STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335103	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Rehabilitation and Nursing Care Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Based on record review and interview during the abbreviated survey (NY00382934), the facility did not ensure residents had the right to be free from abuse for one (1) of three (3) residents reviewed (Resident #1). Specifically, on 06/08/2025, Registered Nurse Supervisor #1 held Resident #1 around their neck while yelling at them, causing the resident physical pain and mental anguish. This resulted in actual harm, past non-compliance, to Resident #1 that was not Immediate Jeopardy. The facility policy Abuse and Neglect, revised 01/2023, documented the definition of abuse was the willful infliction of injury, unreasonable confinement, intimidation, or punishment which results in physical harm, pain or mental anguish. An example of abuse included, but was not limited to, rough handling during care. Resident #1 had diagnoses including chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), shortness of breath, and vertigo of central origin (central nervous system problem causing a sensation of spinning or whirling, even when stationary). The 06/05/2025 Minimum Data Set assessment documented the resident had intact cognitive function and no behavioral symptoms. The resident was dependent for sitting to standing. The Comprehensive Care Plan initiated 06/05/2025 documented the resident required maximum assistance of two (2) for transfers using the sit-to-stand (mechanical device to aid in standing). The resident was at risk for alteration in communication due to depression, new environment, diagnosis of amnesia, and slightly hard of hearing (did not have hearing aids). Interventions included: face resident when speaking, monitor non-verbal responses, obtain resident's attention before speaking. The 06/08/2025 facility investigation documented:- Registered Nurse Supervisor #1 was called to assist certified nurse aides that were transferring Resident #1 due to the resident's unwillingness to use the sit-to-stand device. As the resident stood on the sit-to-stand device, they began to scream, actively pushing themselves away from the device into the chair (recliner). After the resident sat back into the chair, they began to rock back and forth. Registered Nurse Supervisor #1 placed their hand on their back and up to the neck region, asking the resident to calm down, while raising their voice so as to be heard over the resident's yelling. -Registered Nurse Supervisor #1 continued to hold the resident's neck. The resident stated something to the effect, 'You're hurting me, my discs (back), let go,' made a fist, cocked their arm, and threatened to hit Registered Nurse Supervisor #1.- Registered Nurse Supervisor #1 responded to the effect of, 'I'll hit you back,' and Resident #1 stated the nurse would go to jail. Registered Nurse Supervisor #1 replied, Ok, three hots and a cot.- Resident #1 stopped rocking back and forth and yelling and agreed to attempt the transfer again. Staff were able to successfully transfer them and provide care. - Resident #1 continued to be upset and staff noted a scratch on their neck. - Licensed Practical Nurse #6 was alerted by Certified Nurse Aide #3 and went to see the resident and stated when the resident's spouse arrived, the resident said they were going to call the police and wanted the supervisor arrested. - Registered Nurse Supervisor #7 assessed the resident and noted a small scratch on the left backside of their neck, no mobility impairments were noted and the resident complained of pain. - The incident was reenacted with Registered Nurse Supervisor #1, Certified Nurse Aides #2, 3 and 4, the Administrator, and Director of Social Services (to take notes). - The investigation did not identify abuse occurred by Registered Nurse Supervisor #1; they used a loud voice to be heard over the resident. The origin of the scratch could not be determined. It was possible it was from Registered Nurse Supervisor #1 holding them, to prevent the resident from falling forward, with one hand in front of them and one behind them, or when the resident was rocking back and forth in their chair.- Resident #1 did not recall the incident, other than they were grabbed by the neck and wanted to press charges. - The Director of Social Services saw the resident after the incident and there was no apparent emotional distress or memory of the incident.- Staff interviews confirmed Registered Nurse Supervisor #1 did not yell or threaten the resident, rather they reacted inappropriately and never intended an actual threat. Registered Nurse Supervisor #1's hold on the resident was not reported as aggressive, as they were attempting to hold the resident to prevent them falling forward from their chair. If the scratch was a result of Registered Nurse Supervisor #1's hold, it was accidental.- Resident #1 was able to calm down and agreed to transfer immediately following the incident, without noted fear or emotional distress. No fear or emotional distress was noted in the days following. - Registered Nurse Supervisor #1 was found to have responded inappropriately in holding the resident in the manner they did as well as in their verbal response. The nurse will remain suspended until education on customer service and abuse with a final warning in their personnel record. Written staff statements with the 06/08/2025 investigation included:- Certified Nurse Aide