

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/30/2024
NAME OF PROVIDER OR SUPPLIER  Waterview Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  119 15 27th Avenue Flushing, NY 11354	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>48907</p> <p>Based on observation, record review, and interviews conducted during an abbreviated survey (NY00351262), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, and mistreatment, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. This was evident in one out of four residents sampled (Residents #1). Specifically, on 08/13/2024 at 12:45 PM, Resident #1 identified Maintenance Employee #1 by name to the Administrator and stated that Maintenance Employee #1 entered their room on 08/06/2024 around 5:00 PM to fix something in their room. Maintenance Employee #1 touched and pulled Resident #1's breast prior to leaving the room. Maintenance Employee #1 was suspended pending the investigation. The facility did not report the alleged sexual abuse to law enforcement.</p> <p>The findings include:</p> <p>The Facility's Policy and Procedure on Abuse Prevention Program revised 07/2024, documented that any case in which abuse, neglect, or mistreatment has been suspected will be reported in accordance with State and Federal regulations. The facility's policy further documented on page 4, Federal Elder Justice Act: Suspicions must be reported to at least one local law enforcement agency as well as to the New York State Department of Health.</p> <p>Resident #1 was admitted to the facility with diagnoses including Non-Alzheimer's Dementia, Depression, and Major Depressive Disorder.</p> <p>The Minimum Data Set (an assessment tool), dated 07/26/2024, documented Resident #1 had a Brief Interview of Mental Status (used to determine attention, orientation, and ability to recall information) score of 15 associated with intact cognition.</p> <p>The Potential for Victimization Comprehensive Care Plan dated 12/06/2022, documented interventions to provide emotional support, redirection, and reality orientation.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/30/2024
NAME OF PROVIDER OR SUPPLIER  Waterview Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  119 15 27th Avenue Flushing, NY 11354	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Investigation Summary dated 08/19/2024 documented Resident #1 alleged being touched inappropriately by Maintenance Employee #1. After an investigation was conducted, which included, interviews with staff, reviews of surveillance footage and examination of relevant records, there were no definitive proof to support the allegation. No further action against Maintenance Employee #1 was warranted. Maintenance Employee #1 was removed from Resident #1's unit for added safety and security. Corrective Actions included enhanced staff training on professional boundaries and residents' rights.</p> <p>During an interview on 08/15/2024 at 9:15 am, Administrator stated they asked Resident #1 if they wanted law enforcement to be contacted. Resident #1 refused, so they did not call law enforcement.</p> <p>10 NYCRR 415.4(b)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/30/2024
NAME OF PROVIDER OR SUPPLIER  Waterview Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  119 15 27th Avenue Flushing, NY 11354	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39365</p> <p>Based on record review and interviews conducted during the abbreviated survey (NY 00329642) on 08/15/2024-08/16/2024, the facility failed to ensure that the resident is free of significant medication errors. This was evident for one out of five sampled residents (Resident #4). Specifically, on 12/06/2023, Licensed Practical Nurse #1 did not identify the right resident for tube feeding and started to administering tube feeding formula through Resident #4's Gastrostomy tube with no Medical Doctor's orders.</p> <p>The findings are:</p> <p>The facility policy titled Medication Administration and Documentation, revised on 12/2023, documented that medications shall be administered and documented in a safe and timely manner. The individual administering medications must verify the resident 's identity before giving the resident his/her medications. Methods of identifying the resident include checking identification band.</p> <p>A review of the Facility's Incident Report Summary dated 12/07/2023, documented on 12/06/2023, Resident #4 was accidentally administered tube feeding, which was not their medical order. Resident #4 was assessed by the Registered Nurse Supervisor #1, and no adverse effects were noted. The Gastrostomy tube was flushed as per the Medical Doctor's Order. Resident #4 was monitored for 24 hours for any changes, and none were observed. All staff members were educated on medication rights. Licensed Practical Nurse #1 was re-educated on medication administration.</p> <p>Resident #4 was admitted to the facility with a diagnosis including Cerebral Infarction, Aphasia, and Hemiplegia.</p> <p>The Minimum Data Set, dated dated dated [DATE], identified that Resident #4 had a Brief Interview on Mental Status and scored 3 out of 15, which identified the Resident #4's cognition as severely impaired.</p> <p>Physician Orders dated 11/24/2023, documented an order to flush the feeding tube with 50 milliliters of water to keep the feeding tube [NAME] and clean the Gastrostomy feeding tube site with normal saline.</p> <p>The Care Plan for Tube Feeding dated 12/06/2023, documented that Resident #4 was inadvertently administered approximately 50 milliliters of feeding formula via Resident #4's Gastrostomy feeding Tube. No adverse reaction was noted. Continue to monitor.</p> <p>A Nurse's note dated 12/07/2023 at 8:47 PM, written by the Registered Nurse Supervisor #1 documented on 12/06/2023, staff inadvertently attached the Resident #4 to the external pump, and Gastrostomy Tube feeding formula was started. Resident #4 received approximately 50 milliliters of the feeding formula before the feed was removed, and the Gastrostomy feeding tube was flushed with water.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/30/2024
NAME OF PROVIDER OR SUPPLIER  Waterview Nursing Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  119 15 27th Avenue Flushing, NY 11354	
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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 08/16/2024 at 11:23, Registered Nurse Supervisor #1 stated that on 12/06/2023, they were called by Resident #4's spouse to come to the resident's room because the nurse started tube feeding on their spouse and Resident #4 should not be getting feed via Gastrostomy tube. Registered Nurse Supervisor #1 stated that upon arrival to Resident #4's room, they observed that the feeding tube was connected to Resident #4's Gastrostomy tube. Feeding was running, but they could not recall what it was. Registered Nurse Supervisor #1 stated that Resident #4 had no order for feeding, just flushing Gastrostomy tube with water. Registered Nurse Supervisor #1 stated the feeding was immediately stopped. Nurse Supervisor #1 stated on their observation the feeding had just started entering the Gastrostomy tube.</p> <p>During an interview on 8/16/2024 at 2:40 pm, the Assistant Director of Nursing stated Registered Nurse Supervisor #1 made them aware on 12/06/2023 afternoon, that Licensed Practical Nurse #1 connected Gastrostomy tube feeding to the wrong resident. The Assistant Director of Nursing stated the incident was investigated with the Director of Nursing. The Assistant Director of Nursing stated that Licensed Practical Nurse #1 connected Resident #4 to the feeding pump but there were orders to flush the Gastrostomy tube with water. The Assistant Director of Nursing stated they assessed Resident #4, and there was no harm to the resident. The Assistant Director of Nursing stated that Licensed Practical Nurse #1 did not follow the five rights of medication administration.</p> <p>During an interview on 08/16/2024 at 3:20 PM, the Director of Nursing stated they became aware of a Gastrostomy feeding incident on 12/06/2023 and investigated the incident. The Director of Nursing stated Licensed Practical Nurse #1 did not follow facility policy for medication administration and did not check the right resident before attaching the Gastrostomy tube feeding to Resident #4. The Director of Nursing stated Licensed Practical Nurse was re-educated on safe medication administration, suspended, and terminated.</p> <p>During a follow-up telephone interview on 08/21/2024 at 11:35 am, Licensed Practical Nurse #1 stated that they prepared feeding for residents who had medical orders first. They checked the orders in the Electronic Medication Administration Record and identified the resident, labeled the feeding bottle, primed it, and hung it on the machine to administer it later when it was time to start feeding. Licensed Practical Nurse #1 stated that in Resident #4's room, there was another resident with a feeding tube, and feeding was prepared for that resident. Licensed Practical Nurse #1 stated when they returned to start feeding, the machine was next to Resident #4 (they don't know who moved it, maybe the aids during care), and they connected it to their Gastrostomy without checking the Identification bracelet. Licensed Practical Nurse #1 stated the resident was alert and agreed to start feeding. Licensed Practical Nurse #1 stated they realized that feeding was for Resident #4's roommate within five minutes by checking the medical chart and was coming to the resident's room to fix it. Licensed Practical Nurse #1 stated the family was there and told them that they had started feeding on Resident #4, who had no doctor's order for Gastrostomy feeding.</p> <p>10 NYCRR 415.12 (m)(2)</p>		