STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335259	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterview Hills Rehabilitation and Nursing Center	537 Route 22 Purdy Station, NY 10578

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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review and interviews conducted during the Abbreviated Survey (NY00375616), the facility did not ensure that a resident's right was supported by the facility for 1 or 3 residents reviewed. Specifically, Resident #1 filed a grievance which was reported to the Director of Nursing in January 2025 that they prefer not to receive cares from Certified Nurse Aide #1 because they were too strong in their touch and at times manhandled them. On 3/18/2025, Certified Nurse Aide #1 provided care to Resident #1 and the resident reported to their family representative that Certified Nurse Aide #1 came to their room at approximately 4:45 am, woke them out of their sleep and provided cares to them after they refused the care. Resident #1 also alleged that they were manhandled by Certified Nurse Aide #1. There was no documented evidence that Resident #1's care plan was updated with their preference. The facility did not provide evidence that the Nurses and Certified Nurse Aides were made aware of Resident #1's preference. The findings are: The 7/1/2019 facility policy title Activities of a Daily Living (ADL) Supporting last revised on 11/7/23 documented that appropriate care and services will be provided for residents who are unable to carry out Activities of a Daily Living(ADL's) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with elimination (toileting) Resident #1 was admitted with diagnoses including but not limited to atrial fibrillation, deep vein thrombosis, and rhabdomyolysis. The 12/18/24 5 day Minimum Data Set documented that Resident #1 had intact cognition and required total assistance with bathing, bed mobility and toileting. The 1/22/2025 Grievance/Complaint Form documented that Resident #1 reported that some Certified Nurse Aides manhandle and cup their legs which hurts them because their legs are sensitive. During an interview on 5/28/25 at 12:24 pm, the Complainant stated Resident #1 was awaken out of their sleep at 4:45 PM by two Certified Nurse Aides to be changed and that Resident #1 refused because they did not get a reasonable amount of sleep, and Certified Nurse Aide #1 told Resident #1 that they must do it now because they're not coming back. The Complainant stated that they have complained about Certified Nurse Aide #1 aide in the past and they were supposed to been banned from giving cares to Resident #1. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon review of the Certified Nurse Aide Documentation, there was no evidence to show that Resident #1's preference to not have Certified Nurse Aide #1 provide cares to them, in their plan of care. During an interview on 5/28/2025 at 1:54 PM, the Director Social Services stated that Resident #1 had complained in the past to the team that staff were insensitive to their feet, and that they filed a grievance on 1/22/2025 due to staff manhandling their legs. During an interview on 5/28/25 at 3:00 PM, Certified Nurse Aide #1 stated that Resident #1 had complained about them in the past that that they were too strong, and they were afraid that they would roll them out of their bed. During an interview on 5/28/25 at 2:45 PM, The Administrator stated prior to the incident on 3/18/25, they were informed by the Director of Nursing that Resident #1 complained about Certified Nurse Aide #1 being too strong with them while giving cares and that they prefer them not to give cares to them. During an interview on 5/28/25 at 3:16 PM, the Director of Nursing stated that one day they visited Resident #1, and they complained that Certified Nurse Aide #1 does not know their strength and that they requested to have other aides instead of Certified Nurse Aide #1 and that prior to the incident on 3/18/25, they told Certified Nurse Aide not to provide cares to Resident #1 and for while they were from their assignment and don't know how they ended providing care that night. The Director of Nursing stated that they did not write the instructions down for the nurse to give to the Certified Nurse Aide, they verbally informed them and that it was not put in the Kardex Care Guide. The Director of Nursing stated that they only put Resident's preferences of not wanting a male Certified Nurse Aide in the Care Plan, not for a particular person. 10NYCRR415.12

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F 0600 Level of Harm - Minimal harm or potential for 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. Based on record review and interviews conducted during the Abbreviated Survey (NY00375616), the facility did not ensure for 1 (Residents #1) of 3 residents reviewed for abuse, had the right to be free from abuse, neglect, or mistreatment. Specifically, Resident #1 was awaken at 4:45am by Certified Nurse Aide #1 to provide personal hygiene care. Resident #1 refused cares but Certified Nurse Aide #1 continued to provide cares despite Resident #1's refusal. Resident #1 reported Certified Nurse Aide #1 mishandled them. Resident #1 was very upset because thier sleep was interrupted by Certified Nurse Aide #1 and reported to their family representative. The findings are: The 1/28/21 Facility policy titled Abuse Prevention/Prohibition documented that all Residents will be free from abuse, mistreatment, neglect, exploitation, misappropriation of property, corporal punishment, and involuntary seclusion. The 1/23/28 Facility policy titled Residents Rights documented that all residents have a right to a dignified existence and self-determination, has a right to make choices about aspects of his or her life in the facility that are significant to the resident. Resident #1 was admitted with diagnoses including but not limited to atrial fibrillation, deep vein thrombosis, and rhabdomyolysis. The 12/18/24 5 day Minimum Data Set documented that Resident #1 had intact cognition and required total assistance with bathing, bed mobility and toileting. The 12/12/24 Mood Care Plan documented that Resident #1 had altered mood state or feelings as manifested by resident showing signs of an unpleasant mood in the morning. The 3/18/25 Investigation Summary documented that on 3/18/25 at approximately 8:45 am, the Complainant reported to the Administrator that their mother left them a message early in the morning on 3/18/25, upset and stated that they were cleaned by two Certified Nurse Aides after asking them not to change them at that time. Resident #1 stated that at approximately 5:15 am, they told two Certified Nurse Aides that they did not want to be cleaned and changed but they cleaned and changed them due to having a bowel movement. The involved staff members were interviewed, and both stated that they changed Resident #1 out of concern of skin breakdown because they were soiled. Education was provided to all Certified Nurse Aides that if a resident refuses care to alert the nurse and/or supervisor for further guidance and document accordingly. Both Certified Nurse Aides were removed the Resident's care. The 3/18/25 Employee Statement by Certified Nurse Aide #1 documented that they were training Certified Nurse Aide #2 and being that Resident #1 is two assist with cares, they both went in to provide incontinence cares to Resident #1. Certified Nurse Aide #1 stated that they were afraid that their skin would breakdown and that was why they changed them. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/18/25 Employee Statement by Certified Nurse Aide #2 documented that on the morning of 3/18/25 they went in the room with a coworker to change resident due to the be soiled. Resident #1 told them hat they do not need to be changed and that they are fine, and although Resident #1 was getting upset, they changed them anyway. The Administrator Statement documented that on 3/18/25, they were notified by the Complainant that Resident #1 left a message and was upset telling them two Certified Nurse Aides cleaned them after asking not to be changed at the time. The Administrator explained to the Complainant the consequences of the resident lying in their incontinence for long periods of time. The Administrator interview both Certified Nurse Aides and they both confirmed that Resident #1 did not want to be changed but they insisted on changing them, and one aide stated that Resident #1 seemed unhappy that they were changing them at that time. Resident #1 told the Administrator that they felt they were being manhandled. The Grievance/Complaint Form dated 3/18/25 documented that on 3/18/25 at approximated 5:15 am, Resident #1 told two Certified Nurse Aides that they did not want to be cleaned and changed, and the Certified Nurse Aides changed them due to their concerns of large incontinence. Education provided to all Certified Nurse Aides that if a Resident refuses cares to alert the nurse and/or supervisor for further guidance and document accordingly. The 3/19/25 In-service and Continuing education titled Health Care Plan(HCP) for Resident #1 documented that Certified Nurse Aides were educated to document refusals of care and to report to nurse/supervisor. Both Certified Nurse Aides who provided cares were removed from taking care of Resident #1. The 3/18/25 Corrective Action Notice Form documented that Certified Nurse Aide #1 received a verbal counseling for failure to follow instruction for Residents, and education was provided. The 3/18/25 Corrective Action Notice Form documented that Certified Nurse Aide #2 received a verbal counseling for failure to follow instruction for Residents, and education was provided. During an interview on 5/28/25 at 11:45am, the Administrator stated the Complainant reported to them that Resident #1 told them that they were rough handled by two Certified Nurse aides while being provided with cares after they refused, and that they did an investigation, and the Attorney General called for information related to the incident. During an interview on 5/28/25 at 12:24 pm, the family representative stated Resident #1 was awaken out of their sleep at 4:45am by two Certified Nurse Aides to be changed and the Resident #1 refused because they wanted to get some more sleep, and Certified Nurse Aide #1 told Resident #1 that they must do it now because they're not coming back. The family representative stated that they had complained about Certified Nurse Aide #1 aide in the past to the facility administration and they were supposed to have banned them from giving cares to Resident #1. During an interview on 5/28/25 at 1:54pm , the Director of Social Services stated that Resident #1 has complained in the past to the team that staff were insensitive to their feet, and that they filed a grievance on 1/22/25 due to staff manhandling their legs. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 3:00pm, Certified Nurse Aide #1 stated that they changed Resident #1 anyway after they refused to be changed because they were soiled, and they didn't want to leave them like that for the next shift. Certified Nurse Aide #1 stated that they went into Resident #1's room while they were still sleeping and explained to them that the shift changes at 7am and they wanted to change them so that they can finish their shift. Certified Nurse Aide #1 stated that Resident #1 refused to be changed and was upset but they continued changing them because they were soiled, and they know were supposed to tell the nurse that they refused. Certified Nurse Aide #1 stated that Resident #1 has complained about them before the incident that they were too strong, and they were afraid that they would turn them out of their bed. During an interview on 5/28/25 at 3:16pm, the Director of Nursing stated that Residents have the right to refuse care, and that Certified Nurse Aides should not provide care if a resident says no and to report to a nurse and /or supervisor and to document. The Director of Nursing stated that one day they visited Resident #1, and they complained that Certified Nurse Aide #1 does not know their strength and they requested to have other aides instead of Certified Nurse Aide #1 and that prior to the incident on 3/18/25, they told Certified Nurse Aide not to provide cares to Resident #1 and for a while they were removed from their assignment and don't know how they ended providing care that night. 10 NYCRR 415.4(b)(3)

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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 Abbreviated Survey (NY00375616), the facility did not ensure for 1(Residents #1) of 3 residents reviewed for abuse, that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately, but not later than two hours after the allegation is made, to the State Survey Agency in accordance with State law through established procedures. Specifically, 1.) On 3/18/25, the facility initiated an investigation of alleged abuse due to a report from Resident #1's family on 3/18/25 that Resident #1 called them early in the morning on 3/18/25 upset that two certified nurse aides came into their room at approximately 4:45 am while they were asleep and insisted on changing them despite their refusal and while providing cares, they were manhandled by the Certified Nurse Aides. Resident #1 was very upset by the actions of the Certified Nurse Aide #1 & #2. The findings are: The 1/28/21 Facility policy titled Abuse Prevention/Prohibition documented the Federal and state regulations require the reporting of alleged violations of abuse, mistreatment, and neglect immediately to the facility administrator and in accordance with state law, to the Department of Health. Resident #1 was admitted with diagnoses including but not limited to atrial fibrillation, deep vein thrombosis, and rhabdomyolysis. The 3/18/25 Investigation Summary documented that on 3/18/25 at approximately 8:45 am, the Complainant reported to the Administrator that their mother left them a message early in the morning on 3/18/25, upset and stated that they were cleaned by two Certified Nurse Aides after asking them not to provide incontinence care. Resident #1 stated that at approximately 5:15 am, they told Certified Nurse Aides #1 & #2 that they did not want to be cleaned and changed but they cleaned and changed them. The involved staff members were interviewed, and both stated that they changed Resident #1 out of concern of skin breakdown because the resident was soiled. Education was provided to all Certified Nurse Aides that if a resident refuses care to alert the nurse and/or supervisor for further guidance and document accordingly. Both Certified Nurse Aides were removed from the Resident's care. The Administrator Statement documented that on 3/18/25, they were notified by the Complainant that Resident #1 left a message and was upset telling them two Certified Nurse Aides cleaned them after asking not to be changed at the time. The Administrator explained to the Complainant the consequences of the resident lying in their incontinence for long periods of time. The Administrator interview both Certified Nurse Aides and they both confirmed that Resident #1 did not want to be changed but they insisted on changing them, and one aide stated that Resident #1 seemed unhappy that they were changing them at that time. Resident #1 told the Administrator that they felt they were being manhandled. During an interview on 5/28/25 at 3:16 PM, the Director of Nursing stated that Residents have the right to refuse care, and that Certified Nurse Aides should not provide care if a resident says no and to report to a nurse and /or supervisor and to document. The Director of Nursing stated that they did not report the incident to the Department of Health because an investigation was initiated by the Administrator. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/25 at 2:45 PM, the Administrator stated that the family representative reported to them that Resident #1 complained about two Certified Nurses' Aides mishandling them and provided cares to them even though they refused causing them to be upset. The Administrator stated that they did not report the incident on 3/18/25 because they did their own investigation and Resident #1 always has made accusations and they were not sure if it they were really abused or not. The Administrator stated that they gave Certified Nurse Aide #1 and Certified Nurse Aide #2 verbal counseling because they provided cares to Resident #1 despite them refusing incontinence cares. 10 NYCRR 415.4(b)