STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335585	A. BUILDING _____ B. WING _____	09/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey, the facility did not ensure the development and implementation of comprehensive person-centered care plans for 1 of 2 residents (Resident #48) reviewed. Specifically, Resident #48 did not have skin breakdown prevention boots in place as planned. Findings include: Resident #48 had [DIAGNOSES REDACTED]. The 7/15/20 Minimum Data Set (MDS) assessment documented the resident was severely cognitively impaired, totally dependent for all activities of daily living (ADLs), had one Stage 3 and one Unstageable (obscured full-thickness skin and tissue loss) pressure ulcer and had a pressure relieving device for bed and chair. The comprehensive care plan (CCP) initiated 1/8/20 documented the resident had a Stage 3 left foot bunion and was to wear Z-Flex fluidized heel boots to bilateral feet when in bed. The 1/13/20 physician order [REDACTED]. An 8/10/20 nursing progress note documented staff were unable to locate heel boots. An 8/27/20 nursing progress note documented the resident only had the left boot and staff were unable to locate the second boot. Nursing would follow up with physical therapy when they arrived on that date to obtain another boot. A 9/9/20 nursing progress note documented staff were unable to locate boots and the resident's feet were elevated off of the bed. The 9/2020 Kardex (care instructions) documented the resident was to wear Z-Flex fluid heel boots to bilateral feet when in bed. The 9/2020 treatment administration record (TAR) documented the resident was to wear Z-Flex fluidized heel boots to bilateral feet and lower legs to relieve pressure to the heels while in bed every evening and nightshift for pressure relief. Staff signed the treatment as completed. The resident was observed in bed on 9/9/20 at 1:51 PM and on 9/10/20 at 1:51 PM with no heel boots or supportive devices to the heels. The resident's feet were resting directly on the mattress. During an interview with CNA #6 on 9/10/20 at 2:08 PM, he stated the resident had boots for their feet when in bed. The boots would go on at nighttime. The boots were wet that morning, so they were currently in the laundry. During an interview with licensed practical nurse (LPN) Unit Manager #5 on 9/11/20 at 8:42 AM, she stated the resident was to have Z-Flex boots on anytime while in bed. If the boots were not located, staff were supposed to contact laundry or therapy right away. If interventions were not in place the resident could have skin breakdown. During an interview with physical therapy assistant (PTA) #7 on 9/11/20 at 9:28 AM, he stated the therapy department would supply the Z-Flex boots to the resident. He stated staff did call that morning and the therapy department supplied the boots to the unit. Typically, when the boots were washed, they were brought back to therapy and therapy would send them back to the resident. The boots should be brought back to the resident by the next day. This resident was to wear them whenever they were in bed. This boot would cushion the resident's lower extremity up to the high ankle. If the resident did not wear them, it could cause pressure and the resident had a history of [REDACTED]. 10NYCRR 415.22(c)(1)
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey the facility did not ensure that residents with limited range of motion (ROM) received appropriate treatment and services to prevent further decrease in ROM for 2 of 2 residents (Residents #31 and 48) reviewed. Specifically, Residents #31 and 48 did not have hand contracture devices in place as care planned. Findings include: The 11/2014 Contracture policy documented residents would be given care to prevent formation and progression of contractures and deformities. 1) Resident #48 had [DIAGNOSES REDACTED]. The 7/15/20 Minimum Data Set (MDS) assessment documented the resident was severely cognitively impaired, totally dependent on staff for all activities of daily living (ADLs) and had functional limitation of both arms. The 7/27/20 comprehensive care plan (CCP) documented the resident was to wear a Posey hand orthotic (palm device used for hand contractures) to the left upper extremity. An 8/12/20 nursing progress note documented the resident was using a washcloth in their hand and physical therapy was asked about obtaining a new orthotic for the resident. The 9/2020 Kardex (care instructions) documented the resident had a Posey hand orthotic that was to be applied to the resident's left upper extremity under their shirt/cameo every day shift. The 9/2020 treatment administration record (TAR) documented a licensed nurse was to check for a hand Posey orthotic every shift on the resident's left hand and was signed as completed for 9/8, 9/9 and 9/10/20. The resident was observed in her geriatric chair and/or bed without a hand orthotic device in place to the contracted left hand on 9/8/20 at 3:32 PM; on 9/9/20 at 1:51 PM; and on 9/10/20 at 12:58 PM and 1:51 PM. During an interview with certified nurse aide (CNA) #6 on 9/10/20 at 2:08 PM, he stated the staff put rolled up wash clothes in the resident's hands in the morning after care. He took the washcloths out when he did ADL care and the nurse would replace them. He had not seen the Posey orthotic in a long time. He did not know if the plan changed for the resident as the nurses signed off on that device. The device was used so the resident's hands did not dig into their palms and the contractures did not get worse. During an interview with licensed practical nurse (LPN) Unit Manager #5 on 9/11/20 at 8:42 AM, she stated therapy was responsible for issuing the palm protectors. She had called therapy and they said a washcloth would be fine until they got new devices in. Therapy was responsible for updating the care plan and then notifying nursing with any changes. The resident was to have a palm guard on the left hand. She stated if a device was not in place her contracture could get worse. During an interview with physical therapy assistant (PTA) #7 on 9/11/20 at 9:28 AM he stated the care plan documented a Posey hand orthotic was to be used to the left hand. Wash cloths would be an acceptable alternative for one day as a washcloth was not designed for a hand, where a Posey was. The resident should have had a Posey in place to the left hand. He did not have any ordered and did not recall being notified the resident needed a replacement. 2) Resident #31 had [DIAGNOSES REDACTED]. The 7/1/20 Minimum Data Set (MDS) assessment documented the resident was severely cognitively impaired, had impairment to both sides of her upper body and was totally dependent on staff for activities of daily living (ADLs). The 6/25/20 comprehensive care plan (CCP) documented bilateral hand Poseys (palm device used for hand contractures) were to be worn at all times except when completing hygiene/bathing tasks. The 7/24/20 occupational therapy (OT) discharge summary documented staff were educated on proper use of the orthotic device. The resident had bilateral contractures to the hands and a hand Posey was to be applied daily. The 9/2020 Kardex (care instructions) documented staff were to apply bilateral hand Posey and it was to be worn at all times except when completing hygiene/bathing tasks. The resident was observed seated in a geriatric chair with both hands and fingers tightly closed without contracture devices in place on 9/8/20 at 10:58 AM and 3:29 PM; on 9/9/20 at 9:55 AM; and on 9/10/20 at 10:29 AM. During an interview with certified nurse aide (CNA) #3 on 9/10/20 at 1:34 PM, she stated the resident was to have hand rolls (hand Poseys) in each hand at all times. They would be taken off for showers only. She could not remember if she had put them on the resident in the last couple of days. She stated the hand

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

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.

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) rolls were not hard to put on the resident and they had a strap that went over the back of the hand. The surveyor and CNA observed the resident who was seated in the main dining and the CNA stated the resident did not have their hand rolls in place and they should have. She walked to the resident's room and the hand rolls were on the nightstand. During an interview with occupational therapist #4 on 9/10/20 at 1:41 PM, she stated the resident had been in program for contracture of their hands. Therapy had tried several devices and they found the palm guards worked best. The resident had been having some hygiene concerns with the contracted hands and it was important for the resident to have the palm guards in place at all times. She stated it was the therapist's responsibility to update the CCP with contracture interventions. 10NYCRR 415.12(e)(2)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview during the recertification survey the facility did not ensure drugs and biologicals were labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 2 of 2 medication rooms (East and West) and 2 of 3 medication carts (East and West) observed. Specifically, multiple expired medications were found in 2 medication rooms and 2 medication carts. Findings include: The 2/2020 facility Medication Policy documented multi-dose vials which have not been opened or accessed should be discarded according to the manufacturer expiration date. Multi-dose vials that have been opened or accessed should be dated and discarded within 28 days unless manufacturer specifies a different date for that opened vial. During an observation on 9/10/20 at 10:39 AM, the West Unit medication storage room contained liquid [MEDICATION NAME] (pain medication) with an expiration date of 4/2020. Licensed practical nurse (LPN) #12 stated the [MEDICATION NAME] was expired, and all expired medications were counted until the Director of Nursing (DON) picked them up. During an observation on 9/10/20 at 10:39 AM, 1 West Unit medication cart contained: - An open [MEDICATION NAME] propriate nasal spray (steroid) that did not have an opened date; - an open azelstine spray solution ([MEDICATION NAME]) that did not have an opened date; - An opened and undated bottle of [MEDICATION NAME] (laxative) with an expiration date of 5/20/20; and - an opened and undated bottle of antacid with manufacturer expiration of 4/2020. On 9/10/20 at 10:39 AM, LPN #12 stated typically drugs were to be disposed of within 30 days and should not be in the cart. On 9/10/20 at 11:06 AM, the East Unit medication storage room contained an opened bottle of milk of magnesia (laxative) that did not have an opened date. On 9/10/20 at 11:06 AM, 1 East Unit medication contained an opened nasal spray with no opened date and an expiration date of 4/20/20. 10NYCRR 415.18(d)(e)(1-4)
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.** Based on observation, record review, and interview during the recertification survey, the facility did not ensure food and drinks were palatable, attractive, and at a safe and appetizing temperature for 3 of 3 meals (breakfast, lunch, and dinner) reviewed. Specifically, food and drinks were not served at palatable temperatures for 3 meals (chipped beef, ham and cheese sandwich, pancakes, milk). Findings include: The 9/4/18 facility Food Temperature Checks Policy documented hot and food temperatures will be monitored. Temperatures would be recorded at each meal served to the residents within the proper temperature range (<41 F to >140 F). The Resident Council Meeting Minutes documented: - On 6/4/20, passing of resident trays was taking 20-30 minutes. - On 7/9/20, food would sit at the nursing station for some time and by the time resident received their trays the food was cold. - On 8/6/20, cold food continued to be an issue, temperatures were worse in the morning. - On 9/3/20, cold food remained an issue. The Food Council Minutes/Resident Receipt Planning documented on 7/15/20, meals were served late; and breakfast and supper were cold. On 8/12/20, food was going to the resident unit halls late and was usually cold. During a resident council meeting on 9/8/20 at 2:15 PM, 3 anonymous residents stated that hot items were served cold and cold items were served warm. During an interview on 9/9/20 at 9:47 AM, Resident #285 stated the hot food items were served cold. On 9/9/20 at 12:20 PM, the meal tray for Resident #285 was delivered at 12:20 PM, fifteen minutes after the food cart where the tray had been sitting, came onto the floor. Temperatures and a taste test were conducted on the tray and the resident received a replacement. At 12:23 PM the chipped beef had a temperature of 118 degrees Fahrenheit (F) and was lukewarm. The milk had a temperature of 51 degrees F. On 9/9/20 at 6:03 PM, a meal tray was delivered to Resident #72. Temperatures and a taste test were conducted on the tray and the resident received a replacement. Between 6:03 PM and 6:10 PM, the ham within the ham and cheese sandwich had a temperature of 81 degrees F. The cheese within the ham and cheese sandwich was temped at 78 degrees F, was sweating and discolored and was not palatable. On 9/10/20 at 9:00 AM a meal tray was delivered to Resident #70 who was set up to eat in the hallway. Temperatures and a taste test were conducted on the tray and the resident received a replacement. Between 9:02 AM and 9:04 AM, the two pancakes were had a temperature of 95 degrees F and the milk was 61 degrees F. The pancakes were lukewarm, not flavorful and hard in spots. The milk was lukewarm and not palatable. On 9/10/20 at 9:09 AM, food temperatures were measured with Temporary Co-Food Service Supervisor #9 present. The milk was 63 degrees F using both the state thermometer and the facility stick-type thermometer. A pancake was 87 degrees F using the state thermometer and 89 F using the facility thermometer. During an interview on 9/10/20 at 9:25 AM, Temporary Co-Food Service Supervisor #9, stated when the facility had a permanent Food Service Director, test trays were done more frequently by staff. Currently test trays were being completed approximately 1 to 3 times a month and were documented in test tray logs. She stated milk should be served to residents at 40 degrees F or less, and milk being served at 51 or 61 degrees F was not acceptable. Pancakes were hard to maintain a higher temperature range because the facility had not wanted to over cook them. Chipped beef should be served 140-160 degrees F, and 118 F was not acceptable. The ham and cheese sandwich was a cold meal and she was not sure why it was served on a hot plate. The 78 degree F cheese and the 81 degree F ham was not acceptable and should have been served between 40-60 degrees F. During an interview on 9/10/20 at 3:05 PM, Temporary Co-Food Service Supervisor #9, stated that the temperatures of the food for the 9/9/20 dinner meal prior to serving were not documented on the temperature log sheet in the kitchen. During an interview on 9/10/20, between 4:45 PM and 5:00 PM, food service worker #10 stated that he did not record the temperature of the food on the steam tables prior to serving the 9/9/2020 dinner meal. 10NYCRR 415.14(d)(1)(2)