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	10/10/2024

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 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. 47626 Based on interviews and record review, conducted during the recertification survey from 10/3/24 to 10/10/24, the facility did not ensure the residents' Minimum Data Set assessments were completed not less frequently than once every 3 months. This was evident for 3 (Residents # 11,14, and 23) of 18 residents reviewed for Resident Assessment. Specifically, Minimum Data Set assessments for Resident #11, Resident #14, Resident #23, were not completed within 14 days of the Assessment Reference Date. The findings are: The facility's policy titled Minimum Data Set Completion, initiated 9/1/18 last reviewed 6/14/24 documented assessments will be completed no later than 92 days after the previous Assessment Reference Date. 1) Resident #11's Quarterly Minimum Data Set (an assessment tool) with an Assessment Reference Date of 8/6/24 documented a completion date of 10/1/24, more than 14 days (8 weeks) after the Assessment Reference Date. 2) Resident #14's Quarterly Minimum Data Set (an assessment tool) with an Assessment Reference Date of 8/21/24 documented a completion date of 10/1/24, more than 14 days (6 weeks) after the Assessment Reference Date. 3) Resident #23's Quarterly Minimum Data Set (an assessment tool) with an Assessment Reference Date of 7/22/24 documented a completion date of 10/1/24, more than 14 days (10 weeks) after the Assessment Reference Date. During an interview with the Director of Minimum Data Set on 10/07/24 at 11:12 AM, they stated the Rehabilitation Director was out and they could not close the Minimum Data Set due to section GG being incomplete. They stated they notified the Administrator, and the Interdisciplinary Team was aware. During an interview on 10/07/24 at 11:28 AM, the Administrator stated they were aware of an issue with section GG. They stated the Minimum Data Set were being completed and they knew there was transmission issue but did not realize they were out of compliance. 415.11(a)(4)

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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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 45478 Based on observation, record review and interview during the recertification survey, the facility did not ensure 1 of 3 residents (Resident #16) reviewed for positioning and range of motion, had the necessary treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Specifically, Resident #16 was observed poorly positioned and their plan of care did not include interventions to address body, head, and neck positioning. Findings include: Resident #16 was admitted to facility with diagnoses including Diabetes, Non-Alzheimer's Dementia, and osteoarthritis of the right shoulder. The 10/1/24 Quarterly Minimum Data Set (MDS) an assessment tool documented Resident #16 had moderately impaired cognition, received regularly scheduled pain medication, and was not receiving rehab services. The Minimum Data Set documented Resident #16 required set up or clean up assist for eating. The Activities of Daily Living Care Plan created 10/16/15 documented Resident #16 required set up and supervision for feeding. The 6/11/24 Occupational Therapy evaluation documented the resident was seen for a quarterly screen. The resident was functioning at their baseline, required set up for oral hygiene and feeding, and maximum assistance for activities of daily living and was dependent for transfers. Skilled occupational therapy was not recommended. There was no documented evidence in the resident electronic medical record that resident was referred or screened for occupational therapy after June 2024. During a lunch observation on 10/03/24 at 11:49 AM, Resident #16 was at the dining room table. Resident #16's left side was pushed in toward table while the right was further away from table. The resident attempted to reposition themselves in front of the table, but their feet did not touch floor and they could not move the chair on their own. Resident #16 was leaning to the left and their armpit was resting on the armrest of the wheelchair while they tried to eat. Food was observed on the floor and the resident appeared tired and closed their eyes while chewing food and leaning to the left. Their head was also leaning to left. There were no positioning devices in the resident's chair and no observations of staff offering to assist with repositioning resident at table and in wheelchair. During a lunch observation on 10/07/24 at 11:51 AM, Resident #16 was in wheelchair at dining room table. There was about a 10 inch a gap between the resident and table. Resident #16 was observed leaning to left side with armpit leaning on armrest. Resident #16 was eating only using the right hand and had to reach far across to tray to eat. Resident #16 appeared tired and resting eyes while chewing and head leaning to left side. Food was observed dropped on floor and tray. There were no observations of staff offering to assist with repositioning the resident at table and in wheelchair. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 10/09/24 at 11:31 AM, Certified Nurse Aide #12 stated the resident was very difficult and the staff must do whatever the resident wanted. Certified Nurse Aide #12 stated the Rehab Department was aware the resident was leaning to the left side. Certified Nurse Aide #12 stated if they tried to readjust the resident, the resident would yell or scream. Certified Nurse Aide #12 stated the resident had a pain on right side and stated that was the reason the resident leaned to the left side. Certified Nurse Aide #12 stated they thought rehab worked with the resident about 2 months ago. Certified Nurse Aide #12 stated if they put a pillow to assist with sitting the resident up, the resident would remove it. When interviewed on 10/09/24 at 11:38 AM, Registered Nurse #2 stated the resident was not receiving Occupational Therapy services at the time and the last occupational therapy evaluation was 6/11/24. Registered Nurse #2 stated the resident had been observed leaning and when they attempted to reposition the resident, the resident got upset. Registered Nurse #2 stated even when resident sits in a more upright position, they noticed the resident leaned to the left side. Registered Nurse #2 stated they had not made a referral for occupational therapy. When interviewed on 10/09/24 at 12:00 PM, the Occupational Therapy Supervisor stated the resident had been able to eat okay. The Occupational Therapy Supervisor stated there had been no referrals from nursing describing the resident leaning to left side while eating. Occupational Therapy Supervisor stated the dietician observed meals often and was usually quick to refer residents to rehab. The Occupational Therapy Supervisor stated that rehab did rounds occasionally to observe residents, but they usually did quarterly evaluations or got referrals from the dietician. The Occupational Therapy Supervisor stated the occupational therapy evaluation was last done in June of 2024 and documented resident had weakness on right side. They stated the resident had osteoarthritis in the right shoulder and was seen then for that. The Occupational Therapy Supervisor stated Resident #16 was a set up with supervision for self-feeding and if they noticed a decline they would assess and see if they needed any more physical assistance. The Occupational Therapy Supervisor stated when positioning was not addressed it could cause negative outcomes in feeding, pain and could also result in a pressure sore. 10NYCRR 415.12(e)(1,2)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49255 Based on observation, record review and interviews during the recertification survey from 10/3/24 to 10/10/24, the facility did not ensure that each resident received necessary respiratory care including oxygen therapy that was in accordance with professional standards of practice and as ordered by the practitioner for 1 of 2 residents (Resident #312) reviewed for respiratory care. Specifically, Resident #312 had an order for oxygen therapy but there was no documented evidence of monitoring to ensure it was being administered, and there was no evidence the nasal canula tubing was changed per policy. Findings include: The facility policy and procedure titled Oxygen Administration with effective date 3/30/10, last reviewed on 7/8/24, documented the following information should be recorded in the resident's medical record: the rate of oxygen flow, route, and rationale, the frequency and duration of the treatment, the date and time that the procedure was performed, the name and title of the individual who performed the procedure. The facility policy and procedure also documented to change oxygen tubing every Sunday 11:00 PM - 7:00 AM shift and to document the date and time and individual that performed the procedure. Resident #312 had diagnoses including chronic obstructive pulmonary disease, asthma, and heart failure. The Admission Minimum Data Set (resident assessment tool) dated 9/21/24 documented, Resident #312 was admitted to the facility on [DATE]. Resident #312 had intact cognition and was on continuous oxygen therapy on admission. The physician order dated 9/17/24 documented continues oxygen 2 Liter per minute via nasal canula. The comprehensive Care Plan titled Oxygen Dependent dated 9/15/24 documented maintain oxygen/nebulizer/puffer equipment per facility policy. During observations and interview on 10/03/24 at 11:34 AM, 10/04/24 at 9:31 AM, and 10/07/24 at 9:58 AM, Resident #312 was in their bed, wearing a nasal canula with a tube connected to the oxygen concentrator with 2-liter flow oxygen. The oxygen tubing was undated and without a signature. The resident stated they had been on oxygen continuously since they were admitted to the facility. Review of the October 2024 Treatment Administration Record on 10/07/24 at 9:31 AM revealed no documented evidence the oxygen therapy was being administered or monitored. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During observation and interview of Resident #312 in their room on 10/07/24 at 10:01 AM, accompanied by the Licensed Practical Nurse #13, they stated the resident was on the oxygen continuously via oxygen concentrator or oxygen tank. Licensed Practical Nurse #13 said that they monitored and documented the oxygen therapy daily on the Treatment Administration Record. Licensed Practical Nurse #13 said that the oxygen order was not transcribed to the Treatment Administration Record, and it needed to be updated. They stated they maintained oxygen equipment on a weekly basis and as needed. The oxygen tubing was changed by a night shift nurse on Sunday and every tubing needed to be dated and signed. After observation of tubing, Licensed Practical Nurse #13 stated they did not see a date and nurse's signature and did not know if the tubing was changed last Sunday. During an interview on 10/07/24 at 10:18 AM, Registered Nurse Unit Manager #8 stated they had just updated the Treatment Administration Record placing the oxygen order for 2 Liters/min via nasal canula for continuous use. 10 NYCRR 415.12(k) (6)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49255 Based on observations and interviews conducted during the recertification survey from 10/3/24 to 10/10/24, the facility did not ensure food was stored in accordance with professional standards for food safety practice. Specifically, there was undated and without expiration dates food stored in the walk-in freezer and refrigerator. Finding include: The facility policy Food Inventory Receiving and Storage effective 09/09/2018 and reviewed 2/14/2024, documented each item must be dated and labeled. Any items opened/used and returned to storage shall be wrapped, labeled, and dated from initial date of use. During an initial tour of the kitchen on 10/03/24 at 9:08 AM, conducted with Food Service Director, the following were observed in the walk-in freezer: 1. A bag of frozen pork butt, without original box, with receiving date 9/26/24, no expiration date. 2. Open bags of hash brown patties, and French fries, both bags were undated. Observation of walk-in refrigerator on 10/03/24 at 9:21 AM revealed opened and undated packs of American cheese, liverwurst, Raskas Cream Cheese and a bag of opened shredded cheddar cheese with date of opening 9/17/24, an undated metal tray of ham salad and banana puree. Observation of the dry storage room on 10/03/24 at 9:36 AM revealed opened and undated bag of egg noodles, a bag of plain breadcrumbs and a bag of yellow cake mix. During an interview with Food Services Director on 09/26/24 at 9:49 AM, they stated that all opened and used food should be wrapped, labeled and dated from initial date of use. They said they educated the staff about it but could not explain why the staff did not put dates of opening on the food. The Food Services Director collected all undated items and stated that all of them would be discarded. 10NYCRR 415.14 (h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 41666 Based on record review and interview conducted during a recertification survey 10/3/24- 10/10/24, the facility did not properly establish and/or maintain an Infection Prevention and Control Program designed to provide a safe and sanitary environment. Specifically, the facility had not updated the Water Management Plan since 12/16/19. The findings are: During a review of the Legionella Assessment and Water Management Plan on 10/7/24 at 11:50 AM with the Director of Engineering, the facility's Water Management Plan was dated 12/16/19. The facility Administrator and Director of Nursing's names were handwritten on the form over white out from the former Administrator and Director of Nursing. During an interview on 10/7/24 at 11:50 AM, the Director of Engineering stated they were responsible for updating the plan annually but had not done it in the last year. The Director of Engineering stated it was important to have updated information and a current Management team. The plan was to have an outside company come in to do an assessment and formulate a Management Plan, which was scheduled for the upcoming week, but it should have been done sooner. During an interview on 10/08/24 at 10:03 AM, the Director of Nursing stated they were unsure of their role in the Water Management Plan for Legionella. They stated they did not go over the plan often enough to know what to do and was not sure of the steps to take if Legionella was identified in water samples. They stated they hoped to get guidance from the Department of Health if it happened. During an interview on 10/9/24 at 1:28 PM, the Administrator stated the Water Management Plan was important to ensure Legionella was controlled, and all parties involved needed to know their role. 10 NYCRR 415.19