

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/10/2024
NAME OF PROVIDER OR SUPPLIER  Waterville Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48446</b></p> <p>Based on record review, observations, and interviews during the recertification survey conducted 10/7/2024-10/10/2024, the facility did not ensure residents had a safe, clean, comfortable, and homelike environment for 3 of 5 nursing units on the Second floor (all resident units were located on the Second floor), the middle dining room, the first floor hair salon area, and the staff hallway near the timeclock Specifically, room [ROOM NUMBER] had a strong smell of urine; the floors in the 2nd floor middle dining room were dirty and sticky; the staff hallway near the timeclock had a section of plywood that was unclean and not flush with the wall; the East 100's unit shower room toilet was not attached to the floor and the radiator was rusty and had sharp edges; the East 200's unit shower room had chipped wall tiles near the floor; and the hair salon on the first floor was missing a ceiling tile and on the floor below the tile there was a bucket to collect dripping water.</p> <p>Findings include:</p> <p>The facility Infection Control Manual documented soiled and damp linen was to be placed in a plastic bag and removed from resident rooms and a routine cleaning of the residents surroundings was completed daily.</p> <p>The following observations were made:</p> <ul style="list-style-type: none"> <li>- on 10/7/2024 at 9:52 AM, there was a strong smell of urine in resident room [ROOM NUMBER].</li> <li>- on 10/7/2024 at 11:10 AM a 3 foot by 2 foot section of plywood within a corridor wall in the staff back hallway located near the timeclock was not clean and and not flush with the wall.</li> <li>- on 10/7/2024 at 11:35 AM the 100 Unit shower room's toilet was loose/not attached to the floor and in disrepair. The radiator in the room was rusty and had sharp edges.</li> <li>- on 10/7/2024 at 11:42 AM, the 200 Unit shower room had chipped wall tiles near the floor.</li> <li>- on 10/7/2024 at 2:00 PM, the hair salon had a missing 2 by 2 ceiling tile with a 5 gallon bucket on the floor underneath collecting water.</li> </ul> <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
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 10/7/2024 at 2:17 PM, the Center dining room floors were dirty and sticky during a Resident Council meeting. There was a strong smell of urine in the hallway near room [ROOM NUMBER] which was passed to enter the Center dining room.</p> <p>- on 10/8/2024 at 8:16 AM, the Center dining room had dirty floors. There was a brown liquid stain the size of an orange on the round table closest to the bookshelf. There were four brown spots on the floor in the same area.</p> <p>- on 10/9/2024 at 8:09 AM, there was a strong smell of urine in resident room [ROOM NUMBER].</p> <p>During an interview on 10/9/2024 at 10:33 AM, Certified Nurse Aide #7 stated they had noted a strong smell of urine especially in room [ROOM NUMBER]. A fabric chair was removed from the room. They were not sure where the smell had originated and sometimes the smell was coming from a mattress. They did not know what to do when the mattress smelled of urine. They stated they had seen both the Center and the Main dining room with dirty tables and floors before breakfast was served.</p> <p>During an interview at 10/9/2024 at 10:49 AM Licensed Practical Nurse #8 stated they had noticed a strong smell of urine in resident room [ROOM NUMBER] and they called housekeeping. If the smell was present after housekeeping cleaned the room they believed it was from the mattress. They called maintenance for a new mattress which was brought up the same day. They noticed the dining rooms with spills that were not cleaned after housekeeping left for the day.</p> <p>During an interview on 10/9/2024 at 1:27 PM, Licensed Practical Nurse Unit Manager #9 stated they had seen dirty and sticky floors when they came in the morning because there were no housekeeping services provided after the dinner meal. They stated nursing staff was responsible for cleaning the dining rooms after the dinner meal and they did not always have the time because families were visiting and call bells were more frequent at those times. They had smelled urine coming from resident rooms and would look to see if a toilet was left unflushed, linens were soiled, or if there was a dirty incontinent brief in the trash can. It was important to keep the resident areas clean and homelike because it could be embarrassing for both the resident and family and was a dignity issue.</p> <p>During an interview on 10/10/2024 at 7:38 AM, Housekeeper #10 stated housekeeping services were offered every day from 7:00 AM to 3:00 PM and each housekeeper was responsible for cleaning a wing. They stated all resident rooms were cleaned daily and included dusting, sweeping, mopping, cleaning sinks and toilets, and emptying trash. The dining rooms were cleaned after breakfast and lunch. They had noted a strong smell of urine especially in room [ROOM NUMBER] and if the resident was out of bed they cleaned the mattress with bleach. If the resident was in bed they asked the certified nurse aide to notify them when the resident was out of bed. There were no check off sheets completed after cleaning resident rooms or the dining rooms. There was no housekeeping services after 3:00 PM and nursing or the kitchen should clean the dining rooms after the dinner meals. They stated it was not always done and they had seen spills on the tables and floors when they started their shift in the morning. They stated it was important for resident areas to be clean because it could make residents feel embarrassed especially if they had family members visiting. They stated there were only 2 housekeepers on 10/7/2024 which is why everything did not get cleaned properly.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/10/2024 at 7:55 AM, Housekeeping Supervisor #11 stated they expected staff to clean sinks, toilets, walls, baseboards, bed frames, dust furniture, bedframes, handrails, door knobs, sweep, and mop every room daily. Additionally, staff was responsible for cleaning the West, Center, and Main dining rooms which included wiping tables, sweeping, and mopping after breakfast and lunch meals every day. They stated normal staffing was four housekeepers and a supervisor. On 10/7/2024 there were two housekeepers and one housekeeper in training that already resigned after only a few days. The supervisor was also off on 10/7/2024. They did not expect floors to be dirty or sticky, or rooms to smell of urine. They stated the floors needed to be stripped and waxed and was working on getting that scheduled for the next month or two. It was important to have rooms clean and homelike because residents could feel dirty and embarrassed.</p> <p>During an interview on 10/10/2024 at 9:45 AM, the Director of Maintenance #12 stated they were aware of a section of plywood that was dirty and warped and was in the process of replacing it. They stated it was important to make sure tiles and toilets were in good working order and not chipped. The ceiling tile was missing from the hair salon for approximately one month due to a leak. They placed a bucket under the missing tile while they were trying to determine the cause of the leak. They should have fixed the leak and replaced broken tiles immediately as it did not look good and was not homelike for residents.</p> <p>During an interview on 10/10/2024 at 10:55 AM, the Administrator stated they did not expect floors to be sticky, smells of urine, tiles chipped or missing, or ceiling tiles missing. They were in the process of repainting the entire building and redoing the floors as the floors were old and urine had soaked into them.</p> <p>10 NYCRR 415.29 (f)(6), (j)(1)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>48446</p> <p>Based on observation, record review, and interviews during the recertification survey conducted 10/7/2024-10/10/2024, the facility did not ensure residents were provided an ongoing program to support their choice of activities, designed to meet their interests and support their physical, mental, and psychosocial well-being for 1 of 1 resident (Resident #28) reviewed. Specifically, Resident #28 was not included in or provided activities to meet their interests and preferences.</p> <p>Findings include:</p> <p>The facility policy, Types of Activity Programs, dated 7/25/2025, documented activity programs were unique and reflected the current resident population as well as the strengths of the activity staff to implement the program. Activities were available to meet the current needs and interest of the resident population.</p> <p>Resident #28 had diagnoses including right sided hemiplegia (paralysis or weakness to one side of the body), dementia, and aphasia (difficulty speaking). The 8/7/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, unclear speech, was rarely understood, did not reject care, and was dependent on staff for all activities of daily living.</p> <p>The Comprehensive Care Plan documented the following:</p> <ul style="list-style-type: none"> <li>- initiated 11/21/2023 and revised 8/12/2024 the resident was rarely understood and required time to communicate their needs. At times they were able to communicate by using a thumbs up response.</li> <li>- initiated 11/22/2023 the resident was provided assistance to activity functions and enjoyed the outdoors, hunting, and fishing.</li> <li>- initiated 5/6/2024 when the resident chose not to participate in activities, they were provided music or television (usually in the west day room) for sensory stimulation.</li> <li>- initiated 5/20/24 the resident was to be invited to recreational activities</li> <li>- initiated 5/22/2024 the resident was provided with 1:1 activities</li> </ul> <p>The 5/6/2024 activities quarterly assessment completed by Activities Director #6 documented the resident preferred both independent and group activities and was interested in activities, however sometimes needed encouragement and was willing to try. The goal was the resident would attend 1-3 plus activities a week to improve overall quality of life.</p> <p>The 9/2024 activities log documented Resident #28 attended 5 activities during the entire month. Two activities were outdoor activities, two were music, movie, or television, and one was domestic (cooking, sewing, knitting).</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The daily activity sheets for the morning of 10/7/24 did not document Resident #28 attended manicures or crafts provided that day. The 10/8/2024 daily activities attendance sheets did not document Resident #28 attended BINGO, or games; two of the three activities for the day. Resident #28 participated in the group activity Reminiscence.</p> <p>Resident #28 was observed sitting facing the window in the main dining room:</p> <ul style="list-style-type: none"> <li>- on 10/7/2024 at 11:06 AM</li> <li>- on 10/8/2024 at 9:58 AM</li> <li>- on 10/8/2024 at 10:33 AM</li> </ul> <p>- on 10/8/2024 from 11:23 AM until 11:56 AM no staff was observed speaking to the resident. At 11:56 AM a certified nurse aide wheeled the resident to their room.</p> <p>During an observation on 10/8/2024 at 2:46 PM, Resident #28 was sitting across from the [NAME] nursing station facing the opposite wall. The day room with a television was only a few feet away.</p> <p>During an interview on 10/9/2024 at 10:33 AM, Certified Nurse Aide #7 stated not every resident was asked if they wanted to attend activities. They had never seen activities staff ask Resident #28 if they wanted to attend an activity or doing a 1:1 activity with Resident #28. They stated not being asked to attend an activity could make a resident feel isolated and impact their emotional well-being.</p> <p>During an interview on 10/9/2024 at 10:49 AM, Licensed Practical Nurse #8 stated residents with dementia needed to be encouraged to participate in activities. They stated Resident #28 did not refuse to attend activities and enjoyed 1:1 activities. They had never seen activities staff do a 1:1 visit with Resident #28. They stated sometimes activities left out residents because they were disruptive. They had never seen Resident #28 be disruptive.</p> <p>During an interview on 10/9/2024 at 11:06 AM, the Activities Director stated they planned a variety of activities every month and asked for resident input on what activities they wanted added. They stated activities were important especially for residents with dementia for socialization and so residents did not feel left out. If a resident was in their room and refused to attend an activity, they would do a 1:1 activity with the resident and expected every resident to participate in at least three activities a week. Every day they logged residents that attended activities and what activities they attended. They stated residents that were not able to communicate could come to BINGO and reminisce and just being with others was what residents enjoyed. They stated they did not ask every resident if they wanted to attend an activity. Resident #28 did not attend any activities on 10/7/2024 or 10/8/2024, and 10/9/2024 was marked as attending an activity when they were left at the window where they spent most of their day. They stated Resident #28 should have been brought to the reminisce activity to be with others since they spent so much time looking out the window.</p> <p>During an interview on 10/9/2024 at 1:27 PM, Licensed Practical Nurse Unit Manager #9 stated activities were important for stimulation, social interaction, to make new friends, feel better, and improve mood. They stated all residents should be asked to attend activities. They saw Resident #28 sitting at the window for extended periods of time.</p> <p>(continued on next page)</p>		

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F 0679  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	10 NYCRR 415.5(f)(1)

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>48675</p> <p>Based on observation, record review, and interviews during the recertification survey conducted 10/7/2024-10/10/2024, the facility did not ensure residents with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote wound healing, prevent infection, and prevent new ulcers from developing for 1 of 2 residents (Resident #30) reviewed. Specifically, Resident #30's pressure relieving heel boots were not in place while in bed as planned.</p> <p>Findings include:</p> <p>The facility policy, Pressure Relieving Devices, revised 3/30/2024, documented pressure relieving devices were used to reduce pressure on specific parts of the body to prevent tissue damage. Nursing, along with therapy, selected appropriate pressure relieving devices based on individual assessments and specific risk factors. All individuals identified at risk were provided with appropriate pressure devices as part of their care plan.</p> <p>Resident #30 had diagnoses including a Stage 3 (full thickness tissue loss) pressure ulcer of the sacral region (lower back and tailbone), diabetes, and morbid obesity. The 7/9/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition, did not reject care, required substantial/maximal assistance with bed mobility, was at risk for pressure ulcers, had one Stage 3 pressure ulcer that was not present upon admission, was on a turning and repositioning program, and had a pressure reducing device for their chair and bed.</p> <p>The Comprehensive Care Plan initiated 12/20/2022 and revised 10/3/2024 documented the resident had a Stage 3 pressure ulcer to their coccyx (tailbone). Interventions included administer wound treatments as ordered, assess/monitor wound healing weekly, skin team to monitor weekly and document, pressure relieving devices on bed/chair, and application of blue boots (pressure relieving heel boots) on bilateral feet while in bed.</p> <p>The 3/7/2024 physician order documented apply skin prep (skin protectant) to bilateral heels every shift for skin care.</p> <p>The 9/20/2024 at 3:24 PM Licensed Practical Nurse Manager #13 progress note documented pressure points were assessed. A skin impairment was noted, and the resident's heels were boggy (spongy texture).</p> <p>The undated care instructions (Kardex) documented blue boots on bilateral feet when in bed.</p> <p>Resident #30 was observed:</p> <p>- on 10/7/2024 at 10:11 AM and at 1:15 PM, lying in bed with their bare heels resting directly on the bed. They were not wearing blue boots. The blue boots were at the end of the bed pushed down between the footboard and the mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- on 10/8/2024 at 8:58 AM, lying in bed with no socks on. Their left heel was resting directly on the mattress and the right blue heel boot was in place. The left pressure relieving heel boot was at the end of the bed pushed down between the footboard and the mattress. The resident stated they just received personal care, they were unsure the last time their left pressure relieving heel boot was put in place, and they were supposed to always wear both boots. At 11:04 AM, lying in bed with no socks on. Their left heel was resting directly on the mattress and the right blue heel boot was in place. The left blue heel boot was at the end of the bed pushed down between the footboard and the mattress.</p> <p>- on 10/9/2024 at 9:00 AM, 9:45 AM, 10:40 AM, 12:04 PM, and 12:50 PM, lying in bed with no socks on. Both heels were resting directly on the mattress and the blue heel boots were at the end of the bed by the footboard.</p> <p>The 10/2024 Certified Nurse Aide Task Documentation included blue boots on bilateral feet when in bed and was documented as completed 10/7/2024-10/9/2024 on the day and night shifts. The 10/8/2024 and 10/9/2024 evening shift was blank.</p> <p>During an interview on 10/9/2024 at 1:35 PM, Certified Nurse Aide #16 stated they cared for Resident #30 during the day shift. Resident care information was found in the care instructions, and it included pressure relieving devices. The resident had pressure relieving heel boots that were to be worn while they were in bed. They thought they checked to ensure the heel boots were on when they provided care, but they could not recall everything they did because they had a lot of residents to care for. It was important for the resident to always wear the pressure relieving heel boots in bed to protect their heels from rubbing and to prevent skin breakdown.</p> <p>During an interview on 10/9/2024 at 1:50 PM, Licensed Practical Nurse #17 stated the skin on Resident #30's heels was intact, but they had an order to apply skin prep every shift. Pressure relieving devices would be in the resident's care plan and on their care instructions. Resident #30 was supposed to be repositioned every 2-4 hours and have pressure relieving heel boots on while in bed. They could not recall if the resident had their pressure relieving heel boots in place during their med pass. If the certified nurse aides documented the boots were in place during their shift they should have been checking every time they entered the resident's room or walked by their room. It was important for Resident #30 to have their pressure relieving heel boots in place to prevent skin breakdown and direct heel contact on the mattress.</p> <p>During an interview on 10/10/2024 at 9:15 AM, Certified Nurse Aide #15 stated they cared for Resident #30 on 10/7/2024 and 10/8/2024 during the day shift. Resident #30 had a pressure ulcer on their coccyx, had to be turned and repositioned every 2-4 hours, and should wear pressure relieving heel boots while in bed. They stated the resident usually had their heel boots in place when they arrived in the morning, and they could not recall if they put them on the resident on 10/7/20204 or 10/8/2024. It was important for the resident to wear the pressure relieving heel boots at all times to prevent pressure sores from developing.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/10/2024 at 9:20 AM, Licensed Practical Nurse Manager #13 stated Resident #30 used to have a deep tissue injury (purple or maroon discoloration to intact skin due to underlying tissue damage) on their heel. They had a gel overlay mattress and heel boots for pressure relief. The resident would slide the pressure relieving heel boots off at times. They stated the certified nurse aides had to turn and reposition the resident every 2-3 hours so they would expect them to check the resident and ensure the pressure relieving heel boots were in place. The certified nurse aides had to document the pressure relieving boots were in place every shift. If the documentation section was left blank, that meant they did not get the chance to check or they forgot to sign for it. They stated it was important for Resident #30 to wear the pressure relieving heel boots in bed to prevent their heels from rubbing on the mattress causing skin breakdown.</p> <p>During an interview on 9/10/2024 at 10:09 AM, Registered Nurse #14 stated Resident #30 was care planned to be turned and repositioned every 2-4 hours and have pressure relieving heel boots on while in bed. They expected the nurse or certified nurse aide to ensure the boots were in place every time they entered the resident's room. If the certified nurse aide documentation section was left blank, that meant they did not check to ensure they were in place or they forgot to sign for it. They stated it was important for Resident #30 to wear the pressure relieving heel boots in bed to reduce the pressure on their heels and prevent a pressure ulcer from developing.</p> <p>10NYCRR 415.12(c)(1)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48446</b></p> <p>Based on observation, record review, and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles and include the expiration date when applicable for 2 of 6 medication carts (East and Center medications carts), and for 2 of 2 treatment carts (East and [NAME] treatment carts) reviewed.</p> <p>Specifically,</p> <ul style="list-style-type: none"> <li>- The East and Center medication carts contained multiple packaged 3 milliliter syringes that expired on [DATE].</li> <li>- The Center medication cart contained one insulin pen that was opened and did not have an expiration date.</li> <li>- The East and [NAME] treatment carts were left unlocked and unattended.</li> </ul> <p>Findings include:</p> <p>The facility policy, Drug Procurement, Storage, and Inspection, revised ,d+[DATE] documented medications were stored in a secure manner and locked when not in use. All medications and chemicals used to prepare medications were accurately labeled with contents, expiration date, and appropriate warnings. Expired, damaged, and/or contaminated medications were removed from drug storage facilities.</p> <p>During an observation on [DATE] at 1:28 PM, the East treatment cart was in the hall outside the nursing station unlocked and unattended. There were 2 residents sitting in the day room and 4 other residents sitting across from the treatment cart. The treatment cart's contents included: triamcinolone cream (used to treat skin conditions); antibiotic ointment; vitamin A; sunscreen lotion; skin prep skin barrier; Volteran gel (pain relief); miconazole 2% antifungal cream; and Calmoseptine ointment (skin protectant). At 3:10 PM the treatment cart was unlocked and unattended.</p> <p>During an observation on [DATE] at 9:09 AM the unlocked East treatment cart was unlocked and unattended.</p> <p>During an observation on [DATE] at 9:16 AM, the East medication cart contained several 3 milliliter packaged syringes that expired on [DATE].</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Waterville Residential Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on [DATE] at 9:26 AM, the Center medication cart contained several 3 milliliter syringes that expired on [DATE]. There was an opened and unlabeled Lantus insulin pen for Resident #24. Licensed Practical Nurse #18 stated it was the facility's policy to label all insulin pens with an expiration date when they were opened because insulin was only good for a short number of days. They stated Resident #24 got insulin on the evening shift and since it was in the cart, they believed it had been used the night before since it was in the drawer. If a resident got insulin that was expired it may not be as effective. They stated medication carts and treatment carts should be always locked for safety, because there were residents that wandered.</p> <p>During observations on [DATE] at 1:12 PM and 2:42 PM, and on [DATE] at 7:32 AM, the [NAME] treatment cart was across from the nursing station unlocked and unattended. The treatment cart's content included: scissors; antibiotic ointment; body cream; A &amp; D ointment; anti-fungal powder; zinc oxide cream; dandruff shampoo; and ammonium lactate cream.</p> <p>During an interview on [DATE] at 9:10 AM, the Assistant Director of Nursing stated the facility had six medication carts and two treatment carts. They stated the treatment carts contained dressing supplies, creams, A &amp; D ointment, bacitracin, antifungals, and they were kept locked for the safety of the residents. They stated many of the residents wandered and if the contents of the treatment cart were ingested it could cause harm to the residents.</p> <p>During an interview on [DATE] at 10:55 AM, the Administrator stated the facility had many wandering residents and they expected treatment carts to be always locked when they were not in use. They stated the treatment carts contained dressing supplies, creams, and ointments and they were unaware they contained scissors. They stated it was a safety concern if the treatment carts were not locked.</p> <p>10NYCRR 415.18(d)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>33421</p> <p>48446</p> <p>Based on observation and interviews during the recertification survey conducted 10/7/2024-10/10/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 2 meal test tray reviewed (the 10/8/2024 lunch meal and the 10/9/2024 breakfast meal). Specifically, food was not served at palatable and appetizing temperatures during the lunch meal on 10/8/2024 and the breakfast meal on 10/9/2024. Additionally, Residents #11, #16, #22, #27, #29, #44, #48, #51, and #84 stated the food did not taste good and was cold.</p> <p>Findings include:</p> <p>The Daily Temperature Log for facility food documented recommended serving temperatures as follows:</p> <ul style="list-style-type: none"> <li>- Cold foods below 40 degrees Fahrenheit.</li> <li>- Soups 160-180 degrees Fahrenheit.</li> <li>- Meat/poultry/seafood/eggs 145-165 degrees Fahrenheit.</li> <li>- Sauces and Gravies 160-180 degrees Fahrenheit; and</li> <li>- Vegetables 160-180 degrees Fahrenheit.</li> </ul> <p>Resident interviews included:</p> <ul style="list-style-type: none"> <li>- on 10/7/2024 at 10:13 AM, Resident #16 was sitting on the edge of their bed with a meal tray on the bedside table in front of them. The resident stated the food was not good and usually cold.</li> <li>- on 10/7/2024 at 10:24 AM, Resident #46 stated the food had gotten worse, the food came to their room cold, lacked flavor, and the tray was commonly missing items.</li> <li>- on 10/7/2024 at 10:42 AM, Resident #48 stated the food was not good and the meat was usually undercooked.</li> <li>- on 10/7/2024 at 10:47 AM, Resident #22 stated the food had no flavor and the hot food was only lukewarm.</li> <li>- on 10/7/24 at 2:07 PM, Resident #11 stated the hot food was normally cold. Many times, items were missing on the tray and the food got colder as they waited for dietary to bring what was missing.</li> <li>- on 10/7/2024 at 3:05 PM, Resident #29 stated the food was not good and had no flavor.</li> <li>- on 10/8/2024 at 8:39 AM, Resident #51 stated there was not enough food on their tray and the food did not taste good.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- on 10/8/2024 at 12:20 PM, Resident #27 stated the food was not good.</p> <p>During an observation on 10/8/2024 at 12:52 PM, Resident #11's meal was delivered and was used as a test tray and a replacement was ordered. The meatloaf was measured at 124 degrees Fahrenheit, the scalloped potatoes were 124 degrees Fahrenheit, and the broccoli was 117 degrees Fahrenheit. There were no drinks on the tray.</p> <p>During an observation on 10/9/2024 at 8:25 AM, Resident #84's breakfast tray was used as a test tray and a replacement was ordered. The scrambled eggs were measured at 120 degrees Fahrenheit, the toast was 110 degrees Fahrenheit, the coffee was 133 degrees Fahrenheit, and the orange juice was 58 degrees Fahrenheit.</p> <p>During an interview on 10/10/2024 at 11:21 AM, the Food Service Director stated cold foods should be served at 45 degrees Fahrenheit or lower, and hot foods should be at 130 degrees Fahrenheit or higher. The meatloaf, the broccoli, the eggs, and the toast hot food temperatures were not palatable or within range. The orange juice was also not palatable or within range with a measured temperature of 58 degrees Fahrenheit. Orange juice was taken from the dispenser and placed into a cooler. The orange juice should be placed in the tray at the same time as the hot food and then served to the resident.</p> <p>During an interview on 10/8/2024 12:23 PM, Certified Nurse Aide #26 stated residents complained about the taste of the food, the food not having any flavor, it was not hot, the ice cream was mushy, and there were items missing from their trays.</p> <p>During an interview on 10/8/2024 at 12:54 PM, Licensed Practical Nurse #14 stated residents had complained in the past about the food being bland, not hot enough, and the ice cream being melted.</p> <p>During an interview on 10/9/2024 at 9:08 AM, Dietary Aide #27 stated eggs should be served at 170 degrees Fahrenheit, and juice served at 40 degrees Fahrenheit. Scrambled eggs at 120 degrees Fahrenheit was considered cold and should not be served. Toast at 110 degrees Fahrenheit should also not be served. Coffee at 133 degrees Fahrenheit was cold and orange juice at 58 degrees Fahrenheit was warm. If a resident ate food outside the required temperatures, there was a chance they could get sick. If they did not eat the food, they could lose weight over time. Kitchen staff did test tray audits, but they were unsure how often. They heard residents complaining in the past about the food being cold, ice cream being melted, and items missing from their trays.</p> <p>10NYCRR 415.14(d)(1)(2)</p> <p>48675</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27522</b></p> <p>48446</p> <p>Based on observation, record review, and interviews during the recertification survey conducted [DATE] - [DATE], the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards for food service safety in the main kitchen and in 1 of 3 nursing unit kitchenettes (West Unit) reviewed. Specifically, in the main kitchen the hot water boost pump was turned off on the dishwasher and was not heating properly; there were outdated, expired, moldy food items, and dented cans; and the sanitizer at the three bay sink registered as empty. The [NAME] Unit dining room refrigerator contained undated, outdated, and moldy food items.</p> <p>Findings include:</p> <p>The facility policy, Food Storage, revised [DATE], documented food was stored in a manner that maintained high quality, avoided spoilage, and prevented contamination.</p> <p>The dish machine temperature log documented temperatures were checked for breakfast, lunch, and dinner dishes and the high temperature wash ranged from ,d+[DATE] degrees Fahrenheit, and the rinse was 180 degrees Fahrenheit. The [DATE] log documented 7 breakfast temperatures that were over 150 degrees Fahrenheit, 10 lunch temperatures over 150 degrees Fahrenheit, and 23 dinner temperatures over 150 degrees Fahrenheit. The remainder of the [DATE] temperatures were either not recorded or under the required 150 degrees Fahrenheit. The [DATE] log documented 5 breakfast temperatures over 150 degrees Fahrenheit, 8 lunch temperatures over 150 degrees Fahrenheit, and 21 dinner temperatures over 150 degrees Fahrenheit. The remainder of the [DATE] temperatures were either not recorded or under the required 150 degrees Fahrenheit. The [DATE] log documented 5 breakfast temperatures that were over 150 degrees Fahrenheit, 4 lunch temperatures over 150 degrees Fahrenheit, and 18 dinner temperatures over 150 degrees Fahrenheit. The remainder of the [DATE] temperatures were either not recorded or under the required 150 degrees Fahrenheit.</p> <p>The Sanitation log documented the acceptable sanitation solution paper test was ,d+[DATE] parts per million and completed twice a day. The log for [DATE] was missing 8 tests in the morning and 17 tests in the evening. The documented tests were within acceptable range.</p> <p>Main Kitchen:</p> <p>During an observation on [DATE] at 10:00 AM the lunch and dinner drinks refrigerator contained 7 thickened apple juice concentrate (46 ounce) containers that had a use by date of [DATE] and 1 with a use by date of [DATE].</p> <p>The following observations were made on [DATE] at 10:05 AM with the Food Service Director present:</p> <ul style="list-style-type: none"> <li>- crab cake in a bag dated [DATE].</li> <li>- undated juice in an unmarked plastic container.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<ul style="list-style-type: none"> <li>- two containers of unmarked rice dishes and eggrolls in a bag were moldy.</li> <li>- a container of unopened hot dog rolls that expired [DATE].</li> <li>- an opened container of chicken salad with a preparation date of [DATE].</li> <li>- an opened container of broccoli salad with a preparation date of [DATE].</li> <li>- three moldy and slimy hot dogs in an undated bag.</li> </ul> <p>During an observation on [DATE] at 10:15 AM with the Food Service Director, the main kitchen dry storage rack had three 64 ounce cans of peanut butter that expired on [DATE].</p> <p>The following observations were made in the walk in cooler on [DATE] at 10:20 AM with the Food Service Director:</p> <ul style="list-style-type: none"> <li>- one bowl of pasta salad dated [DATE].</li> <li>- 8 stacks of American cheese wrapped in plastic and not dated.</li> <li>- 1 stack of Swiss cheese wrapped in plastic and not dated.</li> <li>- 1 stack of provolone cheese wrapped in plastic and not dated.</li> <li>- 1 buttermilk container (32 ounces) expired [DATE].</li> <li>- 1 mustard container (32 ounces) expired [DATE].</li> <li>- sour cream (5 pounds) opened on [DATE].</li> </ul> <p>During an observation on [DATE] at 10:37 AM with the Food Service Director, the bread table station contained undated packages of bagels, dinner rolls, and marble rye bread (,d+[DATE] of a loaf).</p> <p>During an observation on [DATE] at 1:30 PM, the hot water booster pump for the dish machine was turned off. The rinse temperature was 150 Fahrenheit. After it was turned on the rinse water was 180 degrees Fahrenheit at 1:40 PM.</p> <p>During an observation on [DATE] at 1:35 PM, the three bay sink sanitizer was tested with a strip and it read 0 parts per million showing there was no sanitizer available.</p> <p>During an observation on [DATE] at 1:45 PM, the monthly log for the dish machine water temperatures had wrong values documented.</p> <p>During an observation on [DATE] at 1:55 PM the lunch and dinner drinks refrigerator contained 7 thickened apple juice concentrate (46 ounce) containers that had a used by date of [DATE] and 1 with a use by dated of [DATE].</p> <p>Dry Storage Room:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The following observation were made on [DATE] at 10:48 AM in the dry storage room with the Food Service Director:</p> <ul style="list-style-type: none"> <li>- two (32 ounce) mustard containers expired [DATE]</li> <li>- two dented cans of 6 pound diced tomatoes.</li> <li>- 1 dented can of 6 pound marinara sauce.</li> <li>- 1 dented can of 6 pound sausage gravy.</li> <li>- 1 dented can of 4 pound tuna.</li> </ul> <p>West Dining Room:</p> <p>The following observations were made on [DATE] at 12:50 PM in the [NAME] Dining Room refrigerator:</p> <ul style="list-style-type: none"> <li>- Macaroni and cheese in a plastic container dated [DATE]</li> <li>- moldy shredded cheese in an unmarked and undated container</li> <li>- an opened cream cheese container was undated</li> </ul> <p>During an interview on [DATE] at 10:38 AM, the Food Service Director stated the [NAME] dining room refrigerator was supposed to be checked every day by the food service worker and documented on a log. They did not check to confirm this was being completed daily. There was no one assigned to check the lunch/dinner refrigerator to make sure there was no expired or moldy food. The food service worker was responsible for adding new juice containers into the refrigerator when needed. The moldy and outdated food, other than juice, had been in the refrigerator for about one month, was resident owned, and reported missing by residents and the Director of Nursing was never notified. They were responsible for checking the dry storage and did not which was why the expired peanut butter was missed. The undated cheese in the walk in cooler should have been dated when opened and was good for three days before being discarded. The bowl of pasta salad dated [DATE] should have been discarded immediately after that meal. The Food Service Director stated they were responsible for checking the walk in cooler for expired items and the expired buttermilk and expired mustard should have been discarded. The sour cream should have been discarded 3 days after opening. The day cook was responsible for ensuring bread was dated and they had not been checking behind them to verify this. The dented cans in dry storage room observed on [DATE] were not observed [DATE] as they had been discarded. They were not aware that the hot water booster for the dish machine had not been turned on at the start of day on [DATE] and should have been turned on by the morning kitchen staff prior to running the dish machine in order for water rinse temperature to be maintained at 180 degrees Fahrenheit. They stated temperatures were recorded every day and were not. The sanitizer test strips for the three bay sink were the wrong type of test strip and is why they registered as 0 parts per milliliter. They stated the sanitizer log was not completed properly. It was important that the main kitchen and ancillary refrigerators were maintained in a clean and functional manner so there was no cross contamination and for the safety of the residents.</p> <p>10NYCRR 415.14(h)</p>		