

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335711	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Slate Valley Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 10421 State Route 40 Granville, NY 12832	

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 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>Based on record review and interview conducted during the recertification and abbreviated (Case #NY00338414) survey, the facility did not ensure residents were provided the proper treatment and assistive devices to maintain vision for one (1) (Resident #86) of one (1) resident reviewed for vision. Specifically, for Resident #86, the facility did not ensure that the resident ' s glasses were replaced and follow up appointments for optometry were obtained.</p> <p>This is evidenced by:</p> <p>Resident #86</p> <p>Resident #86 was admitted to the facility with diagnoses of polyneuropathy (multiple peripheral nerves are damaged or diseased, leading to symptoms like weakness, numbness, and burning pain), type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar and using it for energy), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The Minimum Data Set (an assessment tool) dated 3/30/2024 documented the resident usually understood others, sometimes was understood by others, and was severely cognitively impaired. The Minimum Data Set documented the resident had moderately impaired vision and used corrective lenses.</p> <p>A Consult Form dated 5/18/2023 documented the resident had been seen by the optometrist with the next follow-up scheduled for 11/2023. A handwritten note at the bottom of the consult dated 12/5/2023 documented the resident would be seen because their glasses were broken.</p> <p>There was no documented evidence of any other consult forms for optometry services.</p> <p>Record review of an email provided by the facility from the optometry service dated 4/18/2025 documented the resident was not seen by the optometrist following the 5/18/2023 visit.</p> <p>During an interview on 4/18/2025 at 11:15 AM, Director of Nursing #1 did not recall this issue with the resident and stated the resident should have had a follow up appointment and should have received new glasses.</p> <p>10 New York Codes, Rules, and Regulations 415.12(2)(b)</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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