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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice that met each resident's physical, mental, and psychosocial needs for six (6) of 21 residents (Residents #33, #42, #90, #179, #204, and #209) reviewed. Specifically,-Resident #209 returned from the emergency department on 10/01/2025 and there was no documented evidence the resident was assessed and their treatment in the emergency department was reviewed upon return, or the physician was made aware of their return. Subsequently, the resident was hospitalized on [DATE] for an untreated, worsening urinary tract infection. -Resident #42 returned from the hospital on [DATE] and was not started on an antibiotic per hospital discharge recommendations until 11/07/2025. Additionally, hospital recommendations for a basic metabolic panel (a lab that checks for fluid balance and metabolism) in one (1) week was not completed. Subsequently, the resident was re-hospitalized on [DATE] for gross hematuria (blood in the urine). -Resident #204 returned from the emergency department on 11/21/2025 with an after-visit summary recommending discontinuation of acetaminophen. The resident was administered three (3) doses of acetaminophen before the order was discontinued on 11/22/2025. -Resident #33 returned from the emergency department on 11/03/2025 and there was no documented evidence the resident had a follow up appointment scheduled with gastroenterology (digestive system specialist) as recommended. -Resident #90 returned from the emergency department on 11/22/2025. The 11/23/2025 Physician #12 progress note documented the plan included awaiting emergency department imaging results/after visit summary and follow recommendations once available and to continue routine medications unless contraindicated by emergency room evaluation. There was no documented evidence the resident's treatment in the emergency room was reviewed. -Resident #179 returned from the hospital on [DATE]. The hospital after-visit summary documented the antibiotic recommended to be given twice daily was last administered in the hospital the morning of 11/25/2025. Upon return to the facility, the resident did not receive the recommended antibiotic at bedtime on 11/25/2025 or in the morning on 11/26/2025. This resulted in actual harm to Resident #209 and the likelihood of serious injury, serious harm, serious impairment, or death that was Immediate Jeopardy and Substandard Quality of Care to resident's health and safety for all residents admitted or readmitted to the facility. Findings include: There was no documented evidence of facility policies related to readmission procedures. 1) Resident #209 had diagnoses including quadriplegia (paralysis of all four limbs), dysfunction of the bladder, benign prostatic hyperplasia (enlarged prostate causing trouble urinating) with lower urinary tract symptoms, and presence of urogenital implants (surgical medical devices to help the urinary system work properly). The 09/21/2025 Minimum Data Set (a resident assessment tool) documented the resident had severe cognitive impairment, was dependent for all activities of daily living, and had an indwelling urinary catheter. The 10/01/2025 Licensed Practical Nurse Unit Manager #14 progress note documented the resident's suprapubic catheter (a tube placed through an incision in the abdomen to drain urine) was leaking and they were advised by Physician Assistant #49 to send the resident to the hospital for possible replacement. The 10/01/2025 hospital emergency department notes by Physician #50 documented (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335082	A. Building B. Wing	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	there was no drainage around the suprapubic tube, and it was draining. The catheter was irrigated and flushed without difficulty. There were no fevers and no white count on previous urines with alternating infection verses colonization. The urine was sent for culture (determines possible growth of bacteria) and was okay for continued outpatient follow up. The resident was discharged back to the facility the same day (10/01/2025). There was no documented evidence in the resident's medical record when they returned to the facility, or that a nursing assessment was completed upon return. There was no documented evidence the resident's emergency room treatment was reviewed, recommendations for medical management were reviewed or addressed, or the resident's attending physician was notified upon their return to the facility. There was no documented follow-up on the urine culture obtained in the emergency room. The hospital notes from the 10/01/2025 emergency room visit were printed on 10/08/2025 by former admission Coordinator #55 and included a prescription from hospital Physician Assistant #52 dated 10/03/2025 for amoxicillin-potassium clavulanate (antibiotic) tablet 875-125 milligrams every 12 hours for urinary tract infection for ten (10) days. There was no documented evidence the resident's physician was notified of the prescription for the antibiotic.The 10/07/2025 physician order documented the resident was to receive amoxicillin-potassium clavulanate tablet 875-125 milligrams every 12 hours for urinary tract infection for ten (10) days. The October 2025 Medication Administration Record did not document any administered doses of the 10/07/2025 prescribed antibiotic. The 10/08/2025 one (1) week after the emergency room visit) Physician #12 progress note documented an acute care visit for follow up for urinary tract infection. The resident went to the emergency room last week where a urinalysis and culture were obtained, and the resident was later discharged back to the facility. The facility received a call today the urine culture was positive (presence of bacteria indicating an infection). An antibiotic was ordered per emergency department recommendations. The 10/08/2025 at 3:02 PM Licensed Practical Nurse #13 progress note documented the resident was sent to the emergency room at their spouse's request. There was no documentation of signs or symptoms related to the transfer. The 10/08/2025 hospital Physician #51 progress note documented the resident presented to the emergency department for evaluation and treatment of abdominal pain. The resident was seen and evaluated in the emergency room last week and was diagnosed with a urinary tract infection and sent home with an order for antibiotics. The resident was not started on treatment as the order was not received by the nursing facility. The resident had increased abdominal pain and tenderness suggestive of a progressive worsening urinary tract infection. Overall, the resident seemed to be worsening since returning home (to the facility). The differential diagnoses were urinary tract infection, pyelonephritis (a serious bacterial infection of the kidney), and acute kidney injury. They attempted to call the facility but were unable to reach them to confirm their ability to fill a prescription. Given the difficulty getting this filled, they did not feel comfortable sending the resident back to the facility. During an interview on 12/10/2025 at 4:05 PM, Licensed Practical Nurse Unit Manager #14 stated the cart nurse (medication nurse) was responsible for documenting a resident's return. The cart nurse was also responsible for reviewing the after-visit summary and should note if there were any new orders. They stated as the Unit Manager, they were also responsible to follow up on any resident returns the following day. They documented in a note on 10/01/2025 that Resident #209 went to the hospital and should have followed up the next day, but they did not. During an interview on 12/11/2025 at 10:14 AM, Assistant Director of Nursing #15 stated the emergency room often did not send paperwork, and the admissions department was asked to print it. Usually there was no nurse-to-nurse report from the emergency department when a resident returned to the facility. They recalled Resident #209's family member telling them about an antibiotic the resident was supposed to have. If the family member had not brought it up, the facility would never have known about it. They called the pharmacy who informed them the emergency department had sent a prescription, but it was not filled because it was not sent from a facility authorized provider. They stated they told Physician #12 the antibiotic needed to be ordered. The nurse manager should have (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	followed up on the paperwork and the emergency room visit. If a resident returned after hours, it was the nursing supervisor's responsibility. This happened another time as well, around the same time frame but they could not recall the other resident's name. The cart nurse or the supervisor should document a progress note upon resident's return. If a resident needed an antibiotic for any reason and did not get it, the infection would get worse. Antibiotics should be started within 24 hours. Resident #209's family member was upset and wanted the resident sent back to the hospital because the facility was not taking care of them, and they did not want the resident in the facility anymore. If there had been communication with the hospital, the facility would have known there was a urine culture pending and could have followed up about the need for an antibiotic. They stated the floor nurses were not knowledgeable about getting report and ensuring there was paperwork, but the nurse managers and supervisors should know. Nurse managers were supposed to review what residents went out to the hospital and what residents returned in morning report. During a telephone interview on 12/11/2025 at 11:34 AM, Physician #12 stated on 10/08/2025, Resident #209's family member informed the facility the resident was supposed to be on an antibiotic. If nursing had followed up sooner, they would have ordered the antibiotic, and the resident may not have had to go out to the hospital again. Unfortunately, without the antibiotic the resident's condition deteriorated, and they had to go back to the hospital.During a telephone interview on 12/11/2025 at 12:58 PM, Resident #209's family representative stated the resident had to be hospitalized on [DATE] with a worsening urinary tract infection because they were never administered an antibiotic. They spoke with Licensed Practical Nurse Unit Manager #14 who told them they spoke with the hospital and there was no mention of an antibiotic. During a telephone interview on 12/16/2025 at 1:56 PM, the Director of Nursing stated the emergency room return with Resident #209 fell through the cracks. If the resident returned without paperwork, the nurse should have contacted the hospital. It was the facility's responsibility to ensure resident needs were met and followed up on appropriately. They did not recall being made aware of the issue with Resident #209, or any other residents, or they would have followed up. 2) Resident #42 had diagnoses including urinary tract infection, hematuria (blood in urine), and acute kidney failure. The 10/20/2025 Minimum Data Set documented the resident was cognitively intact, required partial/moderate assistance with toileting hygiene, and had an indwelling urinary catheter. The 11/02/2025 Registered Nurse #8 nursing progress note documented the resident's urinary catheter had a substantial amount of blood throughout the tubing and in the bag. The on-call provider was notified and ordered the resident to be sent to the hospital. The 11/05/2025 hospital Physician #53 Discharge Summary documented the following for Primary Care Provider follow up: -Urology follow up for trial void in one (1) to two (2) weeks and for hematuria work up with cystoscopy (an exam of the inside of the bladder using a camera). -Outpatient follow-up for a large hiatal hernia (the top of the stomach bulges through the diaphragm). -Start amoxycillin (antibiotic) one (1) gram three (3) times a day to complete ten (10)-day course. -Basic metabolic panel lab test in one (1) week to monitor creatinine (a waste product from protein breakdown used to assess kidney function). The 11/05/2025 Registered Nurse #42 progress note documented the resident returned to the facility. There was no documented evidence of review or follow-up on the resident's emergency department treatment, or recommendations for medical management. The 11/06/2025 Physician #12 progress note documented the resident was seen for evaluation following recent hospitalization for hematuria. Recommendations included a urology follow-up appointment in one (1) to two (2) weeks and continue amoxycillin for enterococcus (type of bacteria) urinary tract infection. The gastrointestinal/abdominal exam was negative and did not indicate there was a large hiatal hernia. The 11/07/2025 physician orders documented amoxycillin 1000 milligrams three (3) times a day for urinary tract infection for ten (10) days and a complete blood count (measures the number and size of cells in the blood) and basic metabolic panel labs one (1) time only for renal (kidney) function evaluation.There was no documented evidence the 11/07/2025 complete blood count and Basic Metabolic Panel labs were completed or that a urology appointment was scheduled. The 11/14/2025 (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Change in Condition by Licensed Practical Nurse #37 documented the resident was sent to the emergency room for evaluation of hematuria. 3) Resident #204 had diagnoses including chronic kidney disease, adult failure to thrive (overall physical decline), and end stage heart failure. The 11/08/2025 Minimum Data Set documented the resident had moderate cognitive impairment, required supervision for most activities of daily living, and received a scheduled pain medication regimen. The 11/20/2025 Registered Nurse Supervisor #42 progress note documented the resident was assessed after an unwitnessed fall. The resident was sent to the emergency department for further evaluation. The 11/21/2025 hospital after visit summary medication list documented a large red stop-sign and directions to stop taking acetaminophen. The 11/21/2025 Licensed Practical Nurse #37 progress note documented the resident returned to the facility. There was no documented evidence the resident's emergency treatment was reviewed or recommendations for medical management were reviewed or addressed. There were no documented orders to discontinue acetaminophen. The November 2025 Medication Administration Record documented acetaminophen 500 milligrams, give to (2) tablets by mouth three (3) times a day for pain. The acetaminophen was documented as administered on 11/21/2025 at 7:00 PM, and 11/22/2025 at 9:00 AM and 2:00 PM. The acetaminophen was discontinued on 11/22/2025 at 5:12 PM. During an interview on 12/09/2025 at 11:35 AM, Licensed Practical Nurse #13 stated they let their nurse manager, or a supervisor know when a resident returned to the facility from the hospital, and they did not document if a resident returned to the facility. They stated they never reviewed the paperwork. It was the Nurse Manager's or Supervisor's, and the Medical Provider's responsibility to obtain and review hospital paperwork. During an interview on 12/10/2025 at 2:04 PM, the Admissions Director stated they alerted staff of a hospital return, printed the hospital paperwork, and uploaded it to the medical record. If it was only an emergency room visit, they were not involved unless they were asked to print something from the hospital record. During a telephone interview on 12/11/2025 at 11:34 AM, Physician #12 stated nursing should follow up on all emergency room visits and call the hospital to obtain the discharge paperwork if needed. It was important the facility knew what the hospital recommendations were to provide what was needed in the nursing home. When residents went out to the hospital or returned, it was discussed in morning meeting. If nursing did not report to them a resident returned from the hospital, they had no way of knowing. Residents who returned to the facility were typically seen by medical the next day. During an interview on 12/12/2025 at 10:59 AM, the Administrator stated the facility did not always receive paperwork from the hospital. The cart nurse or nurse manager was responsible to go through the paperwork, talk to the provider, put any new orders in, and complete an assessment. Each unit was responsible, and several people would have been doing parts of a hospital or emergency department return. Paperwork should be reviewed within 24 hours; they did not know the whole process, but it had to be team effort. There should have been a progress note written when residents returned to the facility. Leadership had a telegram text communication on their cellular phones and any movement of a resident in and out of the facility should be communicated there. They asked the nurses to request the emergency room paperwork, but they were not sure if there was a formal education with the nurses about the return process. They were not aware of hospital return issues for Residents #33, #42, #90, #179, and #204. The paperwork should have been reviewed and followed up on for patient care. Something was changed for a reason, antibiotics should not be missed, and there could be negative effects. Resident #209 got worse and had to be hospitalized . The nurses did not follow up and the provider did not follow up. Assistant Director of Nursing #15 or the Director of Nursing should have investigated how this happened and how this was missed. They expected the Director of Nursing to investigate the issue with Resident #209 after they were made aware on 10/08/2025, but they did not follow up with them. 10NYCRR415.23Immediate Jeopardy was identified, and the Administrator was notified on 12/12/2025 at 5:35 PM. Immediate Jeopardy was removed on 12/16/2025 at 3:38 PM prior to survey exit based on the following corrective actions taken:-A new process was started with residents returning from the hospital that included reviewing medications, (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and a new emergency department checklist was implemented. -Admissions staff uploaded emergency room visits the next business day. -The Assistant Director of Nursing educated staff on the evening shift on 12/12/2025. -The nursing supervisor educated the night shift on 12/12/2025 and the day shift on 12/13/2025. -The nursing supervisor on duty educated over the weekend and the Assistant Director of Nursing and the Director of Nursing followed up. -The nursing supervisor was made aware when the hospital was sending a resident back, and was responsible to ensure the checklist was filled out. -The nurse on west 1 (ambulance bay door) notified the nursing supervisor of a resident's arrival. -On 12/12/2025 at 7:20 PM, the facility's immediate plan was reviewed and accepted. -On 12/15/2025 it was identified the facility was not in compliance with one (1) of two (2) hospital readmissions from over the weekend.-The facility staff involved were re-educated on 12/15/2025 and verification of re-education was received.-Staff education was verified onsite during interviews on 12/16/2025. Multiple licensed nursing staff were interviewed. -Staff were able to report content of education.

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure adequate supervision to prevent accidents for three (3) of seven (7) residents (Resident #34, #44, and #100) reviewed. Specifically:-Resident #100 who was cognitively impaired and wore a wander alert device, left the faciity on [DATE] undetected, and attempted to enter staff vehicles in the parking lot. The resident was not provided 30-minute checks as ordered following the incident. The elopement was not reported to the New York State Department of Health as required. Additionally, the resident was observed attempting to exit through stairwell doors without their wander alert device alarming; and staff were observed silencing the wander alert alarm without checking the area for residents. -Resident #34 was at risk for falls, had an unwitnessed fall on 11/13/2025 resulting in a scalp laceration and neurological checks were not completed following the fall. Additionally, the resident was observed not wearing non-skid socks as care planned. -Resident #44 was at risk for falls, had multiple falls (09/16/2025, 09/18/2025, 11/24/2025, and 12/08/2025), was not provided fall interventions as care planned, interventions were not reviewed or revised following recurrent falls, neurological checks were not completed as ordered, and the falls were not thoroughly investigated to determine a root cause. This resulted in Immediate Jeopardy and Substandard Quality of Care to Resident #100 and placed all 28 residents identified as at risk for elopement, at risk for the likelihood of serious harm, serious injury, serious impairment, or death. Findings include:ELOPEMENT The facility policy Elopements revised 01/2025, documented staff was to investigate and report all cases of missing residents. A resident who left the premises or a safe area without the facility's knowledge and supervision was considered an elopement. When the individual returned to the facility, the Director of Nursing or charge nurse were to examine the resident for injuries, notify the attending physician and the resident's responsible party, complete and file a report of Incident/accident and document the event in the resident's medical record. Resident #100 had diagnoses including dementia with psychotic disturbance and Parkinson's disease (a progressive neurological disorder). The 10/03/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, fluctuating disorganized thinking and inattention, had no behaviors, and required supervision for mobility. The 11/03/2025 Comprehensive Care Plan documented the resident was at risk for elopement related to a change in their environment and cognitive impairment. Interventions included to check placement of the wander alert device each shift, provide the wander alert device number and location, and check the wander alert bracelet every shift. The 10/18/2025 Elopement Risk Assessment documented the resident was at risk for elopement and had one (1) or more elopement attempts. The 10/18/2025 Incident report, signed off by the Director of Nursing on 11/26/2025, documented:- on 10/18/2025 at 12:26 PM, the unit was notified Resident #100 was observed outside by Certified Nurse Aide/Concierge #9. The resident was attempting to open car doors. - the resident was redirected back inside by Certified Nurse Aide/Concierge #9 and the Supervisor, Director of Nursing, and Nurse Practitioner were notified.- Resident #100 was last seen at 12:15 PM wandering around the unit. - there were no findings on the head-to-toe assessment, the placement and function of the wander alert device was checked and found to be functioning, and the Resident #100 was placed on one-hour checks.- Maintenance checked the function of all doors and elevators with no issues found. There was no documented evidence of a review of the resident's care plan to ensure interventions were in place and appropriate, no documented evidence of a summary of the incident and no documented evidence of a report to the New York State Department of Health. The 10/18/2025 Physician Assistant #61 progress note documented they spoke with Registered Nurse #8 who informed them that Resident #100 was found outside of the facility. The resident was last seen approximately ten (10) minutes before being found outside, near the building. They were unsure how (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the resident left the building. Resident #100 was without injuries. They ordered the resident be placed on 30-minute checks, continue the wander alert device and ensure the device was functioning properly, obtain a urinary analysis related to a urinary tract infection and labs, and obtain a psychiatric consult to evaluate for medication adjustments. The October 2025 Treatment Administration Record documented Resident #100 was placed on 30-minute checks on 10/18/2025 during the 7:00 AM - 3:00 PM shift and the order was discontinued on 10/18/2025 at 1:59 PM. One-hour checks were initiated at 2:00 PM on 10/18/2025. There was no documented evidence of a physician order for discontinuing 30-minute checks or initiating one-hour checks. The 10/13/2025 and 11/06/2025 Wanderguard Door Inspection documented all alarms were working properly. There was no documented evidence of door checks on 10/18/2025. Resident #100 was observed on:-12/04/2025 9:47 AM wandering around the hallway and stopping in front of other residents that were sitting in the hallway. At 10:27 AM, wandering up and down the hallway. At 11:41 AM, attempting to follow a staff member through the stairwell to the right of the elevator and the wander alarm went off. -12/08/2025 from 11:50 AM to 12:26 PM, wandering the hallway. -12/09/2025 at 10:59 AM quickly following Registered Nurse #8 and a licensed practical nurse toward the E2 stairwell. The resident grabbed the door right before it shut and attempted to follow Registered Nurse #8 through the door. Registered Nurse #8 directed Resident #100 to let go of the door and then shut the door. The wander alert system did not alarm when the resident went to the door. At 11:02 AM, the resident had a wander alert device on their ankle. At 11:14 AM, the resident walked back toward the E2 stairwell and was redirected towards the dining room by a staff member. During an observation and interview on 12/08/2025 at 11:16 AM in the E stairwell, Registered Nurse Unit Manager #38 stated the door alarmed if the door stayed open too long and a code had to be put in to exit. If the door was open too long the code had to be put in to silence the door or it could be silenced at the nursing station desk. During an observation on 12/08/2025 at 3:05 PM, the E stairwell door was tested, there was an approximate three (3) second delay when the door was opened and the alarm sounded. The alarm was silenced with no staff checking the doorway to see why the alarm was triggered. There was no camera in the area for monitoring. At 3:19 PM, the door to the outside was set off and silenced with no staff checking to see why the alarm was triggered. An unidentified staff member was observed at the nursing station turning off the door alarm without checking the stairwell. During an observation on 12/09/2025 at 11:05 AM, the wander alert system was tested with a wander alert device obtained from Licensed Practical Nurse Unit Manager #37. The wander alert device sounded appropriately at the elevator. At 11:06 AM, the wander alert device did not audibly alarm at the F2 door to the stairwell but did signal light blink. The door relocked immediately when the code was entered on the wander alert box at the door. At 11:09 AM, an exit was attempted by the surveyor at the E2 door to the stairwell with the wander alert device. There was no signal light flashing, the door did not lock when the code was put in, and exit was successful without the wander alert device alarm triggering. During an interview on 12/09/2025 at 11:55 AM, Maintenance Worker #57 stated they completed the wandering alert device door checks. They checked all the doors except the first floor. The wander alert devices did not lock the doors, they only locked the elevators. Once the doors open from the delayed egress (when the exit door locks and it cannot be immediately opened until after several seconds), the wander alert alarm went off. The door checks were done monthly and if something was not working properly, they alerted the Director of Environmental Services. The wander alert alarm was turned off by entering the door code. During an observation and interview on 12/09/2025 at 1:39 PM with the Director of Environmental Services and Maintenance Worker #57, the wander alert system was not working at the E2 door to the stairwell. The Director of Environmental Services stated the sensitivity was not strong enough and needed to be adjusted and it may have weakened due to residents wandering near the door. Maintenance Work #57 stated they only tested the delayed egress when they did their door check and was confused on how to test the wander alert system. During an interview on 12/09/2025 at 12:05 PM, Certified Nurse Aide #59 stated all three (3) doors and the elevator on the [NAME] 2 unit (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	had wander alert device alarms. The door wander alert device alarms were supposed to alarm when a resident went near the door or beeped if a resident tried to push on the door. If a resident was exit-seeking, the resident should be redirected, the nurse alerted, and staff should attempt to keep an eye on the resident. They believed when Resident #100 eloped on 10/18/2025, they were let out or they went behind someone as they could not leave through the unit door without a code. They stated they thought maintenance was fixing the doors that day because the resident's wander alert alarm did not go off. Resident #100 had their wander alert device on their ankle, and it was functioning. During an interview on 12/09/2025 at 12:21 PM, Registered Nurse #8 stated the doors in the dining room had wander alert alarms that were supposed to sound when residents with wander alert devices went near them. They stated on 10/18/2025, Resident #100 was found by staff outside in the back by the loading docks. When they went to get the resident, the resident was already coming up the stairwell from the back door with a staff member. The resident was gone for approximately ten (10) minutes. They did not know how the resident got outside as they had their wander alert device on, and it was functioning. Registered Nurse #8 said, they believed something was going on with the doors and codes to the doors, they were just open, and the resident went down the E stairwell. They were informed after the incident there were issues the night before with the wander alert system as it kept beeping. When maintenance checked the system after Resident #100 was back on the unit, they said everything was working. During a phone interview on 12/09/2025 at 12:44 PM, Certified Nurse Aide/Concierge #9 stated on 10/18/2025, Resident #100 was outside in the parking lot when they were coming back from lunch. They saw Resident #100 trying to get into cars. When they called the resident's name they went over to the loading dock. They asked the resident to come inside, and the resident followed them in. Registered Nurse #8 met the Certified Nurse Aide/Concierge on the stairs after they called them on the supervisor phone. During an interview on 12/09/2025 at 12:50 PM, Licensed Practical Nurse Unit Manager #37 stated wander alert devices were checked for placement every shift and function twice a day. The function was checked by walking the resident to the elevator or by the box in the supervisor's office that sounded off if it was functioning. All staff had the codes to the wander alert device keypads and could turn off the alarms. Nursing should only shut off the alarms after they made sure no residents had gone out the doors or got on the elevator. The only wander guard alarm that sounded was at the elevator because the doors were coded. They were unsure how Resident #100 got outside, but the resident was placed on safety checks after the elopement. If the door to the E stairwell door did not shut all the way, it would engage the alarm, but they were unsure how long it took. During an interview on 12/09/2025 at 1:06 PM, the Director of Nursing stated if there was an elopement, staff notified the supervisor. They and the Administrator were also notified. The situation would be investigated. They should make sure the resident was safe, inform the physician and responsible party, and report the incident to the Department of Health within two (2) hours. Staff had been educated on elopement risk, there were evaluations to identify residents as elopement risk which were included in the resident's chart. The facility also had wander alert devices for residents who had tendencies to wander and possibility to elope. The wander alert devices were checked every shift, but they were unsure how often the alarms at the doors and the elevator were checked. On 10/18/2025, Resident #100 was noted by the dock outside. It was not considered an elopement even though the resident had gotten off their unit with a wander alert device. The report they originally received documented the resident was standing on the loading dock and was seen by a staff member walking towards the dock. When they received the staff statements, they found out the resident was outside alone trying to get into cars. The elopement was not reported to the New York State Department of Health. They were new to the facility at the time and had followed up on reporting protocol and they were past the two (2)-hour reporting timeline, so it was not reported. They informed the Administrator the resident was outside unattended, but they were not provided any direction on reporting the incident. They were unsure how the resident got outside as their wander alert device was working. During an interview on 12/09/2025 at 1:37 PM, the (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administrator stated staff were educated upon hire and annually regarding elopements. There was an elopement binder at the front desk. Resident #100 eloped in October 2025. They were informed the wander alert system was not functioning correctly and the resident was found outside. However, when maintenance came in to check the system, everything was working correctly. They were informed maintenance had to reset the system, but it was functioning correctly. They believed Resident #100 got out via the E stairwell. All the doors on the second and third floor were supposed to have a wander alert alarm on them if a resident with a wander alert device got near them. If the door did not alarm, the staff were to immediately call maintenance. All staff were able to shut off the wander alert alarms at the doors and elevators. Regular door alarms should not be turned off at the nursing station without checking to see who went out the door. It was important to have a functioning wander alert system to prevent a resident from eloping. Resident #100's elopement was not reported to the New York State Department of Health as it was past the reporting deadline by the time they found out about the incident. They were not made aware the resident was unattended in the parking lot until the following Monday (10/20/2025) and they should have been made aware of the elopement right away. During a phone interview on 12/09/2025 at 4:19 PM, the Medical Director stated they were unsure if they were notified of Resident #100's elopement from the facility in October 2025. It was not a situation that necessarily needed to be escalated to the Medical Director, but a physician should be notified. Facility wander alert systems were not under their control, but they expected the devices in the facility were properly functioning and safety measures were in place. If an on-call provider ordered 30-minute checks of a resident, the facility should follow through on the order. During a phone interview on 12/09/2025 at 5:03 PM, Physician #12 stated if a resident eloped, they expected the resident to be placed on one-to-one monitoring. The resident should be assessed by a registered nurse and the assessment communicated to the medical team. They were made aware Resident #100 was found outside the facility. If 30-minute checks were ordered by a provider, staff should not change them to one (1) hour checks without another medical order. FALLS The facility policy Fall Prevention Program revised 01/2025, documented residents must be assessed in a timely manner for potential causes of a fall and the environmental issues addressed promptly. After a first fall, the team reviewed the resident's gait, balance, and current medications. Based on the assessment, the interdisciplinary team would identify interventions to prevent subsequent falls. The interdisciplinary team, with physician's guidance, were to follow up on any fall with an associated injury and monitor as delayed complications could occur. If the interventions were successful in preventing falls, the staff continued with the current approaches or determined if they are still needed if the problem had resolved. If a resident continued to fall, the staff and the physician were to re-evaluate the situation and current interventions. 1) Resident #34 had diagnoses including repeated falls and unsteadiness on feet. The 10/17/2025 Minimum Data Set documented the resident was cognitively intact, had no behaviors, required supervision to touching assistance for transfers and ambulation, and had two (2) or more falls without injury.The 04/16/2025 Comprehensive Care plan documented the resident was at risk for falls related to weakness, deconditioning, restlessness, and history of recurrent falls. Interventions included to ensure resident was wearing appropriate footwear for movement, and non-slip socks while out of bed. The undated Kardex (care instructions) documented for safety, the resident was to wear non-slip socks while out of bed. A 09/04/2025 physician order documented neuro checks per facility protocol for 72 hours post-fall every shift for three (3) days. The 11/13/2025 Incident Report completed by Licensed Practical Nurse #14 documented Resident #34 was found in their room on the floor with a small amount of blood coming from the right side of their scalp. The incident was unwitnessed, and injuries were observed at the time of the incident. The resident had an abrasion to the top of the scalp. The incident report documented there were no predisposing physiological or situational factors documented. The 11/13/2025 Medical Provider #24 note documented the Resident #34 was seen for an unwitnessed fall. The unit nurse found the resident at their bed side with blood oozing from the right side of their (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	head. It was suspected the resident hit their head on the nightstand next to the bed. The resident had a laceration to the right side of their head measuring approximately 1.5 centimeters by 0.3 centimeters with shallow depth. No other injuries were noted. The resident had a history of repeated falls. The orders were to monitor for delayed signs or symptoms; fall precautions: non-skid shoes/footwear, call bell within reach, bed at the lowest position, floor mats on both sides of the bed, and remove nightstand from the bedside; to monitor vitals for at least 72 hours; and neurological checks for at least 72 hours post fall. There was no documented evidence neurological checks were completed as ordered. Resident #34 was observed out of bed without non-skid socks on:-12/04/2025 at 11:20 AM;-12/05/2025 at 10:51 AM sitting in their recliner. At 11:13 AM, while Certified Nurse Aide #62 and an unidentified certified nurse aide assisted the resident up from bed to their chair; -12/08/2025 at 12:07 PM, propelling themself in their wheelchair. During an interview on 12/08/2025 at 1:57 PM, Certified Nurse Aide #62 stated they should check the care plan every day to ensure no changes were made. If non-skid socks were on the resident's care plan, staff should ensure they were on. The night shift got Resident #34 up for safety reasons as the resident was a fall risk, and the night shift was responsible for getting them dressed. When they assisted the resident with transferring, they were not paying attention and did not check to see if the resident had non-skid footwear on. During an interview on 12/15/2025 at 4:23 PM, Licensed Practical Nurse #13 stated nursing staff should check the care card every shift. Resident #34 had fall precautions in place and should have non-slip socks on as they tried to get up and was unstable. The resident needed the non-skid socks to prevent falls. Neurological checks were documented in the computer and on paper. Neurological checks were documented for 72 hours and were supposed to be completed for unwitnessed falls. During an interview on 12/16/2025 at 12:16 PM, Licensed Practical Nurse Manager #14 stated if there was an unwitnessed fall, they should start neurological checks. On 11/13/2025, Resident #34 hit their head and the medical provider's note from the incident documented there should have been neurological checks. Neurological checks were documented on paper and then given to the Assistant Director of Nursing or Director of Nursing to put with the investigation. Resident #34 should wear non-skid socks as they were at risk for falls, and it is on their care plan. During a phone interview on 12/18/2025 at 10:14 AM, the Assistant Director of Nursing #15 stated the certified nurse aides should review care plans daily. All falls were investigated if they were unwitnessed. Neurological checks were initiated immediately after an unwitnessed fall. Typically, a registered nurse would start the neurological checks and instruct the licensed practical nurse on what forms to complete. Neurological checks were documented on the neurological check sheet and placed in the 24-hour binder. The nursing staff were responsible to ensure the neurological checks were completed as ordered. The 24-hour binder was monitored by the nurse manager. When they reviewed unwitnessed fall accident and incident reports they also reviewed to see if neurological checks were completed. Resident #34 was high risk for falls and staff should follow the fall interventions on the care plan and Kardex. The resident was care planned for non-skid socks and should have them on. The 11/13/2025 fall incident report was started by Licensed Practical Nurse Manager #14. Medical Provider #24 recommended neurological checks to be completed, and they should have been completed. They were unaware neurological checks were not completed, and they did not recall reviewing the accident/incident report for the fall on 11/13/2025. During a telephone interview on 12/18/2025 at 3:39 PM, Physician #12 stated the facility protocol was to do neurological checks every shift after a fall. Resident #34 has a lot of falls. A registered nurse should assess the resident, call the medical provider and then they were to follow fall protocol and start neurological checks. During a phone interview on 12/19/2025 at 9:17 AM, the Director of Nursing stated neurological checks were completed for head strikes or unwitnessed falls. The registered nurse would do the initial neurological check and then the cart nurse (medication nurse) assigned would continue the neurological checks. These were completed for 72 hours. Neurological checks were documented on a paper form and placed in the 24-hour report book on the unit. The nurse on the unit and the unit (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	manager were responsible for ensuring neurological checks were completed. The purpose of a neurological check was to ensure there were no cognitive or mental status changes. Neurological checks were facility protocol. With a head strike, they expected neurological checks to be completed. During a phone interview on 12/19/2025 at 11:20 AM, Medical Provider #24 stated Resident #34 had a history of frequent falls and was seen by them on 11/13/2025 for a fall. Neurological checks should have been completed, and they were not aware they were not completed. All falls should have neurological checks completed for 72 hours and it was nursing's responsibility to complete them each shift.2) Resident #44 had diagnoses including dementia, glaucoma (eye condition that damages the optic nerve), and a history of falling. The 10/05/2025 Minimum Data Set (a tool to assess resident) documented the resident had severe cognitive impairment, required supervision for transfers/ ambulation, had one (1) fall with no injury, and two (2) or more falls with minor injury. The Comprehensive Care Plan initiated 05/06/2024 and revised 10/03/2025 documented the resident was at risk for falls and had actual falls related to history of falls, poor bed mobility, impaired cognition, and poor safety awareness. Interventions included items were kept within reach, ensure appropriate footwear, bilateral floor mats, and initiate an investigation to identify the cause of falls. The 09/16/2025 at 6:00 PM fall incident completed by Registered Nurse #42 documented an unwitnessed fall. Resident #44 was found on the floor sitting on their left side next to the dresser. Neurological checks were within normal limits, the resident had a laceration to their right eyebrow and was sent to the emergency room for evaluation. There were no predisposing environmental or situational factors documented. There was no documented evidence of staff statements, neurological checks, or determination if the resident's care planned interventions for falls were in place. The 09/16/2025 fall risk evaluation by Licensed Practical Nurse Unit Manager #43 documented Resident #44 had multiple falls in the past six (6) months and was at moderate risk for falls. The 09/18/2025 at 2:05 AM fall incident completed by Licensed Practical Nurse #44 documented Resident #44 had an unwitnessed fall and was observed on the floor with no injury. Neurological checks were completed on 09/18/2025 at the time of the incident. There was no documented evidence to determine if the resident's care planned interventions for falls were in place. The 09/18/2025 72-hour neurological check sheet documented neurological checks were completed at 3:00 AM and 3:15 AM, with resident refusals documented until from 3:30 AM - 7:00 AM. There was no documented evidence of additional neurological check sheets after 7:00 AM on 09/18/2025. The 11/24/2025 at 4:15 PM fall incident completed by Licensed Practical Nurse #4 documented an unwitnessed fall with no injury. The resident was found in the bathroom on the floor without injury. Predisposing physiological, situational, and environmental factors were documented as other without an explanation. There were no statements, no documented neurological checks, and no documented evidence to determine if the resident's care planned interventions for falls were in place. The 12/08/2025 at 2:55 AM fall incident completed by Licensed Practical Nurse #44 documented an unwitnessed fall with no injury. Resident #44 was heard falling by staff at the nursing station and was observed on the floor in their room. Predisposing environmental factors included incontinence and behavior; predisposing physiological factors included gait imbalance and incontinence; and predisposing situational factors included ambulating without assistance. There were no statements to determine the last time Resident #44 was toileted, no documented neurological checks, and no documentation to determine if the resident's care planned interventions for falls were in place. There was no documented evidence the care plan was reviewed or revised post incident. Resident #44 was observed at the following times:-On 12/02/2025 at 3:38 PM, lying in bed. They stated they had a lot of falls and their back hurt. There were no fall mats on the floor next to the bed as care planned. -On 12/04/2025 at 10:47 AM, 1:11 PM, and 1:47 PM, sleeping in bed with a bed sheet over their head. The bed was at hip height (versus in low position) and there were no fall mats on the floor as care planned. -On 12/05/2025 at 9:54 AM, sleeping in bed with a bed sheet over their head. There were no fall mats on the floor next to the bed. At 11:26 AM in bed yelling they could not find their shoes and they needed to go to the bathroom. (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	There were no fall mats on the floor next to the bed as care planned. -On 12/08/2025 at 3:14 PM, sleeping in bed with no fall mats on the floor next to the bed as care planned. -On 12/09/2025 at 11:56 AM, in bed watching television. The bed was at hip height and there were no fall mats on the floor next to the bed as care planned. -On 12/10/2025 at 12:00 PM, sleeping in bed with a bed sheet over their head. The bed was at hip height and there were no fall mats on the floor next to the bed as care planned. During an interview on 12/09/2025 at 12:04 PM, Certified Nurse Aide #45 stated fall interventions were located on the Kardex (care instructions), and they were expected to follow the Kardex. They were not aware of any falls for Resident #44, and they did not have any fall interventions. During an interview on 12/09/2025 at 12:29 PM, Licensed Practical Nurse #4 stated a resident with a history of falls should have the bed in the lowest position and fall mats. Resident #44 had falls, they got up on their own, so they tried to do frequent checks on the resident. During an interview on 12/10/2025 at 1:10 PM, Licensed Practical Nurse Unit Manager #43 stated interventions for fall prevention were in the care plan and they expected them to be followed. After a fall, they initiated the fall risk management screen but the supervisor or the Assistant Director of Nursing were responsible to complete the investigation and update the care plan. Resident #44 had three (3) or four (4) falls, maybe more. They did not know how to access the fall care plan to see the interventions that were in place but stated they knew the resident did not have fall mats because the resident could trip on them. During a telephone interview on 12/16/2025 at 1:36 PM, the Director of Nursing stated Assistant Director of Nursing #15 was responsible for risk management including falls. After the investigation was completed, it was given to them. They then signed off on the investigation and the Administrator closed them out. The facility was working on falls and attempting to ensure all falls were investigated and that care plans were being reviewed and revised for effective interventions. During an interview on 12/16/2025 at 2:58 PM, Assistant Director of Nursing #15 stated they were responsible for all accident/incident reports for the facility and ensuring there were thorough and complete investigations. There should be statements from all staff. Falls were discussed in morning meeting. If neurological checks were indicated, that was part of the packet. The process of the investigation would show if there was a break in the care plan. They relied on the unit managers to alert them if interventions were not effective. Most fall investigations were not completed, and they had to follow up. In reviewing Resident #44's care plan, it was not being reviewed or revised with each fall. The investigations for Resident #44 were not done and they were not sure how they missed them. During an interview on 12/22/2025 at 11:00 AM, the Administrator stated they were teaching staff how to complete a proper investigation which included witness statements, a documented registered nurse assessment, and to review/revise interventions. Falls were discussed in morning meeting and the care plan was reviewed to ensure there were no care plan violations. There were no complete and thorough investigations for Resident #44. The Director of Nursing was ultimately responsible, had support, was not asking for help, and was not completing investigations timely. 10 NYCRR 415.12(h)(1)(2)Immediate Jeopardy was issued to the Administrator for F-689 Elopement on 12/09/2025 at 6:00 PM. The Immediate Jeopardy was lifted on 12/11/2025. The following steps were taken to lift the Immediate Jeopardy:-As of 12/09/2025 at 7:49 PM, the facility's immediate plan was reviewed and accepted. -As of 12/11/2025 at 1:15 pm 100% of all staff currently working had been educated on elopement and wander alert malfunction. -85% of all staff had been educated on elopement and wander alert malfunction.-The remaining staff would be educated prior to the start of their next shift. -Staff education was verified onsite during interviews on 12/11/2025. Multiple staff including nursing, maintenance

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0675 Level of Harm - Actual harm Residents Affected - Many	Honor each resident's preferences, choices, values and beliefs. Based on observations, record review, and interviews conducted during the survey, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care resulting from the cumulative effect of noncompliance cited for F684 Quality of Care, F677 Activities of Daily Living, F689 Accident Hazards, F865 Quality Assurance and Performance, and for 242 of 242 residents residing in the facility. This noncompliance was found to be widespread and created an environment reflecting pervasive disregard for one (1) or more residents' well-being and quality of life, which caused or was likely to cause serious injury, harm, impairment or death that was Immediate Jeopardy and Substandard Quality of Care. Findings include:F684 - Quality of CareWhen Resident's #33, #42, #90, #179, #204, and #209 returned from a hospital or emergency department visit, nursing did not assess the residents, the physician was not made aware, and hospital recommendations for medical management were not reviewed or addressed. The facility's failure to have a process in place when a resident returned from the hospital or emergency department to follow up and review the residents' treatment, order/stop necessary medications or diagnostic testing, and/or schedule follow up visits, placed all residents returning from the hospital at risk for serious harm, serious injury, serious impairment, or death. This resulted in actual harm to Resident #209 that was Immediate Jeopardy and Substandard Quality of Care to resident health and safety for all residents returning from the hospital or emergency department. F677 - Activities of Daily Living Care Provided for Dependent ResidentsResident #132 was not assisted with showering, incontinence care, personal hygiene, and getting out of bed as planned. This resulted in psychosocial harm to Resident #132 that was not Immediate Jeopardy and was Substandard Quality of Care. F689 - Free of Accident Hazards/Supervision/DevicesResidents #34, #44, and #100 were not provided supervision to prevent accidents. Resident #100 eloped from the facility undetected; Resident #34 was at risk for falls, was not wearing their no skid socks as care planned and did not have neurological checks completed following a fall; and Resident #44 was at risk for falls, was not provided fall interventions as planned, interventions were not reviewed or revised following recurrent falls, neurological checks were not completed as ordered, and their falls were not thoroughly investigated. F 865 QAPI Program The facility did not implement and maintain the approved plans of correction from the Extended Recertification Survey dated 05/09/2025 for Resident Rights/Exercise of Rights (F550), Safe/Clean/Comfortable/Homelike Environment (F584), Quality of Life (F675) ADL Care Provided for Dependent Residents (F677), Quality of Care (F684), Treatment/Services to Prevent/Heal Pressure Ulcers (F686), Free of Accident Hazards/Supervision/Devices (F689), Dialysis (F698) Label/Store Drugs and Biologicals (F761), Nutritive Value/Appear, Palatable/Prefer Temp (F804) and Food Procurement, Store/Prepare/Serve- Sanitary (F812), Administration (F835) QAPI Program/Plan, Disclosure/Good Faith Attempt (F865) and Infection Control (F880) 10 NYCRR 415.5

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure the interdisciplinary team determined a resident's ability to self-administer medications was clinically appropriate for one (1) of one (1) resident (Resident #147) reviewed. Specifically, Resident #147 had expired and/or discontinued medications and used insulin needles in their room.Findings include: The facility policy Self- Administration of Medications dated 01/2025, documented residents had the right to self-administer medications if the interdisciplinary team determined that it is clinically appropriate for the resident to do so. Self-administered medications must be stored in a safe and secure place, which is not accessible by another resident. If safe storage is not possible in the resident's room, the medications of the resident permitted to self-administer would be stored on a central medication cart or in the medication room. Nursing would transfer the unopened medication to the resident when the resident requested them. Resident #147 had diagnoses including diabetes, depression, and high blood pressure. The 12/02/2025 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact and required set up or clean up assistance with most activities of daily living.The 06/12/2023 physician order documented the resident may self-administer the following medication: by mouth medications, insulin and check own blood glucose levels. There was no documented evidence the resident was assessed for their ability to safely self-administer medications. The Comprehensive Care Plan initiated on 02/10/2023 and revised on 07/11/2025 documented the resident had poor adherence to care regimen and medications. Interventions included assess ability to understand and adhere to therapeutic regimen. The Comprehensive Care Plan initiated 10/03/2023 and revised 08/21/2025 documented the resident required assistance with self-care related to confusion and limited range of motion. There was no documented evidence the resident was care planned to self-administer medications or check blood glucose levels. The following medications were ordered for Resident #147:-On 03/27/2025, Trulicity (diabetes medication) subcutaneous solution pen-injector 3 milligrams/0.5 milliliter inject 0.5 milliliters subcutaneously one (1) time a day every Tuesday for diabetes, may self-administer.-On 07/31/2025, insulin aspart (rapid acting insulin) Injection solution 100 unit/milliliter, inject 60 units subcutaneously two (2) times a day for diabetes. Hold for blood glucose less than 120.-On 07/31/2025, insulin aspart injection solution 100 unit/milliliter, inject 74 units subcutaneously in the morning for diabetes starting on 08/01/2025. Hold for blood glucose less than 120. -On 10/07/025, insulin degludec (long-acting insulin) subcutaneous solution- pen injector 100 unit/milliliter, inject 50 units at bedtime for diabetes. Hold for blood sugar less than 100. -On 08/20/2025, pen needles 5/16 (insulin needle) inject one (1) pen needle subcutaneously before meals for diabetes. The following medication were discontinued for Resident #147:-discontinued on 06/13/2023 selegiline hydrochloride (used for depression) 5 milligram tablets-discontinued on 06/13/2025 losartan (antihypertensive) 100 mg. During an observation on 12/02/2025 at 4:12 PM, in a cabinet in the resident's bathroom (the resident had a private room) there was a sharps container, a 30 day blister pack of selegiline 5 milligram tablets with a refill date of 01/2024, and a 30 day blister pack of losartan 100 milligrams labeled with refill dates of 02/03/2025 and 03/02/2025. On the resident's bedside table there was an insulin pen 100 units in a bag, and six (6) used insulin needles in a fabric bag. During an observation on 12/05/2025 at 10:55 AM, Resident #147 was sleeping in their bed, and the fabric bag with capped needles was hanging from the over-the-bed tray table. During an observation on 12/08/2025 at 12:35 PM, there were four (4) used insulin needles capped in a fabric bag attached to the over-the-bed tray table, Resident #147 was lying in their bed. During an interview and observation on 12/15/2025 at 4:08 PM, Resident #147 stated the needles in the felt bag on the over-the-bed table with the caps on them were used. They stated the nursing staff would bring them a sharps container and they put them in the container. The sharps container and the expired medications remained in the cabinet. During an interview on 12/15/2025 at 4:23 PM, Licensed Practical Nurse #13 stated Resident #147 had an order (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Actual harm Residents Affected - Few	to self-administer medications and had been self-administering since they were admitted . They thought Resident #147 was assessed by medical and nursing. They stated they administered Resident #147 their ordered narcotic, but Resident #147 did their own blood glucose checks and administered their own insulin. They stated they documented Resident #147's reported blood glucose. Resident #147 had blister packs of medications and was supposed to keep their medication in the drawer. Resident #147 had their own sharps container and let nursing staff know when they needed a new container. Discontinued medications should be removed from the resident's room immediately and they were not aware of any discontinued medications in the resident's room. During an interview on 12/16/2025 at 11:29 PM, Licensed Practical Nurse Unit Manager #14 stated they had a self-administration assessment for Resident #147, and this should be re-done quarterly. They were not sure who completed the assessment, but it would be documented in the resident chart. Resident #147 had been able to self-administer their medications since they were admitted to the facility. Nursing staff brings the medication to the resident room and Resident #147 keeps them at the bedside. Resident #147 should not have expired or discontinued medications at the bedside. If a medication was discontinued, nursing staff should remove it from the bedside. Resident #147 should not be keeping needles in the pouch. They should be put in the sharp's container. They were not aware of the expired or discontinued medication or needles in the pouch. During a telephone interview on 12/18/2025 at 10:14 AM, the Assistant Director of Nursing #15 stated they provided education to ensure the resident took their medications and knew what the medications were. A resident should have an assessment completed for self-administration of medications completed quarterly. They were not aware Resident #147 did not have an assessment for self-administration of medications. If a medication was discontinued or changed, it should be removed from the resident's room, Staff should ensure there are no expired medications or discontinued medications in the room. Staff should also check to ensure the resident was taking their medications. Needles should be placed in the sharp's container, and nursing staff should be assisting the resident with disposal of the needles. Resident's #147's losartan was discontinued on 03/06/2025. Assessment for self- administration should be completed to ensure the resident was safe to take the medication and to ensure the resident had the correct medications in their room. 10 NYCRR 415.3 (f)(1)(vi)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for one (1) of seven (7) residents (Resident #132) reviewed. Specifically, Resident #132 was not assisted with showering, incontinence care, removal of facial hair, and getting out of bed as planned. Additionally, staff documented care was completed when it was not. The lack of regular and consistent care resulted in psychosocial harm to Resident #132 that was not Immediate Jeopardy. Findings include: The facility policy Resident Care with Activities of Daily Living (ADLs) reviewed 01/2025, documented residents were accurately assisted with support for basic activities of daily living. The resident's care plan was reviewed to assess for any special needs of the resident. The date and time care was provided was documented in the resident's activities of daily living and/or in the resident's medical record. Any refusals were reported to the supervisor. The facility policy Resident Rights reviewed 01/2025, documented all residents were treated with kindness, respect, and dignity. Residents had the right to a dignified existence, were free from abuse and neglect, and had the right to self-determination. Resident #132 had diagnoses including multiple sclerosis (a progressive central nervous system disease), cerebral palsy (a condition affecting movement), and depression. The 11/07/2025 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact, was dependent for all activities of daily living, and did not reject care. The Comprehensive Care Plan documented:-On 07/18/2024 and revised 10/17/2025 the resident was at risk for functional decline in self-care related to multiple sclerosis. Interventions included dependent for transfers, toileting, dressing, personal hygiene, and showering/bathing. The resident was dependent on two (2) for mechanical lift for shower transfer and a shower bed for safety. -On 07/18/2024 and revised 11/13/2025 the resident used psychotropic medication related to depression, insomnia, and bipolar disorder. Interventions did not include person-centered care. -On 08/01/2024 and revised 07/17/2025, the resident was incontinent of bowel and bladder related to multiple sclerosis. Interventions included check every two (2) hours and assist with toileting as needed. Brief check and change every 3-4 hours and as needed. -On 08/03/2024 and revised 11/05/2025, the resident was at risk for being a victim related to dependence on others for activities of daily living. Interventions included activities of daily living assistance was provided as needed. There was no documented evidence on the November 2025 Certified Nurse Aide Flow Sheet Resident #132 received a shower. The documentation for showers was coded as not applicable-not attempted. The resident Kardex (care instructions) active as of 12/09/2025 did not indicate a scheduled shower day for the resident. Their incontinence brief was to be changed every three (3) to four (4) hours and as needed. The resident was dependent on two (2) for transfer from bed to chair and shower transfer. The shower bed was recommended for safety. They were dependent on one (1) for personal hygiene. During an observation and interview on 12/02/2025 at 12:08 PM, Resident #132 was lying in their bed in a hospital gown. Their hair was down to their shoulders and greasy. They had facial hair resembling a full beard and mustache that was approximately two (2) inches long. They stated they preferred short hair, and their family member was going to cut their hair for them, but it was problematic because they had to be up in the chair when they visited for them to be able do it. Staff knew the resident wanted a shave, but the resident stopped asking because it was not getting done. They always kept themselves clean shaven, but they could no longer use their arms and had to rely on staff to do it. They did not even know what day their shower day was. They stated their hair was greasy and they felt the grease was building up in their ears. They had to request care; it was not just offered to them. They stated the staff did not listen to their needs. It made them feel like they were not important enough to worry about.The 12/02/2025 Certified Nurse Aide #45 flow sheet documented they changed the resident's incontinence brief at 11:48 AM (scheduled for 8:00 AM) and 11:49 AM (scheduled for 12:00 PM); transferred them into the tub/shower and provided personal (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	hygiene that included shaving at 11:51 AM; and transferred them to their Geri chair at 11:52 AM.The 12/03/2025 Certified Nurse Aide #59 flow sheet documented they changed the resident's incontinence brief at 1:21 PM (scheduled for 8:00 AM) and 1:22 PM (scheduled for 12:00 PM); gave them a shower at 1:23 PM; provided personal hygiene that included shaving at 1:26 PM; transferred them into the tub/shower at 1:27 PM; and transferred them to their Geri chair at 1:37 PM. During an observation and interview on 12/04/025 at 9:12 AM, Resident #132 was lying in bed in a hospital gown. They stated they asked the staff daily to get up in the chair, but they were lucky to get up once a week. They told Resident Assistant #66 they wanted to get out of bed at 7:30 AM but they just answered the call bells, and they could not actually do anything, and would have to tell the certified nurse aides or nurses. Certified Nurse Aide #64 gave them a shower and a shave yesterday. That was the first shower they received since they moved to this unit on 11/04/2025. At 2:00 PM, they were lying in bed in a hospital gown. The 12/04/2025 Certified Nurse Aide Flow sheet documented Licensed Practical Nurse #4 changed the resident's incontinence brief at 8:00 AM and 12:00 PM; transferred them into the tub/shower and their Geri chair at 2:59 PM. At 2:59 PM they provided personal hygiene care that included shaving.During an observation and interview on 12/05/2025 at 10:02 AM, Resident #132 was lying in bed in a hospital gown. They stated Licensed Practical Nurse Unit Manager #43 told them they would make sure they got up in the chair today. They wanted to get up every day, but stated the facility did not have enough staff to get them up every day. At 11:37 AM, Resident #132 was up in their Geri chair (a chair that provides more support than a regular wheelchair) wearing clothing. At 11:42 AM, Licensed Practical Nurse Unit Manager #43 approached the resident and said Oh you are up in the chair and not in a gown. You look good.The 12/05/2025 Certified Nurse Aide #63 flow sheet documented they changed the resident's continence brief at 2:52 PM (scheduled for 8:00 AM) and 2:53 PM (scheduled for 12:00 PM); provided personal hygiene that included shaving at 2:58 PM; transferred them into the tub/ shower and their Geri chair at 2:59 PM. The 12/06/2025 Certified Nurse Aide #63 flow sheet documented they changed the resident's incontinence brief at 2:13 PM (scheduled for 8:00 AM). There was no other activity of daily living care documented on the day shift (7:00 AM-3:00 PM). The 12/07/2025 Certified Nurse Aide #64 flow sheet documented they changed the resident's incontinence brief twice at 2:39 PM (scheduled for 8:00 AM and 12:00 PM); provided personal hygiene that included shaving at 2:41 PM; and transferred them into the tub/shower and their Geri chair at 2:42 PM. On 12/08/2025 during a continuous observation and interview starting at 10:37 AM, Resident #132 was lying in bed in a hospital gown. They stated they were waiting for their incontinence brief to be changed and had asked at 7:00 AM when Resident Assistant #66 answered their call bell, and said they would tell the certified nurse aides, but they were cleaning up from breakfast right now. They had facial hair approximately a quarter of an inch long. At 1:25 PM, the call light was on. At 1:27 PM, Resident Assistant #66 answered the call light, left the room, and returned to the dining room where lunch was taking place. At 2:03 PM, the Resident #132 stated they were still waiting for their incontinence brief to be changed, and it was last changed at 6:00 AM this morning. At 2:06 PM, Certified Nurse Aide #65 entered the room. At 3:07 PM, the resident was lying in bed in a hospital gown and their facial hair was approximately a quarter of an inch long. They stated staff had finally changed their incontinence brief. The 12/08/2025 Certified Nurse Aide #68 flow sheet documented they changed the resident's incontinence brief at 6:04 AM (scheduled for 4:00 AM). Certified Nurse Aide #65 documented they changed the resident's incontinence brief at 2:21 PM (scheduled for 8:00 AM) and 2:22 PM (scheduled for 12:00 PM); provided personal hygiene that included shaving; transferred them into the tub/shower at 2:25 PM; and transferred them into their Geri chair at 2:26 PM. During an interview on 12/08/2025 at 2:06 PM, Resident Assistant #66 stated they assisted the residents with simple tasks like filling a water pitcher, making their bed, or answering their call bells. If a resident needed an incontinence brief changed, they had to tell the certified nurse aides. When they answered Resident #132's call light, Resident #132 told them they needed to be changed. They stated they waited until lunch was over to (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	tell someone, but they could not recall who they told. During an interview on 12/08/2025 at 3:49 PM, Certified Nurse Aide #64 stated care was documented in the electronic record and if a resident was provided with care more than once on their shift it was documented that way. Shower days were on the paper assignment sheet. They tried to shave residents on their shower days or if they looked scruffy, they asked the resident. Shaving was supposed to be offered daily. Residents should be offered to get up before breakfast but if they did not want to, they would try again after breakfast. Residents were toileted everyone (1) to two (2) hours, and if they said they were wet or needed to be changed. The number of times a resident's incontinence brief was changed on a shift was documented. Documenting a task as completed meant it was done. Residents should receive the care as indicated and people should be treated how you would want to be treated. Resident #132 could not get in the shower because they could not control their body. The other day they went to find the shower bed so they could shower the resident. They had seen it before on other units, so they knew it existed, and they found it in the basement. The resident had only had bed baths prior to that. Certified Nurse Aide #64 stated Resident #132 was very appreciative and said it made them feel good. It had been a while since the resident was shaved and they needed it. The resident had never refused care from them. The 12/09/2025 Certified Nurse Aide #45 flow sheet documented they changed the resident's incontinence brief at 11:40 AM (scheduled for 8:00 AM) and 11:41 AM (scheduled for 12:00 PM); provided personal hygiene that included shaving at 11:42 AM; transferred them into the tub/shower at 11:43 AM, transferred them into their Geri chair at 11:44 AM. During a follow up interview on 12/09/2025 at 11:47 AM, Resident #132 was lying in bed in a hospital gown. They stated they could not do things for themself and felt the staff were not there to help them. When they did care for them, they made negative comments. The facility was unable to provide care sufficient for their needs. It did not make them feel good and they felt like they were abandoned. They never refused care and when they asked for help, they were given excuses such as staff was busy, they would get to it in a minute, or it was a shift change. If they put the call bell on now, they would be told it was mealtime. During an interview on 12/09/2025 at 12:04 PM, Certified Nurse Aide #45 stated the charting included incontinence brief changes and how many times. If there was only one (1) documentation, it meant they were only changed once in eight (8) hours. They asked their residents daily if they wanted to be shaved. Residents should get out of bed every day but when there were only two (2) certified nurse aides like today, there was not enough time. Resident #132 required total care and a mechanical lift to get out of bed. They did not ask them to get out of bed, especially on days there were only two (2) certified nurse aides. The resident's hair was greasy last week on Tuesday, but the resident stated they only wanted incontinence care that day. They were told the resident could be difficult. Documentation was supposed to be accurate and if something was not done it should not be documented as done. During an interview on 12/09/2025 at 12:29 PM, Licensed Practical Nurse #4 stated personal care such as bathing, toileting, and getting residents out of bed was expected to be done daily and was the responsibility of the certified nurse aides and the nurses. If a task could not be completed, it should be reported to them. The care plan/Kardex was the guideline for the resident's care. If they provided activity of daily living care, they documented it. Documentation needed to be accurate. Resident #132 was clean shaven when they arrived on the unit, and they knew Certified Nurse Aide #64 shaved and showered them last week. The resident was typically in bed, but they knew they requested to get up. During an interview on 12/10/2025 at 12:48 PM, Certified Nurse Aide #65 stated care was supposed to be documented after it was completed but it got busy, so they often completed it at the end of their shift. Shaving was done if the resident needed it, and they offered it daily. On days when there were only two (2) certified nurse aides, the nurse would have to watch the floor to get a resident requiring a mechanical lift out of bed. Showers were completed once a week per the assignment sheet. Residents were toileted every two (2) to three (3) hours and documented with each occurrence. If they were toileted three (3) times, it was documented three (3) times. Resident #132 was dependent for all care and did not refuse care. During (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	an interview on 12/10/2025 at 1:10 PM, Licensed Practical Nurse Unit Manager #43 stated residents should be provided with daily care that makes them presentable. Incontinence care should be every two (2) hours. Residents should get out of bed daily. The Kardex should be followed for resident safety. Ultimately, they were responsible for appropriate care being provided. If a resident was dependent for care and was not getting the care they needed, they could feel left out or forgotten about. Resident #132 required total care, was new to the unit and had just received their first shower since arriving on the unit. The resident came to their unit because they were upset with the care on their previous unit. They thought the resident had been out of bed every day except for 12/02/2025 because they were short staffed that day, and they were assigned a medication cart. If there were only two (2) certified nurse aides, it was hard to care for 40 people. They tried to help but they were often on a cart and could not help as much. Resident #132 was happy to have been showered, shaved and up in the chair the other day. During a telephone interview on 12/11/2025 at 1:58 PM, Physician #12 stated if resident was not physically able to complete activities of daily living, staff should be helping. If a resident was dependent on staff and was not receiving appropriate assistance, they could feel horrible. Resident #132 was dependent and could not do anything for themselves. Resident #132 was cognitively intact and could feel frustrated, depressed, or they might even have an outburst. During a telephone interview on 12/16/2025 at 1:56 PM, the Director of Nursing stated it was important residents received the care needed and everyone was responsible. If residents were not getting the assistance they needed or asked for, they would lose trust, feel like they could not depend on us, and it was just poor customer service. 10NYCRR 415.12(a)(3)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review, observations, and interviews the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers and wound care for one (1) of six (6) residents (Resident #10) reviewed. Specifically, Resident #10 had a leg immobilizer that was not removed for skin checks that resulted in an unstageable pressure ulcer. This resulted in actual harm to Resident #10 that was not Immediate Jeopardy.Findings included:The facility policy Prevention of Pressure Ulcers/Injuries, revised 01/2025 documented comprehensive skin assessment were done on admission and included areas of impaired circulation due to pressure from positioning or medical devices and skin would be checked daily during care. Support surfaces were selected as appropriate based on the resident's mobility, continence, skin moisture and perfusion, body size, weight, and overall risk factors.The facility policy Wound Care revised 01/2025 documented gloves were worn to remove old dressings, removed and hands washed and dried before putting on new gloves; sterile tongue blades and applicators were used to remove ointments and creams from containers; and reusable supplies, such as scissors, were wiped with alcohol.Resident #10 had diagnoses including a fracture of the left lower leg, peripheral vascular disease (narrowing or blockage of blood vessels leading to reduced blood flow), and diabetes. The 09/18/2025 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition, was dependent for transfers and bed mobility, and was at high risk for developing pressure ulcers.The Comprehensive Care Plan revised 10/16/2025 documented the resident had alteration in skin integrity related to an actual pressure ulcer related to a fracture of left lower leg and an unstageable wound of the left ankle. Interventions included heel protectors and a chair pressure relieving device.Immobilizer The 09/16/2025 physician order documented the left knee immobilizer was to be removed every evening shift for skin integrity assessment and hygiene.The 09/30/2025 Orthopedic Report of Consultation documented the left leg fracture was treated with a knee immobilizer for 6-8 weeks and non-weight bearing at all times.The 10/09/2025 weekly skin monitor documented the resident's skin was intact.The 10/16/2025 Initial Wound Evaluation and Management Summary documented the immobilizer caused friction/pressure to the back of the left ankle resulting in a pressure wound with necrosis (dead tissue).The 10/16/2025 Physician #24 progress note documented the resident had an appointment with the orthopedic surgeon for the left leg fracture. A wound was seen on the back of the left ankle, most likely caused by the immobilizer. The resident had refused removal of the immobilizer for skin checks on multiple occasions.There was no documented evidence of refusals by Resident #10 for immobilizer removal on the October 2025 treatment administration record.The October 2025 treatment administrator record documented Resident #10's immobilizer was removed daily, and skin checks were completed.During an interview on 12/09/2025 at 10:17 AM, Licensed Practical Nurse #19 stated Resident #10 would not allow staff to remove their immobilizer and that should be reflected in the treatment administrator record. They did not see that the resident had gone back to orthopedics. They did not know if the secretary had scheduled the appointment, but they should have been seen by orthopedics.During an interview on 12/16/2025 at 9:18 AM, Registered Nurse #58 stated there was an order to remove a splint or immobilizer to check for any skin breakdown or irritation for Resident #10. If checks were not performed, it needed to be documented. The resident refused a lot because they feared it being touched. They signed for removal of the immobilizer on 10/14/2025 but did not think they had removed it because if they did, they would have seen the wound. The refusals should had been documented.During an interview on 12/16/2025 at 9:56 AM, Licensed Practical Nurse #39 stated they did not recall doing a skin check or removing the immobilizer for Resident #10. Licensed Practical Nurse #39 reviewed the treatment administration record and confirmed they signed for removal of the immobilizer. If a resident refused treatment, it was reflected in the administration record as a refusal and the nurse supervisor would have been notified.During an interview on 12/16/2025 at 12:25 PM, Resident #10 stated no one removed their (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	brace. When they first returned with the long leg immobilizer, they were very protective of the leg and refused to let anyone remove the brace. They had never broken a bone before and were afraid. They now allowed removals with the short immobilizer, but no one had removed it.During an interview on 12/18/2025 at 11:48, Physician #24 stated immobilizers could cause pressure ulcers if they were located over a boney prominence, but most were designed not to cause pressure. A resident who wore an immobilizer, who was having their skin checked daily, would have their pressure ulcer identified early. Pressure ulcers did not happen over a few minutes. If an immobilizer was to be removed with daily skin checks for Resident #10, they would expect that it was being done.During an interview on 12/19/2025 at 2:30 PM, Physician #40 stated pressure ulcers may be caused by splints and immobilizers if they did not fit properly. Everyone who applied it had to ensure that it was done properly and was the right size. Immobilizers removed daily to check skin could prevent pressure ulcers. Resident #10's wound was caused by the metal bar on their immobilizer rubbing while in bed. They expected that if skin checks happened daily, an abnormality would have been found before the resident developed a pressure ulcer.10NYCRR 415.12(c)(1)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations and interviews the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of one (1) Resident (Resident #34) reviewed. Specifically, Resident #34 who had a history of abnormal weight loss and dysphagia (difficulty swallowing) had significant weight loss and weekly weights were not obtained per the registered dietitian's recommendations. This resulted in harm to Resident #34 that was not Immediate Jeopardy. Findings include:The facility policy Nutritional Assessment, revised 01/2025 documented the dietitian would complete a nutritional assessment for changes in condition that placed a resident at risk for impaired nutrition. A care plan would be developed to minimize the resident's risks for nutritional complications.The facility policy Weight Assessment and Interventions, revised 01/2025 documented nursing staff measured resident weights on admission, the day after admission, then weekly for two (2) weeks. Any weight change of 5% or more since the last weight assessment would be retaken the next day for confirmation. If the weight was verified, nursing immediately notified the dietitian in writing. Assessment information would be analyzed by the multidisciplinary team.Resident #34 had diagnoses including abnormal weight loss, dysphagia (difficulty swallowing) and altered mental status. The 10/17/2025 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact, weighed 129 pounds, had 5% or more weight loss in the last month or 10% or more in the last six months, and was not on a prescribed weight loss program. The 04/16/2025 Comprehensive Care Plan documented Resident #34 was at risk for malnutrition and/or had a nutritional problem related to cognitive impairment, dysphagia, need for mechanically altered diet, and significant weight changes. Interventions included monthly weights and weights as needed. The 04/24/2025 physician order documented the resident would be weighed on admission, the next day, and weekly for four (4) weeks. If no weight concerns were noted, weights would be measured monthly. Resident's #34 weight record documented the following weights: -04/16/2025, 158 pounds, with reweight 04/17/2025 160.4 pounds,-05/09/2025, 148 pounds (7.7% loss in three weeks),-07/08/2025, 145.2 pounds (9.5% loss in three months),-08/05/2025, 133.6 pounds (8% in one month)-10/16/2025, 128.8 pounds -11/05/2025, 123.6 pounds (16.5% loss in six months). The 10/16/2025 Registered Dietitian #7 progress note documented an unplanned weight loss of 5.8% in one (1) month and 19.4% in six (6) months with a request for weekly weights for four (4) weeks. There was no documented evidence of a physician order for weekly weights, no documented weekly weights, and no documented evidence the Comprehensive Care Plan was updated to include weekly weights. During a telephone interview on 12/15/2025 at 2:03 PM, Registered Dietitian #7 stated weights were obtained by the seventh of each month and they reviewed the weights for any significant weight changes of 5% in one (1) month, 7.5% in three (3) months, or 10% in six (6) months. They sent a list of weekly and missing weights to the unit nursing manager, and reminders of weekly weights to the unit nursing manager, the Assistant Director of Nursing, the Director of Nursing, and the Administrator. They also notified the medical staff of significant weight changes. During an interview on 12/16/2025 at 11:29 AM, Licensed Practical Nurse Unit Manager #14 stated the registered dietitian sent out electronic mail to alert them of weight changes or needed weights. Weekly weights required a physician order, and either they or the registered dietitian entered the order into the electronic medical record. The licensed practical nurse should document the weights as ordered by the physician. Resident #34 did not have documented weekly weights. They were unaware of any weight refusals by Resident #34. During a telephone interview on 12/18/2025 at 10:14 AM, Assistant Director of Nursing #15 stated the registered dietitian notified them and the unit manager of residents who needed weekly weights. The registered dietitian was provided the weights, entered them into the electronic medical record, and electronically mailed them for reweights. If the registered dietitian wanted weekly weights, they electronically mailed them and the provider, and either the physician or nursing placed the order. Resident #34 had weight loss and if the registered dietitian (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	requested weekly weights they should have been obtained. During a follow-up telephone interview on 12/18/2025 at 12:08 PM, Registered Dietitian #7 stated nursing sent the weights to them by electronic mail or entered them into the electronic medical record. They reviewed the weights and notified the unit nursing manager, Assistant Director of Nursing, and Director of Nursing of needed reweights. If a resident refused weights nursing documented that in the medical record. They notified the unit nursing manager, medical staff, Assistant Director of Nursing, and Director of Nursing of recommended weekly weights. They requested weekly weights for Resident #34, and they were not obtained. During an interview on 12/19/2025 at 9:17 AM, the Director of Nursing stated the registered dietitian did not work onsite but sent electronic mail about weight loss and residents who were on weekly weights. The unit nursing manager should ensure the weights were obtained. If a resident refused a weight, it was documented in the medical record. 10NYCRR 415.12(i)1

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0840 Level of Harm - Actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on observations, record review, and interviews during the survey, the facility failed to provide specific services outside the facility when they did not employ a qualified professional to furnish the specific service for one (1) of four (4) residents (Resident #17) reviewed. Specifically, Resident #17 was not provided with neurology follow up appoints as recommended. This resulted in harm to Resident #17 that was not Immediate Jeopardy. Findings include: The facility policy, Consultations, last reviewed 01/2025 documented the facility was responsible to provide residents with specific services that were not provided by in-house medical providers. The facility was to facilitate the services in a timely manner to ensure the resident did not suffer ill effects from the delayed service. Resident #17 had diagnoses including sciatica (pain caused by compression of the sciatic nerve) and liver disease. The 09/06/2025 Minimum Data Set assessment documented the resident had intact cognition, was independent with most activities of daily living, received scheduled pain medications, and had constant pain that affected sleep.The 09/23/2025 Physician #24 progress note documented Resident #17 complained of pins and needles to both lower extremities and a neurology follow up was recommended for ongoing headaches and neuropathic pain. There was no documented evidence a neurology appointment was scheduled for Resident #17. The 11/07/2025 Physician #24 progress note documented the resident was seen for pain despite gabapentin being started. The resident had intractable headaches and neuropathic pain in both legs and was still waiting for a neurology appointment. There was no documented evidence a neurology appointment was scheduled for Resident #17.The 12/01/2025 Nurse Practitioner #25 progress note documented the resident was seen for worsening headaches and was requested a neurology appointment. On 12/01/2025 a physician order was placed for a neurology referral for worsening headaches. The order was signed off as completed by Licensed Practical Nurse #19.During an interview on 12/02/2025 at 1:10 PM, Resident #17 stated they were supposed to see a neurologist but did not have an appointment. On 12/11/2025 at 11:49 AM, Resident #17 was observed wearing sunglasses. The resident stated they wore them when they had a headache. During an interview on 12/09/2025 at 10:17 AM, Licensed Practical Nurse #19 stated they were notified last week Resident #17 need a neurology consult. There was a neurology consult order dated 12/01/2025 but was not done at the time as Unit Clerk #27, who scheduled the appointments, was not working.During an interview on 12/15/2025 at 3:34 PM, Assistant Director of Nursing #21 stated outside appointments for residents should be made as soon as possible. If the secretary was having a difficult time making an appointment they were to call the provider for possible assistance. If Resident #17 had a recommendation, then they should have had an appointment scheduled. During an interview on 12/18/2025 at 11:48 AM, Physician #24 stated the unit secretaries scheduled outside appointments. Physician #24 would put in an order and verbally tell the secretary an appointment needed to be scheduled. They entered an order and verbally told the secretaries about consults that needed to be scheduled. They would expect to be notified if there was a delay in scheduling an outside appointment. 10NYCRR 415.26(e)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations and interviews during the survey, the facility failed to ensure food was stored, prepared, distributed and served in accordance with professional standards for food service safety for one (1) of one (1) main kitchen. Specifically, the main kitchen was in disrepair, including cracked and uneven flooring, worn grout, damaged door thresholds, corroded plumbing, and broken shelving; personal items were stored with clean food service equipment; and food storage practices did not support the prevention of potential cross-contamination. Findings include:The facility policy Food Storage, last reviewed 01/2025, documented food was to be stored in a manner that prevented contamination and cross-contamination, including storing raw animal foods on lower shelves and protecting food items during storage.The facility policy Food Safety, last reviewed 01/2025, documented kitchen environments and food service operations were to be maintained in a sanitary condition to prevent biological and physical food safety hazards, and unsanitary surfaces, equipment, or storage practices could contribute to food contamination.The facility policy Food & Nutrition Services Responsibilities, last reviewed 01/2025, documented kitchen and food storage areas were to be maintained in a clean, sanitary, and safe condition, and dietary leadership was responsible for ensuring compliance with food safety and sanitation standards.The facility policy Hours of Operation, last reviewed 01/2025, documented the kitchen was to be cleaned daily, including food preparation and service areas, to maintain sanitary conditions.The following observations were made in the main kitchen on 12/02/2025 at 10:30 AM:-kitchen flooring had cracked, missing, and uneven tiles throughout the kitchen.-flooring surfaces had worn grout, peeling areas, and exposed subflooring.-debris was noted throughout the kitchen floor, embedded within cracked and recessed grout lines.-damaged and deteriorated door thresholds.-accumulated debris and residue beneath kitchen equipment.-soil and grime were present along wall edges, in corners, beneath equipment, and around storage areas.-plumbing beneath sinks and dishwashing equipment had visible corrosion and buildup.-damaged shelving in the dry storage area.-personal items stored on shelving with clean food service equipment.-frozen meat was stored on a shelf in the freezer directly above uncovered pizza shells. Internal dietary and kitchen audits conducted on 12/03/2025, 12/08/2025, and 12/15/2025, completed by Employee #23 documented overall passing scores and compliance with routine food safety practices, including food temperatures, labeling, equipment cleanliness, and staff hygiene. The internal audits identified no concerns related to the physical condition, cleanliness, or repair of the kitchen environment. There were no identified food storage practice issues that would contribute to cross-contamination. During an interview on 12/11/2025 at 1:13 PM, the Director of Food Service stated environmental and maintenance staff were responsible for deep cleaning and physical repairs in the kitchen. Work orders were submitted when issues were identified; however, no current work orders were submitted for environmental conditions in the kitchen. Kitchen staff swept and mopped floors daily after breakfast, lunch, and dinner. They stated floors accumulated dirt rapidly due to heavy traffic. Deep scrubbing and floor repairs were not completed routinely and poor repair of some floor surfaces made effective cleaning difficult. There was a dedicated floor technician previously employed; however, that position was currently vacant. Maintenance and environmental services were responsible for floor repair and corrosion on dishwasher piping. Some flooring issues, including areas near the tray line, were previously addressed but later recurred. Corrosion on the dishwasher piping existed prior to their employment, and no specific work order was submitted for that condition. They stated standard practice was to store frozen meats in a separate freezer section from pizza shells and vegetables. Storing meat above an unsealed box of pizza shells was not consistent with their storage process and could cause for cross contamination.During a telephone interview on 12/16/2025 at 1:04 PM, the Director of Maintenance and Environmental Services stated they were responsible for oversight of maintenance in the kitchen areas, including floors, walls, fixtures, (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment, and surfaces. Kitchen staff were responsible for routine cleaning of the kitchen. Environmental and maintenance issues were reported through work orders. They relied on staff notification to identify kitchen issues that needed to be addressed. They were not aware of any issues that needed to be repaired, and no recent work orders were received from the kitchen staff. They stated while there was significant corrosion built up on the dishwasher pipes; they did not leak. During a telephone interview on 12/15/2025 at 2:59 PM, the Administrator stated kitchen staff were responsible for routine cleaning of the kitchen, including floors and food preparation areas. Weekly kitchen audits focused on outdated food, refrigerator and freezer temperatures, and cleanliness of high-use equipment such as slicers and can openers. Flooring integrity and plumbing conditions were not a primary focus of these audits. They stated the kitchen flooring had areas of wear, and a deep cleaning was planned. Recent turnover in floor care staff had a negative effect on regular cleaning, and a replacement floor technician was hired. When issues were identified, maintenance work orders should be submitted. Maintenance would log the requests, assign staff, and document when the work order was completed. Repairs related to deteriorated flooring, corroded plumbing, or other structural kitchen issues were initiated by the Director of Food Services. They stated the condition of the kitchen floors and disrepair did not stand out as a particular concern or focus of their kitchen audits. 10 NYCRR 415.14(h)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, record review, and interviews, the facility failed to 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, administration failed to ensure residents received appropriate quality of care by allowing the following deficient practices to exist, placing residents at risk for serious injury, serious harm, serious impairment, or death: F689 Free of Accident Hazards and F684 Quality of Care. Administration failed to ensure policies and procedures were properly identified, communicated, and consistently implemented and were not aware of the extent of the deficient practices cited. Additionally, administration failed to ensure resident safety and attain the highest practicable physical, mental and psychosocial well-being leading to several deficient practices in the areas of: F677 Activities of Daily Living Care Provided for Dependent Residents, F686 Treatment and Services to Prevent/Heal Pressure Ulcers, F675 Quality of Life, and F880 Infection Prevention and Control.Findings include:The facility job description Administrator documented the administrator provided overall direction for all activities related to administration, personnel, office management, and safety for the facility. The administrator was responsible for the development and training in all areas, as well as working closely with all members of the management team to ensure that responsibilities were effectively discharged . Essential functions included, but not limited to, the provision of quality health care and daily living services for residents in conformance with state and federal laws, as well as promoted respect for the individuals and protection of their basic rights. A safe, sanitary, and pleasant environment was maintained for all residents. They made certain that all residents received proper assessment of needs, care planning, and treatment in a manner that promoted dignity, self-esteem, and quality of life of the individual and all care was properly documented. Deficient Practice Information:Resident's Free from Accident, Refer to the citation text under F689. The facility failed to ensure adequate supervision to prevent accidents for three (3) of seven (7) residents reviewed. Quality of Care. Refer to the citation text under F684. The facility failed to ensure residents received treatment and care in accordance with professional standards of practice that met each resident's physical, mental, and psychosocial needs for six (6) of 21 residents reviewed. Activities of Daily Living Care Provided for Dependent Residents. Refer to the citation text under F677. The facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for one (1) of seven (7) residents reviewed. Treatment and Services to Prevent/ Heal Pressure Ulcers. Refer to the citation text under F686. The facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers for two (2) of six (6) residents reviewed. Quality of Life. Refer to the citation text under F675. The facility failed to ensure residents were provided with an environment that supported and enhanced each resident's quality of life for all 242 residents residing in the facility.Infection Prevention and Control. Refer to the citation text under F880. The facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (5) of five (5) residents reviewed. During an interview on 12/09/2025 at 1:37 PM, the Administrator stated staff were educated upon hire and annually regarding elopements. There was an elopement binder at the front desk. Resident #100 eloped in October 2025. They were informed the wander alert system was not functioning correctly and the resident was found outside. However, when maintenance came in to check the system, everything was working correctly. They were informed maintenance had to reset the system, but it was functioning correctly. They believed the resident got out via the E stairwell. All the doors on the second and third floor were supposed to have a wander alert alarm on them if a resident with a wander alert device got near the doors. If the door did not alarm, the staff were to immediately call (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	maintenance. All staff were able to shut off the wander alert alarms at the doors and elevators. Regular door alarms should not be turned off at the nursing station without checking to see who went out the door. It was important to have a functioning wander alert system to prevent a resident from eloping. Resident #100's elopement was not reported to the New York State Department of Health as it was past the reporting deadline by the time they found out about the incident. They were not made aware the resident was unattended in the parking lot until the following Monday (10/20/2025) and they should have been made aware of the elopement right away. During an interview on 12/12/2025 at 10:59 AM, the Administrator stated the facility did not always receive paperwork from the hospital. The cart nurse or nurse manager was responsible to go through the paperwork, talk to the provider, put any new orders in, and complete an assessment. Each unit was responsible, and several people would have been doing parts of a hospital or emergency department return. Paperwork should be reviewed within 24 hours; they did not know the whole process, but it had to be team effort. There should have been a progress note written when residents returned to the facility. Leadership had a telegram text communication on their cellular phones and any movement of a resident in and out of the facility should be communicated there. They asked the nurses to request the emergency room paperwork, but they were not sure if there was a formal education with the nurses about the return process. They were not aware of hospital return issues for Residents #33, #42, #90, #179, and #204. The paperwork should have been reviewed and followed up on for patient care. If something was changed for a resident, there was a reason for it; antibiotics should not be missed, because there could be negative effects. Resident #209 got worse and had to be hospitalized . The nurses and the provider did not follow up. Assistant Director of Nursing #15 or the Director of Nursing should have investigated how this happened and how this was missed. They expected the Director of Nursing to investigate the issue with Resident #209 after they were made aware on 10/08/2025, but they did not follow up with them.During an interview on 12/22/2025 at 11:00 AM, the Administrator stated they were teaching staff how to complete a proper investigation which included witness statements, a documented registered nurse assessment, and to review/revise interventions. Falls were discussed in morning meeting and the care plan was reviewed to ensure there were no care plan violations. There were no complete and thorough investigations for Resident #44. The Director of Nursing was ultimately responsible, had support, was not asking for help, and was not completing investigations timely. 10NYCRR 483.70(i)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, interviews, and record review conducted during the survey, the facility failed to 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 05/09/2025 for Resident Rights/Exercise of Rights (F550), Safe/Clean/Comfortable/Homelike Environment (F584), Quality of Life (F675) ADL Care Provided for Dependent Residents (F677), Quality of Care (F684), Treatment/Services to Prevent/Heal Pressure Ulcers (F686), Free of Accident Hazards/Supervision/Devices (F689), Dialysis (F698), Nutritive Value/Appear, Palatable/Prefer Temp (F804) and Food Procurement, Store/Prepare/Serve- Sanitary (F812), Administration (F835) QAPI Program/Plan, Disclosure/Good Faith Attempt (F865) and Infection Control (F880). The findings include: The undated facility Quality Assurance and Performance Improvement (QAPI) Plan included the Healthcare System's mission, which is to provide exceptional clinical care coupled with a luxury experience for their residents and their loved ones. The purpose included an evaluation of the residents' experience of services approach to improve the delivery of care provided to residents. The design and scope of the Quality Assurance and Performance Improvement Plan will be integrated and coordinated among all direct or indirect services provided to their residents. They will monitor effectiveness of resident care including identification of trends in performance will be monitor, evaluated, and assessed from improvement in the areas of nursing services, food and nutrition services, infection control, physician services, housekeeping and laundry, pharmaceutical services and rehabilitation services. The Administrator will ensure a leadership role and encourage input from facility staff, Residents as well as their families and or representatives. Resident Rights/Exercise of Rights (F550)The facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for two (2) residents reviewed. Safe/Clean/Comfortable/Homelike Environment (F584)The facility did not ensure residents resided in a safe, clean, sanitary, and homelike environment. Quality of Life (F675)The facility did not provide an environment which supported and enhanced each resident's quality of life. This noncompliance resulted in Immediate Jeopardy. ADL Care Provided for Dependent Residents (F677)The facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for one (1) resident reviewed. This resulted in psychosocial harm to Resident #132 that was not Immediate Jeopardy. Quality of Care (F684)The facility failed to ensure residents received treatment and care in accordance with professional standards of practice that met each resident's physical, mental, and psychosocial needs for six (6) residents reviewed. This resulted in Immediate Jeopardy. Treatment/Services to Prevent/Heal Pressure Ulcers (F686)The facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers for two (2) residents reviewed. Free of Accident Hazards/Supervision/Devices (F689)The facility failed to ensure adequate supervision to prevent accidents for three (3) residents reviewed related to Elopement and Falls. This resulted in Immediate Jeopardy. Dialysis (F698) The facility did not ensure that residents who required dialysis services (a process that filters the blood when the kidneys do not work properly) received such services consistent with professional standards of practice for one (1) resident reviewed. Nutritive Value/ Appear Palatable/Prefer Temp (F804)The facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature. Food Procurement, Store/Prepare/Serve- Sanitary (F812)The facility did not ensure the kitchen environment and food storage practices were maintained in a manner that supported safe and sanitary food service operations. Administration (F835)The facility failed to ensure it was (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Infection Control (F880) The facility did not establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for five (5) residents reviewed. During an interview on 12/22/2025 at 12:00 PM, the Administrator stated the Quality Assurance and Performance Improvement committee meets monthly and has been focusing on their high risk, high volume, problem prone areas. The Administrator stated they and the Quality Assurance & Performance Improvement committee looks at every general opportunity to improve where they think they can do better. They have audits, staff, resident and family feedback to learn about continued areas of concerns. They currently have performance improvement plans for Dignity, Environment, Professional Standards, weekly audits for activities of daily living (ADL), pressure ulcers/wounds, accidents, food services and medication storage and infection control. They were not aware of identified concerns regarding Quality of Care with regards to hospitalizations and emergency room visits and nursing documentation. 10 NYCRR 415.27(a-c)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for six (6) of six (6) residents (Residents #10, #188, #192, #77, #217 and #17) reviewed and five (5) of ten (10) staff (Certified Nurse Aides #62 and #91, Registered Nurse Manager #38, and Licensed Practical Nurses #35 and #71) reviewed for influenza vaccination.Specifically:-Resident #10 had an unstageable pressure ulcer to the left ankle and was on enhanced barrier precautions. Licensed Practical Nurse #39 was observed performing wound care using inappropriate infection control practices including lack of proper hand hygiene and glove use, insufficient personal protective equipment and use of unclean scissors.- Residents #188 and #192 tested positive for COVID-19 and did not have transmission-based precaution (droplet precautions) signage posted outside their rooms and staff were observed not wearing appropriate personal protective equipment into the designated rooms.- Resident #77 was on transmission-based precautions (enhanced barrier precautions) and did not have signage posted outside their room.- Resident #217 was on transmission-based precautions (enhanced barrier precautions) and staff was observed performing care without appropriate personal protective equipment.- Resident #17 was on transmission-based precautions (droplet precautions) and staff was observed not wearing appropriate personal protective equipment into the room.- Multiple staff members (Certified Nurse Aides #62 and #91; Registered Nurse Manager #38; and Licensed Practical Nurses #35 and #71) were unvaccinated for influenza and were observed in resident areas not wearing a mask or wearing a mask improperly.Findings include: The facility policy Influenza Vaccine reviewed 01/2025, documented between October 1st and March 31st each year, the influenza vaccine would be offered to employees, unless the vaccine was medically contraindicated, or the employee had already been immunized. For those who received the vaccine, the date of vaccination, lot number, expiration date, and site of vaccination would be documented in the employee's medical record. If an employee refused the vaccine for reasons other than medical contraindications, that would be documented on the employees informed consent for influenza vaccine. Administration of the influenza vaccine would be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.The facility policy Enhanced Barrier Precautions reviewed 01/2025, documented enhanced barrier precautions required the use of a gown and gloves for high contact resident care activities; signage would be posted outside of the resident room; hand hygiene should be performed; a new gown and gloves should be put on before caring for a different resident. High contact activities included: dressing, bathing/showering, transferring that required hands on assistance, changing linens, changing briefs, assisting with toileting, device care or use, and wound care.The facility policy Droplet Precautions reviewed 01/2025, documented droplet precautions were used for resident's known or suspected to be infected by microorganisms transmitted directly from the respiratory tract of the susceptible mucosal surfaces of another resident. A physician's order was required for the initiation of transmission-based precautions. As soon as precautions were implemented, Stop Report to Nurse signage would be placed on the resident's door and remain in place until precautions had been discontinued.The facility policy Wound Care revised 01/2025, documented to use disposable cloth to establish a clean field on the resident's overbed table; wash and dry hands; put on gloves; remove dressing; pull glove over dressing and discard; wash and dry hands; put on gloves; apply treatment as indicated; wipe reusable supplies with alcohol; wash and dry hands.1) Resident #10 had diagnoses including a fracture of left lower leg, peripheral vascular disease (poor circulation), and diabetes. The 09/18/2025 Minimum Data Set (a resident assessment tool) documented the resident had intact cognition and was dependent for transfers and bed mobility.The Comprehensive Care Plan documented:-10/16/2025 the resident had an actual unstageable wound of the left ankle. The goal was the wound would not show any signs of (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection.-12/02/2025 resident was on enhanced barrier precautions. Interventions included staff would wear gloves and gown and hand hygiene.The 10/16/2025 physician order documented to cleanse the back of the left ankle with wound cleanser, pat dry, and apply Alginate Honey-Impregnated gauze (type of topical dressing that absorbs the wound drainage), cover with abdominal pad and wrap with Kerlix daily and as needed.During a wound care observation on 12/16/2025 at 9:56 AM, Resident #10's door had a droplet/contact precaution sign and an enhanced barrier precaution sign on the wall outside the door. Licensed Practical Nurse #39 entered the resident's room with a surgical mask and gloves on. They used scissors to cut off the old dressing, placed the scissors on the table next to clean supplies; sprayed wound cleanser on the wound; used gauze to cleanse the wound; and used gloved fingers to remove dressing that was stuck to the wound bed. Without changing gloves, Licensed Practical Nurse #39 dispensed antiseptic gel onto their gloved finger, applied the gel to the wound bed, cut a piece of alginate using the same unclean scissors; applied the alginate to the wound bed, covered the area with an abdominal pad then wrapped the leg with gauze.During an interview on 12/16/2025 at 10:11 AM, Licensed Practical Nurse #39 stated they should have removed their gloves after they removed the old dressing, washed their hands, and then put on clean gloves. The gloves and scissors were contaminated after removing the old dressing. They should have changed gloves prior to dressing the wound and should not have used the same scissors from dirty to clean. They stated should have worn full personal protective equipment.During an interview on 12/16/2025 at 2:10 PM, Assistant Director of Nursing/Infection Control Nurse #21 stated they expected hand hygiene to be performed prior to starting a dressing change, in between glove changes, and after a dressing was completed. The wound could become contaminated if dirty gloves were worn to apply a new dressing.During an interview on 12/18/2025 at 11:48 AM, Physician #24 stated an infected pressure ulcer on a resident with comorbidities such as diabetes and vascular disease had a higher risk of infection.2) Resident #77 had diagnoses including kidney disease and diabetes. The 09/13/2025 Minimum Data Set documented the resident had severely impaired cognition and received dialysis (a process that filters the blood).The Comprehensive Care Plan, revised 08/05/2024, documented the resident required hemodialysis related to end stage renal disease. Interventions included maintain enhanced barrier precautions every shift and monitor for signs and symptoms of infection to the access site. The 11/05/2024 physician order documented maintain enhanced barrier precautions every shift.Resident #77 had no transmission-based precaution signage posted outside their room at the following times: on 12/04/2025 at 10:34 AM, 12/08/2025 at 12:10 PM, 12/09/2025 at 9:05 AM, 12/10/2025 at 1:07 PM, and 12/11/2025 at 12:03 PM.During an interview on 12/09/2025 at 11:38 AM, Certified Nurse Aide #1 stated they were assigned to care for Resident #77 that day and most of last week during the day shift. They stated the resident was not on transmission-based precautions so they would just wear gloves when caring for them. If they were on transmission-based precautions, there would be a sign posted outside their room to alert them. The sign would also tell them what personal protective equipment was needed to go into the room. They thought the nurse manager was responsible for putting residents on transmission-based precautions, and no one ever told them Resident #77 was on precautions.During an observation and interview on 12/11/2025 at 12:03 PM, Registered Nurse #58 was standing at the medication cart outside of Resident #77's room. They stated Resident #77 was not on transmission-based precautions and if they were, there would have been a sign posted outside their room. There was an order for enhanced barrier precautions, but they thought it could have been wrong because it was from 2024.During an interview on 12/15/2025 at 1:58 PM, Licensed Practical Nurse Manager #33 stated Resident #77 was on enhanced barrier precautions because they had a dialysis catheter. They were just made aware the resident did not have signage posted so they hung a sign and placed a bin full of personal protective equipment outside their room. They stated staff should have known the resident was on enhanced barrier precautions because they had an order, and it was on their care plan. Staff should wear appropriate personal protective equipment when caring for the resident.Employee Masks and (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Influenza Vaccines The following observations were made of improper wearing of surgical masks or lack of surgical masks:-On 12/04/2025 at 10:13 AM, Certified Nurse Aide #62 was obtaining resident weights while wearing a surgical mask that did not cover their nose.-On 12/04/2025 at 10:14 AM, Certified Nurse Aide #91 walked through the resident unit wearing a surgical mask positioned below their nose.-On 12/04/2025 at 10:20 AM, Certified Nurse Aide #91 brought a resident into a room. The certified nurse aide was wearing a surgical mask positioned below the nose. At 12:57 PM, Certified Nurse Aide #91 leaned over a resident to shave them while wearing a surgical mask covering their mouth only. At 1:05 PM, Certified Nurse Aide #91 exited the room and walked to the nurses' station wearing the mask below the nose. At 1:06 PM, Certified Nurse Aide #91 stated they needed to wear a mask due to not receiving the influenza vaccination.-On 12/05/2025 at 9:25 AM, Registered Nurse Manager #38 was seated at the nursing station wearing a surgical mask positioned under their chin.-On 12/08/2025 at 12:24 PM, Licensed Practical Nurse #35 was seated at the nursing station wearing a surgical mask below their chin. At 12:35 PM, Licensed Practical Nurse #35 walked down the hallway with a medication cart while wearing a surgical mask positioned below their nose.-On 12/09/2025 at 8:40 AM, Licensed Practical Nurse #71 was observed at a medication cart putting on a mask after entering the unit. They stated they had not received the influenza vaccination. Staff vaccination records documented:-Certified Nurse Aide #62 received an influenza vaccine on 12/04/2025 at an undocumented time.-Certified Nurse Aide #91 received their influenza vaccine on 12/11/2025 (after the observations of improper face mask use).-Registered Nurse Manager #38 declined the influenza vaccine on 12/01/2025.-Licensed Practical Nurse #35 did not have documentation of influenza vaccination or declination.-Licensed Practical Nurse #71 declined the influenza vaccine on 12/12/2025.During an interview on 12/05/2025, the Administrator stated staff who had not received the influenza vaccine were required to wear a mask at all times in the facility and masks were required to be worn correctly, covering the nose and mouth.During a telephone interview on 12/16/2025 at 10:00 AM, Assistant Director of Nursing/Infection Control Nurse #21 stated their responsibility included oversight of the facility's infection prevention and control program, staff education on hand hygiene, appropriate personal protective equipment uses, and correct donning and doffing procedures, in collaboration with nurse managers and the facility educator. They stated nursing staff could initiate Enhanced Barrier Precautions when clinical criteria were present and they were responsible for notifying the provider and obtaining required physician orders. The precaution status was expected to be reflected in the medical record, provider orders, daily census, and assignment sheets. Signage and personal protective equipment bins were expected to be placed immediately upon initiation of precautions. Nurse managers were responsible during business hours and supervisors were responsible during evenings and weekends. Staff were expected to don required personal protective equipment prior to entering rooms on precautions and were not to exit isolation or COVID-positive rooms wearing personal protective equipment. Hand hygiene was required before and after glove use, between tasks, and upon exiting resident rooms. Staff who had not received the influenza vaccine were required to wear masks during flu season, masks were required to be worn correctly covering the nose and mouth, and enforcement was the responsibility of managers and supervisors through routine rounding.10 NYCRR S415.19

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, record review, and interviews, the facility failed to maintain an effective pest control program so that the facility was free of pests for one (1) of one (1) main kitchen reviewed. Specifically, there was evidence of roaches in the main kitchen. Findings Include:The facility policy Pest Control, reviewed 03/2026, documented the facility would implement a continuing and effective pest control prevention and monitoring program to maintain the facility as pest and rodent free as possible.The third-party vendor pest control customer service reports documented the following:-On 02/12/2026, a liquid preventive and a dust bait were applied by the dishwasher area and joining wall bathroom and a recommendation was made for an after-hour escalation treatment.-On 02/16/2026, a treatment for German roaches was applied in the kitchen; moderate activity was seen with heavy activity noted underneath the garbage disposal by the dishwasher; the area where the hole in the wall was, had been the focus problem. Recommendations included floor fans to keep the area as dry as possible after the kitchen closed and to completely empty and remove all garbage from the kitchen at closing time.-On 02/24/2026, the food disposal in the kitchen where the main roach concerns were, was still being used even though it was broken. During follow-up night jobs, if the pest control technician finds the disposal to continue to be in use, guarantee for services will be withheld due to a constant source being provided to the roaches.The following observations of roaches in the main kitchen were made on 03/02/2026 at 12:40 PM:-The women's bathroom had over 25 dead roaches on the floor and three (3) crawling roaches. -One (1) dead roach on the floor near the microwave and cases of thickened juices. -Several roaches on the floor, wall and ceiling inside the dish room. One roach was observed dropping from the ceiling. During an interview on 03/03/2026 at 1:10 PM, Assistant Food Service Director #23 stated maintenance had to replace the garbage disposal pipe. Maintenance said the exterminator asked to keep the hole open, so it was being left open. They never had fans on the floor. They stated maintenance came in at night to re-grout the floor and they were unsure if they were using fans. During an interview on 03/05/2026 at 8:52 AM, the Director of Maintenance stated the kitchen had leaks in the wall pipes and food was going into the wall. The exterminators recommended letting the area dry out. The area had been treated. At nighttime, after the dishes were done, a fan was set out by dietary staff to dry the area. During an interview on 03/05/2026 at 5:02 PM, the Administrator stated maintenance oversaw pest control and should follow vendor recommendations including putting fans in the kitchen after hours. 10 New York Codes, Rules and Regulations 415.29(j)(5)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observations, record review, and interviews the facility did not ensure residents had the right to a dignified existence in a manner and an environment that promoted the maintenance or enhancement of quality of life for two (2) of five (5) residents (Residents #8 and #5) and for 5 of eight (8) resident rooms (201B, 202A, 202B, 209 and 324B) reviewed. Specifically, Residents #8 and #5 were observed on multiple occasions being transported in their padded reclining wheelchair facing backwards on multiple occasions and rooms 201B, 202A, 202B, 209 and 324B were not clean, sanitary and homelike. Findings include:The facility policy, Quality of Life-Dignity, last reviewed 01/2023, documented each resident should be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Staff should keep the resident informed and oriented to their environment. Procedures should be explained before being performed and residents would be told in advance if they were going to be taken out of their usual or familiar surroundings. 1)Resident #8 had diagnoses including Alzheimer's disease. The 09/25/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, did not use a wheelchair, did not walk, and was dependent for transfers. The Comprehensive Care Plan revised 09/27/2025 documented Resident #8 was at risk for functional decline in mobility and self-care related to weakness and cognition. Interventions included the resident was dependent with wheeling 50 and 150 feet and engage, encourage, and regularly assess the resident's ability to use appropriate assistive devices. Resident #8 was observed:-On 12/04/2025 at 1:10 PM, seated in their padded reclining wheelchair. Resident Assistant #84 transported resident down the hallway towards the dining room while the resident was facing backwards. -On 12/05/2025 at 10:12 AM, seated in their padded reclining wheelchair. Certified Nurse Aide #26 transported the resident out of their room and down the hallway while the resident was facing backwards. 2)Resident #5 had diagnoses including schizophrenia (serious mental health disorder) and bipolar disorder (mental health disorder causing extreme mood swings). The 09/16/2025 Minimum Data Set documented the resident had severely impaired cognition, was dependent for all activities of daily living, and did not use a wheelchair or walk. The Comprehensive Care Plan revised 08/01/2024 documented Resident #5 required assistance with self-care and mobility related to confusion and limited mobility. Interventions included dependence with wheeling 50 and 150 feet and encouragement to fully participate with each interaction. Resident #5 was observed: -On 12/02/2025 at 1:30 PM, seated in their padded reclining wheelchair. Licensed Practical Nurse Manager #19 transported the resident into the dining room while the resident was facing backwards. -On 12/04/2025 at 1:12 PM, seated in their padded reclining wheelchair. Certified Nurse Aide #26 transported the resident from the hallway and into the dining room while the resident was facing backwards. -on 12/05/2025 at 10:12 AM, seated in their padded reclining wheelchair at a table in the dining room. Certified Nurse Aide #90 walked up from behind the resident without saying anything and transported them through the dining room while the resident was facing backwards. -On 12/09/2025 at 9:11 AM, seated in their padded reclining wheelchair. Certified Nurse Aide #60 transported the resident down the hallway while the resident was facing backwards. During an interview on 12/05/2025 at 10:12 AM, Certified Nurse Aide #90 stated residents in wheelchairs should be alerted before they were moved. They stated they should have pushed Resident #5 facing forward so they could see where they were going. Pushing the resident forward also decreased the risk of bumping them into walls. During an interview on 12/05/2025 at 1:28 PM, Licensed Practical Nurse Manager #19 stated staff were expected to notify the resident before moving them in their chair, the residents were supposed to be facing forward, and always going in the direction staff walked. During an interview on 12/15/2025 at 3:34 PM, Assistant Director of Nursing #21 stated staff were expected to approach a resident from the front, explain the plan, and ask their permission before moving their (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chair. Residents should not be transported backwards because it could scare the resident or cause an accident or injury. The resident should always be able to see where they were going. 3) On 12/02/2025, the following observations were made:At 12:01 PM - room [ROOM NUMBER] had an odor consistent with feces. The mattress had a dark brown stain measuring approximately two (2) feet by one (1) foot.At 12:33 PM - the resident in room [ROOM NUMBER] A was sleeping on a mattress without sheets. A fly was on the resident's leg. There were empty beverage containers and a partially full cup on the bedside table. Multiple boxes were stored along the wall across from the bed.At 12:34 PM - room [ROOM NUMBER] B was unoccupied. The bed was stripped and the exposed mattress and had a strong urine odor.At 1:00 PM - room [ROOM NUMBER]B room had a strong urine odor. Furniture surfaces had scuff marks and chipped areas. A sheet was tied to the curtain rod and used as a window covering. The bed sheet was torn.At 3:38 PM - room [ROOM NUMBER] B had a soiled privacy curtain.During an interview on 12/11/2025 at 2:00 PM, Assistant Director of Nursing #21 stated staff were responsible to maintain the rooms in a clean and organized condition.During a telephone Interview on 12/16/2025 at 1:04 PM the Director of Maintenance and Environmental Services stated their responsibility was to oversee maintenance and housekeeping services throughout resident care areas, dining areas, common areas, and support spaces. Environmental issues were identified primarily through staff reports. There was no formal inspection schedule or routine environmental audit process. They had no pending work orders or escalated environmental concerns they identified as urgent at the time of interview. 10NYCRR 415(a)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observations, record review, and interviews the facility failed to ensure residents resided in a safe, clean, sanitary, and homelike environment for eight (8) resident rooms (rooms 102 A, 105, 116, 201 B, 202 A, 202 B, 209, and 324 B) and four (4) of six (6) resident units (North 1, [NAME] 1, South 1, and South 2) reviewed.Findings include: The facility policy Resident Rights revised 01/2025, documented residents were entitled to a safe, clean, comfortable, and homelike living environment.The facility policy Floors last reviewed 01/23/2025, documented floors were cleaned daily.The facility policy Linen Handling and Transport reviewed 01/2025, documented soiled linens were removed promptly, and clean linens were maintained free from contamination.The facility policy Cleaning and Disinfection of Resident-Care Items and Equipment reviewed 01/2025, documented resident-care items and equipment were cleaned, disinfected, and stored appropriately.On 12/02/2025, the following observations were made:At 12:01 PM - room [ROOM NUMBER] had an odor consistent with feces. The mattress had a dark brown stain measuring approximately two (2) feet by one (1) foot.At 12:33 PM - the resident in room [ROOM NUMBER] A was sleeping on a mattress without sheets. A fly was on the resident's leg. There were empty beverage containers and a partially full cup on the bedside table. Multiple boxes were stored along the wall across from the bed.At 12:34 PM - room [ROOM NUMBER] B was unoccupied. The bed was stripped and the exposed mattress and had a strong urine odor.At 1:00 PM - room [ROOM NUMBER]B room had a strong urine odor. Furniture surfaces had scuff marks and chipped areas. A sheet was tied to the curtain rod and used as a window covering. The bed sheet was torn.At 3:38 PM - room [ROOM NUMBER] B had a soiled privacy curtain.On 12/03/2025, the following observations were made: At 11:09 AM - North 1 Hallway: A posted activity calendar reflected the month of November.At 11:21 AM - [NAME] 1 Hallway: A posted activity calendar reflected the month of October.At 2:27 PM - The South 1 medication room sink area was heavily soiled, had visible residue and debris within the basin and on surrounding surfaces.At 3:00PM - North 1 unit, the vinyl tile flooring had significant wear, discoloration, and staining. Several tiles were mismatched in color and appearance. Cracked tiles, chipped edges, and visible separations between tiles were present, some areas appeared uneven or recessed. Darkened seams and gaps were visible, particularly near door thresholds and along the base of walls and door frames, paint was worn and chipped, with underlying material exposed in several locations. The lower portions of walls had scuffing and deterioration near the floor level. Transitions between rooms were uneven, with visible breaks where flooring materials met. Black anti-slip strips affixed to the floor near a doorway and the surrounding floor surface in the area showed additional wear and discoloration. A door was marked with a black marker that indicated the room was the North 1 dirty utility room.During an observation on 12/09/2025 at 9:36 AM, the South 2 labeled Clean Utility Room had a used hairbrush with hair debris and a cloth garment stored on a treatment cart. An intravenous solution was stored on a shelf in the room with an empty soda can tucked beside it. Cardboard boxes were stored directly on the floor. Cabinets and shelving had visible dirt and residue. A winter coat was rolled into a ball and stored on clean sheets on the shelf. Outside the room across the hallway there was a wooden door labeled S2 handwritten in black marker. During an observation on 12/09/2025 at 10:44 AM, resident room [ROOM NUMBER] had a disposable soiled incontinence brief on the floor in plain view from the hallway. During an observation on 12/09/2025 at 10:45 AM, in resident room [ROOM NUMBER], the wall behind the bed had missing paint, scuff marks, scratches, and discoloration near the electrical outlet. An activity calendar was posted on the wall with a single piece of tape, the edges were folded in, and the copy was dark and not legible. During an observation on 12/09/2025 at 10:56 AM, the South 2 dining area ice machine had rust and corrosion on the metal piping beneath the ice machine. Peeling paint and residue were present on pipes. The floor beneath the plumbing was (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stained. A plumbing connection was wrapped with paper towels. The top surface of the ice machine contained medication packaging, caps, personal drink containers, and visible residue.During an observation on 12/11/2025 at 10:09 AM, the South 1 dining area ice machine had a flexible tubing attached to the piping and secured with plastic ties. An open funnel-style drain emptied directly into a plastic-lined trash receptacle positioned below the pipe. The interior of the receptacle contained dark liquid debris. The surrounding floor tiles showed discoloration, staining, and accumulated dirt, particularly along grout lines. The area had staining, moisture exposure and rotted peeling baseboard.During an interview on 12/03/2025 at 3:30PM Licensed Practical Nurse #18, stated the South 1 medication room sink condition did not meet expected standards of cleanliness. The sink and surrounding area were cleaned after the initial inspection because they were disgustingDuring an interview on 12/11/2025 at 9:57AM, Licensed Practical Nurse Manager #19 described the clean utility room as a place where clean items for residents would be stored, including linen, shampoo, soaps, catheters, dressings, and lotions. There should not be any personal items in the clean utility room, and all items should be maintained in a clean manner. There should not be any staff articles mixed, nor should there be empty soda cans in any area of supplies.During an interview on 12/11/2025 at 2:00 PM, Assistant Director of Nursing #21 stated clean utility rooms were intended for the storage of clean items used for resident care. They should be clearly identified and protected from contamination. The room contained items including intravenous fluids and clean linens and other necessities for resident care. They stated the clean utility areas were expected to be restricted to appropriate supplies only, with food, beverages and personal item prohibited. Staff were responsible to maintain the rooms in a clean and organized condition.During a telephone Interview on 12/16/2025 at 1:04 PM the Director of Maintenance and Environmental Services stated their responsibility was to oversee maintenance and housekeeping services throughout resident care areas, dining areas, common areas, and support spaces. Environmental issues were identified primarily through staff reports. There was no formal inspection schedule or routine environmental audit process. They stated minor floor damage was not considered significant unless it worsened or was reported. Dining area sinks and clean utility rooms relied on staff notification for corrective action. Ice machines were serviced approximately every six (6) months. Handwritten room signage was acknowledged as not homelike but functional. They had no pending work orders or escalated environmental concerns they identified as urgent at the time of interview.10 NYCRR 415.29(j)(1)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure residents were provided ongoing programs to support each resident in their choice of activities for three (3) of five (5) residents (Residents #9, #104, and #184) and on three (3) of seven (7) units (South 3, North 1 and [NAME] 1) reviewed. Specifically, Residents #9 and #104 were not invited or assisted to meaningful activities that included their interests and preferences; Resident #184 did not have a plan for meaningful activities that included their interests or preferences; there were no unit specific activities conducted on the South 3 unit from 12/02/2025 - 12/11/2025; the posted activity calendar on North 1 reflected the month of November; and the activity calendar on [NAME] 1 reflected the month of October.Findings include: The facility policy Activity Programs last reviewed 01/2025, documented activity programs were designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident. Activities were offered based on the comprehensive resident-centered assessment and the preferences of each resident. The activities program was ongoing and included facility-organized group activities, independent individual activities and assisted individual activities. Residents were encouraged to participate in scheduled activities. The December 2025 Activity Calendar documented the following activities:-On 12/01/2025 at 10:30 AM bible study; at 2:00 PM floor games; at 3:30 PM German Singer; and at 5:30 PM coffee hour. -On 12/02/2025 at 10:30 AM yoga; at 2:00 PM Xmas craft; at 3:30 PM coffee hour; and at 4:30 PM 1:1 visits. -On 12/03/2025 at 10:30 AM paper snowflakes; at 2:00 PM chit chat; at 3:30 PM bingo; at 4:00 PM music with Troy; and at 5:00 PM movie night. -On 12/04/2025 at 10:30 AM socials; at 2:00 PM uno; at 3:30 PM board games; and at 4:30 PM noodle ball. -On 12/05/2025 at 10:30 AM church; at 2:00 PM guess who; at 3:30 PM gingerbread house; and at 4:30 PM Xmas coloring. -On 12/06/2025 at 10:30 AM daily news; at 2:00 PM activity carts; and at 3:00 PM room visits. -On 12/07/2025 at 10:30 AM book club; at 2:00 PM heads up; and at 3:30 PM broom ball. -On 12/08/2025 at 10:30 AM bible study; at 2:00 PM [NAME] H; at 3:30 PM Res. choice; and at 4:30 PM coffee hour. -On 12/09/2025 at 10:30 AM Xmas songs; at 2:00 PM [NAME] L; at 3:30 PM karaoke; and at 4:30 PM bowling. -On 12/10/2025 at 10:30 AM floor visits; at 2:00 PM Xmas craft; at 3:30 PM games; and at 4:30 PM movie night. -On 12/11/2025 at 10:30 AM 1:1's; at 2:00 PM [NAME] B; at 3:30 PM crafts; at 4:30 PM table games; and at 5:30 PM broomball. 1) Resident #9 had diagnoses including dementia, depression, and anxiety. The 05/19/2025 Minimum Data Set (a resident assessment tool) documented the resident had severe cognitive impairment; it was very important to have books, newspapers, and magazines to read, listen to music they liked, and do their favorite activities; it was somewhat important to be around animals such as pets, do things with groups of people, and participate in religious services or practices. The Comprehensive Care Plan initiated 05/19/2025 documented the resident was a new admission to the facility and needed time to adjust to their routine. Resident #9 attended/participated in activity programs of interest/choice. They chose to engage in independent activity pursuits such as television, walking on the unit, socializing with other residents, 1:1 visits with staff, and outside time. Interventions included encourage the pursuit of individual activities, provide with equipment/supplies as needed; invite and escort to activities, special events, and parties of choice/interest; provide with appropriate cognitive/sensory activities; provide a monthly calendar/daily schedule of activity programs; provide with personal 1:1 bedside visits; and provide with reminders and encouragement as needed. The unsigned 11/03/2025 Recreation Quarterly Assessment documented the resident actively participated in small groups, large groups, and 1:1 activities. The resident preferred on and off unit programs, their own room, and outside settings with positive response. The resident required reminders and transport assistance. Resident #9 was observed pacing the hallways without staff interaction on 12/02/2025 at 11:03 AM, 11:36 AM, 12:31 PM; 12/04/2025 at 9:00 AM: 12/05/2025 at 9:46 AM, 11:04 AM, and 1:21 PM; and 12/08/2025 at 10:57 AM, 11:40 AM, 12:26 PM, and 1:58 PM. (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #9 was not observed engaged in any activities. During an observation on 12/08/2025 at 2:13 PM, a musician was playing holiday songs on their guitar and singing in the main lobby. Resident #9 was not present. At 3:02 PM, the musical activity continued in the main lobby and Resident #9 was not present. At 3:13 PM, Resident #9 was pacing the South 3 unit without any interaction with staff or other residents. 2) Resident #104 had diagnoses including dementia, adult failure to thrive (overall decline), and wandering. The 09/19/2025 Minimum Data Set documented the resident had severe cognitive impairment; it was very important to listen to music they liked, keep up with the news, and do their favorite activities; it was somewhat important to have books, newspapers, and magazines to read, be around animals such as pets, do things with groups of people, go outside to get fresh air when the weather was good, and participate in religious services or practices. The Comprehensive Care Plan initiated 10/15/2025 documented the resident was a new admission to the facility and needed time to adjust to their routine. They attended/participated in activity programs of interest/choice. The resident chose to engage in independent activity pursuits such as visiting with their spouse, outings, reading, television, Spanish programs and some group activities like music, live entertainment, and socializing with other residents and staff. Interventions included to encourage the pursuit of individual activities and provide with equipment/supplies as needed; invite and escort to activities, special events, and parties of choice/interest; provide with appropriate cognitive/sensory activities; provide with a monthly calendar/daily schedule of activity programs; provide with personal 1:1 bedside visits; and provide with reminders and encouragement as needed. The unsigned 09/16/2025 Recreation Assessment documented Resident #104 was interviewed for daily and activity preferences. It was very important to the resident to do their favorite activities. The resident's interests included Bingo, books/magazines, cards, fresh air, movies, music, pet visits, spiritual/religious, and television/radio. The resident preferred small groups, large groups, and 1:1 settings. The resident had positive response to group programs. Resident #104 was observed at the following times:-On 12/02/2025 at 11:03 AM, 11:36 AM, 12:01 PM, and 12:27 PM pacing the hallway without any interaction with staff or other residents. At 1:13 PM eating in the dining room seated by themselves in the corner facing a wall without any interaction with staff or other residents. -On 12/05/2025 at 9:49 AM, 10:37 AM, 11:05 AM, 11:22 AM, and 1:20 PM pacing the hallway without any interaction with staff or other residents. -On 12/08/2025 at 11:16 AM, 11:33 AM, 12:30 PM, 1:20 PM, and 3:05 PM pacing the hallway without any interaction with staff or other residents. During an interview on 12/05/2025 at 9:50 AM, Resident #104 stated they liked to dance and liked music including polka and fast dance. During a follow up interview on 12/08/2025 at 12:51 PM, Resident #104 stated they liked music and used to play the guitar and the bongos. They stated there were no music activities at the facility. During an observation on 12/08/2025 at 2:13 PM, there was a musician playing holiday songs on their guitar and singing in the main lobby. Resident #104 was not present. At 3:02 PM the musical activity continued in the main lobby and Resident #104 was not present. At 3:05 PM, Resident #104 was standing in the hallway on South 3 unit and immediately approached and talked with the surveyor as they got off the elevator. 3) Resident #184 had diagnoses including dementia, depression, and anxiety. The 05/15/2025 Minimum Data Set documented the resident had moderate cognitive impairment; it was somewhat important to have books, newspapers, and magazines to read, listen to music they liked, be around animals such as pets, do their favorite activities, go outside to get fresh air when the weather was good, and participate in religious services or practices. There was no documented evidence of a person-centered comprehensive care plan that included the resident's activities preferences. The unsigned 08/06/2025 Recreation Assessment documented Resident #184 was interviewed for daily and activity preferences. It was somewhat important to the resident to do their favorite activities. The resident's interests included Bingo, current events/history, fresh air, movies, music, pet visits, spiritual/religious, and television/radio. The resident preferred self-directed/independent, small groups, large groups, and 1:1 settings. The resident had positive response to group activities. There was no documented evidence Resident #184 (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had a quarterly recreation assessment.Resident #184 was observed at the following times:-On 12/02/2025 at 12:06 PM, sitting in their wheelchair in the hallway without any interaction with staff or other residents. -On 12/04/2025 at 9:10 AM and 9:44 AM sitting in their wheelchair in the hallway without any interaction with staff or other residents. At 10:06 AM, sleeping in their wheelchair in the hallway. At 10:23 AM sitting in their wheelchair in the hallway without any interaction with staff or other residents. At 11:06 AM sleeping in their wheelchair in the hallway. -On 12/08/2025 at 10:59 AM, and 12:30 PM, sitting in their wheelchair in the hallway without any interaction with staff or other residents. During an observation on 12/08/2025 at 2:13 PM, there was a musician playing holiday songs on their guitar and singing in the main lobby. Resident #184 was not present. At 3:02 PM the musical activity continued in the main lobby and Resident #184 was not present. At 3:07 PM, Resident #184 was sitting in their wheelchair in the hallway without any interaction with staff or other residents. During an interview on 12/09/2025 at 12:04 PM, Certified Nurse Aide #45 stated they had not seen any activities on the South 3 unit. If there were large group activities it was announced over the loudspeaker. During an interview on 12/09/2025 at 12:29 PM, Licensed Practical Nurse #4 stated there were not currently any unit activities because there was COVID in the building. During an interview on 12/10/2025 at 12:48 PM, Certified Nurse Aide #65 stated activities were held down on the first floor and not on the unit. During an interview on 12/10/2025 at 1:10 PM, Licensed Practical Nurse Unit Manager #43 stated they had an activities aide assigned to the unit, but they did not know their name. There were not usually unit activities, but they saw them once come up and color with the residents. Activities were important for quality of life, to maintain normalcy, and so residents did not just sit in front of walls. During an observation and interview on 12/12/2025 at 11:38 AM, Activity Aide #70 was coloring in the South 3 dining room. There were residents present and coloring, but Activity Aide #70 did not engage with the residents. Activity Aide #70 stated activities were based on the calendar and unit activities were held every other day. They invited residents to the large group activities downstairs. If a resident could get themselves downstairs, they could come, otherwise, they just tried to talk with the residents on the unit. The residents needed things to do that kept them from being lonely. It was important residents attended activities to feel at home and make them comfortable. They stated the residents on the South 3 unit were not all there so there were not many things they could do, but they could do crafts. They were new so they were still getting to know the residents. They had not done any unit specific activities on South 3 the past couple of weeks because the residents were not really involved so they hung out on another unit with another activity aide. During an interview on 12/15/2025 at 11:52 AM, Activities Aide #6 stated they were covering for the Director of Activities because they were currently out. They were making sure activities were completed on the unit but were also assigned their own unit to complete activities. They stated it was hard to do both. There were a lot of group activities at the facility but because there currently was COVID in the building, they were focusing on unit specific activities. At least once a day there should be an activity on the unit. As activity aides, they just knew which activities were unit activities and which were large group activities. Even if the activity aide was not doing an activity at that time, it was expected they were on the unit engaging with the residents. They stated Certified Nurse Aide #64 told them on 12/12/2025 unit activities were not occurring on South 3. When they approached Activity Aide #70 about this, Activity Aide #70 stated they were told they should not be on the unit because there was COVID. They felt Activities Aide #70 was afraid because they were new. Activities made the residents feel at home and they were still human and a part of the world. During an interview on 12/15/2025 at 12:56 PM, the Director of Social Work stated it was the resident's right to attend activities. It should be a part of their everyday life and brought them joy, happiness, hope, and a meaningful purpose.During an interview on 12/16/2025 at 12:18 PM, the Director of Activities stated they were responsible for activities care plans upon admission. The care plans were then reviewed with each care plan meeting to reassess and update preferences. Not everyone came down for large group activities but there were smaller unit activities as well. They usually only went to the floors if (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	someone was off, otherwise they relied on their staff to report any changes. They knew Resident #184 well and did not know why they did not have an activity care plan. Their assessment was late, they had a computer problem that they were not seeing the schedule of when the assessments were due. Resident #104 was due for an assessment. They were not aware of any issues with activities on South 3 and Activities Aide #70 was new. They stated they relied on Licensed Practical Nurse Unit Manager #43 to tell them if there were any issues, and they had not. There were supposed to be activities on the South 3 unit at 10:30 AM. If there was a large music activity at 2:00 PM activities staff were supposed to be on the unit at 1:30 PM getting the residents downstairs. There was a coffee/social hour at 3:15 PM and then another activity on the floor at night. There should be unit specific activities, so residents stayed active and socialized. Resident #9 was hard because they just walked but the activities aide should attempt to converse with them. Resident #104 liked music and enjoyed activities much more now than when they first came to the facility. Resident #184 like to play cards and attend music and religious activities. Each resident was supposed to be invited to each activity every day. 10NYCRR 415.5(f)(1)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews conducted during the survey, the facility failed to ensure alleged violations involving abuse and neglect were reported immediately to the State Agency in accordance with State Law for one (1) of one (1) resident (Resident #100) reviewed. Specifically, Resident #100 who was cognitively impaired and wore a wander alert device, eloped from the facility on 10/18/2025 and there was no documented evidence the incident was reported to the New York State Department of Health as required. Findings include: Refer to F 689 Free of Accident HazardsThe facility policy Accidents and Incidents-Investigating and Reporting last reviewed 01/2025 documented all accidents or incidents involving residents occurring on the facility premises shall be investigated and reported to the administrator. The policy did not include procedures for reporting of accidents and incidents to the New York State Department of Health. Resident #100 had diagnoses including dementia with psychotic disturbance and Parkinson's disease (a progressive neurological disorder). The 10/03/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition, fluctuating disorganized thinking and inattention, had no behaviors, and required supervision for mobility. The 11/03/2025 Comprehensive Care Plan documented the resident was at risk for elopement related to a change in their environment and cognitive impairment. Interventions included to check placement of the wander alert device each shift, provide the wander alert device number and location, and check the wander alert bracelet every shift. The 10/18/2025 Incident report, signed off by the Director of Nursing on 11/26/2025, documented:- on 10/18/2025 at 12:26 PM, the unit was notified Resident #100 was observed outside by Certified Nurse Aide/Concierge #9. The resident was attempting to open car doors. - the resident was redirected back inside by Certified Nurse Aide/Concierge #9 and the Supervisor, Director of Nursing, and Nurse Practitioner were notified.- Resident #100 was last seen at 12:15 PM wandering around the unit. - there were no findings on the head-to-toe assessment, the placement and function of the wander alert device was checked and found to be functioning, and Resident #100 was placed on one (1) hour checks.- Maintenance checked the function of all doors and elevators with no issues found. There was no documented evidence of a report to the New York State Department of Health. During an interview on 12/09/2025 at 1:06 PM, the Director of Nursing stated if there was an elopement staff notified them along with the supervisor and the Administrator and the situation would be investigated. They should make sure the resident was safe, inform the physician and responsible party, and report the incident to the Department of Health within two (2) hours. On 10/18/2025, Resident #100 was noted by the dock outside. They stated at that time, it was not considered an elopement even though the resident had left their unit while wearing a wander alert device. The report they originally received documented that a staff member saw the resident standing on the loading dock and then walking towards the dock. When they received the staff statements, they found out the resident was outside alone trying to get into cars. The elopement was not reported to the New York State Department of Health. They were new to the facility at the time and had followed up on reporting protocol and they were past the two (2) hour reporting timeline, so it was not reported. They informed the Administrator the resident was outside unattended, but they were not provided any direction on reporting the incident. They were unsure how the resident got outside as their wander alert device was working. During an interview on 12/09/2025 at 1:37 PM, the Administrator stated they were informed the wander alert system was not functioning correctly and the resident was found outside. Resident #100's elopement was not reported to the New York State Department of Health as it was past the reporting deadline by the time they found out about the incident. They were not made aware the resident was unattended in the parking lot until the following Monday (10/20/2025) and they should have been made aware of the elopement right away. 10NYCRR 415.4(b)(1)(ii)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the survey, the facility failed to ensure that each resident was screened for a mental disorder or intellectual disability prior to admission for one (1) of one (1) resident (Resident #121) reviewed. Specifically, the Preadmission Screening and Resident Review (PASRR, New York State Department of Health Form 695) documented Resident #121 had a serious mental illness and the section for Level II referrals and Level II recommendations were not completed. Findings include: The facility policy PP Screen and PASRR last revised on 01/2025, documented all individuals applying for a new admission to the facility must be screened to identify serious mental illness or mental retardation/developmental disability per New York State Department of Health regulations. A screen is needed prior to admission to the facility for every person, for any length of stay. A resident who was previously identified as having mental illness, and/or mental retardation/developmental disability, a new screen and Level II referral must be completed within 14 calendar days. If a Level II referral is necessary, the admission coordinator must ensure that this referral was made by referring entity and that a determination was made by the appropriate independent evaluator (as determined by per New York State Department of Health).Resident #121 was admitted to the facility with diagnoses of anxiety, alcohol abuse history, and other psychotic disorder. The 09/01/2024 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact and able to make themselves understood and understood others. The 08/25/2025 Comprehensive Care Plan documented the resident was at risk for functional decline in mobility and self-care related to psychosis (disruption in thought process and perceptions) diagnosis. The care plan did not document the resident required a Level II screening for serious mental illness. The 08/11/2025 Preadmission Screening and Resident Review documented appropriate community-based living could not be arranged because the resident could not be adequately cared for in the community and/or was at risk to self or others; and they did have a serious mental illness. The Level II referrals and recommendations were left blank and there was no signature that a qualified screener completed the New York State Department of Health form- 695. There was no documented evidenced of Level II Referral completed for Resident #121. The 08/25/2025 hospital discharge instructions documented the resident was admitted for mental health stabilization and support. The resident was brought to the hospital emergency room after being found walking down the street in their underwear. While in the emergency room, they were having auditory hallucinations, instructing them to take off their clothing. The discharge diagnosis was psychotic disorder.The 08/26/2025 at 7:59 AM Social Worker #48 admission/readmission progress note did not document the resident's mental illness or needs for additional services. The 08/25/2025 at 3:54 PM Physician #12 progress noted documented the resident was admitted to the Behavioral Health unit and stabilized over the course of admission. Risperidone (antipsychotic medication) was increased with some improvement to their ability to interact. The resident would benefit from social services/therapeutic recreation/psychologist for management of their depression and anxiety. The facility should continue to provide a safe environment for the resident and continue to provide risperidone. The Comprehensive Care Plan initiated 10/09/2025 documented the resident exhibited behavior symptoms such as socially inappropriate/verbally abuse; physically aggressive/abusive; accusatory statements towards staff (racial slurs/profanity). Interventions included administer psychotropic medications as ordered, determine the cause of the behavior and remove the residents, and distract the resident with activities of interest. On 10/16/2025, the plan was revised after the resident hit a staff member and was verbally abusive toward staff. The updated interventions included social service as needed, psychiatry consults as needed, and when possible, keep resident in line of sight when behavior was escalating and offer diversion. The care plan did not document the resident required a Level II screening for serious mental illness.The 10/16/2025 at 9:25 AM Licensed Practical Nurse/Unit (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manager #14 nursing progress note documented the resident was overheard using racially derogatory language toward staff. Following this incident, an unnamed housekeeper reported that on 10/15/2025, the resident had physically grabbed them and used profane and racially offensive language. On a separate incident the resident attempted to strike them but was unable to make contact. The resident was noncompliant with their medication over the past several days. The on-call provider was notified of the behavioral concerns and recommended the resident be sent out for further psychiatric evaluation due to escalating behaviors and safety concerns. The resident was considered a danger to staff and other residents due to verbal aggression, physical intimidation and refusal of treatment. The 10/20/2025 at 5:13 AM Physician #12 progress note documented the resident was sent to the emergency room on [DATE] due to aggressive and abusive behavior toward staff. The resident admitted to using inappropriate language during the incident and expressed regret. The plan of care included room change, monitor mood and behaviors every shift, reinforce staff communication regarding medication, and consider psychiatry referral if behaviors symptoms reoccur or escalate. There was no documented evidenced of a completed Preadmission Screening and Resident Review) or completion of a Level II referral. During an interview on 12/18/2025 at 2:07 PM, Social Worker #47 stated they were part of the admission screening process. The residents were admitted with the Department of Health Form 695 and that information was typically reviewed by the Director of Social Work. The Director would review for completed Level II and specialized services. They stated if the resident was from the hospital, the hospital should determine if the resident would require a Level II screening. In November 2025, they started auditing screens to ensure the screens were accurate. They were looking to see if there were residents in the facility that required a Level II screening that did not have one completed. All residents should be screened prior to their admission. A resident with suspected mental illness should have a Level II completed prior to admission and was to be submitted by the Director of Social Work. A Level II screen would evaluate if the resident needed specialized care or outside mental health specialist services and possible accommodations. They stated Resident #121 was on their case load since the end of October 2025 and they did not have a Level II. They were not sure if Resident #121 required a Level II screen. They were not aware Resident#121 was admitted to the facility from inpatient psychiatry for hallucinations and delusions. During an interview on 12/19/2025 at 9:21 AM, the Director of Social Services stated admission staff reviewed the screens and tried to get the Social Work department more involved in the process of screen reviews. A resident that required a Level II should have the screen completed prior to admission. They stated mental Illness diagnoses would determine if the resident required a Level II screening. The Level II indicated if a special level of care was required and a customized care plan with recommendations for successful living arrangements. They were not sure if Resident #121 required any special services or a Level II screening. Resident #121 came from an inpatient psychiatric stay for hallucinations and delusions and did not have a completed Level II screen. They stated a resident should be reviewed and referred for a Level II screen if they had a psychiatric inpatient hospital stay for hallucination and delusions, and behaviors such as striking out at staff and residents. 10NYCRR 415.11(3)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure residents with limited range of motion received appropriate treatment and services to prevent further decrease in range of motion for two (2) of two (2) residents (Residents #132 and #170) reviewed. Specifically, Resident #132 had orders for a carrot orthotic (a device placed in the hand) for a left hand contracture (shortening of muscle or tendons preventing normal movement) and bilateral ankle boots for leg contractures that were not applied as ordered; and Resident #170 had an order for bilateral resting hand splints and was observed not wearing them. Findings include:The facility policy Contracture Management Program last reviewed 01/2025, documented the facility engaged residents as appropriate in contracture management interventions to improve, maintain and prevent the deterioration of mobility of joints, flexions and extension of extremities. All residents were assessed for range of motion of joints and muscles by the registered nurse and physical therapist on admission. Recommendations were made to the medical professional for treatments and/ or orthotics as appropriate. Relevant care plans were initiated that addressed actual impairments and the interventions to address them. Nursing documentation included the resident's ability to participate in activities of daily living and prescribed therapies, improvement or decline, skin integrity and physical mobility. 1) Resident #132 had diagnoses including multiple sclerosis (an autoimmune disease affecting the nervous system), cerebral palsy (disease affecting movement), and muscle wasting. The 11/07/2025 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact, was dependent for all activities of daily living, did not reject care, and received occupational and physical therapy services.The Comprehensive Care Plan initiated 09/14/2024 documented the resident required assistance with activities of daily living related to limited mobility, limited range of motion, and musculoskeletal impairment. Interventions included a left hand carrot splint and left/right progressive ankle contracture splints to be worn at all times as resident tolerated. Remove for skin checks and hygiene/bathing. The 10/31/2025 Physical Therapist #73 Evaluation and Plan of Treatment documented due to physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient was at risk for further decline in function and limited out of bed activity. Recommendations were bilateral ankle plantar fasciitis splints (provides a consistent stretch by keeping the toes up). The 10/31/2025 Occupational Therapist #74 Evaluation and Plan of Treatment documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient was at risk for increased dependency upon caregivers and further decline in function, pressure sores, and contractures. The current orthotic device for the left hand was a hand roll. Recommendations included occupational therapy would follow up on a positioning device for the right hand. The 11/07/2025 physician order documented left-hand orange/red carrot orthotic to be removed every day shift for skin integrity assessment and hygiene and reapply when completed. Remove left and right ankle contracture boots day shift for skin integrity assessment and hygiene. Notify therapy if lost/needed replacement.During an observation on 12/02/2025 at 12:08 PM, Resident #132 was in bed. The resident had bilateral hand contractures and bilateral foot drop (cannot lift the front part of the foot/toes). Their bilateral leg braces were on the nightstand next to the bed. They did not have their carrot splint for their left hand. There was no documented evidence on the 12/02/2025 nurse aide flow sheet for the 7:00 AM -3:00 PM shift the left carrot splint and/or left and right ankle contracture boots were in place. During an observation and interview on 12/04/2025 at 9:12 AM, Resident #132 stated therapy was supposed to get a splint for their right hand for nighttime use because their hand was closing, but they had not seen it yet. They had a splint for the left hand, but they had not seen it in a week. The splints kept their fingers from curling into their palm. Their bilateral leg braces were observed in their recliner chair. At 1:50 PM, the resident was lying in bed and did not have any splints in place. The resident stated they needed their splints because their hands (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were closing and therapy usually put the splints on, but the therapist was on vacation. At 2:00 PM, the resident's left arm was positioned on a pillow without a splint. On 12/04/2025 at 2:59 PM Licensed Practical Nurse #4 documented on the nurse aide flow sheet the resident's splints were not on for the 7:00 AM - 3:00 PM shift. Licensed Practical Nurse #4 documented on the 12/04/2025 Treatment Administration Record, the left-hand carrot and bilateral contracture boots were in place for the 7:00 AM -3:00 PM shift. During observations on 12/05/2025 at 10:02 AM, 11:37 AM, and 1:33 PM, Resident #132 had a left-hand roll splint in place (not the carrot splint) and the bilateral leg braces were in their recliner chair. On 12/05/2025 at 2:59 PM Certified Nurse Aide #63 documented on the nurse aide flow sheet the resident's splints were all in place for the 7:00 AM - 3:00 PM shift. Licensed Practical Nurse #76 documented on the 12/05/2025 Treatment Administration Record the bilateral contracture boots, and the left-hand carrot were in place for the 7:00 AM - 3:00 PM shift. During an observation and interview on 12/08/2025 at 10:57 AM, Resident #132 had a left-hand roll splint on (not the carrot splint). Their bilateral contracture boots were on top of their dresser. They stated they had been lax in asking staff to apply their bilateral contracture boots, but really wanted the hand splints as they stated their hands were getting worse and closing. On 12/08/2025 at 2:26 PM, Certified Nurse Aide #65 documented on the nurse aide flow sheet the splints were all in place for the 7:00 AM - 3:00 PM shift. Licensed Practical Nurse #4 documented on the 12/08/2025 Treatment Administration Record the bilateral contracture boots, and the left-hand carrot were in place for the 7:00 AM - 3:00 PM shift. During an interview on 12/08/2025 at 3:49 PM, Certified Nurse Aide #64 stated splints were placed either by the nurses or by the certified nurse aides. Resident #132 had a hand splint to keep their muscles from contracting but it was not usually on. They did not know what their leg braces were for. During an interview on 12/09/2025 at 12:04 PM, Certified Nurse Aide #45 stated they had never seen splints on Resident #132. During an interview on 12/09/2025 at 12:29 PM, Licensed Practical Nurse #4 stated nurses or therapy were responsible to ensure splints were placed. Certified nurse aides should not be placing splints. Splints corrected mobility and prevented deterioration. Therapy decided if splints should be worn. Documentation should be accurate for the resident's safety. They did not recall if Resident #132 had splints. During an interview on 12/10/2025 at 1:10 PM, Licensed Practical Nurse Unit Manager #43 stated a nurse, certified nurse aide, or anybody could place a splint. Documentation should be accurate for proper care and safety. Therapy decided who needed splints. They thought Resident #132 had leg splints, but they only had one (1) resident on the unit with hand splints, and it was not Resident #132.During an interview on 12/11/2025 at 9:49 AM, the Director of Therapy stated after they determined splints should be worn, there was staff education. The unit manager was trained as well. The application of splints was added to the certified nurse aide flow sheet for documentation. If splints were indicated, they were expected to be on unless the resident refused and then it should be documented as a refusal. Resident #132 had been working with occupational and physical therapy since 10/31/2025. Most of the time the resident participated in therapy. They had a left-hand carrot and bilateral leg splints to be worn at all times. The splints prevented worsening contractures. The resident was at risk for decline because they were limited in their ability to work on range of motion themselves. The resident's diseases were progressive, and therapy's job was to limit the speed of progression. 2) Resident #170 had diagnoses including spinal stenosis (narrowing of spaces within the spine), rheumatoid arthritis (an autoimmune disorder of the joints), and muscle weakness. The 09/12/2025 Minimum Data Set documented the resident had moderately impaired cognition, did not refuse care, was dependent for most activities of daily living, and had no limitation of their upper extremities.The 05/30/2025 physician order documented the resident's splints were to be applied by therapy in the morning for contractures. The 07/17/2025 Occupational Therapist #89 Discharge Summary documented the resident was being released from the occupational therapy caseload with the nursing department taking over applying and removing the bilateral resting hand splints daily. The splints were to be worn eight (8) hours during the day and/or as tolerated. Skin checks were to be completed before and after applying and removing the hand (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splints for skin hygiene. The unit manager was responsible to train any new certified nurse aides, and the nursing staff assigned to the resident. The 07/17/2025 Comprehensive Care Plan documented Resident #170 had limited physical mobility related to contractures. Interventions included bilateral resting hand splints to be applied and worn for eight (8) hours during the day and/or as tolerated, and skin checks before and after applying and removing the bilateral splints and for skin hygiene. The 07/17/2025 physician order documented to remove bilateral resting hand splints every evening shift for skin integrity assessment and hygiene to maintain/monitor skin integrity and to notify therapy if the splints needed to be replaced.The 07/22/2025 Record of In-Service Training documented Occupational Therapist #89 nursing staff was educated on applying the bilaterial resting hand splints, removing the bilateral hand splints with skin checks, and the unit manager was responsible to train any new certified nurse aides and nurses assigned to the resident. The December 2025 Treatment Administration Record documented:- The resident had their contracture brace signed as administered from 12/01/2025-12/15/2025 except for 12/08/2025. - The resident had their contracture brace signed as removed on the evening shift from 12/02/2025-12/14/2025. The resident was observed:-On 12/02/2025 at 11:27 AM, with contractures on their left wrist/hand and their right arm was straight out. There were no braces on the resident's bilateral hands.-On 12/04/2025 at 9:43 AM, lying in bed with their left wrist bent in contracture with no brace on. -On 12/05/2025 at 11:00 AM, in bed with their left wrist bent in with no splint and their right hand flat on the bed with no splint. At 1:32 PM, the resident stated the staff used to apply their splints, but they did not like to wear them anymore because the braces were very stiff, and their joints were stiff. -On 12/08/2025 at 11:07 AM, lying in bed with no braces or contracture devices on either wrist/hand. At 1:29 PM lying in bed with no braces/contracture devices on their wrist or hands. -On 12/09/2025 at 10:23 AM, in bed with arms visible, without contracture management devices or braces on their wrist or hands. -on 12/15/2025 at 1:55 PM, in bed without braces/contracture management devices on their wrist or hands. There was no documented evidence the resident refused the placement of contracture management devices. During an interview on 12/15/2025 at 1:01 PM, Certified Nurse Aide #94 stated the care plan listed any contracture devices or splints a resident needed. Most of the time the nursing staff was responsible putting on the splint devices as well as therapy. Certified nurse aides were responsible to make sure the hand was clean, and the splint was in the proper place. Resident #170 was supposed to have splints, but they had not seen any in the resident's room when they searched the room and nightstand. They stated nursing staff was supposed to be working with therapy to get the devices. The resident could not remove the splints by themself. If the resident refused the splints or they were unavailable, it was documented in the electronic medical record. When the task was signed off in the electronic medical record, it meant the task was completed. Resident #170 did not have their hand splints on this morning, and they did not know why they charted the resident did. They stated sometimes they did not read the questions all the way through as they had a lot of people to chart on and not a lot of time to do it. They should not document the splints are in place if they were not. During an interview on 12/15/2025 at 1:32 PM, Licensed Practical Nurse #3 stated the care plan listed any contracture devices or splint care the resident had and it was on their Treatment Administration Record. There was a mix up between nursing and therapy regarding who was to put on and/or remove the splint devices. The order stated to remove by therapy, but therapy stated they did not remove them. Resident #170 had splints that were worn at night and removed in the morning. The resident could not remove their own splints. If the resident refused their splints, it was documented as a refusal in the Treatment Administration Record or in the progress notes. If the order was signed off as completed that meant the resident was wearing the splints. They stated most of the time the resident refused the splint. Resident #170 was wearing their splints this morning, that is why they signed it off in the Treatment Administration Record as they had not removed them yet. The splints should not be signed for if the resident was not wearing them. During a follow up interview and record review at 1:56 PM, Licensed Practical Nurse #3 showed the orders in the computer for putting on and (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	taking off Resident #170's splints. They stated therapy was supposed to put them on per the order. They did not know why they signed the braces were on when they were not. They believed they checked it as done when they were checking off the resident's hourly safety checks. During an interview on 12/15/2025 at 2:30 PM, Occupational Therapist #89 stated when the resident was in therapy, they built up tolerances for brace/splint devices. Once the resident was stable with wearing the splint consistently, they trained staff how to apply and remove the brace. A signed in-service was done with staff, and they also trained the Nurse Manager to be able to train any new staff that worked with the resident. After training was completed, it was added to the care plan for the nursing staff to put on and remove the splint. Therapy should be notified if the resident consistently refused their splint, if the splint was hurting the resident, or the resident was not wearing their splint consistently for eight (8) hours so the resident could be assessed for an adjustment or decline. It was not reported to them Resident #170 was not wearing their splint. If a resident was not wearing their ordered splint, the contracture could worsen. During an interview on 12/15/2025 at 3:41 PM, Licensed Practical Nurse Unit Manager #33 stated therapy was supposed to be putting splint/contracture devices on in the morning. They were unaware nursing staff was trained by therapy. The order was for therapy to put the brace on, and they did not know if there was a reason it stayed that way. They did not know who was responsible for getting the updated order once therapy had trained nursing staff. The nurses should not be signing the resident was wearing their splint if the resident was not. They were aware Resident #170 did not like to wear their braces. If the resident was consistently refusing or not wearing them, therapy should be informed. There was a referral for therapy to screen them, but they did not know how to do it. During an interview on 12/16/2025 at 10:18 AM, Assistant Director of Nursing #15 stated once therapy was completed for a resident regarding splints, therapy trained staff. The nurse would ensure the resident had it on their orders and the certified nurse aides could see it on the care card. If the resident refused to wear the splint, the nurse should document the refusal. The nurse was responsible for updating the provider's order after training occurred and it should have been done in July. The nursing staff should not be signing off that the resident was wearing their brace if they were not. The provider and Physical/Occupational therapy should be notified if the resident was refusing their splint. The referral was made through the electronic medical record, and all nurse managers were educated on how to make the referral. Resident #170 should have been referred to Occupational Therapy if they had not been wearing their splints so they could be assessed. 10NYCRR 415.12(e)(2)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review, observations and interviews, the facility failed to ensure residents who were fed by enteral means (tube feeding, delivery of nutrition directly to the stomach or small intestine) received the appropriate treatment and services to prevent complications of enteral feeding for two (2) of two (2) residents (Residents #15 and #187) reviewed. Specifically, Resident #15 was not administered their tube feeding formula volume as ordered, and Resident #187 was not administered their enteral water flushes as ordered. Findings include:There was no documented evidence of a facility policy addressing enteral feeding administration. 1) Resident #15 had diagnoses including cerebral palsy (neurological condition affecting muscle movement), dysphagia (difficulty swallowing), and recurring ileus (lack of intestinal movement). The 10/10/2025 Minimum Data Set (a resident assessment tool)documented the resident had severely impaired cognition, did not eat by mouth, had a swallowing disorder, weighed 58 pounds, did not have weight loss, and received nutrition through a feeding tube. The 07/05/2023 comprehensive care plan, revised 10/07/2025, documented:-the resident required tube feeding related to dysphagia and advanced cerebral palsy,-tube feeding and water flushes administered per registered dietitian recommendation and physician orders. -Nutren 2.0 (tube feeding formula) via enteral feeding at 30 milliliters per hour for 20 hours, for a total volume of 600 milliliters every 24 hours. Flush with 140 milliliters six (6) times per day (did not specify what the flush was). -check for tube placement and gastric contents/residual volume per facility protocol and record. If greater than 200 milliliters, stop feed and call provider. If less than 200 milliliters, continue with feeding,-elevate the head of bed 30 degrees at all times,-monitor and report any gastrointestinal symptoms (coughing, choking, indigestion, vomiting etc.) to physician. Physician orders documented:-10/06/2025 resident was to receive nothing by mouth and enteral feeding for nutrition. -10/08/2025 free water flush via enteral tube every four (4) hours (did not indicate the volume of free water). The 10/26/2025 Registered Dietitian #7 progress note documented Resident #15 was prescribed Nutren 2.0 enteral feeding at a rate of 30 milliliters per hour and multiple attempts were made to increase the rate, but the resident did not tolerate due to recurrent ileus. They recommended total parenteral nutrition (intravenous nutrition support). The 11/07/2025 physicians order documented Nutren 2.0 via enteral tube at a rate of 30 milliliters per hour for a total volume of 600 milliliters to be delivered over a 20-hour run time. If Nutren 2.0 was not available, substitute Peptamen 1.5 via enteral tube at a rate of 10 milliliters per hour and increase by 10 milliliters every four (4) hours to the goal rate of 40 milliliters per hour for a total volume of 800 milliliters to be delivered over 20-hour run time. The 12/2025 Medication Administration Record documented Nutren 2.0 via enteral tube at a rate of 30 milliliters per hour to begin at 8:00 AM for a total volume of 600 milliliters to be delivered. If Nutren was not available Peptamen 1.5 was substituted at a rate of 10 milliliters per hour and increased every four (4) hours by 10 milliliters to the goal rate of 40 milliliters per hour for a total volume of 800 milliliters. The following total daily volume of tube feeding administered were recorded as follows (did not document which formula was administered):-12/01/2025: 886 milliliters-12/02/2025: 630 milliliters-12/03/2025: 240 milliliters-12/04/2025: 330 milliliters-12/5/2025: 690 milliliters-12/6/2025: 630 milliliters During an observations on 12/05/2025 at 9:26 AM and 12:28 PM, Resident #15's enteral feeding of Nutren 2.0 was infusing at 60 milliliters per hour. Licensed Practical Nurse #72 signed for the enteral feeding on the 7:00 AM-3:00 PM shift. During an observation on 12/05/2025 at 1:05 PM, Licensed Practical Nurse #72 entered Resident #15's room, stopped the enteral feeding and administered the resident's medications. The head of the bed was elevated more than 30 degrees, and the resident coughed up a white substance. The enteral feeding pump read 344 milliliters had been infused. During an interview on 12/05/2025 at 2:00 PM, Licensed Practical Nurse #72 stated they were responsible for checking the resident's enteral feeding to ensure the rate was correct and the nutritional content was being administered. At the start of their (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift, they cleared the enteral feeding pump to zero, so they knew how much feeding had been infused during their shift. The registered dietitian or physician determined the rate and orders should be followed. If the rate was running higher than ordered, medical should be called. Resident #15 was currently receiving Nutren 2.0 at a rate of 30 milliliters per hour. If it was running higher than ordered they should have called the medical provider. If the rate was higher the resident would not tolerate it. During an observation on 12/05/2025 at 2:12 PM with Licensed Practical Nurse #72, the pump was checked, and the feeding was running at 60 milliliters per hour. They stated Resident #15 had spit up a little during the medication administration, and they were going to call the provider to let them know the rate was not infused correctly. During an interview on 12/18/2025 at 10:14 AM, Assistant Director of Nursing #15 stated nursing should check the tube feeding rate whenever they encountered the resident and should notify the provider if it was wrong. Resident #15 had several episodes of not tolerating their enteral feeding and if the rate was set too high, they could have more intolerance issues. During a telephone interview on 12/18/2025 at 12:08 PM Registered Dietitian #7 stated medical ordered the enteral feedings with their input. Resident #15 had recurrent ileus's and was unable to tolerate large volume of enteral feedings and needed a slower rate. Nursing was responsible to ensure the correct formula was provided at the correct rate. If the wrong formula or rate was infused nursing staff should notify medical. 2) Resident #187 had diagnoses including dementia and cerebrovascular disease (poor blood flow to the brain). The 09/23/2025 Minimum Data Set documented the resident had moderately impaired cognition, required moderate assistance or was dependent for most activities of daily living, had swallowing disorders, weighed 149 pounds, had a feeding tube, and received 51% or more of their total daily calorie intake and 501 or more cubic centimeters of their average fluid intake through tube feeding daily. The 10/08/2024 Comprehensive Care Plan, revised 10/22/2025, documented the resident required tube feeding related to dysphagia. Interventions included administer tube feeding and water flushes per registered dietitian recommendation and medical provider orders, keep head of bed always elevated at 30 degrees, and monitor, document, and report to the medical provider aspiration (inhaling food/fluid into the lungs), tube dislodgement, infection, tube disfunction, abdominal pain, vomiting or abnormal lab values or lung sounds. Physician orders documented:-06/24/2025 nothing by mouth and aspiration precautions. -08/11/2025 Isosource 1.5 (tube feeding formula) via percutaneous endoscopic gastrostomy tube (feeding tube) at 55 milliliters per hour to start at 2:00 PM and end at 10:00 AM for a total of 1100 milliliters of feed delivery. Provide water flushes of 60 milliliters every two (2) hours. -12/05/2025 provide free water flushes of 60 milliliters via enteral tube every two (2) hours for a total of 720 milliliters. The 11/17/2025 Registered Dietitian #7 progress note documented Resident #187 was ordered Isosource 1.5 via enteral tube at 55 milliliters per hour for a total volume of 1100 milliliters (20-hour run time). The start time was 2:00 PM. Resident #187 received 60 milliliters of free water flush before and after the feeding. Additional 60 milliliter free water flushes were ordered every two (2) hours for a total of 720 milliliters every 24 hours. During an observation on 12/04/2025 at 10:01 AM the resident's water flush bag hanging on the tube feeding pole was almost completely full of water, a little over 1000 milliliters. The bag was labeled with the run rate of 60 milliliters per two hours and was signed as being hung at 2:00 PM on 12/03/2025. The machine read the setting for the water flushes was zero (0) milliliters per hour and the tube feeding pump was set to run at 55 milliliters per hour. At 10:23 AM, the tube feeding pump showed total infused was 1040 milliliters for the tube feeding and zero (0) milliliters infused for water flush. At 1:32 PM the tube feeding pump was turned off but still connected to the resident. The water flush bag was full at slightly over 1000 milliliters. The 12/2025 Medication Administration record documented provide water flushes of 60 milliliters every two (2) hours every 24 hours for a total of 720 milliliters with a start date of 06/27/2025 and end date of 12/05/2025. The Medication Administration Record only included an area for the 7:00 AM - 3:00 PM shift to document water flushes and did not include 3:00 PM - 11: 00 PM or 11:00 PM - 7:00 AM shifts. The 12/04/2025 water flush was signed as completed by Licensed (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Practical Nurse Unit Manager #37 during the 7:00 AM - 3:00 PM shift. On 12/05/2025 the following was observed:-at 9:46 AM the enteral pump was beeping due to an empty enteral formula bag.-at 9:52 AM Registered Nurse #8 turned off the pump and Licensed Practical Nurse #67 stated they did not see how much formula had infused before the pump was reset and cleared but since the bag was empty, they were not concerned. During an interview on 12/10/2025 at 2:19 PM, Licensed Practical Nurse Unit Manager #37 stated Resident #187 had an order to confirm the resident was receiving their 60 milliliter flushes every two (2) hours. Each shift was to confirm the resident was receiving their flushes as ordered. There was no order to verify the settings on the pump each shift, but it was nursing judgement, and the nurses should be checking when they administered the resident's medications. When they marked off the 60 milliliter flush order on the Medication Administration Record on 12/04/2025 they were confirming the resident got their 60 milliliters every two (2) hours as ordered. They were unsure what level of water the water flush bag was at when they turned off the resident's tube feeding on 12/04/2025 nor what the machine stated the flush rate was. If the resident did not receive their flushes as ordered, the provider should be notified. During a telephone interview on 12/18/2025 at 12:08 PM Registered Dietitian #7 stated their role in tube feeding was to determine the formula the resident needed, the rate, and the total volume of water flushes based on their weight and nutritional needs. They determined the fluid needs of each resident along with medical recommendations. A resident who had their tube feeding pump set to zero (0) milliliters for their water flushes and did not receive their water flushes could become dehydrated, and their electrolytes could be off. That is something they would like to be notified of. They were not notified Resident #187 had not received their water flushes from 12/03/2025 into 12/04/2025. 10 NYCRR 415.12(g)(2)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure that residents who required dialysis services (a process that filters the blood when the kidneys do not work properly) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #77) reviewed. Specifically, Resident #77 did not receive pre-dialysis and post-dialysis assessments as ordered and the facility did not maintain ongoing communication and collaboration with the dialysis center. Findings includeThe facility policy Dialysis Communication last reviewed 01/2025, documented all residents who received dialysis at an outpatient dialysis center would have a communication book. On dialysis days, prior to transport for treatment, the nurse would take vital signs, document relevant labs and pre dialysis weight into the communication book. An evaluation of the resident's access site would be completed and all findings documented in the communication book as well as the resident's medical chart. Any relevant events as well as diagnostic test, change in condition would be documented in the book for the dialysis center's review. The resident would be transported with the communication book. Upon return the nurse would review the book for communication from the dialysis center regarding the resident's treatment, labs, vital signs, and post dialysis weight. Any adverse events would be reported to the medical professional. The dialysis book would be placed at the nurse's station and all nursing staff would be educated on the location of the dialysis books. Resident #77 had diagnoses including end stage renal disease (kidney disease), diabetes, and dependence on renal dialysis. The 09/13/2025 Minimum Data Set (a resident assessment tool) documented the resident had severely impaired cognition and received dialysis. The Comprehensive Care Plan, revised 08/05/2024, documented the resident required hemodialysis related to end stage renal disease. Interventions included monitor for any signs and symptoms of infection to the access site (the place on the body that connects to a dialysis machine), obtain vital signs and weight per protocol, and encourage resident to go for scheduled dialysis appointments. Physician orders documented:-On 04/10/2024, nurse to check hemodialysis catheter (access site) to the right chest every shift and document abnormal findings. -On 06/18/2025, chart pre-dialysis note (did not specify what the note should include) in the morning every Tuesday, Thursday, and Saturday. -On 06/18/2025, chart post-dialysis note (did not specify what the note should include) after dialysis in the evening every Tuesday, Thursday, and Saturday. -On 10/23/2025, resident to attend dialysis center, pick up time 12:30 PM, every Tuesday, Thursday, Saturday, and return time 4:20 PM. There was no documented evidence Resident #77 had a dialysis communication book or facility communication sheets were provided to the dialysis center. The December 2025 Treatment Administration Records documented, pre-dialysis note every day shift and post-dialysis note in the evening every Tuesday, Thursday, and Saturday. The Treatment Administration Record documented:-On 12/02/2025: 7:00 AM-3:00 PM signed by Registered Nurse #29; 5:00 PM signed by Licensed Practical Nurse #30. There was no documented evidence in the electronic medical record a pre-dialysis note or post-dialysis note was completed. -On 12/04/2025: 7:00 AM-3:00 PM signed by Licensed Practical Nurse #32; 5:00 PM signed by Licensed Practical Nurse #32. There was no documented evidence in the electronic medical record a pre-dialysis note or post-dialysis note was completed. -On 12/06/2025: 5:00 PM signed by Licensed Practical Nurse #31. There was no documented evidence in the electronic medical record a post-dialysis note was completed. -On 12/09/2025: 5:00 PM not completed by Licensed Practical Nurse #31. There was no documented evidence in the electronic medical record a post-dialysis note was completed. During an interview on 12/09/2025 at 12:14 PM, Registered Nurse #29 stated residents who received dialysis were supposed to have a dialysis communication book they took back and forth to the dialysis center. They also required a pre-dialysis note and post-dialysis note which consisted of vital signs, dialysis access site information, and their most recent weight. Resident #77 did not have a dialysis communication book. Registered Nurse #29 stated they were new, so they were unsure what was (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to be in the communication book or what was supposed to be sent with the resident. They sometimes printed out the pre-dialysis note and sent it with the resident because they were supposed to communicate with the dialysis center on how the resident was doing and if there were any complications before their treatment. The dialysis center would send back a communication sheet with the resident that was uploaded to the electronic medical record. They were unsure why there was no pre-dialysis note on 12/02/2025 because they signed they completed the pre-dialysis note on the treatment administration record. During an interview on 12/09/2025 at 12:20 PM, Licensed Practical Nurse Manager #33 stated the medication cart nurse was supposed to get vital signs and a weight before sending Resident #77 to dialysis. They were unsure if the resident was supposed to have a communication book or if anything was supposed to be sent with them to the dialysis center because they were still new to their role. When the resident returned from dialysis, they should be monitored for complications, but they were unsure if that was documented anywhere in the electronic medical record. They thought the dialysis center sent back a communication sheet with the resident's vital signs on it, but they would have to follow up with the Director of Nursing to find out how things worked at the facility. During a telephone interview on 12/09/2025 at 1:04 PM, the outpatient dialysis center Registered Nurse Manager #34 stated they were familiar with Resident #77, and they could not recall the last time the resident was sent from the facility with a communication book or any kind of communication paperwork. If they needed a current medication list or to communicate with the facility, they called them directly and asked them to fax over what was needed. After every dialysis treatment, they sent the resident back to the facility with a communication sheet that included their most recent weight and vital signs. On 12/10/2025 at 11:59 AM, Licensed Practical Nurse #31 stated they were too busy and not available for an interview. During an interview on 12/10/2025 at 4:01 PM, Licensed Practical Nurse #30 stated when a resident was on dialysis, they were responsible for obtaining their vital signs and weight. They also had to complete a pre-dialysis note before the resident left the facility, and a post-dialysis note when they returned. The pre-dialysis and post-dialysis notes were a template, and they had to fill in the answers to the questions which included how the resident's access site looked, their vital signs, and their weight. The purpose of the notes was to show the resident was being monitored for complications like bleeding. They stated Resident #77 was sent to dialysis with their meal/snack and they did not bring anything else with them. They did not recall ever seeing a communication book for Resident #77 and if they returned from dialysis with paperwork, they would review it or have a registered nurse review it. They could not recall why there was no post-dialysis note on 12/02/2025 because they signed they completed the post-dialysis note on the treatment administration record.During an interview on 12/16/2025 at 12:24 PM, Assistant Director of Nursing/Infection Preventionist #21 stated before residents left for dialysis, the nurse was responsible for completing a pre-dialysis evaluation in the electronic medical record which included their vital signs, weight, how their access site looked, and other information they could not recall. The resident should have a communication book on the unit but if they did not, they could send the pre-dialysis evaluation in an envelope. When the resident returned to the facility, the nurse was responsible for obtaining vital signs, completing a post-dialysis evaluation, and reviewing the paperwork sent back from the dialysis center. It was the nurse manager's responsibility to ensure pre-dialysis and post-dialysis evaluations were being completed along with ongoing communication with the dialysis center. 10NYCRR 415.12(k)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observations, record review, and interviews conducted during the survey, the facility failed to ensure drugs and biologics were stored in accordance with manufacturer specifications and accepted professional standards for one (1) of one (1) resident (Resident #147) reviewed. Specifically, Resident #147 had medications that were expired and discontinued, and previously used insulin needles were stored in their room.Findings Include:Please refer to F 554 Resident Self-Administration of MedicationsThe facility policy Storage of Medications last reviewed January 2024, documented medications were stored securely in locked compartments, under proper environmental conditions, with controlled substances stored separately, refrigerated medications monitored daily for temperature, and access to medication storage limited to authorized staff.The facility policy Self- Administration of Medications dated 01/2025, documented self-administered medications must be stored in a safe and secure place, which is not accessible by another resident. If safe storage is not possible in the resident's room, the medications of the resident permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them.Resident #147 had diagnoses including diabetes, depression, and high blood pressure. The 12/02/2025 Minimum Data Set (a resident assessment tool) documented the resident was cognitively intact.The 06/12/2023 verbal physician order documented the resident may self-administer the following: by mouth medications, insulin and check own blood glucose levels, every shift.The following medications were ordered for Resident #147:-On 03/27/2025, Trulicity subcutaneous solution pen-injector 3 mg/0.5 ml (dulaglutide) inject 0.5 ml subcutaneously (under the skin) one (1) time a day every Tuesday for diabetes.-On 07/31/2025, insulin aspart Injection solution 100 unit/ml- inject 60 units subcutaneously two (2) times a day for diabetes. Hold for blood glucose less than 120.-On 07/31/2025, insulin aspart injection solution 100 unit/ml, inject 74 units subcutaneously in the morning for diabetes starting on 08/01/2025. Hold for blood glucose less than 120.-On 10/07/025, insulin degludec- subcutaneous solution pen injector 100 unit/ml, inject 50 units at bedtime for diabetes.-On 08/20/2025, pen needles 5/16 (insulin pen needle) inject one (1) pen needle subcutaneously before meals for diabetesThe following medication were discontinued for Resident #147:-selegiline hydrochloride 5 milligram tablets (indication depression) discontinued on 06/13/2023, and losartan 100 mg (indication hypertension) discontinued on 06/13/2023.There was no documented evidence in the medical record the resident was assessed for self- administration of medications.During an observation on 12/02/2025 at 4:12 PM, the cabinet in the resident's bathroom contained a sharps container, a 30-day blister pack supply of selegiline 5 milligrams with a refill date of 01/2024, and a 30-day blister pack of losartan 100 milligram with labels that had refill dates of 02/03/2025 and 03/02/2025. There was an insulin pen 100 units in a bag and six (6) used insulin needles in a fabric bag next to the resident on their bedside table.During an observation on 12/05/2025 at 10:55 AM, Resident #147 was sleeping in their bed, and the fabric bag with capped needles was hanging from the over the bed tray table.During an observation on 12/08/2025 at 12:35 PM, there were four (4) used insulin needles capped in a fabric bag attached to the over the bed tray table, the resident was lying in their bed.During an interview and observation on 12/15/2025 at 4:08 PM, Resident #147 stated the needles in the felt bag on the over the bed table with the caps on them were used. They stated the nursing staff would bring a sharps container to place the used needles in. The sharps container and the expired medications were observed in the bathroom cabinet.During an interview on 12/11/2025 at 2:00 PM, Assistant Director of Nursing #21 stated medications left in unsecured areas was not an acceptable practice.During an interview on 12/15/2025 at 4:23 PM, Licensed Practical Nurse #13 stated the resident had an order for self-administration of medication. They had a blister pack of meds and were supposed to keep (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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their medications in the drawer. The resident had their own sharps container and let nursing staff know when they needed a new sharps container. Discontinued medications should be removed from the resident room immediately. They were not aware of any discontinued medications in the resident's room.During an interview on 12/16/2025 at 11:29 PM, Licensed Practical Nurse Unit Manager #14 stated nursing staff brought the medications to the resident's room and the resident kept them at the bedside. The resident should not have expired or discontinued medications at the bedside. If a medication was discontinued, nursing staff should remove it. The resident should not be keeping needles in the pouch. They should be put in the sharp's container. They were not aware of expired or discontinued medications or needles in the pouch.During a telephone interview on 12/22/2025 at 11:33 AM, the Director of Nursing stated expired medications were stored in locked areas pending pickup.10 NYCRR 415.18(d)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews conducted during the survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for one (1) of one (1) meal tray (12/10/2025 lunch meal) reviewed. Findings include: Findings include:The facility policy General HACCP [Hazard Analysis Critical Control Point] Guidelines for Food Safety revised 01/2025 documented food would be held above 135 degrees Fahrenheit or below 41 degrees Fahrenheit. The facility policy Food Temperatures, revised 01/2023 documented food temperatures would be taken periodically to assure hot foods stayed above 135 degrees Fahrenheit and cold foods stayed below 41 degrees Fahrenheit during the holding and plating process until food was served to the resident. The facility policy Handling Cold Foods for Tray Line revised 01/2023 documented cold items would be placed in the refrigerator and chilled to below 41 degrees Fahrenheit prior to meal service. During an interview on 12/02/2025 at 11:23 AM, Resident #7 stated the food was never warm. During an interview on 12/04/2025 at 11:36 AM, the Ombudsman stated meal delivery was a resident concern, specifically meals were cold. During an observation on 12/10/2025 12:14 PM, Resident #2 agreed to have their lunch tray tested and a replacement meal was immediately ordered. The tray ticket documented zucchini, however orange squash was served. Food temperatures were measured in the presence of Registered Nurse Unit Manager #38 and were as follows: corned beef hash 109.2 degrees Fahrenheit, orange squash 104.7 degrees Fahrenheit, diet ginger ale 71.9 degrees Fahrenheit, pineapple 57.2 degrees Fahrenheit, and tossed salad 64.9 degrees Fahrenheit. The pineapple and ginger ale tasted warm and unappetizing. During an interview on 12/11/2025 at 1:13 PM, Food Service Director #22 stated food temperatures were important to maintain food safety and palatability. The food was expected to remain in the correct range when it reached the residents. They stated zucchini comes in many colors and could be orange in color. They stated hot foods should be greater than or equal to 135 degrees Fahrenheit and cold foods should be less than or equal to 41 degrees Fahrenheit. 10NYCRR 415.14(d)(1)(2)

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	12/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Heights Rehabilitation and Nursing Cente	135 Meridan St. Rochester, NY 14612

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to ensure they provided the appropriate liability and appeal notices to Medicare beneficiaries for two (2) of three (3) residents (Residents #223 and #224) reviewed. Specifically, Residents #224 and #223 were discharged from the facility and were not provided with Notice of Medicare Non-Coverage (NOMNC) CMS-10123 as required. Findings include:The CMS form instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 documented a Medicare provider or health plan must deliver a completed copy of the Notice of Medicare Non-Coverage to beneficiaries/enrollees receiving covered skilled nursing services. The Notice of Medicare Non-Coverage must be delivered at least two (2) calendar days before Medicare-covered services end, or the second-to-last day of service if care is not being provided daily.Resident #224 was discharged from the facility to home. There was no documented evidence the resident or resident representative received a Notice of Medicare Non-Coverage CMS-10123 or appeal rights information prior to discharge.Resident #223 was discharged to the community on 11/05/2025. There was no documented evidence a Notice of Medicare Non-Coverage CMS-10123 or appeal rights information was issued to the resident or resident representative prior to discharge.During an interview on 12/11/2025 at 1:28 PM, Business Office Associate #16 (responsible for beneficiary notices) stated the required beneficiary notices were not issued due to a staffing transition in the department responsible for medical records and beneficiary notifications. They stated they were newly assigned this responsibility. They had not been oriented on the process and requirements of issuing beneficiary notices. They stated the notices were inadvertently missed during the transition and were not intentionally omitted. The process had since been reviewed and clarified, and the currently assigned staff member is now following the correct workflow.10 NYCRR 415.3(g)(2)(iii)