STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335103	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Rehabilitation and Nursing Care Center	510 Fifth Avenue Owego, NY 13827

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 48895 Based on observations and interviews during the recertification survey conducted 11/12/2024-11/15/2024, the facility did not ensure the results of the most recent Federal and State survey was posted in a place readily accessible where individuals wishing to examine the survey results did not have to ask for them. Specifically, the most recent survey results and plan of correction were located above the front desk and were not readily accessible. Additionally, the facility did not post notice of the availability of survey results in areas of the facility that were prominent and accessible to the public. Findings Include: The undated Resident Orientation Handbook documented the yearly survey results were in the front lobby. During the Resident Council Meeting on 11/12/2024 at 1:46 PM, 11 anonymous residents stated they did not know the location of the previous survey results. They stated they did not know they had the right to read the survey results or that the facility had to provide them to the residents. The following observations were made: - on 11/12/2024 at 12:41 PM, a binder labelled Annual Survey, was on a wall cabinet over 6 feet above the ground in a hallway between the front lobby and the Administrator's office. There was no signage observed in the front lobby with the location of the survey results. - on 11/12/2024 at 5:30 PM, the survey results were not visible in the front lobby area. The binder in the hallway between the front lobby and the Administrator's office was no longer on the cabinet. - on 11/13/2024 at 10:15 AM and 4:00 PM, the survey results or signage regarding the location of the survey results were not visible in front lobby. (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

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	- on 11/14/2024 at 8:00 AM and 8:47 AM, the blank binder labeled Annual Survey, was located at the front desk in a mailbox style cubby above the front panel of the desk, and behind a bedside table used for signing in. The cubby was approximately 5 feet off the ground and the table was approximately 18 inches in depth from the front panel of the desk. The binding of the binder faced the window, and not the direction of the sign in table. The binder was readily accessible to all. During an interview on 11/14/2024 at 8:36 AM, Certified Nurse Aide #4 stated they did not know where to find the survey results. They thought there was a sign at the elevator, but there was no visible signage when they approached the elevator. They stated maybe the signage was only on the second floor at the elevator. During an interview on 11/14/2024 at 8:46 AM, Receptionist #3 stated they did not know if the black binder labelled, Annual Survey, was the survey results. They stated they did not know who was responsible for updating the binder, or who used it. During an interview on 11/15/2024 at 8:47 AM, Certified Nurse Aide #5 stated the survey results were discussed with the residents at Resident Council. There was a box on the second floor they might keep the results in. During an observation on 11/15/2024 at 8:56 AM, there were no survey results or signs for the location of the survey results on the second floor. During an observation and interview on 11/15/2024 at 9:35 AM, the Administrator stated they were responsible for the survey results. There used to be signs in frames about the survey results, but they did not know where they went. The Administrator walked to the front desk at 10:22 AM, to show the location of the results. They reached over the table and the desk front to obtain the binder labelled, Annual Survey. When asked if all residents could obtain that binder without asking, they stated the results were chained to the front of the desk, but when they remodeled, they did not put it back. 10NYCRR 415.3(1)(c)(1)(v)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. 48895 Based on observation, interview, and record review during the recertification survey conducted 11/12/2024-11/15/2024, the facility did not ensure a resident's right to personal privacy of accommodations, medical care, and personal care for 50 of 77 residents reviewed. Specifically, all resident rooms were equipped with individual monitoring devices which currently transmitted personal health information to a third-party company and the facility did not obtain resident or resident representative consent for monitoring. Findings include: The undated facility document Privacy Practices documented the facility was required to maintain the privacy of the resident's health information and the residents had the right to not have their health information used or disclosed in certain ways. The undated [Third Party] instructions for passive vital devices documented the monitoring system was meant to provide physiologic data that qualified clinicians reviewed for health data trending purposes. The devices were strictly an adjunct tool for facility staff to monitor for trends in heart rate and respirations to allow staff to intervene and provide early interventions in resident care, potentially avoiding hospital readmission and reducing any associated health care costs. The measurements were remote and in real-time. The system worked by measuring only ballistocardiograph micro-movements (noninvasive method based on measurement of the body motion generated by the ejection of blood at each cardiac cycle). The monitoring field was a 6 foot span directly over the bed. The device collected 3,600 resident-specific physiologic data points per hour and were reviewed by clinicians daily for trends in heart rate and respirations. The undated document [Third Party] Health Informed Consent documented the facility had contracted with [Third Party] and provided Communication Technology-Based Services such as Remote Physiologic Monitoring (where patient health data is collected, transmitted, and communicated by electronic devices) to residents. By signing, the resident was consenting to those monthly services. During an observation and interview on 11/12/2024 at 1:27 PM Resident #73 was in their room lying in bed. There was a monitoring device above their bed. They stated they did not know there was a device there or what it was used for. Resident #73's 9/3/2024 Minimum Data Set assessment documented the resident had moderately impaired cognition. During an interview on 11/13/2024 at 12:08 PM, Resident #41 stated one day, about 6 months ago, someone came in and put the device up. They believed it was an outside company that did so, and the devices were in every room. No one explained what they were, and no one asked for their consent for the devices to be placed. They thought it was a camera and had asked an aide if it was used to spy on them. The aide told them they did not think that was what it was for. The resident did not think it had ever been plugged in or adjusted. Resident #41's 9/13/2024 Minimum Data Set assessment documented the resident had intact cognition. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/13/2024 at 2:27 PM, Certified Nurse Aide #24 stated an outside company had installed the monitoring devices a long time ago, about a year ago. They were installed in every room in a week's time. They were told the devices were installed because of the Department of Health. They were not sure what the devices were for but thought the nurses said they periodically took vital signs. During an interview on 11/14/2024 at 8:52 AM, Licensed Practical Nurse Unit Manager #13 stated the devices were from an outside company. The device took vital signs, and the Administrator received an email if they were abnormal. The devices were only turned on if there was consent from the resident. During an interview on 11/14/2024 at 4:57 PM, the Administrator stated they did not know what the abnormal findings report from the outside company was or what was included in the report. During an interview on 11/14/2024 at 4:57 PM, the Corporate Director of Facilities stated sometimes they got a report from the outside company stating a machine was unplugged or some other issue but was unsure why they received it. During a follow up interview on 11/14/2024 at 5:30 PM, the Administrator stated the monitoring devices were not yet turned on. The third-party company came in and did an assessment and had consents signed on 10/10/2024. They did not think any residents were being monitored yet. The monitoring device was approved by Medicare/ Medicaid. They did not know if there was any cost passed on to the resident and/or family. They believed the monitoring device recorded resident temperatures, but they did not have all the details. They were not sure how the facility would be notified of abnormal results or how often the third-party company monitored the information. During a follow up interview on 11/15/2024 at 9:35 AM, The Administrator stated the monitoring devices were installed February 2024. Insurance was billed for the service, and they had charity accounts for private pay residents. Residents were not currently being monitored and the devices were not functioning. A Third Party computer screenshot titled Nurse's Station dated 11/15/2024 at 3:19 PM provided by the Administrator documented there were 77 total devices, 50 residents were connected and assigned, 27 were disconnected and assigned, and there was a 65% current utilization rate. The screen included resident names, room numbers, with heart rate and respiration data. During an interview on 11/15/2024 at 4:42 PM, the Regional Administrator stated the devices had been plugged in for 9 months but were not working because they did not have the program and it did not link with their system. They had a meeting with the outside company two months ago, looking for a way to get the consents done and families notified. The person in charge of that at the outside company left, as did the next person in line, and they had not heard from them since. Prior to survey exit on 11/15/2024 at 5:30 PM, the facility was not able to provide any documented consents or declinations for the monitoring devices that were in every resident room above the resident's beds. 10 NYCRR 415.3(d)(1)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 48895 Based on record review, observations, and interviews during the recertification and abbreviated (NY00354914) surveys conducted 11/12/2024-11/15/2024, the facility did not ensure planned menus were followed for 3 of 3 residents (Residents #2, #32, and #528) reviewed. Specifically, Residents #2, #32, #528 did not receive preferred food items as planned per their individualized meal tickets. Findings include: The facility policy, The Dining Experience: Staff Responsibilities, dated 3/2020, documented the Food Service Manager would observe meals for preferences, portion sizes, temperature, flavor, variety, and accuracy. The Food Service Manager would report any concerns to the Administrator, Nursing Director, registered dietitian or designee, or other staff as appropriate. The facility policy, Timely Meal Service, dated 3/2020, documented meals were distributed promptly with supervision as needed by nursing staff. Staff should check each individual name and room number to verify correct information, and check items on the plate or tray against the meal ticket to assure accuracy. During an interview on 11/12/2024 at 11:39 AM, Resident #581 stated they did not get coffee in the facility, they had a friend that lived nearby bring them coffee. They stated they saw that coffee was on their meal ticket, but they never got it. During the Resident Council Meeting on 11/12/2024 at 1:46 PM, 11 anonymous residents stated they did not always get the meals they selected. Their meal trays were often missing food items, and they did not get an alternative meal when they requested a replacement. During a lunch meal observation on 11/13/2024 at 12:38 PM, Resident #32's lunch tray was used for a test tray. The original tray ticket documented the resident was to receive Shepherd's pie, bread, and butter, tossed salad with 2 ranch dressings, fresh fruit, yogurt, regular cottage cheese, regular Lactaid milk, and coffee. Additionally, Resident #32 was noted to get double portion of vegetables. Resident #32 received a grilled cheese sandwich, tossed salad with 1 ranch dressing, pureed cottage cheese, banana, yogurt, and Lactaid milk. Resident #32 did not receive Shephard's pie, bread and butter, or coffee on their tray. During a lunch meal observation in the kitchen on 11/13/2024 at 12:40 PM, the kitchen ran out of the main entree of Shepard's pie, and gave the remaining meal trays the alternative of a tuna melt sandwich. During a lunch meal observation on 11/13/2024 at 12:52 PM, Resident #528's lunch tray was used for a test tray. The original tray ticket documented the resident was to receive Shepherd's pie, bread and butter, regular ice cream, milk, ice water, and coffee. Resident #528 did not receive Shephard's pie or coffee and received a tuna and cheese sandwich. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a lunch meal observation on 11/14/2024 on 1:08 PM, Resident #2's lunch tray was used for a test tray. The original tray ticket documented the resident was to receive meatloaf, beets, mashed potatoes, gravy, crushed pineapple, regular diet cola, milk, ice water, and coffee. Resident #2 did not receive crushed pineapple or coffee on their tray. During an interview on 11/13/2024 at 2:27 PM, [NAME] #15 stated the Administrator was overseeing the kitchen and kitchen tasks since the Director of Dietary left. The meals were prepared with the use of production sheets. The production sheets outlined the amount of food that was to be made for each meal. [NAME] #15 was not sure where the production sheets came from, but stated the residents picked their menus and then the production sheet were made for the cooks to prepare the meal based on the numbers listed. During an interview on 11/14/2024 at 2:36 PM, [NAME] #8 stated the tray line staff was responsible for checking tray accuracy during meal service. The residents were given selective tickets and they circled or noted what they wanted. The tickets came back to the kitchen and were put into the computer. The primary ticket was already printed and put on the trays. The primary ticket was used to get the drinks and the sides by the tray line, and the cook got the selection ticket filled out by the resident to make the plate. The tickets together made up the resident meal. They may not match, but the resident would get what was selected. Coffee was available on the unit and not sent by the kitchen. The production sheets were made after the selection tickets were put into the computer. They rarely ran out of food, as they usually made extras. Dietary Aide #16 printed out meal tickets, printed production sheets, and ordered food. Resident #32 should not have received pureed cottage cheese. During an observation and interview on 11/15/2024 at 8:46 AM, Certified Nurse Aide #14 stated hot beverages did not come from the kitchen. There was a coffee list on the unit, and the residents could get coffee before or during meals. Two full untouched pots of coffee were observed on the unit. Certified Nurse Aides #14 stated they had to ask everyone if they wanted coffee, because residents would get upset if someone else got coffee and they did not. During an interview on 11/15/2024 at 8:58 AM, Licensed Practical Nurse Unit Manager #13 stated they served the coffee to the residents before the meals. If the resident was not on the coffee list, they would have to ask for it. The coffee was located on the unit in the kitchenettes, it did not come up from the kitchen. During an interview on 11/15/2024 at 9:17 AM, Dietary Aide #16 stated the selection menu went to the unit and was selected by the resident. The primary ticket was printed and used for the tray line. The selection ticket was received back to the kitchen and put in the computer to create the production sheets. The primary sheets were printed beforehand and did not match selection sheets and both together made up the tray. If they did not have time to put the selective sheets into the computer, the productions sheets were made from the primary tickets. They stated they had run out of entrees before, but they served the alternative. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 11/15/2024 at 9:35 AM, the Administrator stated they had been without a Director of Dietary for about 3 weeks, and they were overseeing the kitchen. Dietary Aide #16 was helping with the paperwork. The tray line sets up the tickets and checks for accuracy. There were 2 tickets, and they might not match the tray, because the residents select their choices. The selection ticket was put into the computer. The Administrator called Dietary Aide #16 into the meeting. Dietary Aide #16 explained if they had time to put the information into the computer then both tickets would match, but they did not have the time. The way it should work was that the selection tickets went to the resident and were returned to the kitchen, reviewed, and put into the computer. After being put in the computer a meal ticket would be printed that would show what the resident wanted and should receive. In that case, the primary ticket and the selection ticket should match each other. They stated they were not aware that selective meal tickets were not put into the computer. During an interview on 11/15/2024 at 10:51 AM, the Registered Dietitian #17 they had not seen the kitchen run out of an entree, but if the production sheets were printed from the primary tickets, it could skew the amount of food the cook needed to make, and they could run out. The meal ticket and tray should match. 10NYCRR 415.14(c)(1-3)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 48895 Based on observations and interviews during the recertification and abbreviated (NY00354914) surveys conducted 11/12/2024-11/15/2024, the facility did not ensure each resident received food and drink that was palatable, flavorful, and at an appetizing temperature for 2 of 3 meal test trays (the 11/13/2024 and 11/14/2024 lunch meals) reviewed; for 11 of 11 anonymous residents present at the Resident Council meeting; and for one additional resident (Resident #2) interviewed during initial screening. Specifically, the 11/13/2024 and 11/14/2024 lunch meals were not served at palatable and appetizing temperatures and were burnt and not flavorful; 11 residents at the Resident Council meeting stated the food was cold and did not look appetizing; and Resident #2 stated the food was bland and cold. Findings include: The facility policy, The Dining Experience: Staff Responsibilities, dated 3/2020, documented the goals of the dining experience were to enhance the individual's quality of life through person centered dining: providing person centered care and attention; nourishing, palatable, and attractive meals that meet the individual's daily nutritional and special dietary needs. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees Fahrenheit. All cold food items must be maintained and served at a temperature of 41 degrees Fahrenheit or below. Foods sent to the units for distribution (such as meals, snacks, nourishments, and oral supplements) would be transported and delivered to maintain temperatures at or below 41 degrees Fahrenheit for cold foods and at or above 135 degrees Fahrenheit for hot foods. During the Resident Council Meeting on 11/12/2024 at 1:46 PM, 11 anonymous residents stated the food was cold when it should be hot and did not look appetizing. Additionally, grilled cheese sandwiches were too hard to eat, and ice cream was served melted. During an interview on 11/14/2024 at 1:54 PM, Resident #2 stated the food was bland and cold when served. During a lunch meal observation on 11/13/2024 at 12:38 PM, Resident #32 was served their meal tray. Their lunch tray was tested , and a replacement tray was provided. In the presence of Certified Nurse Aide #7, the grilled cheese sandwich was measured at 110.8 degrees Fahrenheit, the salad as 52 degrees Fahrenheit, the cottage cheese was 56.8 degrees Fahrenheit, the milk was 48.4 degrees Fahrenheit, the banana was 85. 6 degrees Fahrenheit, and the ranch dressing was 56.8 degrees Fahrenheit. Resident #32's grilled cheese was burnt on one side, with hard edges. The banana was warm to the touch, and the ranch dressing tasted warm in comparison to the salad. Certified Nurse Aide #7 stated that residents complained about food being cold. During a lunch meal observation on 11/13/2024 at 12:52 PM, Resident #528 was served their meal tray. Their lunch tray was tested , and a replacement tray was provided. In the presence of Certified Nurse Aide #6, the milk was measured at 46 degrees Fahrenheit. The roll for the sandwich was dried out and hard. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During lunch meal observation on 11/14/2024 at 1:08 PM, Resident #2 was served their meal tray. They had lunch with family and declined a replacement tray. In the presence of Certified Nurse Aide #5, the mashed potatoes with gravy were measured at 129.6 degrees Fahrenheit, the beets were 128.1 degrees Fahrenheit, the meatloaf was 133.7 degrees Fahrenheit, the milk was 59.5 degrees Fahrenheit, and the soda was 68 degrees Fahrenheit. The meatloaf was not formed and was a heap of gelatinous material, with hard burnt crust on the bottom. The beets were brown. During an interview on 11/14/2024 at 2:36 PM, [NAME] #8 stated the Administrator did test trays in the facility. They were not sure if they were documented anywhere, as they did not have a form or log for them. Hot food served to the resident should never drop below 140 degrees Fahrenheit. Cold food should be between 36 and 40 degrees Fahrenheit. Milk measuring 46, 48.4. and 59.5 degrees Fahrenheit was not acceptable and should be 36 degrees Fahrenheit. A grilled cheese at 110.8 degrees Fahrenheit might be acceptable, depending on how it looked. 52 degrees Fahrenheit was too warm for a salad. 56.8 degrees Fahrenheit for cottage cheese and 51.6 degrees Fahrenheit for yogurt was too warm, anything over 40 was too warm and not acceptable. 85.6 degrees Fahrenheit was too high for bananas, they should be room temperature. All the food should be palatable and enjoyable to eat. It was important for the residents to have enjoyable and palatable food. During an interview on 11/15/2024 at 1:49 PM, the Administrator stated they did test trays and expected hot food to be served at 130 degrees Fahrenheit or above, and cold food should be cold. The food should be palatable and enjoyable, but it was difficult to please everyone. They had received complaints about food and did their best. 10NYCRR 415.14(d)(1)(2) 49448 50561

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 48895 Based on observations, record review, and interviews during the recertification survey conducted 11/12/2024-11/15/2024, 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. Specifically, in the main kitchen there were unclean areas, potentially hazardous foods were not cooled properly, food storage of cold foods was not maintained, and there was lack of proper hand hygiene during meal service. Findings include: The facility policy, The Dining Experience: Staff Responsibilities, dated 3/2020, documented the staff maintained the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule. Cleaning and sanitation tasks for the kitchen were recorded. The facility policy, Food Preparation and Service, dated 3/2020, documented potentially hazardous foods should be cooled rapidly. This was defined as cooling from 135 degrees Fahrenheit to 70 degrees Fahrenheit within two hours and then to a temperature of below 41 degrees Fahrenheit within the next 4 hours. The total cooling time between 135 degrees Fahrenheit and below 41 degrees Fahrenheit was not to exceed 6 hours. Large or dense foods might need special interventions to meet the time and temperature requirements for cooling. The facility policy, Food Receiving and Storage, dated 6/2022, documented refrigerated foods must be stored below 41 degrees Fahrenheit unless otherwise specified by law. Refrigerators must have working thermometers and were monitored for temperature according to state-specific guidelines. The undated facility documents AM Cleaning Duties and PM Cleaning Duties, documented duties included cleaing and wiping down the oven, wiping down the back counter, take out the kitchen garbage, rinse and clean the three-compartment sink, and wipe down the hand sink. There were no kitchen cleaning logs for November 2024, per electronic communication from the Administrator on 11/15/2024 at 4:31 PM. The following observations of the main kitchen were made: - on 11/12/2024 at 11:41 AM, the hand sink in the dish room had dried brown rings and a dead bug stuck to the side of the wash basin. There was tan sludge on the floor under the 3-bay sink. - on 11/13/2024 at 11:25 AM, there was brown discoloration under the three-bay sink in the kitchen. - on 11/13/24 at 11:29 AM, the hand sink in the dish room had dried brown rings and a dead bug stuck to the side of the wash basin. - on 11/13/24 at 11:50 AM, there was debris on the side of the oven, and debris under the sink next to the oven. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- on 11/13/2024 at 12:08 PM, the dish room hand sink had a dead bug dried into the basin. There was built up grime and debris under equipment, sinks, and the dish machine. There was significant dried on debris beneath the three-bay sink from the floor drain. Both hand sinks basins were dry. Garbage by the kitchen hand sink overflowed onto the floor. The basement hall floor, used for staging trays for meal service, was soiled and stained and meal carts were left uncovered in the hall. - on 11/13/2024 at 2:11 PM, there was a wet, gray liquid beneath the three-bay sink from the floor drain plate cover. Maintenance Director #20 stated the sink did not drain properly and flowed on the floor. - on 11/14/2024 at 12:29 PM, there was debris on the side of the oven and along the left of the stove. Below the sink next to the stove was a coffee pot with dried debris. The following observations were made during meal service in the kitchen: - on 11/13/2024 at 12:09 PM, Dietary Aide #18 left the kitchen wearing blue gloves, returned, grabbed the handle to the kitchen door carrying a box of oatmeal cookies. Their gloves were not changed, and they did not perform hand hygiene upon returning to the kitchen. - on 11/13/2024 at 12:11 PM, an unknown staff exited the kitchen through the hall door wearing gloves, returned wearing gloves, and resumed work. They entered the kitchen by handling the doorknob and did not change gloves or perform hand hygiene. - on 11/13/2024 at 12:16 PM, Dietary Aide #18 went to the dish room and returned with silverware in their hand and did not perform hand hygiene or change their gloves. During an observation on 11/13/2024 at 11:56 AM, the butter in refrigerator #9 was measured at 49.8 degrees Fahrenheit. The thermometer in the refrigerator displayed 36 degrees Fahrenheit. During an observation and interview on 11/13/2024 at 2:27 PM, [NAME] #15 stated the cook on duty was responsible to ensure refrigerator temperatures were checked. They were the cook on duty that evening. Refrigerator #9 thermometer displayed 36 degrees Fahrenheit. The butter measured at 47.8 degrees Fahrenheit. [NAME] #9 stated if the butter was 47.8 degrees Fahrenheit, then the rest of the items in the refrigerator would be that temperature as well. The mozzarella cheese was 42.7 degrees Fahrenheit. They were not sure if that was a safe temperature for the items in the refrigerator. The rapid cooling refrigerator had lasagna dated 11/11, and eggs dated 11/13. There was no information on the refrigerator or in the office regarding the cooling times or temperature for either food. [NAME] #9 stated the rapid cooling process was to get to 70 degrees Fahrenheit in 2 hours, and then an additional 4 hours to drop below 40 degrees Fahrenheit. [NAME] #9 stated they would discard the items given there was no log or information about those foods. Everyone was responsible for cleaning the kitchen. The kitchen was wiped down on each shift. There was a deep clean done at the end of the night with the closing crew. Since the Director of Dietary left, the Administrator was overseeing the kitchen. During an observation on 11/13/2024 at 4:00 PM, refrigerator #9 had one thermometer that displayed 45 degrees Fahrenheit, and the other displayed 42 degrees Fahrenheit. The butter was measured at 51 degrees Fahrenheit. The lasagna and eggs were still in the rapid cooling refrigerator #4. (continued on next page)

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	335103	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River View Rehabilitation and Nursing Care Center	510 Fifth Avenue Owego, NY 13827

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow up interview and observation on 11/13/2024 at 4:03 PM, [NAME] #15 read the thermometer in the butter at 49.6 degrees Fahrenheit. They stated they did not know how long the butter had been out of temperature. 2 hours was the maximum allotted time for food to be out of temperature. A block of cheddar cheese dated 10/25/2024 had visible mold growth, measured at 42 degrees Fahrenheit, and was discarded voluntarily by [NAME] #15. The yogurt measured 46.9 degrees Fahrenheit. During an interview and observation on 11/14/2024 at 2:36 PM, [NAME] #8 stated that cold foods needed to be held under 40 degrees Fahrenheit. The policy for hand hygiene was to wash when you came in for the shift and after anything that was not food was touched. If someone left the kitchen, they should wash their hands when they came back to the kitchen. If someone was preparing trays, touching cups and silverware, they should not be wearing the same gloves they left the kitchen with especially if they had to touch multiple door handles on the way. Hand hygiene was important because of germs. In the kitchen, they cleaned as they went. The kitchen was cleaned every night. It was hard to deep clean in the middle of food service and cooking. They had to wait until all the food was done, because of the chemicals in the cleaning supplies. [NAME] #8 observed refrigerator #9 with 2 thermometers. The butter was measured at 47 degrees Fahrenheit. The surveyor stated the previous temperature measurements for 11/13/2024 and [NAME] #8 stated that they had to empty the contents of the refrigerator into another refrigerator and contact maintenance. If the butter was that temperature, so were the rest of the items in that refrigerator. During an interview on 11/15/2024 at 9:17 AM, Dietary Aide #16 stated that proper hand hygiene was important for the kitchen. If they left the kitchen they should change their gloves. Hand hygiene could be done with washing or hand sanitizer. During an interview on 11/15/2024 at 1:49 PM, the Administrator stated they did not have audits for kitchen cleaning, they just observed the area. The Director of Dietary should check cleanliness, fridge temperatures, and food temperatures, to report monthly. The expectation of kitchen cleaning was that it should be as clean as at home. There should not be anything stuck to the side of the stove for repeated days. There should not be debris on the shelves, or sewage seeping from or on the floor. Staff went through orientation for hand hygiene. They had spot checks for all employees for hand hygiene. The expectation for hand hygiene in the kitchen was hands should always be clean and use gloves when needed. They should wash every time they entered the kitchen and as needed, especially before handling food. Staff should not return to the kitchen without washing their hands. If hand hygiene was being done, there should not be dried bugs squished to the side of the basin. Staff should have washed their hands after exiting the kitchen utilizing multiple door handles. The lack of hand washing could lead to illness. They expected food was stored at safe temperatures. The Administrator did not know the process for rapid cooling, but that there was a process used in the facility. 10NYCRR 415.14(h)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 48895 Based on record review and interviews during the recertification survey conducted 11/12/2024-11/15/2024, the facility did not ensure the Binding Arbitration Agreement (a binding agreement by the parties to submit to arbitration, all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) was explained to the resident and their representative in a form and manner they understood, including the ability to rescind the agreement in 30 days, and the right to communicate with surveyors, state and federal officials, and the Ombudsman for 1 of 3 residents (Resident #63) reviewed. Specifically, Resident #63's Binding Arbitration Agreement was sent with the admission agreement via electronic mail to their representative, and the agreement was not complete, and was not followed up on for completeness. The findings include: The facility document, Voluntary Agreement for Arbitration, documented: A. The section for resident/representative acknowledgements with blank lines in front of them included: 1. Signing the Arbitration Agreement was not required as a condition of admission to the facility, nor to continue receiving care. 2. The agreement had been explained in a form and manner that was understood 3. They understood the agreement and they had the right to rescind the acceptance with 30 calendar days of signing if, by indicating so via electronic mail or via certified mail to the facility, with the attention of the Administrator/Arbitration. 4. They understood they maintained their right to communicate with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal state health department employees, and representative of the Office of the State Long-Term Care Ombudsman. B. If the facility and a resident resolved a dispute through arbitration, a copy of the signed agreement and the arbitrator's final decision would be retained by the facility for 5 years after the resolution of the dispute and be available for inspection upon request. C. The last paragraph with signature for Facility Employee documents for residents who do not have a resident representative: Resident's physical condition and cognitive status have been determined to be at a level sufficient to execute this Agreement, including their ability to make an informed and appropriate decision. Resident #63 had diagnoses including unspecified dementia with psychotic disturbance and delusional disorders. The 6/16/2023 Minimum Data Set assessment documented the resident had moderately impaired cognition. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/9/2023 Health Care Proxy form documented that Resident #63 had an appointed health care agent that made all health care decision for them. Resident #63's Binding Arbitration Agreement documented Resident #63's health care proxy began completing the document on 6/12/2023. The section with the 4 resident/representative acknowledgements did not have completed initials indicating the agreement, ability to rescind, and the ability to communicate with officials was explained. A 6/12/2023 date was documented, there was no signature of acknowledgement by the resident or resident representative. Business Office Manager #27's signature was documented for the section indicating the resident was able to make an informed and appropriate decision. During an interview on 11/12/2024 at 1:05 PM, the Administrator stated they started offering arbitration agreements about 6 months ago. The resident could sign indicating they would attempt to resolve disputes with the facility first, but if they could not resolve the dispute the resident could seek outside council and sue the facility after that point. During an interview on 11/14/2024 at 8:52 AM, Business Office Manager #27 stated the binding arbitration agreement was part of the admission agreement packet. They did not ask specific residents to agree, it was a voluntary option at the end of the admission agreement. They used the resident's Brief Interview for Mental Status score to determine the resident's cognitive ability. The residents usually had family with them, and they were part of the admission agreement process and helped the residents understand. They ensured understanding of the arbitration agreement with the use of the checklist in the arbitration agreement itself. They explained the agreement to the resident by explaining it helped with litigation if there was a reason to go to court with the facility. The examples used by Business Office Manager #27 was if the facility went after the resident for non-payment, the resident could use the arbitration agreement to help resolve the dispute instead of paying for their own lawyer to protect them. Or if the resident had a dispute about their care, they could use arbitration instead of suing. They ensured the resident understood their rights regarding the arbitration agreement, such as their right to refuse to enter into it, and their right to rescind it within 30 days by reading off the checklist from the agreement and asked if they understood before signing at the bottom. Business Office Manager #27 did not know how or when to approach a resident about selecting an arbitrator. They did not know if the agreement could be presented in a language other than English, and the agreement remained in place and on file with the facility for 5 years regardless of whether the resident had a period of time between admission. During a follow up interview on 11/15/2024 at 8:27 AM, Business Office Manager #27 stated Resident #63's admission agreement was emailed to the Resident Representative. They emailed the packet including the arbitration agreement and advised them to reach out with any questions. They did not meet with the Resident Representative or explain the arbitration agreement. When they received the admission packet back, they saw that there was an x for accepted and added the resident to the binding arbitration list. They stated they should have reviewed it, and they should have followed up on the agreement, as it was not completed. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 9:35 AM, the Administrator stated Resident #63's representative accepted the agreement. They stated that [document signing website] should not have returned the document to the facility noting it was completed if it was not completed. The facility should have reviewed it and followed up on it. The resident representative signed and agreed in 2023. The Administrator stated that they ensured the representative understood the agreement, because they accepted it on the form. They were going to reach out to the Representative, and they could decide to rescind it, as they could rescind the agreement at any time. The Business Office Manager #27 (present during the interview) stated they only had 30 days to rescind the agreement and the binding agreement was held in affect for 5 years. 10 NYCRR 415.30

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49448 Based on observation and interview during the recertification survey conducted 11/12/2024-11/15/2024, the facility did not ensure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public in one resident room and one medication room. Specifically, the second-floor medication room was in disrepair and resident room [ROOM NUMBER] had an unclean floor. Findings include: The facility policy, House Keeping, revised 12/2018 documented resident rooms were cleaned daily to ensure cleanliness and safety. Daily cleanings included dust mopping and wet mopping the entire floor to include underneath the beds. The following observations were made in room [ROOM NUMBER]: - on 11/12/2024 at 11:48 AM, there was a greeting card, a brown napkin, and a red beverage cap on the floor under the head of the bed. - on 11/13/2024 at 10:38 AM and 1:38 PM, there was a greeting card and a red beverage cap on the floor under the head of the bed. - on 11/14/2024 at 8:38 AM and 9:55 AM, there was a greeting card and a red beverage cap on the floor under the head of the bed. There was trash debris and dried flower petals scattered on the floor throughout the room. During an interview on 11/12/2024 at 11:48 AM, a visitor stated they visited their family at least every other day. The floors were often sticky, debris on the floor was not cleaned up and would stay there for days, and tray tables were not wiped down. During an interview on 11/14/2024 at 9:56 AM, Certified Nurse Aide #21 stated the resident's rooms were cleaned daily. The floors were swept and mopped and under the beds were cleaned. If they saw something on the floor, they would pick it up. They were assigned to the resident in room [ROOM NUMBER] on 11/12/2024 and today. They did not notice the greeting card or the beverage cap under the bed earlier. There was debris all over the floor in room [ROOM NUMBER] and that could be a fall hazard. The housekeepers were new and were not cleaning under the beds. Residents deserved to have a clean environment as it was their home. During an interview on 11/14/2024 at 2:20 PM, Licensed Practical Nurse Unit Manager #13 stated cleaning the floors in resident rooms was part of daily cleaning. During an interview on 11/15/2024 at 8:09 AM, Housekeeper #22 stated all resident rooms were cleaned daily. Cleaning included sweeping under the beds. They had cleaned room [ROOM NUMBER] this week but did not notice any items under the bed. Residents deserved to have clean living spaces. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/15/2024 at 8:41 AM, Housekeeper #23 stated cleaning resident rooms entailed sweeping under the beds. They cleaned room [ROOM NUMBER] on 11/11/2024 and 11/13/2024. They tried to sweep under the beds, but they did not notice the greeting card or the soda cap under the bed. The residents should have clean living spaces for safety. Medication Room: During a walk-through observation and interview on 11/13/2024 at 10:02 AM with the Corporate Director of Facilities, the second-floor medication room had significant water damage to the ceiling, floors, and walls. There were large areas of brown discoloration and debris. The Corporate Director of Facilities stated this was from a roof leak that was repaired over the summer. During an interview on 11/15/2024 at 9:01 AM, Licensed Practical Nurse Unit Manager #13 stated the second-floor medication room had stains on the ceiling and walls the entire time they had been employed at the facility, approximately 2 years. The roof leaked and needed repair a couple of times. They mentioned this to the Administrator and the previous maintenance staff. There was also water damage to the ceiling above the copy machine at the nurse's station. They felt work areas should be clean and was concerned the discolored areas from the water damage could contain black mold. During an interview on 11/15/2024 at 9:16 AM, the Maintenance Director stated they were hired a couple of months ago and they were the only staff currently employed in the maintenance department. There was no work order in for the water damage to the ceiling in the second-floor medication room. They had seen the water damage and thought it should be repaired as soon as possible. It was an eye sore and probably was not safe as there were medications in that room. During an interview on 11/15/2024 at 1:49 PM, the Administrator stated they were aware of the water damage to the ceiling in the second-floor medication room. The roof was repaired in the summer months. The water damage was not a safety concern it was just cosmetic. 10NYCRR 415.29