

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER River View Rehabilitation and Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 510 Fifth Avenue Owego, NY 13827	

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)
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>48895</p> <p>Based on record review, observations, and interviews during the recertification and abbreviated (NY00354914) surveys conducted 11/12/2024-11/15/2024, the facility did not ensure planned menus were followed for 3 of 3 residents (Residents #2, #32, and #528) reviewed. Specifically, Residents #2, #32, #528 did not receive preferred food items as planned per their individualized meal tickets.</p> <p>Findings include:</p> <p>The facility policy, The Dining Experience: Staff Responsibilities, dated 3/2020, documented the Food Service Manager would observe meals for preferences, portion sizes, temperature, flavor, variety, and accuracy. The Food Service Manager would report any concerns to the Administrator, Nursing Director, registered dietitian or designee, or other staff as appropriate.</p> <p>The facility policy, Timely Meal Service, dated 3/2020, documented meals were distributed promptly with supervision as needed by nursing staff. Staff should check each individual name and room number to verify correct information, and check items on the plate or tray against the meal ticket to assure accuracy.</p> <p>During an interview on 11/12/2024 at 11:39 AM, Resident #581 stated they did not get coffee in the facility, they had a friend that lived nearby bring them coffee. They stated they saw that coffee was on their meal ticket, but they never got it.</p> <p>During the Resident Council Meeting on 11/12/2024 at 1:46 PM, 11 anonymous residents stated they did not always get the meals they selected. Their meal trays were often missing food items, and they did not get an alternative meal when they requested a replacement.</p> <p>During a lunch meal observation on 11/13/2024 at 12:38 PM, Resident #32's lunch tray was used for a test tray. The original tray ticket documented the resident was to receive Shepherd's pie, bread, and butter, tossed salad with 2 ranch dressings, fresh fruit, yogurt, regular cottage cheese, regular Lactaid milk, and coffee. Additionally, Resident #32 was noted to get double portion of vegetables. Resident #32 received a grilled cheese sandwich, tossed salad with 1 ranch dressing, pureed cottage cheese, banana, yogurt, and Lactaid milk. Resident #32 did not receive Shephard's pie, bread and butter, or coffee on their tray.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a lunch meal observation in the kitchen on 11/13/2024 at 12:40 PM, the kitchen ran out of the main entree of Shepard's pie, and gave the remaining meal trays the alternative of a tuna melt sandwich.</p> <p>During a lunch meal observation on 11/13/2024 at 12:52 PM, Resident #528's lunch tray was used for a test tray. The original tray ticket documented the resident was to receive Shepherd's pie, bread and butter, regular ice cream, milk, ice water, and coffee. Resident #528 did not receive Shephard's pie or coffee and received a tuna and cheese sandwich.</p> <p>During a lunch meal observation on 11/14/2024 on 1:08 PM, Resident #2's lunch tray was used for a test tray. The original tray ticket documented the resident was to receive meatloaf, beets, mashed potatoes, gravy, crushed pineapple, regular diet cola, milk, ice water, and coffee. Resident #2 did not receive crushed pineapple or coffee on their tray.</p> <p>During an interview on 11/13/2024 at 2:27 PM, [NAME] #15 stated the Administrator was overseeing the kitchen and kitchen tasks since the Director of Dietary left. The meals were prepared with the use of production sheets. The production sheets outlined the amount of food that was to be made for each meal. [NAME] #15 was not sure where the production sheets came from, but stated the residents picked their menus and then the production sheet were made for the cooks to prepare the meal based on the numbers listed.</p> <p>During an interview on 11/14/2024 at 2:36 PM, [NAME] #8 stated the tray line staff was responsible for checking tray accuracy during meal service. The residents were given selective tickets and they circled or noted what they wanted. The tickets came back to the kitchen and were put into the computer. The primary ticket was already printed and put on the trays. The primary ticket was used to get the drinks and the sides by the tray line, and the cook got the selection ticket filled out by the resident to make the plate. The tickets together made up the resident meal. They may not match, but the resident would get what was selected. Coffee was available on the unit and not sent by the kitchen. The production sheets were made after the selection tickets were put into the computer. They rarely ran out of food, as they usually made extras. Dietary Aide #16 printed out meal tickets, printed production sheets, and ordered food. Resident #32 should not have received pureed cottage cheese.</p> <p>During an observation and interview on 11/15/2024 at 8:46 AM, Certified Nurse Aide #14 stated hot beverages did not come from the kitchen. There was a coffee list on the unit, and the residents could get coffee before or during meals. Two full untouched pots of coffee were observed on the unit. Certified Nurse Aides #14 stated they had to ask everyone if they wanted coffee, because residents would get upset if someone else got coffee and they did not.</p> <p>During an interview on 11/15/2024 at 8:58 AM, Licensed Practical Nurse Unit Manager #13 stated they served the coffee to the residents before the meals. If the resident was not on the coffee list, they would have to ask for it. The coffee was located on the unit in the kitchenettes, it did not come up from the kitchen.</p> <p>(continued on next page)</p>		

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 11/15/2024 at 9:17 AM, Dietary Aide #16 stated the selection menu went to the unit and was selected by the resident. The primary ticket was printed and used for the tray line. The selection ticket was received back to the kitchen and put in the computer to create the production sheets. The primary sheets were printed beforehand and did not match selection sheets and both together made up the tray. If they did not have time to put the selective sheets into the computer, the productions sheets were made from the primary tickets. They stated they had run out of entrees before, but they served the alternative.</p> <p>During an interview on 11/15/2024 at 9:35 AM, the Administrator stated they had been without a Director of Dietary for about 3 weeks, and they were overseeing the kitchen. Dietary Aide #16 was helping with the paperwork. The tray line sets up the tickets and checks for accuracy. There were 2 tickets, and they might not match the tray, because the residents select their choices. The selection ticket was put into the computer. The Administrator called Dietary Aide #16 into the meeting. Dietary Aide #16 explained if they had time to put the information into the computer then both tickets would match, but they did not have the time. The way it should work was that the selection tickets went to the resident and were returned to the kitchen, reviewed, and put into the computer. After being put in the computer a meal ticket would be printed that would show what the resident wanted and should receive. In that case, the primary ticket and the selection ticket should match each other. They stated they were not aware that selective meal tickets were not put into the computer.</p> <p>During an interview on 11/15/2024 at 10:51 AM, the Registered Dietitian #17 they had not seen the kitchen run out of an entree, but if the production sheets were printed from the primary tickets, it could skew the amount of food the cook needed to make, and they could run out. The meal ticket and tray should match.</p> <p>10NYCRR 415.14(c)(1-3)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>48895</p> <p>Based on observations and interviews during the recertification and abbreviated (NY00354914) surveys conducted 11/12/2024-11/15/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 3 meal test trays (the 11/13/2024 and 11/14/2024 lunch meals) reviewed; for 11 of 11 anonymous residents present at the Resident Council meeting; and for one additional resident (Resident #2) interviewed during initial screening. Specifically, the 11/13/2024 and 11/14/2024 lunch meals were not served at palatable and appetizing temperatures and were burnt and not flavorful; 11 residents at the Resident Council meeting stated the food was cold and did not look appetizing; and Resident #2 stated the food was bland and cold.</p> <p>Findings include:</p> <p>The facility policy, The Dining Experience: Staff Responsibilities, dated 3/2020, documented the goals of the dining experience were to enhance the individual's quality of life through person centered dining: providing person centered care and attention; nourishing, palatable, and attractive meals that meet the individual's daily nutritional and special dietary needs. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit. All cold food items must be maintained and served at a temperature of 41 degrees Fahrenheit or below. Foods sent to the units for distribution (such as meals, snacks, nourishments, and oral supplements) would be transported and delivered to maintain temperatures at or below 41 degrees Fahrenheit for cold foods and at or above 135 degrees Fahrenheit for hot foods.</p> <p>During the Resident Council Meeting on 11/12/2024 at 1:46 PM, 11 anonymous residents stated the food was cold when it should be hot and did not look appetizing. Additionally, grilled cheese sandwiches were too hard to eat, and ice cream was served melted.</p> <p>During an interview on 11/14/2024 at 1:54 PM, Resident #2 stated the food was bland and cold when served.</p> <p>During a lunch meal observation on 11/13/2024 at 12:38 PM, Resident #32 was served their meal tray. Their lunch tray was tested , and a replacement tray was provided. In the presence of Certified Nurse Aide #7, the grilled cheese sandwich was measured at 110.8 degrees Fahrenheit, the salad as 52 degrees Fahrenheit, the cottage cheese was 56.8 degrees Fahrenheit, the milk was 48.4 degrees Fahrenheit, the banana was 85.6 degrees Fahrenheit, and the ranch dressing was 56.8 degrees Fahrenheit. Resident #32's grilled cheese was burnt on one side, with hard edges. The banana was warm to the touch, and the ranch dressing tasted warm in comparison to the salad. Certified Nurse Aide #7 stated that residents complained about food being cold.</p> <p>During a lunch meal observation on 11/13/2024 at 12:52 PM, Resident #528 was served their meal tray. Their lunch tray was tested , and a replacement tray was provided. In the presence of Certified Nurse Aide #6, the milk was measured at 46 degrees Fahrenheit. The roll for the sandwich was dried out and hard.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During lunch meal observation on 11/14/2024 at 1:08 PM, Resident #2 was served their meal tray. They had lunch with family and declined a replacement tray. In the presence of Certified Nurse Aide #5, the mashed potatoes with gravy were measured at 129.6 degrees Fahrenheit, the beets were 128.1 degrees Fahrenheit, the meatloaf was 133.7 degrees Fahrenheit, the milk was 59.5 degrees Fahrenheit, and the soda was 68 degrees Fahrenheit. The meatloaf was not formed and was a heap of gelatinous material, with hard burnt crust on the bottom. The beets were brown.</p> <p>During an interview on 11/14/2024 at 2:36 PM, [NAME] #8 stated the Administrator did test trays in the facility. They were not sure if they were documented anywhere, as they did not have a form or log for them. Hot food served to the resident should never drop below 140 degrees Fahrenheit. Cold food should be between 36 and 40 degrees Fahrenheit. Milk measuring 46, 48.4, and 59.5 degrees Fahrenheit was not acceptable and should be 36 degrees Fahrenheit. A grilled cheese at 110.8 degrees Fahrenheit might be acceptable, depending on how it looked. 52 degrees Fahrenheit was too warm for a salad. 56.8 degrees Fahrenheit for cottage cheese and 51.6 degrees Fahrenheit for yogurt was too warm, anything over 40 was too warm and not acceptable. 85.6 degrees Fahrenheit was too high for bananas, they should be room temperature. All the food should be palatable and enjoyable to eat. It was important for the residents to have enjoyable and palatable food.</p> <p>During an interview on 11/15/2024 at 1:49 PM, the Administrator stated they did test trays and expected hot food to be served at 130 degrees Fahrenheit or above, and cold food should be cold. The food should be palatable and enjoyable, but it was difficult to please everyone. They had received complaints about food and did their best.</p> <p>10NYCRR 415.14(d)(1)(2)</p> <p>49448</p> <p>50561</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48895</p> <p>Based on observations, record review, and interviews during the recertification survey conducted 11/12/2024-11/15/2024, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen. Specifically, in the main kitchen there were unclean areas, potentially hazardous foods were not cooled properly, food storage of cold foods was not maintained, and there was lack of proper hand hygiene during meal service.</p> <p>Findings include:</p> <p>The facility policy, The Dining Experience: Staff Responsibilities, dated 3/2020, documented the staff maintained the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Cleaning and sanitation tasks for the kitchen were recorded.</p> <p>The facility policy, Food Preparation and Service, dated 3/2020, documented potentially hazardous foods should be cooled rapidly. This was defined as cooling from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours and then to a temperature of below 41 degrees Fahrenheit within the next 4 hours. The total cooling time between 135 degrees Fahrenheit and below 41 degrees Fahrenheit was not to exceed 6 hours. Large or dense foods might need special interventions to meet the time and temperature requirements for cooling.</p> <p>The facility policy, Food Receiving and Storage, dated 6/2022, documented refrigerated foods must be stored below 41 degrees Fahrenheit unless otherwise specified by law. Refrigerators must have working thermometers and were monitored for temperature according to state-specific guidelines.</p> <p>The undated facility documents AM Cleaning Duties and PM Cleaning Duties, documented duties included cleaing and wiping down the oven, wiping down the back counter, take out the kitchen garbage, rinse and clean the three-compartment sink, and wipe down the hand sink.</p> <p>There were no kitchen cleaning logs for November 2024, per electronic communication from the Administrator on 11/15/2024 at 4:31 PM.</p> <p>The following observations of the main kitchen were made:</p> <ul style="list-style-type: none"> - on 11/12/2024 at 11:41 AM, the hand sink in the dish room had dried brown rings and a dead bug stuck to the side of the wash basin. There was tan sludge on the floor under the 3-bay sink. - on 11/13/2024 at 11:25 AM, there was brown discoloration under the three-bay sink in the kitchen. - on 11/13/24 at 11:29 AM, the hand sink in the dish room had dried brown rings and a dead bug stuck to the side of the wash basin. - on 11/13/24 at 11:50 AM, there was debris on the side of the oven, and debris under the sink next to the oven. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- on 11/13/2024 at 12:08 PM, the dish room hand sink had a dead bug dried into the basin. There was built up grime and debris under equipment, sinks, and the dish machine. There was significant dried on debris beneath the three-bay sink from the floor drain. Both hand sinks basins were dry. Garbage by the kitchen hand sink overflowed onto the floor. The basement hall floor, used for staging trays for meal service, was soiled and stained and meal carts were left uncovered in the hall.</p> <p>- on 11/13/2024 at 2:11 PM, there was a wet, gray liquid beneath the three-bay sink from the floor drain plate cover. Maintenance Director #20 stated the sink did not drain properly and flowed on the floor.</p> <p>- on 11/14/2024 at 12:29 PM, there was debris on the side of the oven and along the left of the stove. Below the sink next to the stove was a coffee pot with dried debris.</p> <p>The following observations were made during meal service in the kitchen:</p> <p>- on 11/13/2024 at 12:09 PM, Dietary Aide #18 left the kitchen wearing blue gloves, returned, grabbed the handle to the kitchen door carrying a box of oatmeal cookies. Their gloves were not changed, and they did not perform hand hygiene upon returning to the kitchen.</p> <p>- on 11/13/2024 at 12:11 PM, an unknown staff exited the kitchen through the hall door wearing gloves, returned wearing gloves, and resumed work. They entered the kitchen by handling the doorknob and did not change gloves or perform hand hygiene.</p> <p>- on 11/13/2024 at 12:16 PM, Dietary Aide #18 went to the dish room and returned with silverware in their hand and did not perform hand hygiene or change their gloves.</p> <p>During an observation on 11/13/2024 at 11:56 AM, the butter in refrigerator #9 was measured at 49.8 degrees Fahrenheit. The thermometer in the refrigerator displayed 36 degrees Fahrenheit.</p> <p>During an observation and interview on 11/13/2024 at 2:27 PM, [NAME] #15 stated the cook on duty was responsible to ensure refrigerator temperatures were checked. They were the cook on duty that evening. Refrigerator #9 thermometer displayed 36 degrees Fahrenheit. The butter measured at 47.8 degrees Fahrenheit. [NAME] #9 stated if the butter was 47.8 degrees Fahrenheit, then the rest of the items in the refrigerator would be that temperature as well. The mozzarella cheese was 42.7 degrees Fahrenheit. They were not sure if that was a safe temperature for the items in the refrigerator. The rapid cooling refrigerator had lasagna dated 11/11, and eggs dated 11/13. There was no information on the refrigerator or in the office regarding the cooling times or temperature for either food. [NAME] #9 stated the rapid cooling process was to get to 70 degrees Fahrenheit in 2 hours, and then an additional 4 hours to drop below 40 degrees Fahrenheit. [NAME] #9 stated they would discard the items given there was no log or information about those foods. Everyone was responsible for cleaning the kitchen. The kitchen was wiped down on each shift. There was a deep clean done at the end of the night with the closing crew. Since the Director of Dietary left, the Administrator was overseeing the kitchen.</p> <p>During an observation on 11/13/2024 at 4:00 PM, refrigerator #9 had one thermometer that displayed 45 degrees Fahrenheit, and the other displayed 42 degrees Fahrenheit. The butter was measured at 51 degrees Fahrenheit. The lasagna and eggs were still in the rapid cooling refrigerator #4.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a follow up interview and observation on 11/13/2024 at 4:03 PM, [NAME] #15 read the thermometer in the butter at 49.6 degrees Fahrenheit. They stated they did not know how long the butter had been out of temperature. 2 hours was the maximum allotted time for food to be out of temperature. A block of cheddar cheese dated 10/25/2024 had visible mold growth, measured at 42 degrees Fahrenheit, and was discarded voluntarily by [NAME] #15. The yogurt measured 46.9 degrees Fahrenheit.</p> <p>During an interview and observation on 11/14/2024 at 2:36 PM, [NAME] #8 stated that cold foods needed to be held under 40 degrees Fahrenheit. The policy for hand hygiene was to wash when you came in for the shift and after anything that was not food was touched. If someone left the kitchen, they should wash their hands when they came back to the kitchen. If someone was preparing trays, touching cups and silverware, they should not be wearing the same gloves they left the kitchen with especially if they had to touch multiple door handles on the way. Hand hygiene was important because of germs. In the kitchen, they cleaned as they went. The kitchen was cleaned every night. It was hard to deep clean in the middle of food service and cooking. They had to wait until all the food was done, because of the chemicals in the cleaning supplies. [NAME] #8 observed refrigerator #9 with 2 thermometers. The butter was measured at 47 degrees Fahrenheit. The surveyor stated the previous temperature measurements for 11/13/2024 and [NAME] #8 stated that they had to empty the contents of the refrigerator into another refrigerator and contact maintenance. If the butter was that temperature, so were the rest of the items in that refrigerator.</p> <p>During an interview on 11/15/2024 at 9:17 AM, Dietary Aide #16 stated that proper hand hygiene was important for the kitchen. If they left the kitchen they should change their gloves. Hand hygiene could be done with washing or hand sanitizer.</p> <p>During an interview on 11/15/2024 at 1:49 PM, the Administrator stated they did not have audits for kitchen cleaning, they just observed the area. The Director of Dietary should check cleanliness, fridge temperatures, and food temperatures, to report monthly. The expectation of kitchen cleaning was that it should be as clean as at home. There should not be anything stuck to the side of the stove for repeated days. There should not be debris on the shelves, or sewage seeping from or on the floor. Staff went through orientation for hand hygiene. They had spot checks for all employees for hand hygiene. The expectation for hand hygiene in the kitchen was hands should always be clean and use gloves when needed. They should wash every time they entered the kitchen and as needed, especially before handling food. Staff should not return to the kitchen without washing their hands. If hand hygiene was being done, there should not be dried bugs squished to the side of the basin. Staff should have washed their hands after exiting the kitchen utilizing multiple door handles. The lack of hand washing could lead to illness. They expected food was stored at safe temperatures. The Administrator did not know the process for rapid cooling, but that there was a process used in the facility.</p> <p>10NYCRR 415.14(h)</p>		