practical Nurse #2 on how to apply and remove the resting hand splints for Resident #178, with instructions to apply daily to both hands and remain on for six hours. Occupational Therapist #1 documented Resident #459 had improved range of motion at that time. In an Occupational Therapy progress note dated 12/20/2024, Occupational Therapist #1 documented they educated and trained Certified Nursing Assistant #2 and Certified Nursing Assistant #13 on how to apply and remove the resident's hand splints. Review of the Occupational Therapy Discharge Summary dated 12/26/2024 revealed discharge recommendations for splints, caregivers were trained and will provide assistance to the resident to wear the splints six hours a day or as tolerated. Occupational Therapist #1 documented the resident had made good progress with the splints, with an increase in hand range of motion while on therapy. Review of Resident #178's current Comprehensive Care Plan, Certified Nursing Assistant Kardex (care plan), and Treatment Administration Records reviewed on 03/12/2025 revealed no documentation that the hand splints had been recommended or provided since discharge from therapy. Review of Resident #178's current physician orders on 03/12/2025 did not include use of daily hand splints. During an observation and interview on 03/09/2025 at 4:24 PM, Resident #178 had contractures (condition where the muscles, tendons and tissues harden causing pain and deformity) of both hands. There were no splints on either hand. Resident #178 stated at this time that they were able to open the right hand slightly, but they could not open their left hand at all. When asked if they wore splints, Resident #178 answered that they needed their nails cut. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During observations on 03/12/2025 at 9:22 AM and 03/14/2025 at 10:59 AM Resident #178 had no splints on either hand. During an interview on 03/19/2025 at 10:45 AM, Certified Nursing Assistant #2 stated if a resident required hand splints, it would be in the Kardex. Certified Nursing Assistant #2 said they have seen splints in Resident #178's room but they are not usually assigned to that hall. During an interview on 03/20/2025 at 2:17 PM, Occupational Therapist #1 stated Resident #178 had contractures, and they made the resident special hand splints that were meant to prevent the hands from curling in, for passive range of motion and to prevent further contractures. Occupational Therapist #1 stated they taught the staff how to apply and remove the hand splints, how long the resident should wear them, and that the resident had built up tolerance to wear them for up to six hours a day. Occupational Therapist #1 stated the Nurse Managers are supposed to put orders in and put the information in the resident's care plans. Occupational Therapist #1 stated they re-evaluated Resident #178 the day before (03/19/2025) and the resident had a decline in range of motion from when the resident was discharged from therapy in December 2024 and had regressed back to where they were when first admitted to the facility. During an interview on 03/21/2025 at 12:48 PM, the Medical Director stated the whole point of a skilled nursing facility is to rehabilitate residents, and with a loss of range of motion to Resident #178's hands, the rehabilitation progress is now gone. The Medical Director stated it sounded like a communication issue which resulted in harm to the resident. During an interview on 03/21/2025 at 2:50 PM the Director of Nursing stated when therapy makes a recommendation, they should communicate with the Registered Nurses to put an order in and add the information to the resident's care plan. The Director of Nursing stated they did not know why there were no orders for the hand splints in the resident's care plans. The facility policy Assistive Devices and Equipment, reviewed January 2025, documented the facility provides, maintains, trains and supervises the use of assistive devices and equipment for residents. Recommendations for the use of devices and equipment are based on the comprehensive assessment and documented in the residents' plan of care. 2. Resident #459 was a recent readmission with diagnoses including chronic kidney disease, history of a kidney transplant, recent pyelonephritis (kidney infection) requiring placement of a nephrostomy tube. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe impairment of cognitive function. Facility admission orders did not include any orders for the care or monitoring of the nephrostomy tube. Review of Resident #459's Treatment Administration Record dated 01/27/2025 to 02/10/2025 did not include any documentation related to any care or flushing of their nephrostomy tube. Current Physician orders dated 03/07/2025 following readmission from the hospital documented a nephrostomy tube dressing change every other day and as needed, to cleanse site with sterile saline, pat dry and cover with border gauze dressing and for a Registered Nurse to flush the nephrostomy tube daily with 5 milliliters of normal saline. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an observation on 03/09/2025 at 10:22 AM the Surveyor found Resident #459 lying on the floor. Their nephrostomy tube was coming out of the right side of their abdomen and stretched to a urine collection bag hanging on the side of the bed. There was no dressing over the nephrostomy insertion site and the tubing was not secured to the resident's body. In a nursing progress note dated 03/11/2025, Licensed Practical Nurse Manager #1 documented the resident was transferred to the hospital due to a dislodged nephrostomy tube. During a telephone interview on 03/13/2025 at 6:04 PM, a family member stated that the hospital staff had told them that the nephrostomy tube should have been flushed when the resident first arrived at the facility. The family member stated the kidney transplant was many years ago. During an observation of care on 03/17/2025 at 11:24 AM there was no dressing on the resident's nephrostomy insertion site and the tubing was not secured to the resident's body. The facility was unable to provide documentation that any nephrostomy care was added to Resident #459's care plan or treatment record or had been ordered by a physician during their initial admission to the facility. During an interview on 03/20/2025 at 11:32 AM Physician #2 stated that Resident #459 did not have any orders for care of their nephrostomy tube during their first admission at the facility but there should have been orders to change the dressing every other day and to flush the tubing daily. When asked if failure to change the dressing and flush the tube daily could have led to the nephrostomy tube infection, Physician #2 stated they could not say for sure. During a telephone interview on 03/21/2025 at 12:48 PM The Medical Director stated the nephrostomy tube should have been secured to the resident's abdomen or it should have been secured with sutures. The Medical Director stated that hospital transfers are usually done by the physician assistant, and facility staff should verify if a resident's nephrostomy tube needed to be flushed, which would depend on if it was just changed or if there was tissue in the tubing that needed to be flushed out. The Medical Director stated these were things that the facility should know when accepting a resident. During an interview on 03/21/2025 at 2:50 PM, The Director of Nursing stated not all nephrostomy tubes require flushing, but there should have been a conversation regarding the expectations for the management of the nephrostomy tube when the report was given. When Resident #459 was admitted , there were no directions on what to do with the nephrostomy tube and the admitting nurse should have asked the provider for orders for care of the tube, including flushing and dressing changes to prevent infection. The facility policy Care of Nephrostomy Tube, reviewed January 2025, documented that during assessments, the staff should check placement of the nephrostomy tubing, monitor for kinks and integrity of the tape, and ensure the drainage bag is below the level of the kidneys. Physician's orders were needed to change the dressing and/or for irrigation (flushing of the nephrostomy tube). Additionally, staff should report any signs of infection, reduced urine output, or inability to irrigate the tube to a physician. 10 NYCRR 415.12

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	335082	A. Building B. Wing	05/09/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observation, interviews and record review conducted during the Extended Recertification Survey and complaint investigation (NY00372404) from 03/09/2025 to 05/09/2025, the facility did not ensure that a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing for one (1) (Resident #158) of six (6) residents reviewed. Specifically, Resident #158 was identified by staff to have skin breakdown to their buttocks on 03/14/2025. There was no documented evidence that a medical provider was notified, or treatments initiated, until three days later. This resulted in actual harm to Resident #158 that was not Immediate Jeopardy. The finding includes: The facility policy Prevention of Pressure Ulcers/Injuries dated January 2025, documented for staff to inspect the skin on a daily basis when performing or assisting with personal care or activities of daily living. Identify any signs of developing pressure injuries; inspect pressure points (sacrum, heels, buttocks etc.); wash the skin after any episodes of incontinence; reposition resident as indicated on care plan; evaluate, report and document potential changes in the skin. Resident #158 had diagnoses that included encephalopathy (impaired brain function), diabetes (high blood sugar levels), and dementia. The Minimum Data Set (a resident assessment tool) dated 03/01/2025 documented Resident #158 had severe cognitive impairment, was incontinent of bowel and bladder, was at risk for the development of pressure ulcers, and had no current pressure ulcers. The current comprehensive care plan, last revised 09/30/2024, documented Resident #158 was at risk for pressure ulcers related to incontinence. Interventions included to minimize extended exposure of skin to moisture by providing frequent incontinence care and prompt removal of wet/damp clothing or sheets as needed, and to monitor, document and report changes in skin status to a medical provider. During observations on 03/09/2025 at 12:52 PM, Resident #158 was wearing sweatpants that were wet throughout the groin area almost down to the knees with a foul odor of urine. At 1:27 PM, 2:27 PM, and 4:20 PM, Resident #158's sweatpants remained unchanged. During an observation on 03/17/2025 at 10:14 AM, Resident #158 was in bed with their incontinence brief visible and partially pulled down from the hip. The sheet under the resident was wet, with yellow/brown discoloration and a strong odor of urine was present. During an observation and interview on 03/17/2025 at 10:51 AM, Certified Nursing Assistant #2 and Certified Nursing Assistant #8 were providing incontinence care to Resident #158, who was slightly rolled on their side. The resident's incontinence brief was heavily saturated with urine and the resident had an open area on the left buttock that was an approximately 1.5 centimeters circle. In an immediate interview, Certified Nursing Assistant #2 stated that the open area was seen on 03/14/2025 when they were assisting another Certified Nursing Assistant with care. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the March 2025 Medication and Treatment Administration Records revealed no documentation that any treatments for the skin impairment had been initiated until 03/17/2025. Review of a Weekly Skin assessment dated [DATE] and signed by the Director of Nursing revealed no documentation of any skin impairment to Resident #158's buttock area. Review of Resident #158's interdisciplinary progress notes and the 03/14/2025 to 03/17/2025 24-hour nurse report sheets at 11:17 AM revealed no documentation of any skin impairment to Resident #158's buttock area. In a medical progress note dated 03/17/2025 at 2:57 PM, Nurse Practitioner #1 documented they were asked to see Resident #158 for an open area on their buttocks. Nurse Practitioner #1 documented the resident had two (2) stage two (2) pressure ulcers, one to their coccyx (at the base of the spine) and one to their ischium (lower back of the hip bone). During an interview on 03/17/2025 at 11:56 AM, Certified Nursing Assistant #8 stated they last cared for Resident #158 on Friday night to day (03/14/2025) and had noticed a reddened area to the resident's buttock but could not remember if the area was opened. Certified Nursing Assistant #8 stated they did tell the nurse about the reddened area but were unable to recall which nurse because they were new to the facility. During an interview on 03/17/2025 at 1:12 PM, Licensed Practical Nurse #5 stated they saw Resident #158 had some skin breakdown on their left buttock earlier that same day (03/17/2025) and there was no treatment ordered for it, but they would contact their supervisor. Licensed Practical Nurse #5 stated they had not been made aware prior to 03/17/2025 that Resident #158 had any skin breakdown. During an interview on 03/17/2025 at 1:53 PM, Certified Nursing Assistant #2 said they were assisting with care for Resident #158 on Friday morning (03/14/2025) with Certified Nursing Assistant #16, who told them that there was an open area on the resident's bottom and to go notify the nurse, which they did. During a phone interview on 03/19/2025 at 10:54 AM, Certified Nursing Assistant #16 stated they had provided care to Resident #158 on 03/14/2025 and the resident did have several open areas on their buttocks that were red and bleeding. Certified Nursing Assistant #16 stated they had notified Licensed Practical Nurse #2, who gave them a cream to apply to the resident's buttocks. Several attempts to contact and interview Licensed Practical Nurse #2 were unsuccessful. During an interview on 03/20/2025 at 3:19 PM, Licensed Practical Nurse Manager #1 stated they had worked on 03/14/2025 and had not been made aware that Resident #158 had any open areas on their sacrum/buttocks area. Licensed Practical Nurse Manager #1 said staff should have informed them of any new open wounds. During an interview on 03/21/22025 at 2:48 PM, the Director of Nursing stated if skin breakdown was identified by staff, they should notify the nurse assigned to the resident and the assigned nurse should let the nurse manager know. The Director of Nursing was not aware of the breakdown. 10 NYCRR 415.12 (c)(2)

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	335082	A. Building B. Wing	05/09/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33313 Based on observations, interviews, and record review conducted during an Extended Recertification Survey from 03/09/2025 to 05/09/2025, the facility failed to ensure that the residents' environment remained as free of accident hazards as possible, and that each resident received adequate supervision and assistive devices to prevent accidents for five (5) (Residents #4, #11, #83, #461 and #508) of five (5) residents reviewed for accidents and five (5) (West One, [NAME] Two, North First Floor, North Two, and South Three) of seven (7) resident areas observed for accident hazards. Specifically, the facility failed to ensure the residents, who were on aspiration precautions (precautionary steps taken by the facility to prevent inhalation of food or drink into the lungs due to swallowing difficulties), received adequate supervision and/or assistance during meals. Additionally, Resident #461 was observed with the incorrect liquid consistency as ordered by the provider (to prevent choking). This resulted in a pattern of no actual harm that was Immediate Jeopardy and Substandard Quality of Care with the likelihood of serious harm, serious impairment, serious injury, or death to 33 residents identified at risk for aspiration precautions when eating. In addition, the heating surfaces of radiators in multiple residents' rooms exceeded 125 degrees Fahrenheit, creating a potential burn risk from accidental contact, as they were accessible to residents, including residents with wandering behavior. Findings include: Issue one (1) The facility's policy Aspiration Precautions, revised February 2022, documented that residents on aspiration precautions must be fed within the direct supervision of licensed personnel. The facility's policy Liquid Consistency, dated July 2021, documented that all meal and liquid preparations will be done in the kitchen. 1.Resident #461 had diagnoses that included gastro-esophageal reflux (a digestive disease of the stomach) and dysphagia (difficulty swallowing). The Minimum Data Set (a resident assessment tool) dated 03/04/2025 documented the resident had moderate impairment of cognitive function, had coughing and/or choking issues during meals or swallowing medications, and required supervision, touching assistance or cueing when eating. Physician orders dated 03/06/2025 documented a regular pureed texture diet with honey (thickened) consistency liquids, and aspiration precautions. The Comprehensive Care Plan and the Certified Nursing Assistant Kardex (care plan) both dated 03/06/2025 documented Resident #461 required supervision or touching assist while eating and was on aspiration precautions with small bites and no straws for all intakes and all meals. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During observations and interviews on 03/12/2025 at 9:22 AM, Resident #461 was in bed eating breakfast. The head of the bed was elevated, but the resident had become slouched down while eating. There were no facility staff in sight of the resident. Resident #461's breakfast tray contained a packet of thickened coffee that was unopened. The resident was drinking hot water from a coffee cup that was not thickened and was coughing. Resident #461 stated that the coffee tasted terrible and, damn, I keep coughing. The resident then drank some milk and again started coughing, and staff were immediately notified. In an immediate interview, Licensed Practical Nurse #1 stated the liquid in the coffee cup was not thickened and added the packet of coffee thickener to the hot water. Licensed Practical Nurse #1 stated that they were from an agency and did not know any of the residents on the unit. During an interview on 03/12/2025 at 9:43 AM, Licensed Practical Nurse Manager #2 on [NAME] Two Unit stated they did not know how many residents on the unit were on aspiration precautions and would have to check with the therapy department to know what level of assistance Resident #461 required for meals. Licensed Practical Nurse Manager #2 stated they were not sure why no one was monitoring Resident #461 during their meal or why no one added the thickened coffee packet to the liquid. During an interview on 03/12/2025 at 11:43 AM, Food Service Director #1 stated regular consistency coffee and hot chocolate are sent to the residents with a packet of thickener and nursing staff were responsible to thicken it for the resident. 2. Resident #11 had diagnoses that included pneumonia, dementia, and dysphagia. The Minimum Data Set, dated dated dated [DATE] documented the resident had moderate impairment of cognitive function and required supervision or touching assist for eating. The current Certified Nursing Assistant Kardex reviewed on 03/12/2025 documented Resident #11 was on aspiration precautions, required supervision while eating, and to maintain an upright posture during meals and for 30-60 minutes after. In a medical progress note dated 12/16/2024, Nurse Practitioner #1 documented that Resident #11 had noted coughing and emesis (vomiting), was at high risk for aspiration, and would start on antibiotics for presumed aspiration pneumonia (respiratory infection caused by inhalation of food or drink into the lungs). A hospital discharge summary dated 12/20/2024 documented that Resident #11 was admitted to the hospital on 12/16/2024 due to respiratory distress and diagnosed with pneumonia most likely due to aspiration. Physician orders dated 02/27/2025 included aspiration precautions and a dysphagia mechanically altered Level 2 textured diet (a diet for individuals with difficulty swallowing requiring foods to be moist, soft-textured, and easily formed into a bolus). During observation of lunch on 03/11/2025 at 1:51 PM, Resident #11 was lying in bed, not sitting upright, with the bed elevated at approximately 45 degrees. Their lunch tray was on the bedside table and positioned over their abdomen. Resident #11 removed the cover from the lunch tray and began eating independently. There was no facility staff in the resident's room or in sight of the resident. In continuous observations between 1:51 PM to 2:18 PM, no staff were observed going into Resident #11's room. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 03/11/2025 at 2:18 PM, a staff member entered Resident #11's room to remove the lunch tray and told Resident #11 that they needed to sit up straight, but left without assisting the resident with positioning. During an observation on 03/12/2025 at 9:58 AM, a staff member entered Resident #11's room and delivered coffee and a bowl of oatmeal. Resident #11 was lying in bed and leaning to the right. The staff member left the room without repositioning the resident for eating. During an interview and observation on 03/12/2025 at 10:12 AM, Certified Nursing Assistant #2 stated Resident #11 was on a pureed diet, due to swallowing issues. They said supervision consisted of walking back and forth down the hallway, peeking in on the residents to see if they needed assistance, and that any resident on aspiration precautions should go to the dining room to be fed. They stated Resident #11 was on aspiration precautions but sometimes refused to get out of bed and should have a staff member present in their room for meals, but they did not always have enough staff. In an immediate observation, Resident #11 remained in bed with the head of bed elevated at approximately 45 degrees and the resident was leaning to the right, eating oatmeal. There was no staff in the room. Certified Nursing Assistant #2 stated someone should be in with the resident while they eat but they did not have enough staff on the unit that day. 3.Resident #4 had diagnoses that included dementia, right hemiplegia (paralysis on one side of the body) and dysphagia. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe impairment of cognitive function. No swallowing disorders were documented. Current Physician orders dated 06/28/2024 documented orders for a regular pureed diet with nectar thickened liquids, and aspiration precaution. Review of Resident #4's Certified Nursing Assistant Kardex revealed the resident required supervision or touching assist with eating, was on aspiration precautions, and to keep the head of bed upright at 90 degrees during meals. Cues for slow pacing included half-teaspoon bites and alternating drinks every one to three bites. If coughing, cue the resident to take deep breaths to allow cough to clear. During an observation on 03/12/2025 at 9:32 AM, Resident #4's breakfast tray was delivered to their room and Certified Nursing Assistant #3 raised the head of the bed to approximately 70 degrees, with the resident positioned on their left side and the bedside table placed over the bed. Certified Nursing Assistant #3 set up the breakfast tray and left the room. Resident #4 fed themselves hot cereal and large gulps of apple juice from the original container. There were no staff in the room or in sight of the resident the entire time the resident was feeding themselves. During an observation and interview on 03/12/2025 at 9:53 AM, Certified Nursing Assistant #1 stated it was normal for Resident #4 to eat breakfast in bed and they were unsure if the resident was on aspiration precautions or not and would have to look it up. After review of Resident #4's electronic medical record they said the resident was on aspiration precautions and should be in a common area for meals so they could be supervised. In an immediate observation, Certified Nurse Aide #1 stated the resident should be on their back and positioned up higher in bed. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/14/2025 at 1:09 PM Licensed Practical Nurse #3 stated the resident was on aspiration precautions and staff should follow Speech Language Pathology recommendations on the care plan including sitting upright and monitor for coughing or signs of choking. 4. Resident #83 had diagnoses that included dysphagia, pneumonia, and anoxic brain injury (loss of oxygen to the brain resulting in mental status changes). The Minimum Data Set, dated dated dated [DATE] documented the resident had severe impairment of cognitive function. Current physician orders dated as revised 08/07/2024 documented Resident #83 required a mechanically altered dysphagia diet and was on aspiration precautions. Review of Resident #83's current Certified Nursing Assistant Kardex on 03/11/2025 revealed the resident was dependent on staff for eating, on a ground diet, on aspiration precautions, and should remain upright for meals and 30-60 minutes after. During observations on 03/12/2025 at 9:47 AM, Resident #83 was in bed with the head elevated approximately 45 degrees and their breakfast tray on the bedside table and not within reach. There were no staff in the resident's room and the resident's call bell was on the floor. A container of orange juice was on the bedside table and was within reach of the resident, who picked it up and began drinking independently. No staff were observed in sight of the resident. During observations and interviews on 03/12/2025 at 10:16 AM, Certified Nursing Assistant #1 said Resident #83 was dependent with meals, which required them (staff) to do everything for the resident and was on aspiration precautions. They said Resident #83 did not want their breakfast when asked earlier. 5. Resident #508 had diagnoses including a subdural hemorrhage (collection of blood between the brain and the inner layer of the skull) and dysphagia. The Minimum Data Set, dated dated dated [DATE] documented the resident was cognitively intact and had issues with coughing or choking during meals or when swallowing pills. Physician orders dated 02/25/2025 included a dysphagia mechanically altered level 2 textured diet, honey (thickened) consistency and aspiration precautions. The Comprehensive Care Plan dated 02/14/2025 documented Resident #508 was on aspiration precautions for all meals, a pureed diet with honey-thick liquids, encourage small bites, slow pacing, and a liquid rinse with swallowing. During an observation on 03/14/2025 at 12:59 PM, Resident #508 was in their room eating lunch independently. There were no staff in sight. The resident was drinking juice. Half a bowl of carrots and half a sandwich had been consumed. The meal ticket included Resident #508 was on aspiration precautions. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/12/2025 at 9:45 AM, Speech Therapist #1 stated when a resident requires supervision while eating or touching assistance, staff need to be in the vicinity of the resident. Residents on aspiration precautions have a higher risk of aspirating on thin liquids and if residents were eating in their room, staff should be in there also. During an interview on 03/12/2025 at 11:28 AM, the Director of Nursing stated aspiration precautions are to protect residents that have difficulty with swallowing so they do not choke and they should have staff in the room (to supervise). The thickened liquids should be prepared by the kitchen and dietary staff. During an interview on 03/13/25 at 11:38 AM, the Medical Director stated residents on aspiration precautions should have therapy recommendations followed and be supervised. The risks include choking, aspiration and death. On 03/12/2025, the survey team identified and declared Immediate Jeopardy and the facility Administrator was notified at 5:00 PM. On 03/18/2025 at 4:05 PM, the survey team declared Immediate Jeopardy was removed effective 03/17/2025 at 2:00 PM, based on the following corrective actions taken by the facility: 1. Review of the 33 residents identified to be on aspiration precautions, medical records, physician orders and care plans. 2. 100% of nursing, dietary and therapy staff, unit clerks, and resident assistants were educated on aspiration precautions, checking meal tickets against tray contents, how to properly supervise and assist residents on aspiration precautions, and the correct procedure for feeding and recognizing signs of aspiration. Post-tests were completed and reviewed. Interviews with several staff members on multiple units revealed appropriate knowledge of aspiration precautions. 3. The Director of Dietary (or designee) was observed reviewing meal tickets during tray preparation, and licensed staff were observed verifying the meal tickets against meal trays for accuracy prior to passing. 4. Review of lunch trays on several units revealed the correct food item consistencies, and interviews with staff revealed appropriate knowledge of the process. 4. Unit binders containing lists of residents on aspiration precautions and guidance on diet consistencies were reviewed. 5. Kitchen/dietary staff were observed preparing thickened liquids before meal trays left the kitchen. 6. The facility's Aspiration policy was reviewed. 7. Trays of residents on aspiration precautions were observed arriving separate from other trays (per the facility's removal plan) and a text-blast informing staff of the new process was sent to 100% of nursing and dietary staff. Interviews with several staff members on multiple units verified appropriate knowledge of the new process. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8. Observations of staff supervising and assisting residents on aspiration precautions with meals. Issue two (2) The heating surfaces of radiators in multiple residents' rooms exceeded 125 degrees Fahrenheit, creating a potential burn risk from accidental contact, and were accessible to residents, including residents with known wandering behaviors. On 03/09/2025 at 11:47 AM, the surveyor verified that the 'Extech Instruments' model 39272 digital thermometer was accurate using the ice-point method and read 32.6 degrees Fahrenheit in a cup of ice water. Observations on 03/09/2025 at 11:55 AM on the South Three Unit in room [ROOM NUMBER] included the surface of the metal grate cover on the top of the heating unit was hot to the touch. When measured by the surveyor using an 'Extech Instrument' model 39272 digital thermometer, the temperature of the metal grate cover was 135.5 degrees Fahrenheit. The resident bed closest to the window was two (2) feet directly adjacent to this heating surface. Observations on 03/09/2025 at 12:10 PM in the [NAME] Two Unit dining room included the surfaces of the metal grate covers for three (3) heaters were 155.7 degrees Fahrenheit, 139 degrees Fahrenheit and 126.7 degrees Fahrenheit, using an 'Extech Instruments' model 39272 digital thermometer. The heaters were four (4) feet long by four inches wide and located approximately three to four (4) feet from adjacent tables with two (2) residents ambulating nearby. During an interview on 03/09/2025 at 3:37 PM, the Director of Maintenance stated that the heat for the [NAME] Two dining room was turned down and the steam heating throughout the facility is a difficult system. Observations on 03/10/2025 at 10:38 AM in the North Two Unit sunporch/resident lounge included the surface of the radiator cover was 149.3 degrees Fahrenheit using an 'Extech Instruments' model 39272 digital thermometer. The radiator was just above the floor level and Resident #149 was sitting in a chair approximately four feet from the radiator. Observations on 03/10/2025 at 12:32 PM in the [NAME] One Unit lounge at the end of the hall near Stairwell G1 included the surface of the two radiator covers were found to be 149.5 to 157.8 degrees Fahrenheit using an 'Extech Instruments' model 39272 digital thermometer. Observations on 03/10/2025 at 12:40 PM in the [NAME] Two Unit dining room included the surface of the heater was 157.8 degrees Fahrenheit using an 'Extech Instruments' model 39272 digital thermometer. There were two (2) residents in wheelchairs and another resident ambulating in the area nearby. Observations on 03/10/2025 at 12:40 PM in the [NAME] Two Unit dining room across from room [ROOM NUMBER] included the surface of the floor level heater was 153.5 degrees Fahrenheit, as measured using an 'Extech Instruments' model 39272 digital thermometer. Resident #140 was ambulating using the handrail directly in front of this heating surface at the time. During an interview on 03/10/2025 at 3:20 PM, the Director of Maintenance stated that they check the surface temperatures of the heaters but do not keep records and were not aware of any issues. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 03/10/2025 at 4:17 PM, the Administrator stated that after review of all incident and accident reports, there have not been any burns identified. Observations on 03/12/2025 at 8:46 AM on the North One Unit outside the activities room included the radiator cover was between 137.8 to 148.3 degrees Fahrenheit using a [NAME] digital infrared thermometer. Observations on 03/12/2025 from 9:12 AM to 9:18 AM in the [NAME] Two (2) Unit hallways included the radiator covers, using a [NAME] digital infrared thermometer, measured 127.6 to 144.1 degrees Fahrenheit near the nurse's station, resident rooms #204, #206, #212, #214, #216, and near the storage room. Each heating unit was just above floor level and approximately seven feet long by one foot high. Three (3) residents were seated outside room [ROOM NUMBER] near the radiators. During an interview on 03/18/2025 at 9:33 AM, Licensed Practical Nurse #10 stated most of the residents on [NAME] Two had wandering behaviors and wore wander guard bracelets (allows the residents to move around the unit independently). 10NYCRR: 415.12(h)(1), 415.29(a)(1), 10NYCRR: 713-1.3(h)(1) 38878 47641 50512 .

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F 0690 Level of Harm - Minimal harm or potential for actual harm 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. 33059 Based on observation, interviews and record review conducted during an Extended Recertification Survey and complaint investigation (#NY00374153) 03/09/2025 to 05/09/2025 the facility did not ensure a resident with an indwelling urinary catheter (a tube inserted into the bladder to drain urine) received the care and services to manage the catheter for one (1) (Resident #1) of two (2) residents reviewed. Specifically, there were no medical orders for routine care of the indwelling urinary catheter upon admission to the facility, there was no care plan related to presence of an indwelling urinary catheter, including goals and interventions for the catheter and the medical team was not notified when the urinary catheter was pulled out and unable to be reinserted. The findings include: The facility policy Foley (indwelling urinary catheter) Catheter Care dated January 2025 documented to provide catheter care every shift and as needed and to change only as needed unless otherwise ordered. Resident #1 had diagnoses including acute kidney injury, obstructive uropathy (flow of urine is obstructed), urogenital implants, urinary retention (the inability to void) and dementia. The Minimum Data Set (a resident assessment tool) dated 02/25/2025, documented the resident had severe impairment of cognitive function and had an indwelling urinary catheter. A Hospital Discharge Summary, dated 02/19/2025, documented the resident had a urinary catheter placed, had failed voiding trials and would need a urology follow up visit. Discharge instructions included to consider a voiding trial, and a catheter change was due 03/12/2025. Physician orders dated 02/19/2025 documented to change the urinary catheter monthly, starting 3/12/2025 and to schedule an appointment with urology. There was no documented evidence of physician orders for catheter care. The Comprehensive Care Plan dated 02/20/2025 did not include that Resident #1 had an indwelling urinary catheter. In a nursing progress note dated 02/19/2025 at 9:30 PM Licensed Practical Nurse Manager #3 documented the resident was found on the bathroom floor attempting to pull out their urinary catheter. In a nursing progress note dated 02/19/2025 at 9:36 PM PM Licensed Practical Nurse Manager #3 documented the resident was found with their urinary catheter pulled out at 8:45 PM, attempts to reinsert it were unsuccessful and the Supervisor was notified of the removal of the catheter by the resident. Review of the 24-hour report sheet (a tool to communicate important resident changes from shift to shift), dated 02/19/2025 revealed that on the evening shift Resident #1 had removed their urinary catheter, had refused replacement and the supervisor was notified. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In a nursing admission/readmission evaluation note dated 02/20/2025 Registered Nurse #1 documented Resident #1 was admitted to the facility recently and was incontinent of bladder. The note did not include that the resident had an indwelling urinary catheter when admitted . Review of medical progress notes dated 02/20/2025, 02/23/2025, 02/24/2025 and 02/26/2025 revealed the resident was seen and no acute issues identified. The progress notes did not include any issues related to Resident #1's urinary catheter or lack thereof. In a medical progress note dated 02/27/2025, Nurse Practitioner #1 documented that the resident was being seen for lethargy and abnormal lab (bloodwork) results and was being sent to the hospital for evaluation. During an interview on 03/10/2025 at 11:56 AM Licensed Practical Nurse Manager #1 stated catheter care should include changing the catheter as ordered, including size to use and catheter care every shift and documented on the Treatment Administration Record. Licensed Practical Nurse Manager #1 stated the resident was transferred to their unit without a catheter and on 02/27/2025 they reinserted a urinary catheter (as ordered by medical) without difficulty. During an interview on 03/10/2025 at 1:17 PM Nurse Practitioner #1 stated they saw Resident #1 due to abnormal lab values and lethargy. Nurse Practitioner #1 stated it was their first encounter with the resident who did not have an indwelling urinary catheter, so they ordered one and was present when a nurse inserted one without difficulty and obtained 700 cubic centimeters of yellow urine. During an interview on 03/10/2025 at approximately 2:00 PM Physician #1 stated they saw Resident #1 several times for falls and knew the resident had a urinary catheter when admitted and that there was an order to change it monthly. Physician #1 said catheter care should also have been ordered on admission. Physician #1 stated they were unaware the resident had pulled the catheter out on 02/19/2025 and should have been notified. During an interview on 03/10/2025 at 3:35 PM Licensed Practical Nurse Manager #2 stated Resident #1 had urinary catheter when they were admitted , and the resident was found with the catheter in their hand at approximately 8:00 PM (on day of admission). They stated they attempted to reinsert the catheter but was unable to as the resident was resistive. They notified the Registered Nurse Supervisor and documented it in the medical record and on the 24-hour report sheet. The following day the resident was transferred to another unit. Attempts to interview the Registered Nurse Supervisor were unsuccessful. When interviewed on 03/11/2025 at 10:47 A.M. the Director of Nursing stated the orders at the time of admission and the resident's care plan should have included the reason for the catheter and care of the catheter every shift. The Registered Nurse on duty should have notified the provider (when it was pulled out and unable to be reinserted). The Director of Nursing stated the 24-hour report sheets are reviewed at the morning meetings and the provider and nurse manager should have followed up. 10 NYCRR 415.12(d)(1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 38878 Based on observation, interviews, and record review, conducted during an Extended Recertification Survey from 03/09/2025 to 05/09/2025 the facility did not ensure that a resident who required dialysis received services consistent with professional standards of practice for one (1) (Resident #153) of three (3) residents reviewed. Specifically, there were no medical orders related to post dialysis (treatments to remove waste products and fluid from the blood when the kidneys fail to) and no documented evidence the resident's permcath (a catheter inserted into a vein to use for dialysis treatments) site was assessed for complications upon return to the facility after dialysis treatments. The findings include: The facility policy Central Venous Catheter Dressing Changes dated January 2023 documented the following should be recorded in the resident's medical record: location and objective description of insertion site, any complications and interventions that were done. Resident #153 had diagnoses that included chronic kidney disease, diabetes mellitus and morbid obesity. The Minimum Data Set (a resident assessment tool) dated 01/11/2025 documented Resident #153 was cognitively intact and received dialysis treatments. The resident's Comprehensive Care Plan dated 01/17/2024 documented Resident #153 was dependent on dialysis and was at risk for infection related to placement of a permcath. Interventions included to monitor, document and report to the medical doctor signs and symptoms of bleeding and/or infection (at the insertion site). Review of Physician orders dated as printed on 03/14/2025 revealed no orders related to dialysis treatments or monitoring Resident #153's permcath for complications. Review of the resident's electronic health record from 02/01/2025 to 03/14/2025 and the 24-Hour Report (nursing shift to shift report) sheets dated 02/13/2025 to 03/15/2025 revealed no documented evidence that Resident #153's permcath site had been assessed upon return to the facility following dialysis treatments. During an observation and interview on 03/11/2025 at 2:21 PM, Resident #153 was in bed and dressed with a dialysis permcath visible in their right upper chest, the dressing was dry and intact, and no bleeding or signs of infection noted. In an immediate interview, Resident #153 stated they have been here a little over a year and they go for dialysis treatments every Monday, Wednesday and Friday. Their port (permcath) was in their right chest and staff at the nursing home do not do anything for their permcath, stating they don't even look at it. During an interview on 03/18/2025 at 10:54 AM, Licensed Practical Nurse #3 stated they were somewhat familiar with Resident #153 who goes to dialysis Monday, Wednesday and Fridays. Licensed Practical Nurse #3 said after dialysis vital signs should be taken, the access site should be assessed for bleeding and/or infection and if present, the medical doctor should be called. They were unsure if there were any medical orders for post dialysis care. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/19/2025 at 12:30 PM, the Director of Nursing stated the dialysis communication sheet should be reviewed by the nurse on the unit following the resident's return, vital signs should be taken, and the access site should absolutely be assessed for any bleeding or signs of infection, no matter what type of access port there was. Additionally, there should be a medical order for dialysis care and the information should be documented. During an interview on 03/19/25 at 12:44 PM, Physician #2 stated they would expect a nurse to assess the resident post dialysis for post treatment hypotension (low blood pressure), vital signs should be taken, and the site should be assessed for bleeding and/or signs of infection and documented in the electronic health record. 10 NYCRR 415.12

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33313 Based on observations, interviews and record review conducted during the Extended Recertification Survey and complaint investigations (NY00372404, NY00372850, NY00364319, & NY00372698) from 03/09/2025 to 05/09/2025, the facility failed to ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for residents in the facility (Units South One, South 2, South 3, North One, North Two, [NAME] One and [NAME] Two). Specifically, there was insufficient staff to meet all resident needs including showers, assistance with eating, toileting, personal hygiene, and receiving medications as ordered by the medical team due to lack of licensed nurses and certified nursing assistants. On 04/23/2025 the survey team identified and declared Immediate Jeopardy. The facility's failure to provide adequate staff to provide activities of daily living care, adequate supervision to those on aspiration precautions, and administer medications results in the likelihood for serious injury, serious harm, serious impairment or death for all residents in the facility. The facility Administrator was notified at 4:40 PM. This is evidenced by, but not limited to the following: The facility policy Minimum Staffing dated January 2025, documented the facility would provide adequate staffing to meet the care and services for the resident population. Minimum staffing needs were identified for implementation in crisis situations, such as weather-related emergencies and staff illness outbreaks to ensure quality care of residents. The Staffing Associate would work collaboratively with the Director of Nursing, the Administrator and the evening and night supervisors to maintain appropriate staffing levels for their respective shifts by scheduling existing staff, per-diem staff, use of voluntary overtime, agency coverage and mandatory overtime to maintain daily staffing hours equal to 3.5 hours of care per resident per day, with at least 2.2 hours provided by a certified aide, and at least 1.1 hours by a licensed practical nurse or registered nurse. In the event the minimum could not be achieved there would be at least 1 nurse per 40 residents on day and evening shifts to deliver the appropriate care as needed and at least 1 nurse per 80 residents on the night shift. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F689 (Free of Accident Hazards/Supervision/Devices): For additional information see Centers for Medicare/Medicaid Services Form 2567, reference: F565 - Resident/Family Group Response: Review of facility Grievances/Complaints revealed filed grievances regarding care concerns including the lack of showers, not being assisted out of bed, and lack of staffing. Additionally, review of Resident Council Meeting Minutes revealed residents reported multiple care concerns including, but not limited to, not receiving showers regularly, call lights not answered timely, and medications not being administered due to lack of staffing. F677 - Activities of Daily Living Care for Dependent Residents: (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Several residents reported no showers for several weeks and were observed with unwashed hair, uncut nails and/or unshaven due to lack of staffing. F689 - Free of Accident Hazards/Supervision/Devices The facility failed to ensure that residents received adequate supervision during meals to prevent accidents for multiple residents that were on aspiration precautions. F760 - Residents are Free from Significant Medication Errors: Review of full-house Medication Administration Audit Reports revealed no documented evidence that 193 residents had received multiple medications on multiple days from 02/13/2025 to 02/17/2025 and 213 residents from 03/21/2025 to 03/30/2025 which was verified by facility staff interviews and record review. The Facility assessment dated [DATE], documented the facility was licensed for 229 beds with an average daily census of 215. The Facility Assessment referred to the emergency staffing policy for their emergency staffing plan. Nursing, nutrition services, and housekeeping staff would be evaluated at the beginning of each shift and adjusted as needed to meet the care needs and acuity of the resident population. There should be 3 Registered Nurses, 17 Licensed Practical Nurses, and 22 Certified Nursing Assistants per day. Based on the Payroll Based Journal Staffing Data report (facility reported staff worked by job title for a specific period) the facility had excessively low weekend staffing with a one-star staffing rating for fiscal year first quarter (October 1 - December 31, 2024). During the entrance conference on 03/09/2025 at 11:39 AM, the Administrator stated the facility census was 214 residents. Observations and interviews on 03/09/2025 on the South One Unit with a census of 38 included: -At 10:23 AM, Licensed Practical Nurse #12 stated they were the only nurse on the Unit with one Certified Nursing Assistant. -At 12:06 PM, Resident #111 stated there was no nursing staff the weekend of Valentine's Day (02/14/2025 through 02/16/2025) and sometimes there was just one (1) nurse and one (1) Certified Nursing Assistant. Resident #111 stated weekends were the worst and recently had to wait over 24 hours before the Certified Nursing Assistant, who was the only one on the unit, helped them get cleaned up when they had the stomach flu and soiled their bed. Observations and interviews on 03/09/2025 on South Two Unit included: -At 9:58 AM, the unit had strong, foul odors of urine. Licensed Practical Nurse #2 stated there was one (1) nurse and one (1) Certified Nursing Assistant for 37 residents. Certified Nursing Assistant #17 stated that they had been a Certified Nursing Assistant for less than a year and it was only their 3rd or 4th day working at the facility. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-At 12:52 PM, Resident #158 was wearing sweatpants that were wet throughout the groin area almost down to the knees with a foul odor of urine. At 1:27 PM, 2:27 PM, and 4:20 PM, Resident #158's sweatpants remained unchanged. -At 3:41 PM, a visitor came into the hall to request help for Resident #148, who had been incontinent. In an immediate observation, Resident #148 had a large amount of stool on their bottom, hip, hands, fingernails and their bed linens. The visitor stated that it had been weeks since Resident #148 had a shower, and that sometimes it took an hour and a half to find staff to help. -At 4:51 PM Licensed Practical Nurse Unit Manager #1 stated that they were supposed to have two (2) Certified Nursing Assistants but there were only the two (2) nurses (licensed) on the unit who were trying to round and give care to every resident. Observations and interviews on 03/09/2025 on South Three Unit with a census of 39 included: -At 10:06 AM, there was one (1) Licensed Practical Nurse, one (1) Certified Nursing Assistant and one (1) Certified Nursing Assistant on light duty (no lifting). -At 10:31 AM, Resident #71 stated the facility was short staffed all the time, most of the time there was only one (1) nurse for the whole floor and sometimes no nurse. Resident #71 stated sometimes they did not receive their medications or are not assisted with their meals. During an interview on 03/10/2025 at 11:39 AM, Resident #100 stated sometimes they have to wait up to three (3) hours for help and once staff had not come in all night (to provide care). Weekends were the worst. Observations and interviews on North One and North Two Units with a census of 39 included: -On 03/09/2025 at 10:00 AM, Licensed Practical Nurse #10 said they were the only nurse till 8:30 AM which happened a lot and no Certified Nursing Assistants. Review of nurse punches revealed a Certified Nursing Assistant punched in at 10:15 AM. (There were no Certified Nurse Assistants from 7:00AM - 10:15AM). -On 03/10/2025 at 8:11 AM, Resident #110 stated staffing was bad every day and once they laid in stool for over five (5) hours. In an observation and interview on 03/09/2025 at 10:40 AM , there was 1 Licensed Practical Nurse and 1 Certified Nursing Assistant for 31 residents on the [NAME] Two Unit. Registered Nurse Supervisor #3 stated they were assisting with passing medications on the unit in addition to being the Nursing Supervisor for the entire building. Review of the Daily Nursing Staff Punches revealed nursing staff clocked in and out at sporadic times during the shifts and included but is not limited to, the following: On 02/14/2025 with a facility census of 223 residents, -The day shift (7:00 AM to 3:00 PM) had 7 Certified Nursing Assistants (1:32 ratio) and 7 Licensed Nurses (1:32 ratio) who punched in at 8:00 AM. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-The evening shift (3:00 PM to 11:00 PM) had 4 Certified Nursing Assistants (1:56 ratio) and 6 Licensed Nurses (Licensed Practical Nurse and/or Registered Nurse) (1:37 ratio) at 5:00 PM. On 02/15/2025 with a census of 221 staffing included: -The day shift had 7 Licensed Nurses (1:32 ratio) at 9:00 AM -The evening shift had 7 Licensed Nurses (1:32 ratio) at 6:00 PM. -The night shift had 5 Certified Nursing Assistants (1:44 ratio) and 6 Licensed Nurses (1:37 ratio). On 02/16/2025 with a census of 220 staffing included: -The day shift had 5 Certified Nursing Assistants (1:44 ratio) and 3 Licensed Practical Nurses (1:73 ratio). The Director of Nursing came in at 11:54 AM. -The evening shift had 4 Licensed Practical Nurses and the Director of Nursing (1:44 ratio) and 8 Certified Nursing Assistants (1:28 ratio). -The night shift had 3 Certified Nursing Assistants (1:73 ratio) and 4 Licensed Nurses (1:44 ratio). On 02/17/2025 with an average daily census of 215 (actual staffing not available) staffing included: -The day shift had 7 Certified Nursing Assistants (1:31 ratio). -The night shift had 3 licensed nurses (1: 54 ratio). On 03/02/2025 with an average resident census of 215 the staffing included: -During the day and evening shifts there were 4 Licensed Practical Nurse (1: 54 ratio). -During the night shift, there were 2 Certified Nursing Assistants (1:108 ratio). -A Registered Nurse punched in for six (6) hours (versus the minimum of eight (8) consecutive hours per the regulation) for the entire day. During an interview on 03/10/2025 at 9:40 AM, Licensed Practical Nurse #2 stated that they did not have enough staff on 03/09/2025 day shift and that was the reason why residents were left wet for hours. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 03/13/2025 at 11:12 AM, Certified Nursing Assistant #4 stated they recalled working the weekend of 02/14/2025, and that they were the only Certified Nursing Assistant on the unit with one (1) nurse and approximately 40 residents. Certified Nursing Assistant #4 stated not much resident care was completed besides feeding the residents and each resident was changed or taken to the bathroom once. Residents who required two (2) staff and a mechanical lift for transfers did not get out of their bed. They said the nurse could not help them with resident care as they were trying to pass all the medications, and it was impossible to get to everyone. During an interview on 03/13/2025 at 11:13 AM, the Certified Nursing Assistant Staffing Coordinator stated that the facility was budgeted for four (4) Certified Nursing Assistants and two (2) nurses a shift for days and evenings, and two (2) Certified Nursing Assistants and one (1) nurse for night shift for each of the six (6) units. They were told for minimal staffing included two (2) Certified Nursing Assistants and one (1) nurse per unit. They said when at critical staffing levels residents could not get out of bed especially if they required two assist and showering residents would not happen unless a resident was covered in stool. The Certified Nursing Assistant Staff Coordinator stated staff complain daily about not having enough staff on the units to care for the residents. Residents and family members have complained there was not enough staff and their complaints were valid. The Certified Nursing Assistant Staffing Coordinator stated on 02/14/2025, the facility was at critical staffing levels, so the Director of Nursing worked on a unit and therapy staff stayed over to help pass meal trays and assist residents. There were times the facility had only six (6) to seven (7) staff total in the building for the night shift. During an interview on 03/13/2025 at 11:51 AM, Certified Nursing Assistant #5 stated they often worked by themselves with one (1) nurse on a unit (40 bed unit). They said when it was just them and a nurse it was impossible to get to all the residents and they would have to pick who needed the most care. For a resident who required two (2) staff assist they would have to care for them on their own. During an interview on 03/13/2025 at 12:00 PM, the Director of Nursing stated their minimum staffing level was one (1) licensed nurse and one (1) Certified Nursing Assistant for 40 residents, but they would then try to infuse other resources including therapy staff. The Director of Nursing stated one (1) nurse passing medications to 40 residents would need help to finish. They said on the weekend of 02/14/2025 through 02/16/2025 they were aware of numerous staff calling in sick as it was Valentine's Day weekend and there was a snowstorm. The facility offered bonuses to staff to come in, and they and the Assistant Directors of Nursing came in and helped wherever they could. The Director of Nursing said more than 20 residents did not receive their medications because there was not enough nursing staff to give them. The Director of Nursing stated that they were aware of the concerns regarding one (1) nurse for 40 residents, but it is within our guidelines. In an telephone interview on 03/13/2025 at 6:04 PM, a family member stated that they were upset that the hospital wanted to transfer Resident #459 back to the facility and they felt the facility did not have the staff to take care of the resident who needed a lot of assistance with care and required special medications for an organ transplant and a nephrostomy tube (tube inserted directly into the kidney through the skin to drain urine). Recently the resident had been left sitting in stool and they could not find any staff to help. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 03/16/2025 at 6:05 AM, Licensed Practical Nurse #14 stated that there were night shifts where there were only one (1) to three (3) nurses in the entire building. Sometimes it was just them and one (1) Certified Nursing Assistant, and they could not get to all of the residents for care. They have begged the facility for help. During an interview on 03/20/2025 at 10:03 AM Licensed Practical Nurse Unit Manager #1 stated they did not have time to do their job as they were always administering medications. During an interview on 03/21/2025 at 12:48 PM, the Medical Director stated that it was a well-known issue that residents did not receive their medications timely or at all and that it was likely due to lack of staffing. The Medical Director stated if residents did not get their hypertensive medications they could and have a heart attack, have a stroke, kidney damage or death. Without pain medication a resident could be in extreme pain, be agitated or have a stroke. Without their antiseizure medication residents could have a seizure and die. If a resident did not get their antirejection medication for day it could lead to rejection of the kidney. In a follow up interview on 03/21/2025 at 2:50 PM and at 6:31 PM, the Director of Nursing stated one (1) Certified Nursing Assistant for 40 resident was a lot, and if staff could not get to all the residents for care, they should say something. They are working on the staffing challenges and trying to hire more staff. During an interview on 03/21/2025 at 6:31 PM, the Administrator stated they were aware of issues with nurse staffing and have hired more agency nursing staff and an in-house recruiter. In a follow up interview on 03/31/2025 at 3:28 PM, the Director of Nursing stated they have worked on the medication carts to ensure medications were passed but this does impact their Director of Nursing duties. After reviewing nursing staff punches (hours worked) the Director of Nursing stated that the punches were not always accurate. Agency staff are supposed to know how to punch in and out but it was difficult to prove how many staff were in the building during a shift. The Director of Nursing stated low nurse staffing numbers could be why so many residents did not receive their medications. On 04/25/2025 at 12:05 PM the survey team declared that the IJ was removed based on the following corrective actions taken by the facility: -The Facility Assessment, dated 04/14/2025, included that staffing would be evaluated and adjusted as needed at the beginning of each shift to meet needs and acuity of the resident population, and was updated to reflect the temporary closing of a resident unit (which housed 19 residents) to help meet the facility's staffing needs. -Review of the Daily Census Report, dated 04/25/2025, revealed the North Two (2) unit (23 beds total) was empty. The unit closure was also confirmed when observed on-site. -The facility policy and procedure, Staffing Minimum, dated January 2025 included details for minimum and emergency staffing and if staffing levels fell below minimum, the Director of Nursing and Administrator would be contacted for direction. (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-Review of training records revealed 29 staff signatures including department heads, ancillary staff, and nursing supervisors had received education related to the facility's emergency staffing plan. An attestation, signed by the Administrator and dated 04/25/25, included 100% of all facility departments heads, nursing supervisors and ancillary staff would receive education prior to the start of their next scheduled shift. -Interviews with the staffing coordinator, nursing supervisors, nurse managers and the Minimum Data Set Coordinator verified receipt of the above education. -A New Hire Report from 04/01/2025 to 04/24/2025, included 27 new hires: 15 certified nursing assistants, 10 licensed practical nurses, 1 licensed practical nurse unit manager, 1 registered nurse admissions nurse. -The facility provided three staffing agency agreements signed between February 2025 and April 2025. -Interview with the Administrator revealed the facility had events planned to increase staff morale and retention and were set to begin in early May 2025. -Resident census and staffing numbers (certified nursing assistants, licensed nurses) for each residential unit were verified while on-site and deemed appropriate to meet the care needs of the current resident population. 10 NYCRR 415.13 (a)(1)(i-iii) 47641

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during the Extended Recertification Survey and complaint investigations (NY00372404, NY00372850, NY00371489, and NY00372698) from 03/09/2025 to 05/09/2025, for four (4) (Residents #3, #32, #111, #459) of nine (9) residents reviewed, the facility failed to ensure that residents were free of significant medication errors. Specifically, there was no documented evidence that the residents received multiple significant medications over the course of several days including but not limited to insulin, antihypertensives (used to treat high blood pressure), antiplatelets (used to prevent blood platelets from forming clots), antidepressants, antipsychotics, antibiotics, antirejection medication (used for kidney transplants) and a medication used to treat kidney disease in dialysis patients. Additionally, review of full-house Medication Administration Audit Reports revealed no documented evidence that 193 residents had received multiple medications on multiple days from 02/13/2025 to 02/17/2025 and 213 residents from 03/21/2025 to 03/30/2025 which was verified by staff interviews and record review. These issues resulted in the likelihood of serious injury, serious harm, or death for all the residents in the facility (census 207) that was Immediate Jeopardy and substandard quality of care. The findings include: Review of the facility policy Administering Medications, dated January 2025, included medications must be administered in accordance with the orders, including required timeframe, and must be administered within one (1) hour of their prescribed time. The individual administering the medication will record in the resident's medical record the date and time the medication was administered and the signature and title of the person administering the drug. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall document same in the eMAR (electronic Medication Administration Record) for that drug and dose. The person withholding, receiving the refusal, or administering medication at a different time will notify the attending/covering physician. 1. Resident #459 was a recent readmission with diagnoses including chronic kidney disease, history of a kidney transplant, and recent pyelonephritis (kidney infection). The Minimum Data Set (a resident assessment tool) dated 02/03/2025 documented the resident had severe impairment of cognitive function. Physician orders dated 01/27/2025 included prednisone once daily for organ transplant/prevent rejection, nifedipine extended release daily for high blood pressure and cyclosporine modified once daily for hydronephrosis (enlarged kidney) of a kidney transplant and pyelonephritis. Review of the January 2025 Medication Administration Record revealed the prednisone, nifedipine extended release, and cyclosporine modified had not been administered for the entire day due to other/see nurses note. In a medication administration note dated 01/28/2025 Licensed Practical Nurse Manager #3 documented the prednisone, nifedipine extended release, and cyclosporine were not administered as they had not arrived from the pharmacy. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	There was no documented evidence the physician was notified that the medications had not been administered. Review of the February 2025 Medication Administration Record revealed the cyclosporine modified was documented as not administered on 02/03/2025 due to the resident being out of the facility. There was no documented evidence in the resident's medical record that the resident was out of the facility on 02/03/2025. Resident #459 was transferred to the hospital on 02/10/2025. In a nursing progress note dated 03/06/2025 Licensed Practical Nurse #2 documented Resident #459 returned from the hospital at 1:45 PM. Physician orders dated 03/06/2025 following readmission from the hospital included cyclosporine modified twice daily for kidney transplant. In a Medication Administration Note dated 03/06/2025 at 9:51 PM Licensed Practical Nurse #2 documented cyclosporine modified was not administered as the medication was not in. There was no documented evidence the physician was notified of the missed dose. In a telephone interview on 03/13/2025 at 6:04 PM Resident #459's family stated that they found out that Resident #459 (who had been readmitted to the hospital on 03/11/2025) had not been receiving their medications consistently because sometimes there were not enough nurses to administer them including their daily antirejection medication that they needed because the resident had a kidney transplant. Physician orders dated 03/14/2025 following readmission from the hospital included cyclosporine twice daily for kidney transplant. Review of the Medication Administration Record dated 03/14/2025 (evening shift) and 03/15/2025 (day shift) revealed the cyclosporine had been documented as not administered due to the order had not been placed in the electronic medical record yet. During an interview on 03/20/2025 at 11:53 AM Physician #2 stated Resident #459 should not miss any medications and that sometimes there is not a provider in house, but the nurses should know how to put all the orders in the electronic medical record. Review of a hospital After Visit Summary (discharge orders) dated 03/21/2025 following readmission to the facility revealed orders for cyclosporine to be given twice daily. Physician orders following readmitted d 03/21/2025 included cyclosporine modified three (3) times a day signed by Physician #2 . Review of the March 2025 Medication Administration Record revealed the cyclosporine modified was administered three (3) times daily from 03/22/2025 to 03/31/2025. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 03/31/2025 at 10:02 AM Licensed Practical Nurse Manager #1 stated when a resident returned from the hospital, nursing reviews the hospital After Visit Summary and puts the orders in the computer which the providers then review and sign off on them. Licensed Practical Nurse Manager #1 stated the cyclosporine being given three times a day was probably due to a typo when the orders were originally put in, that they had most likely been very busy and got called away from the desk. During an interview on 03/31/2025 at 10:14 AM Nurse Practitioner #1 stated that when a resident gets admitted from the hospital the nurses should input the orders into the computer based on the After Visit Summary and then the provider verifies the orders and signs them. Nurse Practitioner #1 stated that the cyclosporine should not have been given three times daily as the After Visit Summary and the discharge summary both documented cyclosporine to be given twice daily and that receiving the medication three times daily could cause hypertension, leukopenia (low white blood cells), or toxicity along with other adverse effects. Nurse Practitioner #1 did not know why the order was put in incorrectly and stated that the providers should be double checking the orders with the After Visit Summary as that would be part of the process for verifying them. During an interview on 03/31/2025 at 3:28 PM the Director of Nursing stated that when a resident gets admitted from a hospital the nurse putting in the orders should have compared the After Visit Summary to what they put in the computer then a provider should compare the orders prior to signing off on them. The Director of Nursing stated they did not know how the cyclosporine got ordered and administered to Resident #459 incorrectly. 2.Resident #32 had diagnoses including End Stage Renal Disease requiring hemodialysis (treatment that removes waste products from the blood when the kidneys fail to), bipolar disorder (mental health condition), diabetes mellitus, and high blood pressure. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact and took high risk medications such as an antipsychotic, antianxiety, antidepressant, and antiplatelet. Review of physician orders dated 01/17/2025 revealed venlafaxine twice daily for depression, quetiapine daily for bipolar disorder, metoprolol twice daily and hydralazine three times daily for high blood pressure, Plavix daily for coronary artery disease, insulin glargine daily for diabetes mellitus, hydroxyzine twice daily for itching and anxiety, and sevelamer daily with meals for kidney disease. In a medical progress note dated 02/17/2025 Physician #1 documented that Resident #32 missed several medications on 02/15/2025. In a nursing progress note dated 02/17/2025 the Director of Nursing documented that Resident #32 did not receive medications on 02/16/2025. Review of Resident #32's February 2025 Medication Administration Record revealed no documented evidence that the following medications had been administered (as indicated by a blank box) and included but not limited to: a. On 02/15/2025 during the evening shift: sevelamer, hydroxyzine, venlafaxine, quetiapine, metoprolol and hydralazine. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	b. On 02/16/2025 during the day shift: sevelamer (8:00 AM and 12:00 PM doses), hydroxyzine, venlafaxine, metoprolol, hydralazine (8:00 AM and 2:00 PM doses), insulin glargine, and Plavix. 3.Resident #111 had diagnoses including diabetes mellitus, bipolar disorder, and high blood pressure. The Minimum Data Set, dated dated dated [DATE], included the resident was cognitively intact and took high risk medications such as insulin, antipsychotic, antidepressant, and anticonvulsant. Current Physician orders reviewed on 03/12/2025 included insulin lispro routine dose and sliding scale before meals for diabetes, insulin glargine daily for diabetes, venlafaxine daily for depression, aripiprazole daily for bipolar disorder with depression, and lisinopril daily for high blood pressure. Review of Resident #111's February 2025 Medication Administration Record revealed no documented evidence that the following medications had been administered (as indicated by a blank box) and included but not limited to: a. On 02/15/2025 during the day shift: insulin glargine b. On 02/16/2025 during the day shift: insulin lispro (7:30 AM and 11:30 AM doses), venlafaxine, aripiprazole, and lisinopril Review of interdisciplinary progress notes from 02/15/2025 to 02/20/2025 did not include any documentation as to why the medications had not been administered or if the medical team had been notified. During an interview on 03/09/2025 at 12:07 PM, Resident #111 stated there had been little to no staff on the weekend of February 15th. They were diabetic, had gone more than 12 hours without receiving their insulin and were supposed to have blood glucose levels checked and receive insulin three (3) times daily before each meal. 4.Resident #3 had diagnoses including urinary tract infection, multiple sclerosis (a debilitating disease of the nervous system), and depression. The Minimum Data Set, dated dated dated [DATE], included the resident was cognitively intact. Review of physician orders dated 02/14/2025 revealed cephalexin (antibiotic) three (3) times daily for 14 days for a urinary tract infection, baclofen three (3) times daily for muscle spasms and escitalopram daily for depression. In a nursing progress note dated 02/16/2025 the Director of Nursing documented that on 02/15/2025 and 02/16/2025 Resident #3 did not receive some of their medications. Review of Resident #3's February 2025 Medication Administration Record revealed no documented evidence that the following medications had been administered (as indicated by a blank box) and included but not limited to: a. On 02/14/2025 during the evening shift: cephalexin (2:00 PM and 7:00 PM doses) b. On 02/15/2025 during the evening shift: cephalexin and baclofen (5:00 PM and 9:00 PM doses). (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 B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	c. On 02/16/2025 during the day shift: cephalexin (9:00 AM and 2:00 PM), baclofen and escitalopram. Additionally, review of a full-house Medication Administration Audit Report revealed no documented evidence that 193 residents had received multiple medications on multiple days from 02/13/2025 to 02/17/2025. During an interview on 03/13/2025 at 11:38 AM the Medical Director stated they were unaware that medications had not been administered to several residents and would expect there were enough nurses scheduled in the facility, so all medications were administered. In a follow up interview on 03/21/2025 at 12:48 PM, the Medical Director stated they were made aware that some residents did not receive medications on time or at all, likely due to lack of staffing. The Medical Director stated all medications prescribed by a provider would be considered significant, a resident not receiving medications was unacceptable and it was never okay for a skilled nursing facility resident to not get their medications. The Medical Director stated missing an antirejection medication for a kidney transplant would set the resident up for rejection of that kidney, even if it was an old transplant and the resident would need lifelong immunosuppressant medication. During an interview on 03/21/2025 at 6:30 PM, the Administrator stated they and the Quality Assurance Committee were aware that many residents did not have significant medications administered . They stated the Director of Nursing should be checking medication administration reports every shift. In a follow up visit on 03/31/2025, review of the March 2025 Medication Administration Audit Report revealed no documented evidence that 213 residents had received multiple medications on multiple days from 03/21/2025 to 03/30/2025 which was verified by staff interviews and record review. During an interview on 03/31/2025 at 1:20 PM the Administrator stated when a resident gets admitted from the hospital the physician should be comparing the orders to the hospital discharge summary. The Administrator said there should be no reason why any residents were missing medications within the last 10 days as they have had at least one (1) nurse on every floor during every shift. During an interview on 03/31/2025 at 3:28 PM the Director of Nursing stated the goal was to audit the Medication Administration Reports after every shift but when the nursing supervisor is on a medication cart, we have to take people at their word that they are doing it. The Director of Nursing stated when they review the weekend audits on Monday morning, I do not know why I see whole floors that did not get their medications when we had nurses assigned. On 04/01/2025 the survey team identified and declared Immediate Jeopardy. The facility Administrator was notified at 11:19 AM. On 04/01/2025 at 5:30 PM the survey team declared Immediate Jeopardy was removed based on the following corrective actions taken by the facility: -The medical team was notified of all residents who had medication errors (missed medications) since 03/21/2025, medical assessments were in process and daily vital signs were initiated and will be ongoing for the next 48 hours. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	-100% of all onsite day and evening shift licensed nursing staff education was completed and included: the facility's policies Administering Medications and Adverse Consequences and Medication Errors, the missed medication daily review process and proper communication of staffing emergencies related to coverage. - Interviews with 14 licensed nurses onsite (100%) were completed to verify the above education including the evening nurse supervisor. An attestation that 100% of all facility licensed nurses including agency nurses would be educated prior to their next shift. - A daily facility wide Medication Administration Audit Report for every shift for any missed or omitted medications will be conducted by the Nursing Supervisor or the Director of Nursing (or designee). Review of the audit report for past 24 hours was done by survey team and no additional significant medication errors identified. -Interviews with facility Administrator, Director of Nursing and Corporate Director of Nursing were completed regarding a root cause analysis of significant medication errors as related to staffing issues and plans initiated to prevent ongoing issues including closing one resident unit down as soon as possible and increased agency presence in the facility as needed (verified with current staff onsite). 10 NYCRR 415.12(m)(2)

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	335082	A. Building B. Wing	05/09/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33313 Based on observations, interviews, and record reviews conducted during the Extended Recertification Survey and complaint investigation (NY00372850) from 03/09/2025 to 05/09/2025, the facility did not ensure that all drugs and biologicals in the facility were properly stored in accordance with State and Federal laws for three (3) (North One, North Two and South One) of seven (7) resident care units. Specifically, 218 blister packs (a type of packaging for some medications) of resident specific prescription medications were left on a counter and in unlocked cabinets behind the North One nurses' station; a five (5) drawer medication/treatment cart containing dozens of topical prescription medications was unlocked on the North Two hallway; a medication room was unlocked with multiple blister packs of residents' prescription medications sitting on the counter; the medication refrigerator containing multiple medications was unlocked on South One, and two (2) medication/treatment carts containing dozens of topical prescription medications were unlocked in the South One hallway. The findings include: The State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities (Rev. 225; Issued: 08/08/2024) documented in accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. During an observation and interview on 03/09/2025 at 11:38 AM, 218 resident specific prescription medication blister packs including but not limited to 16 blister packs of metformin (medication used to treat high blood sugar), 12 blister packs of metoprolol (medication used to lower blood pressure and heart rate), 11 blister packs of norethindrone (female hormone to prevent pregnancy), 11 blister packs of torsemide (diuretic pill), 10 blister packs of Eliquis (blood thinner), nine (9) blister packs of sertraline (antidepressant), six (6) blister packs of amlodipine (medication used to treat high blood pressure), six (6) blister packs of divalproex extended release (medication used to treat seizures), and five (5) blister packs of Keppra (medication used to treat seizures) were observed on a counter and in unlocked cabinets behind the North One nurse's station. During an immediate interview, Licensed Practical Nurse #10 stated the medications were overflow prescription medications that did not fit into the medication carts. They stated the cabinets did not have a key. Licensed Practical Nurse #10 stated medications should be stored in a locked area. During a continuous observation on 03/09/2025 from 11:10 AM to 11:22 AM, the door to the South One medication storage room (located behind the nurse's station) was unlocked and there were no facility staff in the immediate area. The nurse's station was open to the corridor and a resident was ambulating past the corridor near room [ROOM NUMBER]. Inside the storage room was an unlocked medication refrigerator containing multiple medications and on the counter were several blister packets of prescription medications. Two (2) medication carts marked South One long and South One short at the nurse's station were unlocked and open and contained dozens of oral and topical prescription medications. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/09/2025 at 11:52 AM, the Director of Nursing stated all medications (including topical) should be locked in a medication or treatment cart, a cabinet, or the medication room. 10 NYCRR 415.18(e)(1-4)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46526 Based on observation, interview, and record review conducted during an Extended Recertification Survey 03/09/2025 to 05/09/2025, the facility did not ensure food and drink were provided that was at a safe and appetizing temperature for one (1) test tray and for five (5) residents (Residents #3, #37, #62, #104 and #107) interviewed on the South One Unit. Specifically, food and beverages during the meal were served at suboptimal temperatures and were not palatable. The finding includes: The undated facility policy Food Preparation and Service documented nutrition services employees prepare and serve food in a manner that complies with safe food handling practices. The danger zone for food temperatures is between 41 degrees Fahrenheit and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illness. Potentially hazardous foods include meats, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. The longer foods remain in the danger zone, the greater the risk for growth of harmful pathogens. Therefore, properly handled food must be maintained below 41 degrees Fahrenheit or above 135 degrees Fahrenheit During an interview on 03/10/2025 at 10:03 AM, Resident #62 stated the breakfast food was cool, not warm, and the eggs were dry. The meal tray was picked up by staff at the time of the interview, and the eggs, yogurt and milk were not consumed by the resident. During an interview on 03/10/2025 at 12:18 PM Resident #107 stated the food is terrible, cold all the time, are small portions and has no flavor. During observations and interview on 03/17/2025 at 11:30 AM, the lunch meal tray line was started. Meal trays were plated and covered for the South One Unit. The tray cart that included the test tray was open, had no insulating doors, and the cart was covered with a clear plastic bag. Temperatures were taken at the start of tray line service and all hot food items were above 140 degrees Fahrenheit. Cold food and drink items were held pre-portioned and pre-poured on metal trays, and dietary products were in a large metal container on ice at the tray line. The last cart left the kitchen at 1:55 PM and residents were served their lunch at 2:05 PM. A test tray was completed with Dietary Director #1 at 2:06 PM for temperatures and palpability. The temperatures were taken by the surveyor using the surveyor's digital thermometer. The results were as follows: - corned beef was 95.5 degrees Fahrenheit, tasted cold, was tough and was not palatable. - roasted white potatoes were 113.4 degrees Fahrenheit, tasted lukewarm and bland. - cooked cabbage was 109.5 degrees Fahrenheit, mushy, cold and bland. - apple juice was 57.3 degrees Fahrenheit and not cold but lukewarm. - frosted yellow cake tasted dry. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview immediately following the test tray observation, Director of Dietary #1 stated they were upset about the food temperature outcomes, as the kitchen is fully staffed. Tray line takes about two hours for each meal and juices and milk sit out too long, even though some of them are covered in ice. Director of Dietary #1 said it does not help that it took a while for the trays to be passed by the nursing staff. Hot foods items should be at least 135 degrees Fahrenheit and cold foods and drinks below 40 degrees Fahrenheit. During an interview on 03/17/2025 at 2:11 PM, Resident #37 stated the corned beef was cold and dry, they did not like the cabbage, and they asked for an egg salad sandwich about 20 minutes ago but never received it. During an interview on 03/17/2025 at 2:15 PM, Resident #3 stated lunch was not that good, the corned beef was dry and cold, and the cabbage was cold and had no taste. During an interview on 03/17/2025 at 2:16 PM, Resident #104 stated lunch was terrible, like it is every day, the corned beef was thin and dry and not even warm, and the cabbage had no taste and was mushy. During an interview on 03/17/2025 at 2:29 PM, Resident #107 stated lunch was terrible, everything was cold, and the corned beef was so tough they could not eat it. During an interview on 03/17/2025 at 3:07 PM, [NAME] #1 stated they were told all hot foods should be at 165 degrees Fahrenheit and cold liquids should be below 38 degrees Fahrenheit. The Registered Dietician was not available for interview. 415.14(d)(1)(2)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record reviews conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, for 2 (Residents' #17, #461) of 13 residents reviewed for accidents, the facility did not ensure food was prepared in a consistency to meet the residents needs per speech language pathologist recommendations and physician orders. Specifically, Resident #17 had a history of dysphagia (difficulty swallowing), was on a mechanically altered diet (a diet that consists of easy to chew and swallow foods), and received a food item that was not appropriate on their physician ordered diet. Resident #461 was on aspiration precautions (measures to prevent inhalation of food and liquids in the lungs), was on a mechanically altered diet and received a liquid drink in an inappropriate consistency. The findings include: The facility policy Food Consistencies and Definitions dated January 2025, included a ground (dysphagia level 2) diet consistency are foods with a moist, soft texture. The facility policy Liquid Consistencies, review date January 2025, included the facility will adhere to evidenced-based guidelines for thickened liquids as recommended by speech-language pathologists and physicians. The policy aims to prevent aspiration, choking, and dehydration by ensuring that all liquids are prepared and served at the appropriate consistency. Honey thick liquids were defined as fluids that pour slowly and coat a spoon heavily, similar to honey. 1.Resident #461 had diagnoses that included dysphagia, high blood pressure, and atrial fibrillation (irregular heartbeat). The Minimum Data Set (a resident assessment tool), dated 03/04/2025, documented the resident had moderate impairment of cognitive function, required assistance with meals, exhibited signs of coughing or choking during meals or when swallowing medications, and received a mechanically altered diet. Review of physician's orders dated 03/04/2025 revealed a pureed texture diet, honey consistency liquids, and aspiration precautions. The Comprehensive Care Plan revised on 03/06/2025 documented to provide the diet per physician order of regular pureed and honey (thickened) liquids. The Speech Therapy Evaluation and Plan of Treatment report dated 03/04/2025 documented recommendations for pureed solids, honey thickened liquids and close supervision for oral intake. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observations and interviews on 03/12/2025 at 9:22 AM Resident #461 was in bed eating breakfast. The head of the bed was elevated but the resident had become slouched down while eating. There were no facility staff in sight of the resident. Resident #461's breakfast tray contained a packet of thickened coffee that was unopened. The resident was drinking hot water from a coffee cup that was not thickened and was coughing. Resident #461 stated that the coffee tasted terrible and damn, I keep coughing. The resident then drank some of their milk and again started coughing. Staff were immediately notified. Licensed Practical Nurse #1 stated the liquid in the coffee cup was not thickened and added the packet of coffee thickener to the hot water. Licensed Practical Nurse #1 stated that they were from an agency, it was their first time on the unit, and they did not know any of the residents on the unit. During an interview on 03/12/2025 at 9:43 AM Licensed Practical Nurse Manager #2 stated they would need to check with the therapy department before they could say what Resident #461's assistance level was for meals. During a follow-up interview at 9:50 AM, Licensed Practical Nurse Manager #2 stated they were not sure why no one added the thicken coffee packet to the liquid but should have. 2. Resident #17 had diagnoses that included dysphagia and diabetes. The Minimum Data Set, dated dated [DATE], documented the resident had moderate cognitive impairment and received a mechanically altered diet. Review of physician's orders, dated 03/17/2025, revealed a dysphagia Level Two (2) diet (ground solids), thin liquid consistency, and aspiration precautions. The Speech Therapy Evaluation and Plan of Treatment report dated 12/12/2023, documented recommendations for mechanical soft/ground textured solids, thin consistency liquids and supervision for oral intake. Review of Resident #17's meal ticket (a specific menu that includes what each resident should receive for meals, texture of meal, and any other resident specific interventions during mealtime) dated 03/17/2025 included regular dysphagia mechanically altered level two (2) diet, aspiration precautions, and pureed braised cabbage. Review of the unit binder labeled dysphagia on 03/17/2025 documented foods to avoid on a Level Two (2) dysphagia diet included broccoli and cabbage and foods should be soft and moist. During an observation on 03/17/2025 at 12:07 PM, Resident #17's lunch meal tray included a bowl of shredded cabbage (not pureed). During an immediate interview, Certified Nursing Assistant #2 and Licensed Practical Nurse #11 both stated the shredded cabbage in the bowl was pureed. During an observation and interview on 03/17/2025 at 12:25 PM Speech Language Pathologist #1 stated the cabbage was not pureed per the dysphagia level two (2) diet. During a telephone interview on 03/13/2025 at 11:38 AM the Medical Director stated residents should receive the physician ordered consistency of diets secondary to increased risks of aspiration, choking, pneumonia, and death. 10 NYCRR 415.14(d)(3)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38878 Based on observations, interviews, and record review conducted during an Extended Recertification Survey from 03/09/2025 to 05/09/2025, for one (1) of one (1) main kitchen, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, plates were not properly air dried and stored, floors were soiled with food debris throughout the kitchen, food items were undated and unlabeled, a stove top was dirty, food items were stored on the floor, a carton of milk was outdated, food was not stored at proper temperatures, a fan was dirty, and staff were not wearing proper hair restraints (beard guards). The finding includes: The facility policy Food Safety and Sanitation dated 2019 included, all local, state and federal standards and regulations will be followed in order to assure a safe and sanitary food and nutritional service department. [NAME] guards are required when facial hair is visible. Food stored in dry storage is placed on clean racks at least six (6) inches above the floor. All foods including leftovers should be labeled, covered and dated when stored. The policy Preventing Foodborne Illness dated January 2024 included, food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. Functioning of the refrigerator and food temperatures will be monitored at designated intervals throughout the day and documented according to state specific requirements. Observations and interviews in the main kitchen on 03/09/2025 at 9:50 AM included the following: 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. A similar area was a few feet away (near the dietician's office) which measured four (4) tiles by seven (7) tiles. In an immediate interview, Dietary Supervisor #1 stated they were unsure why the floor was like that. b.There was grease and food debris on the stove top from the breakfast meal and food items were on the stove top cooking for the lunch meal. c.There was an undated and unlabeled, 9 inch by 9 inch metal pan covered with clear plastic wrap that contained a slimy, purple substance in the walk-in cooler. In an immediate interview, Dietary Supervisor #1 stated it was jelly to make sandwiches and should be dated and labeled. d.There were six (6) donuts wrapped in an undated and unlabeled clear plastic bag in the walk-in freezer. In an immediate interview, Dietary Supervisor #1 stated they should be dated and labeled and would be discarded. e.A case of six (6) cans of applesauce and an open case of 4-ounce cups of thickened orange juice, five (5) of which had spilled out of the box, were on the floor in the dry storage room. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	f.Staff working in the kitchen, dish room and on tray line had visible facial hair and were not wearing beard guards. Dietary Aide #2 was in the dish room with facial hair measuring over 0.5 inch long without a beard guard. In an immediate interview, Dietary Supervisor #1 stated beard guards were available and did not think staff had to wear them in the dish room. During an observation on 03/09/2025 at 11:09 AM, there was a half pint of 2% milk dated 03/02/2025 in the refrigerator of the South One clean utility room and two (2) trays of food with meal tickets dated 03/08/2025 containing milk, yogurt, meat and potatoes sitting on the counter at room temperature. During an observation on 03/09/2025 at 11:26 AM, there was a 4-ounce container of yogurt, labeled with a resident's name and dated 03/08/2025 sitting on the counter of the South One nurse's station. During the observation, the temperature of the yogurt, measured using an ExTech digital probe thermometer, was 83.1 degrees Fahrenheit. During an observation on 03/13/2025 at 10:29 AM, there was a heavy coating of gray dust on the wall mounted fan and ceiling tiles near the tray line in the main kitchen. During an observation on 03/17/2025 at 9:58 AM, warming covers and warming plates were being washed through the dish machine and stacked on a two-tier industrial cart. On the top tier, 10 warming covers were stacked upside down on top of each other. On the bottom tier there were approximately six (6) piles of 10 warming covers and plates stacked on top of each other that had water droplets on them (not properly air dried). During an interview on 03/17/2025 at 11:30 AM, Dietary Aide #1 stated the warming covers and plates had been on the same cart since earlier that morning. They stated the covers were wet and stacked on top of each other but should not be. During an observation on 03/17/2025 at 11:33 AM, at the start of tray line, the warming lids and plates were visibly wet and Dietary Aide #2 with facial hair measuring approximately 0.5 inches long, was observed plating food without a beard guard in place. During an interview on 03/17/2025 at 1:44 PM, Dietary Director #1 stated warming covers and plates should be stacked on their side to air dry and being wet was a sanitation issue. [NAME] guards are available and staff with facial hair should always be wearing one in the kitchen. All foods should be labeled and dated prior to going into the refrigerators and freezers. Dietary Director #1 stated floors should be swept and mopped after each meal. Dietary Director #1 stated the tiles on the floor adjacent to the tray line did not look clean and did not know why the floors were in that condition. 10NYCRR: 415.14(h), 10NYCRR: Subpart 14-1, 14-1.40(a), 14-1.43(a), 14-1.43(e), 14-1.72(c), 14-110(d), 14-1.116, 14-1.170

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Ctr	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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46526 Based on observations, record review, and interviews conducted during the Extended Recertification Survey 03/09/2025 to 05/09/2025 facility did not ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the Administration did not ensure that residents on aspiration precautions were supervised during meals, that residents were free significant medication errors, that dependent residents were assisted with activities of daily living (basic tasks for self-care and daily functioning) in a timely manner, ad did not ensure sufficient nurse staffing to provide nursing services based on residents' assessments or that residents received treatment and care in accordance with professional standards of practice and did not maintain an effective infection prevention and control program. The findings included: The facility's Quality Assurance and Performance Improvement (QAPI) Plan dated 2025 included the Administrator was responsible for overseeing the Quality Assurance and Performance Improvement and the role of the Administrator consisted of (but not limited to): a. Identify opportunities for improvement through analysis of data, observation of operations and consultation with leadership, staff, residents, families, and stakeholders. b. Organize and facilitate the quality committee and it's meeting by guiding discussion around performance measures and prioritizing and developing quality efforts. c. Lead performance improvement projects and provide education and coaching in order to build needed skills in others to lead performance improvement projects (PIPs). For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F689 (Free of Accident Hazards/Supervision/Devices): The facility failed to ensure that residents received adequate supervision to prevent accidents for multiple residents that were on aspiration precautions. This issue resulted in the likelihood of serious injury, serious harm or death for 33 residents in the facility on aspiration precautions, which resulted in Immediate Jeopardy. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F760 (Residents Are Free of Significant Medication Errors) which is a repeat deficiency: Review of full-house Medication Administration Audit Reports revealed no documented evidence that 193 residents had received multiple medications on multiple days from 02/13/2025 to 02/17/2025 and 213 residents from 03/21/2025 to 03/30/2025 which was verified by facility staff interviews and record review. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	These issues resulted in the likelihood of serious injury, serious harm, or death for all the residents in the facility (census 207) that was Immediate Jeopardy and substandard quality of care. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F725 (Sufficient Nursing Staffing) which is a repeat deficiency: The facility did not ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all residents in the facility. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F684 (Quality of Life) which is a repeat deficiency: The facility did not to ensure that all residents received treatment and care in accordance with professional standards of practice for two (2) residents related to failure to ensure hand splints were worn as ordered for one resident and proper care of a nephrostomy tube was completed for one resident which resulted in actual harm to Resident #178 that was not immediate jeopardy. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F677 (Activities of Daily Living Care Provided for Dependent Residents) which is a repeat deficiency: Several residents reported no showers for several weeks and were observed with unwashed hair, uncut nails and unshaven. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F880 (Infection Prevention & Control) which is a repeat deficiency: The facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections. The administrator was aware of positive Legionella results in the water system for an extended period of time and did not report this to the New York State Department of Health as required, did not have the system issue addressed appropriately, did not notify the Medical Director, did not notify the Director of Nursing and did not have residents with diagnoses of pneumonia tested for Legionnaire's Disease. During an interview on 03/21/2025 at 6:31 PM, the Administrator said the facility's Quality Assurance committee focuses on previously identified deficiencies and plans of corrections. The Administrator said they and the committee were aware of ongoing issues related to insufficient staffing levels and the facility has hired contract staff and an in-house recruiter. The Administrator said they and the committee were aware of issues related to medications not administered as ordered and the audit report should be checked every shift by the Director of Nursing. The Administer stated they were aware of the resident grievances as anything discussed in Resident Council comes across their desk. The Administrator said they and the committee were not aware of issues related to therapy recommendations not being followed, nephrostomy tube care not being done, or dependent residents not being assisted with activities of daily living. The Administrator stated they have been doing audits based on the previous Recertification Survey, but they are only being done quarterly. 10 NYCRR 415.26

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations and interview conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025 for three (3) (South One, South Three, North Two) of seven (7) resident units reviewed, the facility did not ensure compliance with all applicable state codes, including Subpart 713-1, New York State building construction standards for nursing home construction projects completed or approved prior to August 25, 1975. Specifically: beds were less than three (3) feet from windows and/or radiators, a resident room lacked an outside window, beds were located less than three (3) feet apart, and windowsills exceeded three (3) feet above the floor level. The findings include: Observations on 03/09/2025 beginning at 11:40 AM on the South One Unit included resident beds were less than three feet from adjacent radiators in resident Rooms #103, #105, #107, and #114. The bed was occupied in resident room [ROOM NUMBER] and was one foot away from the radiator near the window. Observations on 03/10/2025 at 10:04 AM on the South Three Unit included the resident bed in room [ROOM NUMBER] was pressed directly up against the heating unit, directly adjacent to the window. Observations on 03/10/2025 at 10:22 AM on the North Two Unit included four (4) residents were occupying room [ROOM NUMBER] and there was no outside window within the room. There was an approximately four feet by three (3) feet cutout in the wall approximately six (6) feet above the floor leading to an adjacent sunporch with outside windows. Additionally, the door leading from room [ROOM NUMBER] to the sunporch was padlocked. Observations on 03/11/2025 from 1:20 PM to 2:10 PM on the North Two Unit included the following: a. The windowsills in resident Rooms #220, #221, #222, and #223 were 3 feet 10 inches above the floor level. b. Beds in resident Rooms #219 and #222 were less than three (3) feet from the windows. A bed in room [ROOM NUMBER] was approximately one (1) foot from the windowsill and a bed in room [ROOM NUMBER] was 16 inches from the windowsill. c. Resident Rooms #210, #219, #222, and #223 were less than three (3) feet from radiators. A bed on the back left side in room [ROOM NUMBER] was two (2) feet from a radiator at the foot of the bed, a bed in room [ROOM NUMBER] was approximately six (6) inches from the radiator, a bed in the back of room [ROOM NUMBER] was six (6) inches from a radiator at the foot of the bed, and a bed in room [ROOM NUMBER] was two (2) feet three (3) inches from the radiator at the head of the bed. d. In Rooms #210 and #221 beds there was less than three (3) feet from an adjacent bed. The distance between the two (2) beds on the left side of room [ROOM NUMBER] was 2.5 feet apart and the distance between the two (2) beds on the right side of room [ROOM NUMBER] was 2.5 feet apart. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on 03/12/2025 at 11:30 AM, Licensed Practical Nurse #10 (North One and North Two) stated it was hard for Emergency Medical Services to attend to residents and we must move beds around just to use the mechanical lifts (a type of lift to assist non-ambulatory residents in and out of bed or a chair) in the four (4) person rooms. Licensed Practical Nurse #10 stated there was no place for families to sit and visit because there was not enough room. (Four (4) person rooms are located on the North Two Unit and include rooms #220, #221, #222, #223, #208, #210) 42 CFR: 483.70(b), 10NYCRR: 415.29(a)(2), 713-1.3(h)(1), 713-1.3(h)(3), 713-1.3(j)

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F 0837 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, the facility did not establish and implement procedures and clear communication methods between the administrator and the governing body to ensure management and operation of the facility and regulatory compliance. Specifically, there were multiple serious deficiencies identified that included, but were not limited to, Immediate Jeopardy, harm, substandard quality of care, and multiple repeat deficiencies related to resident care. The findings include: Review of the facility's Quality Assurance and Performance Improvement Plan (QAPI) dated 2025 revealed the steering committee would oversee all projects and include the Administrator, Director of Nursing, Medical Director, Regional Administrator, and Regional Clinical Director. The role of the Regional Administrator/Regional Clinical Director would include the following: a. Assume accountability for ensuring that Quality Assurance and Performance Improvement was defined, implemented and given high priority in the overall management of facility operations. b. Provide overall direction on Quality Assurance and Performance Improvement goals for the organization. Review of the Quality Assurance and Performance Improvement monthly meeting attendance records from October 2024 to February 2025 revealed regional or corporate leadership were not present. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F689 (Free of Accident Hazards/Supervision/Devices): The facility failed to ensure that residents received adequate supervision to prevent accidents for four (4) (Residents #461, #11, #4 and #83) residents during meals who were on aspiration precautions, and for one (1) resident the correct ordered liquid consistency was not provided. This issue resulted in the likelihood of serious injury, serious harm or death for 33 residents in the facility on aspiration precautions, which resulted in Immediate Jeopardy. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference F760 (Residents Are Free of Significant Medication Errors): Review of full-house Medication Administration Audit Reports revealed no documented evidence that 193 residents had received multiple medications on multiple days from 02/13/2025 to 02/17/2025 and 213 residents from 03/21/2025 to 03/30/2025 which was verified by facility staff interviews and record review. These issues resulted in the likelihood of serious injury, serious harm, or death for all the residents in the facility (census 207) that was Immediate Jeopardy and substandard quality of care. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Significant medications included, but were not limited to, insulin for diabetes, high blood pressure medications, antiplatelet medications to prevent the formation of blood clots, antidepressants, antipsychotics, antibiotics to treat active infections, medications used to treat kidney disease in dialysis patients, narcotic pain medications, medications to treat Parkinson's disease, and antiseizure medications. During interviews on 03/13/2025 at 12:00 PM and 03/31/2025 at 3:28 PM the Director of Nursing said residents did not receive their medications (during the dates listed above) because there was not adequate nursing staff to give them. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference to F684 (Quality of Life): The facility did not to ensure that all residents received treatment and care in accordance with professional standards of practice for two (2) (Residents #178 and #459) of 41 residents reviewed. Specifically, Resident #178 was observed on several occasions not wearing specially made hand splints as recommended by Occupational Therapy to maintain range of motion which resulted in loss of range of motion to their hands. Resident #459 did not have orders for care of their nephrostomy tube (tube inserted directly into the kidney through the skin to drain urine) for an extended period of time. This resulted in actual harm to Resident #178 that was not immediate jeopardy. For additional information see Centers for Medicare/Medicaid Services Form 2567, reference to F880 (Infection Control): The facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections for 3 (Residents #82, #148, and #459) of 10 residents reviewed and one (1) of one (1) facility potable water systems (the collection, treatment, storage, and distribution of safe drinking water). Specifically, Residents'#82, was on enhanced barrier precautions (interventions designed to reduce transmission of multidrug-resistant organisms) and staff did not wear appropriate personal protective equipment (PPE-equipment worn to minimize exposure to potential hazards such as a facemask, gloves and/or gown) and did not perform hand hygiene or change soiled gloves following incontinence care and before touching environmental objects. Additionally, the resident's indwelling catheter drainage bag was observed on the floor without a barrier. For Resident #148 staff did not change gloves or perform hand hygiene following incontinence care and before touching environmental objects. Resident #459 had a nephrostomy tube (a tube placed directly into the kidney through the skin to drain urine), was not on enhanced barrier precautions as ordered, and staff were observed providing hands on care without appropriate personal protective equipment. Additionally, Legionella (a bacteria found in [NAME] whose growth in potable water systems can lead to severe respiratory illnesses) water samples exceeded 30% positivity, the New York State Health Department was not notified, there was no documented evidence of short-term control measures after Legionella was detected, follow up sampling was not performed within the required timeframe, and residents diagnosed with pneumonia were not tested for Legionnaires' disease (a type of severe pneumonia) per facility policies and procedures. During an interview on 03/21/2025 at 3:00 PM the Regional (corporate) Director of Nursing stated that there was no Corporate Infection Control person overseeing the facility and they would try to help when able and would try to keep a certified Infection Preventionist in every building. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 03/21/2025 at 6:31 PM, the Administrator stated the facility held Quality Assurance and Performance Improvement committee meetings monthly and the committee reported to Corporate who would sometimes attend meetings via phone. Additionally, the Administrator stated that the Quality Assurance and Performance Improvement committee had not been aware of several of the issues identified during survey. 10 NYCRR 415.26(b)(3)(1)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 46526 Based on observations, interviews, and record review conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, the facility did not ensure a Quality Assurance and Performance Improvement (QAPI) program that put forth good faith attempts to develop, implement, and maintain an appropriate plan of action to address identified issues that impacted resident safety or ensured corrective actions were set around safety, quality, rights, choice and respect. Specifically, the facility did not implement and maintain the approved plans of correction from the Extended Recertification Survey dated 09/17/2024 for F550, F565, F584, F677, F684, F686, F725, F761, and F812. The findings include: For additional information see Centers for Medicare/Medicaid Services Form 2567 for repeat citations of: F550 - Resident Rights/Exercise of Rights; F565 - Resident/Family Group and Response; F584 - Safe/Clean/Comfortable/Homelike Environment; F677 - Activities of Daily Living Care Provided for Dependent Residents; F684 - Quality of Care; F686 - Treatment/Services to Prevent/Heal Pressure Ulcers; F725 - Sufficient Nursing Staff; F761 - Label/Store Drugs and Biologicals; and F812 - Food Procurement, Store/Prepare/Serve - Sanitary. The facility Quality Assurance and Performance Improvement (QAPI) Plan, dated 2025, included the Healthcare System's mission is to provide exceptional clinical care coupled with a luxury experience for their residents and their loved ones. The purpose included to take a proactive approach to improve the quality of life and quality of care of all residents. The scope of the Quality Assurance & Performance Improvement Plan encompasses all segments of care and services provided by the facility that impacts clinical care, quality of life, resident choice and care transitions with the participation of all departments. The Administrator is ultimately responsible for overseeing the Quality Assurance and Performance Improvement committee. During an interview on 03/21/2025 at 6:31 PM, the Administrator stated the Quality Assurance and Performance Improvement committee meets monthly and has been focusing on the deficiencies from the 09/17/2024 survey, the plans of correction, and quality of care. The Administrator stated they and the Quality Assurance & Performance Improvement committee were not aware of identified concerns with the following areas: Resident Rights/Exercise of Rights, Resident/Family Group and Response, Safe/Clean/Comfortable/Homelike Environment, Activities of Daily Living Care Provided for Dependent Residents, Treatment/Services to Prevent/Heal Pressure Ulcers, Label/Store Drugs and Biologicals, and Infection Prevention and Control. The Quality Assurance and Performance Improvement committee was aware of issues related to sufficient nursing staff and has hired an in-house recruiter. The committee was aware of the unsanitary kitchen conditions from the 09/17/2024 survey but there is no excuse for this survey as the kitchen was being audited. 10 NYCRR 415.27(a-c)

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46526 Based on interviews and record review conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, the facility did not maintain a Quality Assessment and Assurance Committee consisting at a minimum of the Director of Nursing Services, the Medical Director or his/her designee, at least three (3) other members of the facility's staff, one (1) of who must be an individual in a leadership role, and the Infection Preventionist. Specifically, the facility could not provide documented evidence the Infection Preventionist, or the Medical Director attended the Quality Assurance and Performance Improvement meetings on a consistent basis. The findings include: Review of the facility's Quality Assurance and Performance Improvement Plan dated 2025 included the Administrator was responsible for overseeing the Quality Assurance and Performance Improvement committee. The committee, which included the Medical Director, was responsible for assuring compliance with federal and state requirements and continuous improvement in quality of care and customer satisfaction. The Quality Assurance and Performance Improvement steering committee, which would oversee all projects, would include the Administrator, Director of Nursing, Medical Director, Regional Administrator, and Regional Clinical Director. Review of the Quality Assurance and Performance Improvement monthly meeting attendance records from October 2024 to February 2025 revealed the Infection Preventionist was not listed as present for any meetings. Review of attendance records for the same timeframe revealed the Medical Director and/or designee was not listed as present in January 2025 and February 2025. During an interview on 03/19/2025 at 11:25 AM, the Director of Nursing stated the facility did not currently have a certified Infection Preventionist as the previous Infection Preventionist had resigned a month ago. During an interview on 03/21/2025 at 6:31 PM, the Administrator stated the facility held Quality Assurance and Performance Improvement meetings monthly and the Medical Director had not come to any meetings since they were only in the facility on Thursdays. The Administrator said a medical provider was present for some meetings to serve as the Medical Directors' designee. The Administrator did not address why the Infection Preventionist did not attend the meetings between October 2024 and February 2025. 10 NYCRR: 415.27(a-c)

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	335082	A. Building B. Wing	05/09/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47641 Based on observations, interviews, and record reviews conducted during an Extended Recertification Survey from [DATE] to [DATE], the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections for three (3) (Residents #82, #148, and #459) of 10 residents reviewed and one (1) of one (1) facility potable water systems (the collection, treatment, storage, and distribution of safe drinking water). Specifically, Issue one (1) includes: The facility failed to 1) provide further testing for Legionnaires' disease for residents diagnosed with pneumonia, 2) to ensure short-term water disinfection control measures were implemented for the potable water system after receipt of samples testing positive for Legionella, and 3) to report potable water system samples exceeding greater than 30% positivity for Legionella to the New York State Department of Health, which resulted in the likelihood of serious injury, serious harm, serious impairment or death to all 214 residents in the facility. Issue two (2) includes: Residents #82 was on enhanced barrier precautions (interventions designed to reduce transmission of multidrug-resistant organisms) and staff did not wear appropriate personal protective equipment (equipment worn to minimize exposure to potential hazards, such as a facemask, gloves and/or gown) and did not perform hand hygiene or change soiled gloves following incontinence care and before touching environmental objects. Additionally, the resident's indwelling catheter drainage bag was observed on the floor without a barrier. For Resident #148, staff did not change gloves or perform hand hygiene following incontinence care and before touching environmental objects. Resident #459 had a nephrostomy tube (a tube placed directly into the kidney through the skin to drain urine), was not on enhanced barrier precautions as ordered, and staff were observed providing hands-on care without appropriate personal protective equipment. The findings include: Issue one (1): Review of the facility policy Legionella Water Management Program, dated [DATE], included the following: a. The water management team will consist of at least the following personnel: the infection preventionist, the administrator, the medical director or designee, the director of maintenance, and the director of environmental services. b. The water management program includes the following elements: specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants), the control limits or parameters that are acceptable and monitored, a system to monitor control limits and the effectiveness of control measures, a plan for when control limits are not met and/or control measures are not effective, and documentation of the program c. The Water Management Program will be reviewed at least once a year, or sooner in cases including, but not limited to, if the control limits are not consistently met. (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 B. Wing	05/09/2025

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the facility policy Legionella Surveillance Detection, dated [DATE], included the following: a. The facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaires' disease will be included as part of our infection surveillance activities. b. As part of the Infection Prevention and Control Program, all cases of pneumonia that are diagnosed in residents more than 48 hours after admission will be investigated for possible Legionnaires' disease. c. If pneumonia or Legionnaires' disease is suspected, the nurse will notify the physician or practitioner immediately. d. Diagnosis of Legionnaires' disease is based on a culture of lower respiratory secretions and urinary antigen testing obtained at the same time. Review of the facility policy Legionella Management Plan Potable Water System, dated [DATE], included disinfection and response procedures to be used when Legionella counts exceed 30% positive and specified that results are reported promptly to program team members to make determinations of effective remediation strategies using New York State guidelines via appendix 4-B of that document. Percentage of positive Legionella test sites greater than 30% includes the following responses: a. Immediately institute short-term control measures in accordance with the direction of a qualified professional and notify the department. b. The water system shall be re-sampled no sooner than seven (7) days and no later than four (4) weeks after disinfection to determine the efficacy of the treatment. c. Retreat and retest. If retest is greater than or equal to 30% positive, repeat short-term control measures. Review of the facility policy Surveillance for Infections, dated [DATE], included the Infection Preventionist would conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and interventions. The Infection Preventionist and the attending physician would determine if laboratory tests were indicated and if special precautions were warranted. Additionally, the Infection Preventionist would determine if the infection was reportable and would gather and interpret surveillance data. Record review and interview on [DATE] at 1:55 PM included the following: a. 10 Legionella water samples for the domestic water supply were submitted to a lab on [DATE]. Results received on [DATE] included 7 of the 10 (70%) samples were positive for Legionella and were obtained from South Three, room [ROOM NUMBER]-bathroom sink; South Two, room [ROOM NUMBER]-bathroom sink; North Two, room [ROOM NUMBER]-bathroom sink; North Unit shower; [NAME] One, room [ROOM NUMBER]-bathroom sink; Main Hall sink; and South One, room [ROOM NUMBER]-bathroom sink. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	b. 10 Legionella water samples for the domestic water supply were submitted to a lab on [DATE]. The [DATE] results included 5 of the 10 (50%) samples were positive for Legionella and obtained from South Three shower room; South Two room [ROOM NUMBER]-bathroom sink; Main Hallway sink; South Three room [ROOM NUMBER]-bathroom sink; and North Two room [ROOM NUMBER]-bathroom sink. Follow-up sampling was not performed until [DATE] (43 days later). In an immediate interview, the Director of Maintenance stated sample results were not reported to the New York State Department of Health. Review of records provided by the Administrator on [DATE] at 9:50 AM included a list of seven (7) residents who were diagnosed with pneumonia ranging from [DATE] to [DATE]. Additional record review revealed three (3) of the seven (7) residents had expired and had resided on North One, South Three, and [NAME] One. During an interview on [DATE] at 2:10 PM, the Administrator stated there were no Legionnaires' disease testing results for the seven (7) residents diagnosed with pneumonia. During an interview and record review on [DATE] at 10:08 AM, the Director of Maintenance stated after receipt of the positive Legionella results in [DATE] and [DATE], the vendor came in and did a high chlorine flush of the water system. Record review of service reports revealed the vendor was at the facility [DATE], [DATE], [DATE], and [DATE] for routine monthly service. The service report dated [DATE] included the dosing pump controls were not responsive, and a new pump would be installed. The service report dated [DATE] included pump controls were unresponsive. The service report dated [DATE] included the replacement of the chlorine pump as interface was not working. The vendor service reports did not document if short term control measures were implemented after greater than 30% of the water samples came back positive for Legionella on [DATE] and [DATE]. During a phone interview on [DATE] at 12:35 PM, the Medical Director stated they were not aware water samples at the facility were positive for Legionella; they would be concerned for the residents and should have been notified. During an interview on [DATE] at 12:48 PM, the Director of Maintenance stated they told the Administrator about the positive Legionella results, and they were taking care of it. The Director of Maintenance stated they did a high chlorine flush of the system each time and sanitized all the shower heads. There was no documented evidence that a chlorine flush of the domestic water system or other short-term control measures had been performed. During an interview on [DATE] at 2:14 PM, the Director of Nursing stated they had not been notified that the facility's water system had tested positive for Legionella. They stated the Director of Maintenance was responsible to collect the water samples and should have informed them of the positive results. The Director of Nursing stated it would have been important for them to be notified to ensure the medical provider was updated and urine and culture tests were completed on any resident testing positive for pneumonia. During an interview on [DATE] at 3:00 PM, the Regional Director of Nursing stated there was no corporate Infection Preventionist to manage the facility's infection control program. On [DATE] the survey team identified Immediate Jeopardy Past Non-Compliance. Based on the following corrective actions it was determined through interviews and record review the facility implemented corrective actions to correct the non-compliance effective [DATE]. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A follow up onsite review on [DATE] included the following: -The Legionella policies and water management plans were reviewed, no revisions required, and the facility is currently compliant with their policies and the regulation. -The supplemental disinfection system is currently functioning properly. -The prior exceedances were reported to NYSDOH on [DATE]. -The round of samples taken [DATE] had a20% positivity rate, requiring no further action on the part of the facility. -Two residents recently diagnosed with pneumonia tested negative for Legionnaires' disease. -The facility is monitoring all residents diagnosed with pneumonia for possible Legionnaires' disease. -Director of Maintenance stated they flush the water system monthly, sanitize the shower heads monthly, and monitor the chlorine residual daily as part of routine preventative maintenance procedures. -The facility provided documentation that on [DATE], Administration provided education regarding Legionella Testing Procedures due to positive water testing. Signature sheet of those present included, but were not limited to: Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Director of Maintenance, Assistant Director of Environmental Services, and multiple Registered Nurses and Unit managers. There is no Plan of Correction required for Issue one (1) of the F880 Issue two (2) The facility policy Barrier Enhanced Precautions, dated [DATE], included 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 to staff hands and clothing. High contact resident care activities include, but are not limited to, transferring residents, changing linens, changing briefs, assisting with toileting, care of medical devices, and wound care for chronic wounds. Hand hygiene should be performed, and a new gown and gloves should be put on before caring for a different resident. The facility policy Standard Precautions dated [DATE] included hands shall be washed after direct contact with bodily fluids. Gloves should be worn when anticipated direct contact with bodily fluids and changed as necessary during care to prevent cross-contamination from one body site to another and to remove gloves after use, before touching non-contaminated items and environmental surfaces and wash hands immediately to avoid transfer of microorganisms to other residents or environments. 1.Resident #82 had diagnoses including bladder dysfunction, benign prostatic hyperplasia (enlargement of the prostate) and chronic kidney disease. The Minimum Data Set (a resident assessment tool) dated [DATE] included the resident had moderately impaired cognition. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident #82's Comprehensive Care Plan dated [DATE] and current Certified Nursing Assistant Kardex (care plan) both included the resident had a suprapubic catheter (a tube inserted directly into the bladder through the abdomen to drain urine into a bag) and was incontinent of bowel. Interventions included to provide catheter care every shift and as needed, maintain the urine collection bag below the level of the bladder, maintain enhanced barrier precautions, and that the resident was dependent on staff for toileting hygiene. Current physician orders dated [DATE] included to maintain enhanced barrier precautions. During an observation on [DATE] at 3:11 PM, an enhanced barrier precaution sign was posted outside of Resident #82's room and included personal protective equipment (gown and gloves) were required for high-contact resident care activities. Personal protective equipment was available outside the room. During observations on [DATE] at 3:31 PM, [DATE] at 12:39 PM, [DATE] at 1:52 PM, [DATE] at 12:13 PM, and [DATE] at 1:46 PM, Resident #82 was lying in bed with their urine collection bag and catheter tubing lying directly on the floor next to the bed or under the bed without a barrier. During an observation on [DATE] at 1:54 PM, Certified Nursing Assistant #14 washed their hands, put on gloves but no gown, and placed the urinary catheter bag on the bed. They then provided care to Resident #82, who was incontinent of stool. They removed the soiled incontinence brief and pad and placed them on the floor with no barrier. Without changing gloves or washing their hands, Certified Nursing Assistant #14 applied a clean brief, then touched clean linens, the bed control, the bedside table, and the closet door, and emptied the urinary catheter bag. During an interview on [DATE] at 2:19 PM, Certified Nursing Assistant #14 stated they did not change gloves or wash their hands after providing incontinence care but should have before they touched other objects in the resident's room. Certified Nursing Assistant #14 looked at the enhanced barrier precaution sign posted outside Resident #82's room and stated they did not see it and should have also worn a gown and mask while providing care. During an interview on [DATE] at 3:07 PM, Licensed Practical Nurse Manager #4 stated Resident #82 was on enhanced barrier precautions because they had a suprapubic catheter and staff should wear gloves, gown and a mask when providing care and emptying their catheter bag to prevent the spread of infections. Licensed Practical Nurse Manager #4 stated staff should also change their gloves and wash their hands after incontinence care and before touching other objects in the room to prevent contamination, and catheter bags should always be placed below the level of the bladder and never directly on the floor. 2.Resident #459 had diagnosis including dementia, encephalopathy (impaired brain function), history of a kidney transplant and immunodeficiency (decreased ability of the body to fight infections). The Minimum Data Set, dated dated dated [DATE] included the resident had severe impairment of cognitive function. Review of Resident #459's Comprehensive Care Plan, dated [DATE], revealed Resident #459 had a nephrostomy tube. Interventions included to monitor intake and output per protocol. The care plan did not include that the resident was on enhanced barrier precautions. (continued on next page)

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	335082	A. Building B. Wing	05/09/2025

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Physician orders dated [DATE] included to flush Resident #459's nephrostomy tube daily and maintain Enhanced Barrier Precautions, due to a nephrostomy tube. During an observation on [DATE] at 11:24 AM, Certified Nursing Assistant #2 and Licensed Practical Nurse Manager #3 were providing care to Resident #459 while wearing gloves but no gowns. Certified Nursing Assistant #2 emptied the resident's urine bag. There was no enhanced barrier precaution sign or personal protective equipment outside the resident's room. During an interview on [DATE] at 10:45 AM, Certified Nursing Assistant #2 stated they did not wear a gown while providing care to Resident #459 but should have because the resident should have been on enhanced barrier precautions. 3.Resident #148 had diagnoses including dementia, failure to thrive and ataxia (lack of muscle coordination, making it difficult to walk). The Minimum Data Set, dated dated dated [DATE] documented the resident had severely impaired cognition. Review of Resident #148's current Comprehensive Care Plan, last revised [DATE], included the resident was incontinent of bowel and bladder and dependent on staff for toileting hygiene. Interventions included to check the resident for incontinence and change them every three (3) to four (4) hours and as needed and provide perineal care after each incontinent episode. During an observation on [DATE] at 3:41 PM, Licensed Practical Nurse #2 was wearing gloves while they provided incontinence care to Resident #148 and applied cream to the buttocks. Licensed Practical Nurse #2 did not change their soiled gloves or wash their hands after changing the resident's soiled brief and before touching clean linens and multiple objects in the resident's room. During an interview on [DATE] at 11:07 AM, Licensed Practical Nurse #2 stated they should have changed their gloves and washed their hands following incontinence care, to avoid contamination of other objects. During interviews on [DATE] at 2:14 PM and 2:50 PM, the Director of Nursing stated that staff should wear the appropriate personal protective equipment while providing resident care. Residents with indwelling medical devices should be on enhanced barrier precautions, and staff should wear gowns, gloves, and masks during care to reduce the spread of infection. The Director of Nursing said staff should change their gloves and wash their hands following incontinence care and before touching clean linens or objects in the room, to prevent contamination. They said soiled linens should not be placed directly on the floor due to infection control concerns, and catheter bags should always be kept below the level of the bladder and not directly on the floor, due to risk for infection. The Director of Nursing stated Resident #459 should have had an enhanced barrier precautions sign on their door and personal protective equipment available outside the room. Since the facility did not have an infection preventionist, the nurses, managers, or certified nursing assistants should put the cart and signage outside the resident's room. 10NYCRR: Section 415.19, 10NYCRR: Part 4, Subparts?,d+[DATE].4(a)(3), ,d+[DATE].7(b) 50512

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 50512 Based on observation and interviews conducted during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, the facility did not designate one (1) or more individuals as the Infection Preventionist responsible for the facility's Infection Prevention Control Practices. Specifically, the facility did not have a designated Infection Preventionist qualified with specialized education, training, experience, or certification on a part time or full-time basis. The findings include: The facility's policy Surveillance for Infections dated January 2025 documented that the Infection Preventionist would conduct ongoing surveillance for healthcare-associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and interventions. The Infection Preventionist and the attending Physician would determine if laboratory tests were indicated and if special precautions were warranted. Additionally, the Infection Preventionist would determine if the infection was reportable and would gather and interpret surveillance data. During the survey entrance conference on 03/09/2025 at 11:39 AM, the Administrator stated that the Director of Nursing was currently serving as the Infection Preventionist for the facility. During an interview on 03/19/2025 at 11:25 AM, the Director of Nursing stated that the facility did not have a certified Infection Preventionist. They stated that the previous Infection Preventionist had resigned a month ago and they had been overseeing the Infection Control and Antibiotic Stewardship Program with the assistance of nursing leadership. The Director of Nursing stated that they had not completed any specialized infection control training and were not certified. During an interview on 03/21/2025 at 2:56 PM, the Administrator stated they were aware there was not a certified Infection Preventionist at the facility and that the Director of Nursing who had been managing the program was not certified. The Administrator stated the role of the Infection Preventionist was a full-time job and that the Director of Nursing was doing the best they could to monitor the program. During an interview on 03/21/2025 at 3:00 PM, the Regional Director of Nursing stated that there was no corporate Infection Preventionist to manage the facility's infection control program. They stated they had just hired two Assistant Director of Nurses for the facility, and both would be trained and certified as the Infection Preventionist to ensure there was a backup. 10 NYCRR 415.19

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations and interview during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, for one (1) (resident room [ROOM NUMBER]) of 114 resident sleeping rooms the facility did not provide enough usable space in a resident room. Specifically, a multiple resident bedroom did not have a minimum of 80 square feet of usable space per resident. The findings include: Observations on 03/10/2025 at 12:07 PM included a room with four residents in bed and four residents listed on the name placard outside room [ROOM NUMBER] on the North Two Unit. The room was measured 17 feet by 20 feet (340 square feet) not including the bathroom and there were three (3) wardrobes each measuring 3 feet by 1 foot 10 inches (16.5 square feet in total), and four (4) nightstands each measuring 1 foot 8 inches by 1 foot 7 inches (10.5 square feet in total). The total room size of 340 square feet minus the space for the wardrobes and nightstands (27 square feet) equaled a total of 313 square feet of usable space for a total of four residents. This equates to 78.25 square feet of usable space per resident in this room. During an interview at this time, Resident #147 stated that the room is made for three (3) people but a while back they (staff) came in and took some measurements and told them a fourth resident was being added to the room. 10NYCRR: 415.29, 415.29(c), 10NYCRR: 713-1.3(g)

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	335082	A. Building B. Wing	05/09/2025

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46526 Based on observations and interview during the Extended Recertification Survey from 03/09/2025 to 05/09/2025, for two (2) (resident rooms #221 and #223) of 114 resident sleeping rooms the facility did not provide resident sleeping rooms that were designed and equipped to assure full visual privacy for each resident. Specifically, privacy curtains were missing or inadequate to provide each resident full visual privacy. The findings include: Observations on 03/10/2025 at 11:55 AM included four (4) residents in bed and four (4) residents listed on the name placard outside room [ROOM NUMBER] on the North Two unit. The bed area for Resident #147 (A-bed on the left side of the room closest to the door) did not have an approximately 6-foot-long section of privacy curtain parallel to the bed to provide visual privacy from the other three (3) residents in the room. When the curtain was extended parallel to the bed to provide privacy from the other three (3) resident beds, there was no visual privacy for Resident #147 from the hallway due to the curtain being too short. During an interview at this time, Resident #147 stated they either close the other three (3) residents' curtains or just go in the bathroom to change. Observations on 03/12/2025 at 1:38 PM included four (4) residents in bed and four (4) residents listed on the name placard outside room [ROOM NUMBER] on the north two unit. Additionally, the bed area for Resident #183 (A-bed on the right side of the room closest to the door) did not have an approximately 5-foot-long section of privacy curtain parallel to the bed to provide visual privacy from the hallway when the door was open. When this curtain was pulled closed to provide privacy for Resident #183 from the hallway, an approximately 5-foot-long section along the side of the bed did not provide full visual privacy from the other residents in the room due to the curtain being too short. 10NYCRR: 415.29, 415.29(c), 10NYCRR: 713-1.3(h)(2)

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F 0917 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26883 Based on observations and interview conducted during an Extended Recertification Survey from 03/09/2025 to 05/09/2025 the facility did not ensure that all residents had adequate functional furniture that meet residents' needs. Specifically, resident #147 did not have private closet space within their resident room, such that each residents' clothing was kept separate from the clothing of their roommate. Observations on 03/10/2025 at 11:55 AM on the North Two Unit revealed Resident room [ROOM NUMBER], a four-person capacity room, lacked private closet space for its residents. There were three freestanding wardrobes for the four (4) residents in this room and one of the wardrobes was shared for resident #147 and another resident. During an immediate interview, Resident #147 stated the room was made for three people but a while back they (staff) came in, took some measurements, and told them they were getting someone else in the room. Resident #147 stated that they do not like to have to share a closet. Additional observations made during the recertification survey revealed a total of six (6) four-person occupancy rooms (220, 221, 222, 223, 208, and 210) on North Two Unit. 10NYCRR: 415.29 10NYCRR: 713-1.3(h)(4)