STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335154	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Nursing Care Center	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility did not ensure all alleged violations involving abuse were reported immediately to the New York State Department of Health no later than 2 hours after the alleged occurrence. This was evident for three (3) (Resident #138, Resident #188 and Resident #108) of four (4) residents reviewed for Abuse out of 37 total sampled residents. Specifically, Resident #138 had an allegation of sexual abuse, Resident #188 had an unwitnessed fall, and Resident #108 had an injury of unknown origin; these allegations were not reported to the Department of Health within a timely manner. The findings include: The facility policy titled, Abuse Prevention, dated effective 03/01/2001 and last reviewed 01/01/2026, documents the facility must report alleged violations related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to all the proper authorities within prescribed timeframes. Alleged violations involving abuse, neglect, exploitation, and mistreatment are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Resident #138 had diagnoses that include bipolar disorder, schizoaffective disorder, major depressive disorder, and multiple sclerosis. The Minimum Data Set 3.0 assessment dated [DATE] documented Resident #138 has severely impaired cognition and requires substantial assistance of one (1) person to assist with activities of daily living. The Accident/Incident Report of the facility's investigation of the occurrence dated 11/11/2025 documented Resident #138 verbalized a male person came into the room a week ago and laid on top of Resident #138. Resident #138 was unable to state the date and time it happened. Resident #138 was examined by the physician and found with no visible injury and refused to be sent to the hospital for further examination. Facility completed the investigation by gathering statements from the staff. Video footage was reviewed and revealed no male person entered the room. Facility concluded there was no perpetrator and determined there was not any abuse, neglect or mistreatment. The facility did not report to state agency. On 05/06/2026 at 11:05 AM The Director of Nursing was interviewed and stated the facility investigated the complaint and concluded there was no abuse, neglect nor mistreatment and therefore there was no need to report to the state agency. On 05/07/2026 at 11:37 AM The Administrator was interviewed and stated the facility regional (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consultant reviewed the investigation and grievance report dated 11/11/2025 from Resident #138 on 01/09/2026 and concluded this investigation needed to be reported to the state agency. Administrator stated a call was made to Department of Health on 01/15/2026 to report the incident of alleged sexual abuse that happened on 11/11/2025. The Administrator also stated they are aware that this citation happened for the last two (2) states surveys and agreed that even with continued in-servicing of staff regarding abuse prevention and reporting this incident with Resident #138 was not reported timely. On 05/08/2026 at 10:01 AM The Director of Social Services was interviewed and stated Certified Nurse Assistant #2 reported on 11/11/2025 that Resident #138 verbalized a male person came into the resident room, but that the resident is confused and unable to provide a clear description of the person. The Director of Social Services also stated if there is an allegation of abuse the Administrator must report it to the New York State Department of Health timely. On 05/08/2026 at 10:37 AM The Facility Regional Consultant was interviewed via phone and stated after reviewing the incident report and noticing that it was not called in to the State Agency, they discussed with the Administrator that even though it was unfounded, the incident still had to be reported to the Department of Health. 2. Resident # 188 was admitted with diagnoses that included repeated falls, dementia and non-traumatic chronic subdural hemorrhage. The admission Minimum Data Set Assessment with a reference date of 11/26/2025 documented Resident #188 has severely impaired cognition skills and requires partial to moderate assistance for activities of daily living. On 12/08/2025 at 12:06 PM the facility reported an unwitnessed fall had occurred on 12/07/2025 at 4:00 AM. The facility report documented the resident was on the floor next to their bed. A full body assessment found no visible injuries and no change in mental status. Later that day at approximately 7:45 AM the resident was noted with a nosebleed and transferred to the hospital. The facility's Nursing Home Transfer Form dated 12/07/2025 was reviewed. The form documented, reason for transfer: status post fall with nosebleed and periorbital edema. The hospital's After Visit Summary dated 12/07/2025 was reviewed. The summary documented the reason for visit as, fall and ecchymosis to face confusion at baseline. Diagnoses listed included closed fracture of right zygomatic (cheek) bone. The Nurse's Note dated 12/07/2025 at 11:36 PM documented that the resident returned to the unit at 10:55 PM via stretcher, and that the nursing supervisor was made aware. The Nursing Home Facility Incident Report documented submission to the Department of Health on 12/08/2025 at 12:06 PM. On 05/05/2026 at 10:20 AM the Director of Nursing was interviewed and stated Resident #188 did not appear to have any visible injury upon assessment and no complaints of pain on 12/07/2025 at 4:00 AM. The Director of Nursing explained that after the resident was discovered, the resident's behavior did not change, and the resident had proceeded to unsafely attempt unassisted walking at that time. As a result, the resident was not immediately sent to the hospital. A few hours later, Resident # 188 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was reported with a nosebleed and was then transferred to the hospital. The Director of Nursing stated they were aware that the resident sustained a facial fracture upon re-admission to the facility and that was when they notified the Department of Health. The Director of Nursing was able to verbalize the components of the Abuse protocols and further stated injuries of unknown origin and unwitnessed falls with injuries are to be reported within two (2) hours. On 05/08/2026 at 8:18 AM The Administrator was interviewed and stated that when an incident occurs the process includes informing the administrator, the director of nursing, or the assistant director of nursing so that the facility can submit a report to the Department of Health. The Administrator stated that the night nursing supervisor did not inform administration that the resident had sustained a facial fracture. They stated that the case was discussed in the morning meeting following the incident on 12/08/2025 at 10:30 AM and it was determined that it needed to be reported. They stated that afterwards, it was reported at 12:06 PM. 3. Resident #108 was admitted to the facility with diagnoses that include coronary artery disease, non-Alzheimer's, and Lewy Body Dementia. The admission Minimum Data Set, dated [DATE] documented resident's cognition as severely impaired with wandering behavior that significantly intrudes on the privacy or activities of others as well as behavior symptoms not directed towards others that significantly disrupts care or living environment occurring daily. The comprehensive care plan titled, Cognitive loss/Dementia as evidenced by inappropriate behavior, initiated 03/04/2026, documented goals that include to sustain current level of cognitive function for a target date of 06/02/2026. Documented interventions included maintaining a calm environment and consistent routine. The comprehensive care plan titled, Behavior, initiated 03/04/2026 documented the resident has inappropriate behavior such as attempting to assist peers in and out of bed and entering other residents' rooms. Goals included that the resident will not exhibit any inappropriate behaviors towards peers such as assisting residents in and out of bed with a target date of 06/02/2026. Interventions included inviting the resident to recreation programs and visits from the social worker. A Nurse's Note dated 04/12/2026 documented Resident is alert and responsive. At start of shift, Certified Nursing Assistant reported to writer that resident was observed with bruise and discoloration under right eye and redness on right hand, Nursing Supervisor notified. Stat X-ray of face and right hand ordered, radiology called with confirmation, no signs of distress. Resident continues every 15 minutes for visual checks this shift for safety. The facility's incident report dated 04/12/2026 at 3:00 PM documented that at the start of the shift, the certified nursing assistant reported that Resident #108 was observed with bruising and discoloration under the right eye and redness on right the right hand. Resident was unable to say what happened. The conclusion of incident report documented that the incident is determined to be behavioral in nature and consistent with the resident's documented dementia-related behaviors. On 05/06/2026 at 11:06 AM Certified Nursing Assistant #3 was interviewed and stated they have been assigned to the resident and that Resident #108 needs total care with activities of daily living, Resident #10 ambulates by self and is on 15-minute visual checks, so they monitor Resident #108's whereabouts to ensure that they are safe. Certified Nursing Assistant #3 also stated that sometimes (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #108 may touch other residents, but they would redirect the resident. On 05/07/2026 at 12:09 PM Licensed Practical Nurse #1 was interviewed and stated that they are the Charge Nurse for the 7:00 AM to 3:00 PM shift and is responsible for keeping the residents safe. They stated that Resident #108 has to be redirected continuously, can be combative, and has not displayed any exit seeking behavior. Licensed Practical Nurse #1 stated that Resident #108 always wants to do things for the residents because Resident #108 previously worked as a home health aide. Licensed Practical Nurse #1 stated there is a fifteen (15) minute monitoring book so they can see where Resident #108 is throughout the shift. On 05/08/2026 at 11:29 AM the Medical Doctor was interviewed and stated that they were not aware that the resident had bruises until it was mentioned in the care plan meeting. They stated that they are usually notified when there is an incident but was not aware of this incident. On 05/08/2026 at 2:35 PM, the Director of Nursing was interviewed and stated that Resident#108 has behaviors and is on fifteen (15) minute monitoring. They stated that monitoring can be difficult, since Resident#108 has a history of wandering on the unit. The Director of Nursing also stated that Resident#108 tends to go into other residents' rooms and that the staff address this behavior. The Director of Nursing stated that they did not report this incident dated 04/12/2026 to the New York State Department of Health reporting system, since they considered it a behavior and treated it as such. The Director of Nursing also stated that although the incident was not witnessed, the staff knew that Resident #108 goes in and out of residents' rooms and tends to bump and hit themselves, so they attributed the bruises to that. 10 New York Codes, Rules and Regulations 415.4 (b)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure that residents' comprehensive care plans were reviewed and revised by the interdisciplinary team periodically and after each comprehensive and quarterly review assessment. This was evident for four (4) residents (Residents #19,11, and 44) out of 38 total sampled residents. Specifically, 1) Resident #19's Vision, Pressure Ulcer Risk, potential for skin breakdown and Behavioral Symptoms care plans were not reviewed and revised after each assessment, 2) Resident #11's Cognition and Falls care plans were not reviewed and revised after each assessment, and 3) Resident #44's Vision's quarterly care plan was not reviewed and revised after each assessment.The findings are: The facility's policy and procedure titled, Care Plans Comprehensive Person-Centered, last reviewed 01/2026, documented that the objective of the comprehensive care plan is to review as necessary and at intervals not to exceed ninety-two (92) resident days after the last assessment reference date, responses to current plan of care and the establishment of new goals and treatment plans, as necessary. 1. Resident #19 was admitted to the facility with diagnoses that include aphasia, cerebral palsy, and seizure disorder. The quarterly Minimum Data Set, dated [DATE] documented unclear speech, rarely/never understood, vision severely impaired, and no behaviors. The comprehensive care plan titled, Perceptual Alteration, Vision, as related to vision impairment/legally blind, was created 01/27/2025. Goals included demonstrate adaptation in vision impairment with a target date of 02/05/2026. Interventions included monitoring environment to support safety. Last evaluation was dated 11/06/2025 and documented resident is legally blind, current care plan remains in effect for the next ninety (90) days. The comprehensive care plans titled, Pressure Ulcer Risk, potential for skin breakdown, was created 01/30/2025. Goals included resident will not develop skin break for ninety (90) days with a target date of 02/05/2026. Interventions included monitoring skin integrity every shift. The last evaluation dated 11/06/2025 documented the current care plan will be maintained for ninety (90) days. The comprehensive care plans titled, Behavioral Symptoms, created 1/30/2025, manifested by continues to remove shoes, ted stockings, clothing, and socks throughout shift, despite staff continually attempting to replace, attempts to remove their clothes while in the wheelchair. Goals included resident will be free of injuries and will ensure their dignity is maintained with target date of 02/05/2026. Interventions included staff will continue to replace resident's shoes and socks to maintain resident's dignity along with safety and prevent injury. 2)Resident #11 was admitted to the facility with diagnoses that include Alzheimer's dementia and schizophrenia. The Significant Minimum Data Set, dated [DATE], documented resident's cognition as severely impaired, no wandering behavior occurring, no impairments, and maximal assistance with eating, dependent on staff for bed mobility, chair to bed transfer and toilet transfer and had one (1) fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The comprehensive care plans titled, Cognitive loss/Dementia, as evidenced by confusion-disorientation was dated 3/28/2025. Goals included sustaining current level of cognitive functioning for ninety (90) days with a target date 1/17/2026. Interventions included maintaining calm environment. The comprehensive care plans titled, Falls, was implemented on 03/28/2025. Goals included resident will have no future falls or sustain any major injury for ninety (90) days with a target date of 01/17/2026. Interventions included ensuring staff will respond in a timely manner with a starting date of 06/02/2025. 3) Resident #44 was admitted to the facility on [DATE] with diagnoses which included open angle glaucoma, age-related cataract, and a history of falling. The Quarterly Minimum Data Set (MDS) dated [DATE] documented that the resident has moderate cognitive impairment and that the resident has impaired vision. The Nursing Progress Notes dated 08/25/2025 stated that the resident has glaucoma and continues to have eye drops instilled in the eyes as ordered. The notes stated that the resident follows up with the independent Ophthalmologist as scheduled. The care plan titled, Vision, dated 04/15/2025, stated that the resident has impaired vision due to diagnosis of glaucoma. The documented goals included that the resident will be safe in the environment for ninety (90) days. The Vision care plan was last updated on 01/30/2026. On 05/06/2026 at 3:18 PM, Registered Nurse #2 was interviewed and stated that they usually work on the 3:00 PM to 11:00 PM shift as the Registered Nurse Supervisor but also works on the 7:00 AM to 3:00 PM and the 11:00 PM to 7:00 AM shifts at times. Registered Nurse #2 stated that when a new admission comes comprehensive care plans are done, otherwise episodic care plans may also be initiated. Registered Nurse #2 stated that the registered nurses are responsible for updating the care plans. The process is that the Minimum Data Set Coordinator sends out a list of residents scheduled for care plan meetings, and from that list, the registered nurses would know whose care plans are to be updated prior to the care plan meeting. This list is given more than a week in advance to be completed. Registered Nurse #2 stated that the care plans are updated quarterly, annually, and episodically (when something occurs). They noted the care plans for the residents should have been updated. On 05/06/2026 at 3:39 PM, the Director of Nursing was interviewed and stated that the registered nurse supervisors are responsible for updating the care plans, and that there is a list that is provided by the Minimum Data Set Coordinator which indicates what care plans are due based on the assessment dates. The social worker gives the care plan list when the care plan meetings are due. The Director of Nursing stated those care plans unfortunately were not updated, and the facility is planning to change the process. 10 New York Code Rules Regulations 415.11(c)(2) (i-iii)