STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335585	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Residential Care Center	220 Tower Street Waterville, NY 13480

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335585	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Residential Care Center	220 Tower Street Waterville, NY 13480

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated survey (IQIES #2576672) the facility did not ensure residents received treatment and care in accordance with professional standards of practice for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 exhibited a change in condition on the morning of [DATE] and was sent to a scheduled pulmonology appointment where they expired during transport. There was no documented evidence of the resident's change of condition and staff provided conflicting versions of what the resident's condition was on the morning of [DATE]. Findings include: The facility policy Notification of Changes, revised [DATE], documented the care center shall immediately inform the resident and consult with the resident's physician when a significant change in the resident's physical, mental, or psychosocial status changed. All notifications were documented.Resident #1 had diagnoses including dementia, sarcoidosis (organ inflammation throughout the body), and diabetes. The [DATE] Minimum Data Set assessment documented the resident's cognition was severely impaired, required supervision or touch assistance with toileting, and moderate assistance for dressing and bathing. The Comprehensive Care Plan, initiated on [DATE], documented the resident had an activity of daily living self-care performance deficit related to activity intolerance and limited mobility. Interventions included physical therapy and occupational therapy per provider orders. The resident was usually understood and sometimes understanded. Interventions included monitoring for any changes in communication and report, and monitor/document/report to provider change in ability to perform activities of daily living and decline in mobility. A [DATE] at 11:30 PM Licensed Practical Nurse #13 progress note documented the resident was lethargic all shift and refused dinner. They took their medication without difficulty, and the nursing supervisor was made aware.There was no documented evidence Resident #1 was assessed by the Nursing Supervisor. On [DATE] at 11:05 AM, Certified Nurse Aid #9 documented they provided the resident with a shower. They required substantial to maximal assistance throughout the shower.A [DATE] at 8:48 AM Licensed Practical Nurse Unit Manager #5 progress note documented the resident was very lethargic and took three staff members to transfer.A [DATE] at 11:15 AM Licensed Practical Nurse Unit Manager #5 progress note documented at 9:10 AM the resident was assisted to their wheelchair by three staff. The resident's eyes were open; they were awake and was able to raise their right arm. The family member was made aware of condition.The Medication Administration Record documented Licensed Practical Nurse #10 administered the resident their day shift oral medications (no administration time documented). There was no documented evidence the resident was assessed by a registered nurse or medical provider or whether vital signs were obtained on [DATE] when the resident had a change in transfer status and responsiveness. The [DATE] Investigative Report labeled, Death Critical Element Pathway, completed by the Director of Nursing, documented during the morning of [DATE], prior to the resident's scheduled appointment, the resident was noted to be very lethargic and required assistance from three staff members for all care tasks; their spouse was made aware. The resident was transferred to a wheelchair where they briefly opened their eyes and raised an arm to their face. The family member was made aware of the resident's condition. The resident passed away on their way to the appointment.During an interview on [DATE] at 10:00 AM, Certified Nurse Aide #4 stated on [DATE], they were scheduled to accompany Resident #1 to their pulmonology appointment. When they arrived on the unit to pick up the resident the resident was in their wheelchair and appeared sleepy and non-verbal. They were not familiar with the resident and nurses informed them the resident was usually non-verbal. They carried an envelope with the resident's face sheet, orders, medications, the primary provider, and their code status. The Resident was awake when they left the facility but immediately fell asleep when placed in the transport van. They assumed the resident remained sleeping during the hour drive to their appointment. When they arrived at the appointment the resident's family was waiting for them. They told the family the ride went fine, and the resident slept the entire ride. The driver took the resident out of the van and handed the wheelchair to the family. At that time the resident's family member screamed the resident was dead. They ran into the facility to get help, and someone called 911. A nurse from the office went outside to bring the family and the resident into the building and into a room. They did not notice any signs of distress from the resident while driving in the van.During an interview on [DATE] at 10:20 AM, Licensed Practical Nurse Unit Manager #5 stated if a resident had a change in condition they called a registered nurse. If the resident did not appear the same to them, they called the physician and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335585	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Residential Care Center	220 Tower Street Waterville, NY 13480

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335585	A. Building B. Wing	08/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterville Residential Care Center	220 Tower Street Waterville, NY 13480

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews during the abbreviated survey (IQIES 2576672), the facility did not ensure residents received adequate supervision and assistive devices to prevent accidents for two (2) of three (3) residents (Residents #1 and #2) reviewed. Specifically, Resident #1 had multiple falls, and the facility investigation did not identify the root cause of the fall and establish person-centered interventions to prevent further falls; and Resident #2's interventions to prevent falls were not implemented as planned. Findings include:The facility policy Resident Incident/Accident Documentation within Electronic Medical Record, revised 7/25/2024, documented all incidents involving resident care would be investigated and documented to evaluate care given to residents, to assist in prevention of incidents, and evaluate interventions given in the event of an incident. Incident/accident reports included a detailed description of the incident, a statement from the resident of what occurred, statements from staff at time of incident, and the root cause of the incident.1) Resident #1 had diagnoses including dementia, muscle weakness, and repeated falls. The 06/02/2025 Minimum Data Set assessment documented the resident's cognition was severely impaired, required supervision or touch assistance with toileting, was frequently incontinent of urine and continent of bowel. The Comprehensive Care Plan initiated 06/03/2025 documented the resident was incontinent of bladder and continent of bowel and was at risk for falls. Interventions included toilet every 2-4 hours and as needed, perform 30-minute safety checks, fall matts on floor, and bed in lowest position. The 06/12/2025 Kardex (care instructions) documented toilet and incontinent care every 2-4 hours and as needed, fall matts on bed and non-skid socks on when out of bed. Resident #1 Fall Incident Reports documented:-on 6/4/2025 at 3:00 AM: resident was found on floor. They were an active exit seeker and ambulated without assistance. Care plan interventions were updated to include fall mats on floor and 30-minute safety checks.-on 6/7/2025 at 4:50 PM: resident was found on the floor in another resident's room. The cause identified was poor safety awareness. Care plan interventions were updated to continue therapy. No staff statements were included in the report. -on 6/8/2025 at 6:00 AM: resident was found lying on the bedside mat next to their bed. The resident stated they had to go to the bathroom. Identified cause was resident had to use the restroom. There was no documented registered nurse assessment or updated care plan interventions. -on 6/8/2025 at 11:20 PM: resident was found lying on their stomach on their bedside mat. The resident stated they had to go to the bathroom. Resident #1 was assisted back to bed. The identified cause was poor safety awareness, non-compliance, and the resident did not use the call bell to ask for help related to their cognition. There was no documented registered nurse assessment, care plan update, or call bell evaluation.-on 6/10/2025 at 1:45 PM: the resident stood up from their wheelchair and fell on their right hip, hitting their left hip on the arm of the wheelchair. The resident stated ow. Vital signs were taken, and the resident's blood pressure was found to be low. The provider was notified and ordered vitals every shift and medication for hypotension (low blood pressure). There was no documented registered nurse assessment.-on 6/10/2025 at 11:00 PM: resident was found on the floor mat next to their bed and was unable to state what happened. Vitals signs were taken and resident assessed for injury. Care plan reviewed and revised to include left side of bed against wall. -on 6/11/2025 at 3:00 AM: resident stood and fell from their easy chair and could not state what happened. No staff statements, care plan revisions, or registered nurse evaluation was documented.-on 6/11/2025 at 3:30 AM: resident was on a one to one observation (constant staff observation). The certified nurse aide who was watching the resident turned to help another resident, Resident #1 stood up and fell out of the wheelchair. Vital signs were taken, and resident was assessed. There were no staff statements, care plan revisions, immediate interventions, or registered nurse assessment documented. -on 6/11/2025 at 6:50 AM: resident was found on the floor mat next to their bed and was unable to state what happened. The resident had unsteady gait and was impulsive. Vitals signs were taken. There were no care plan revisions, immediate interventions, or a registered nurse evaluation.-on 6/11/2025 at 3:45 PM: resident fell in the hallway, lost balance their balance landing on their back. The resident was placed at the nurse's station where there was high visibility to be monitored. Vital signs were taken. There was no documented registered nurse assessment, care plan review or revision, or staff statements.-on 6/12/2025 at 3:55 PM: resident stood up from their wheelchair, lost their balance, and fell on their bottom. The resident was placed in their wheelchair and in a high traffic area. The resident's family member, provider, and the Director of Nursing was notified. A new blood pressure medication was ordered at the time. There was no documented registered nurse assessment, care plan review or revision, or staff