STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335154	A. BUILDING ______ B. WING ______	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW NURSING HOME	**119 15 27TH AVENUE** **FLUSHING, NY 11354**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced	F 225		11/14/08

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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by:
Based on record review and staff and resident interviews, the facility did not thoroughly investigate an allegation of resident abuse by a staff member for 1 of 24 sampled residents. This resulted in no actual harm but has the potential for more than minimal harm that is not immediate jeopardy. (Resident #13)

The Finding is:

Resident #13 is a 48 year old resident and has diagnoses that include Spina Bifida, Cerebral Palsy and Mood Disorder.

The Minimum Data Set (MDS) Assessment dated 9/1/08 documented that the resident is independent in cognition and decision making abilities. No mood, behavior or psychosocial problems were identified.

On interview on 9/24/08 at 10:30AM, the resident stated that about 1 month ago, a 3PM-11PM shift male nurse touched him in a way that he did not like. The nurse tickled him under his chin. The resident stated that he pushed the nurse's hand away when he touched him. After the incident, the resident wrote a letter about the incident and gave it to the Director of Nursing (DNS). The DNS told him that he should be nicer to the staff. No one discussed the incident with him. The nurse still works on his unit but when the nurse enters his room since the incident, he is always accompanied by a Certified Nurse Aide (CNA).

During an interview with the DNS on 9/24/08 at 11:45AM, she stated that she received the letter that the resident wrote and it was inappropriate because in the letter the resident accused the

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F 225	Continued From page 2 3PM-11PM shift male nurse of being gay. The DNS stated that she talked to the nurse and he denied touching the resident. She did not interview any one else. On 9/24/08 at 2:50PM the 3PM-11PM male nurse was interviewed. He stated that on that evening, he went into the resident's room and took his blood pressure. He did not touch him anywhere else, nor did he have any indication that anything happened with the resident. It was not until 2 to 4 days later when the Assistant DNS spoke to him did he find out about the resident's allegations. The Statement of Occurrence dated 9/9/08 contained only the interview with the nurse and the letter from the resident. The report stated that the resident refused to meet with her to discuss the letter. No one else was interviewed about this incident and no further actions were taken. 415.4(b)(1)(ii)	F 225		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY Based on observation and staff interview, it was determined that the facility did not provide effective housekeeping and maintenance services necessary to maintain an orderly and comfortable interior. Reference is made to the cracked floor tiles in resident use corridors on one of two resident use floors. This resulted in no	F 253		11/24/08

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F 253	Continued From page 3 actual harm with potential for greater than minimal harm that is not immediate jeopardy. The findings are: During the annual survey conducted on 9/22/08 and 9/23/08 between 9:00am and 3:30pm, issues that depicted an unkempt environment were observed; these include but are not limited to: a) Soiled and rusty ac/heating unit radiators observed in numerous rooms (e.g. rooms 203, 300, 317, 319, 3rd floor day room and the laundry room- examples not all inclusive). In an interview with the Director of Maintenance on he stated that they are cleaned semi annually. b) Mechanical exhaust vent observed dusty e.g. the vents in 317 and 318 bathrooms (examples not all inclusive). c) Broken wall noted in room 27 and in the corridor by room 317, ; broken wall tiles noted in the 3rd floor tub room; Chipped off wall paint in room 28, chipped off baseboard in room 27. d) Rusty partitions noted in shower room e.g. the male shower room one the 1st floor east wing. e) A broken cabinet in the 3rd floor pantry room. f) The main shower room windows on the 3rd floor lack window screens. g) Soiled linen storage was noted in the tub room of the 1st floor (west wing). This is not an appropriate location for the storage of soiled linen. In an interview with the Director of maintenance on 09/22/08 at approximately 2:50pm, he stated that all issues noted would be fixed. 415.5(h)(2)	F 253		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION	F 323		11/24/08

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F 323	Continued From page 4 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review during the annual survey, the facility did not ensure that an environment free of accident hazards was maintained and adequate supervision was provided for 5 of 11 residents reviewed for smoking. Specifically, 1) Resident # 6 was assessed as demonstrating safe smoking habits and is encouraged to wear smoking apron. The resident was observed smoking, she was not wearing a smoking apron and there was no staff member present in the smoking area. 2) Resident # 21 was assessed as an unsafe smoker; she was observed sitting in the smoking area and was not wearing a smoking apron as per the plan of care. 3) Resident #12 was assessed on 9/23/08 to be an unsafe smoker. The facility was unable to provide documentation that the room was searched on 9/24/08 for cigarettes, matches and cigarette lighters as required in the care plan. 4) Resident #15, an assessed safe smoker, was observed lighting and smoking a cigarette in the carpeted lobby of the facility on 9/24/08 at 1:15 PM. 5) Resident #5 did not have a dated or completed smoking assessment. Resident #5's room search revealed 2 empty packs of cigarettes and a lighter. This resulted in a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 323		

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Findings include but are not limited to:

1) Resident # 6 was admitted on 6/15/97 with diagnoses including schizoaffective disorder, dementia, hypertension, and diabetes mellitus.

The Minimum Data Set (MDS) assessment dated 8/20/08 assessed the resident's cognition as moderately impaired.

Review of the smoking assessments dated 6/30/08 and 8/18/08 documented that the resident was assessed as a safe smoker and wears an apron to prevent burns to clothing. Cigarettes are distributed by Social Service (S.S.) to ensure compliance.

The Comprehensive Care Plan (CCP) dated 6/03/08 documented smoker-resident is encouraged to wear a smoking apron, the interventions included cigarettes held and distributed by social service's office to ensure compliance to smoking policy. Smoking apron to prevent burns to resident and/or clothing. Staff will monitor for any unsafe smoking habits.

On 9/23/08 at 3:35 PM, Resident # 6 was observed smoking in the smoking area, she was not wearing a smoking apron as planned and there was no staff member in the smoking area.

On 9/24/08 at 3:15PM, a search of the resident's room revealed cigarette butts and a lighter.

2) Resident #21 was admitted on 2/18/04 with diagnoses including schizophrenia, hypertension, and morbid obesity.

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The Minimum Data Set (MDS) dated 7/14/08 assessed the resident's cognition as moderately impaired.

The CCP dated 11/13/07 documented Smoker - Resident has been periodically observed smoking discarded cigarettes but is easily re-directed; the resident when questioned, denies she is a smoker and she has been assessed as demonstrating safe smoking habits.

Review of the Social Worker's notes dated 1/20/08 documented that the resident smokes and refuses to wear protective smoking apron after initially accepting it. Resident resists counsel and continues to smoke discarded cigarette butts from the floor. Attempt redirection and encourage diversional activities.

Review of The Smoking Assessments dated 2/5/08, 4/25/08 and 7/14/08 documented that the resident does not smoke or request to smoke frequently, but has been observed smoking discarded butts. The resident is not able to comprehend the smoking contract and has been observed with burn marks on clothes. Will monitor to ensure smoking apron is worn when outside.

Review of the Social Worker's notes dated 7/19/08 documented "frequently re-directed, unable to follow smoking policy. Continue CCP and redirect as needed".

On 9/24/08 at approximately 10:30 AM and 1:30 PM, the resident was observed sitting in the smoking area, she was not wearing a smoking apron and there was no staff member present in the smoking area.

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Interview with the 7AM - 3PM Licensed Practical Nurse (LPN), Charge/Medication Nurse on 9/24/08 at 8:10AM, she stated that she was not aware of the smoking process. Social Service is responsible for monitoring the residents in the smoking area. Aprons are provided by the social worker for residents (smokers) who are assessed as high risk for injury. There are no specific hours assigned for the residents to smoke; the residents are independent smokers. The nursing staff is responsible for monitoring the whereabouts of the resident every half hour and the residents must be physically seen by the staff member before signing the log. They are not responsible for monitoring the smoking.

During an interview with the Assistant Director of Nursing (ADON) on 9/24/08 at 10:05 AM, she stated that Certified Nurses Assistants (CNA's) do not monitor the residents for smoking; social services is responsible for assessing the residents for smoking and also monitoring then when smoking. The residents who are identified as safe smokers hold their own smoking paraphernalia.

3) Resident #12 is a 48 year old male with the following conditions: Left middle cerebral artery stroke, left hemiparesis, mood disorder, seizure disorder, history of cocaine abuse, history of alcohol abuse, tobacco use, depression, hypercholesterolemia, psychosis.

The quarterly MDS 2.0 documents in section B2 short term and long term memory "OK." Section B 4. cognitive skills for daily decision making documented moderately impaired - decisions poor, cues/supervision required.

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On 3/27/08 the comprehensive care plan documented: Smoker- resident smokes and has been assessed as demonstrating safe smoking habits.

On 3/21/08, 6/13/08 and 9/3/08 quarterly smoking assessments were completed and the resident was not considered an unsafe smoker.

On 3/17/08, 6/9/08 and subsequently (on an undocumented date) a "30 Minute Visual Check Form" documented the resident at high risk for elopement, unsafe wandering and was to be visually monitored every 30 minutes. On 9/21/08 at 4:30AM and 9/24/08 at 3PM, the nursing progress notes document that the resident was monitored every 30 minutes.

On 9/22/08 a 11PM nursing note documented that the resident lit up a cigarette in his room in bed. The Nursing supervisor was aware and to follow up with social service in AM.

On 9/23/08 the comprehensive care plan update documented that it was reported that resident was noted attempting to light a cigarette while in bed. Cigarettes were removed from his possession. Resident informed that his room and possessions will be checked daily. All paraphernalia will be removed. CCP meeting will be held with him and his family. Will also refer to psych for evaluation. Reminded resident that he will be now placed on the unsafe smokers list where he will be monitored during smoking. Monitoring Q 30 minutes for safety check.

On 9/23/08 social service documented that the social worker met with resident regarding report

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that resident was attempting to smoke in his room on 9/22/08. Resident would not admit to same but is aware his smoking is now restricted and social service will have to hold his cigarettes. Counseled about the danger of smoking indoors to himself as well as others.

On 9/24/08 at 3:45PM at the request of the surveyor, the resident's room was observed being searched by the director of nursing and a social worker. A cigarette box containing an extinguished cigarette butt and an unused book of matches was found in the 2nd drawer of the night table next to the bed.

On 9/25/08 at 9:45AM and 10:30AM the director of nursing was interviewed and stated that the resident can't use the book of matches because the resident is able to use only one hand. The staff reported that on 9/22/08 the resident attempted to light a cigarette with a cigarette lighter. The director of nursing also stated that on 9/24/08, the resident's room was checked twice prior to the observed search at 3:45PM (during which time the cigarette box containing an extinguished cigarette but and an unused book of matches was found). The room searches are performed by the social worker or the nursing staff. The director of nursing stated that the room checks are documented in the 30 minute safety check list.

Review of the half hour visual check records on 9/23/08 7AM to 11PM, 9/24/08 7AM to 11PM and 9/24/08 7AM to 10:30AM document resident's location and staff initials however the record does not specify that the resident's room was searched for cigarettes, matches and cigarette lighters.

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F 323	Continued From page 10 The facility did not provide documentation that the resident's room was being checked in accordance with the revised comprehensive care plan for an unsafe smoker. 415.12(h)	F 323		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review during the annual survey, the facility did not ensure that residents are free of any significant medication errors. Specifically, Resident # 1 was not administered the medication Metoprolol (Lopressor- a medication to lower blood pressure) 1/2 tablet (12.5 mg) twice a day as ordered by the physician. The resident was given Metroprolol (Lopressor) 25 mg twice a day from 9/17/08-9/22/08. This was evident in 1 resident in a sample of 24. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding is: Resident #1 was admitted on 6/14/89 with diagnoses including hypertension, multiple sclerosis, dysphasia, and hyperthyroidism. The Minimum Data Set (MDS) dated 5/08/08 assessed the resident's cognition as severely impaired.	F 333		11/24/08

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Review of the medication blister pack dated 8/03/08 documented Metoprolol 25 mg: (lopressor). Quantity (Qn) + 15 of 30. 1/2 tablet (12.5) via PEG twice a day (hold if SBP (systolic blood pressure) less than 100 and HR (heart rate) less than 68). Diagnosis of Hypertension.

On 9/23/08 at 10:30 AM, it was observed that 10 tablets had been removed from the blister pack and 20 whole tablets remained.

The Physician's order dated 9/18/08 documented Metropolol 25mg (lopressor) 1/2 tablet (12.5mg) via PEG twice a day. Dx hypertension.

The Medication Administration Record (MAR) for the month of September 2008 documented Metropolol 25 mg (lopressor) 1/2 tablet (12.5) via PEG (a tube insterted in the stomach for medication administration and feeding) twice a day. From 9/17/08-9/22/08 at 9:00 AM and 5:00 PM, there were documented initials on the MAR which indicated that the medication had been administered.

An interview with the 7 AM - 3 PM shift Licensed Practical Nurse (LPN), Charge/Medication Nurse, on 9/23/08 at 10:45 AM, revealed that on 9/22/08 at 5:00 PM, she administered the medication to the resident from the blister pack as dispensed by the pharmacy, a whole tablet.

During an interview with the 3-11 PM LPN, Charge/Medication Nurse on 9/23/08 at 3:55 PM, she stated that on 9/22/08 at 5:00 PM, she administered the medication to the resident from the blister pack as dispensed by the pharmacy, a whole tablet.

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F 333	Continued From page 12 During an interview of the Assistant Director of Nursing (ADON) on 9/24/08 at approximately 11:30 AM, she stated that her investigation regarding the medication received from the pharmacy and the administration of the medication by the nurses revealed that the pharmacy supervisor stated that the incorrect label was placed on the blister pack and incorrect dosage of the medication was sent to the facility. The ADON further stated that the resident was administered the medication lopressor 25 mg (1 whole tablet) instead of 12.5 mg (1/2 tablet) as ordered by the physician. The resident was assessed by the physician and no ill effects were noted. The nurses involved were re-in-serviced and disciplinary actions were given. 415.12 (m)(2)	F 333		
F 371 SS=E	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: REPEAT DEFICIENCY FROM THE SURVEY OF 9/18/2007 Based on observation and interview, it was determined that the facility did not ensure that food was stored, prepared, distributed and served under sanitary conditions. Specifically, the facility	F 371		11/14/08

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F 371	Continued From page 13 did not maintain a clean kitchen environment. This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy. The findings are: During the annual inspection conducted on 9/22/08 between9:00am and 3:00pm, the following was observed in the kitchen: 1) On 9/22/08 at 10:25am, the walk-in freezer temperature was 42°F; a second observation on 9/23/08 at 2:25pm revealed that the walk-in freezer temperature was 28°F. Freezer temperature should be maintained at 0F or below. 2) Storage of boxes of food items in the walk-in freezer was observed cluttered and will not allow for proper air circulation. 3) Foods (hamburger and roast beef) stored in the reaching refrigerator were not labeled and dated. 4) Puddle of water was observed on the kitchen floor; this resulted from the back up from the grease trap. 5) The mechanical exhaust vent and also the chains suspending the kitchen hood were encrusted with dust. 6) The pipe underneath the three compartment sink and the drain of the spray sink were both observed leaking. The plan of correction from previous survey (9/18/07) indicated that the pipes observed leaking were repaired and that the Director of Maintenance revised the facility ' s preventive maintenance program to include the periodic inspection of all pipes by both maintenance and dietary staff and that all leaking pipes will be reported to the maintenance department. 7) The pipe from the ice machine was dripping	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335154	A. BUILDING ______ B. WING ______	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW NURSING HOME	**119 15 27TH AVENUE FLUSHING, NY 11354**

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F 371	Continued From page 14 water on the kitchen floor; it was not extended to allow it empty in to the floor drain. 8) The can opener was rusty and the toaster soiled. In an interview with the Life Safety Director on 09/22/08 at approximately 10:35am, he stated that the issues would be addressed. 415.14(h)	F 371		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews during the annual survey, the facility did not ensure that pharmacy services obtained were safe and accurate to meet each resident's	F 425		11/24/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 15 needs. Specifically, Resident # 1's physician ordered Metoprolol (Lopressor- blood pressure lowering medication) 1/2 tablet (12.5mg) twice a day. The pharmacy dispensed Metoprolol 25mg twice a day. This was evidenced in 1 resident in a sample of 24. This resulted in no actual harm with potential for more than minimal harm that is not immediate jeopardy. Finding is: Resident #1 was admitted on 6/14/89 with diagnoses including hypertension, multiple sclerosis, dysphasia and hyperthyroidism. The Minimum Data Set (MDS) dated 5/08/08 assessed the resident's cognition as severely impaired. The physician's order dated 9/18/08 documented Metoprolol 25 mg (Lopressor) 1/2 tablet (12.5 mg) via PEG (a tube inserted in the stomach for medication administration and feeding) twice a day. The Medication blister pack dated 8/03/08 documented Metoprolol 25 mg: (lopressor). Quantity 15 of 30 1/2 tab (12.5mg) via PEG twice a day. (Hold if SBP (systolic blood pressure) is less than 100 and HR (heart rate) less than 68) Dx Hypertension. The Medication Administration Record (MAR) for the month of September 2008 documented that the resident was administered the medication Metoprolol 25mg from 9/17/08-9/22/08 at 9:00AM and 5:00PM.	F 425		

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F 425	Continued From page 16 On 9/23/08 at 10:30 am, the blister pack was observed to contain 20 whole tables and 10 tablets had been removed. Interview with the medication nurse at approximately 11:00AM regarding the medication of the blister pack, she stated the blister pack contained whole tablets instead of half tablets as ordered by the physician, she called the pharmacy who informed her that another blister pack had been sent to the facility, she reported it to the nursing supervisor. The physician was notified who assessed the resident and no ill effects were found. On 9/24/08 at approximately 11: 30AM The Assistant Director of Nurses (ADON) was observed interviewing the pharmacist supervisor via speaker phone regarding the medication Metoprolol received from the pharmacy. The pharmacy supervisor stated that the incorrect label was placed on the blister pack and incorrect dosage of the medication was sent to the facility and he would look into it. 415.18 (a)	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced	F 428		11/28/08

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F 428	Continued From page 17 by: Based on record review and staff interview, the facility did not ensure that a resident drug regimen review was done monthly by a licensed pharmacist. This was noted for 1 of 24 sampled residents. (Resident #10). This resulted in no actual harm with potential for more than minimum harm. The finding is: Resident #10 is a 60 year old female with diagnoses including Diabetes Mellitus, Hypertension, Multiple Sclerosis, Paraplegia and Neurogenic Bladder. A review of the Physician's Order Form dated 8/6/08 and 9/3/08 documented that the resident received 11 medications. The facility did not provide any evidence that the drug regimen was reviewed monthly by a licensed pharmacist from 7/25/08 through 9/25/08 for the resident. On 9/25/08 at 2:15p.m. an interview was conducted with the Pharmacy Consultant who stated that he reviews all the charts and the ones that he have problems with, he gives copies to the facility. Once in a while, a chart might be missed if it is off the floor. This Pharmacist further stated that he tries to do the best possible job. He could not explain why these reviews were not done for this resident. 415.18 (c)(1)	F 428		
F 441 SS=E	483.65(a) INFECTION CONTROL The facility must establish and maintain an	F 441		11/24/08

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	335154	A. BUILDING ___ B. WING ___	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW NURSING HOME	**119 15 27TH AVENUE FLUSHING, NY 11354**

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F 441	Continued From page 18	F 441		

Continued From page 18

infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility did not adhere to infection control practices, in that:
1) The irrigation sets (used for the tube feedings) were not maintained in a clean and sanitary manner during a tour of 1 of 5 resident units. (3rd Floor).
2) Items were not stored in a sanitary manner necessary to minimize the spread of infection as evidenced by nursing supplies and food items in cardboard boxes being stored directly on the floor.
This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy.

The findings are:

During the initial tour conducted on 9/22/08 on the 3rd Floor between 9:30a.m. to 11:a.m., the following was noted:

Room 301A: The irrigation set was not labelled or dated. Water was left in the container.
Room 301C: The irrigation set was not labelled

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F 441	Continued From page 19	F 441		

or dated. Water was left in the container.
Room 302A: The irrigation set was not labelled and was dated 9/19/08.
Room 312A: The irrigation set was left on the bedside table with water in it. The set was not dated or labelled.
Room 313B: The irrigation set was dated 9/19/08 and the container had water in it.
Room 315B: The irrigation set was not dated, and was on the resident's bedside table with the syringe separate from the container. (There was no barrier between the syringe and the table).
Room 319A: The irrigation set was on the resident's bedside table. It was not labelled or dated.

On 9/22/08 at 11:30a.m., the Nursing Supervisor was interviewed and stated that the sets are changed by the Night Shift. They should have been changed every 24 hours. There should not be any water in the containers. The containers should be placed in the plastic bags and hung on the poles labeled with the resident's names and the date that it was opened.

2) During environmental and life safety rounds conducted on 9/15/08 and 9/16/08 between 9:00am and 3:30pm, items in cardboard boxes were observed stored directly on the floor in different locations. Examples include

a) Two boxes of suction catheter tray.
b) Two boxes of isolation gown.
c) One box of leg bags.
d) One box of quick cream wheat.

(All stored on the floor in the central supply room).

e) One box of tootie fruities (breakfast cereal).
f) One box of disposable cups.

(Both stored on the floor in the Kitchen storage

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F 441	Continued From page 20 room) g) A plastic bag of disposable trays stored on the floor in the paper storage room. (Examples not all inclusive). In an interview on 9/23/08 at approximately 10:20am, the Director of Maintenance stated that he is responsible for the storage in the central supply room. He relocated the items from the floor to the top of other boxes stored on a stand. 415.19(a)(1-3)	F 441		
F 458 SS=B	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: The following waiver is on file with this office. Repeat waivers are granted on previous justifications by the owner, previous NYSDOH and USDHHS reviews and certification that the condition under which the waivers have been granted have not changed. Please indicate if the facility wishes the waiver to be continued. Include your request for renewal of this waiver or plan of correction in the space provided on this form. 42 CFR 483.70(d)(1)(ii) F-458 S/S=B A total of 56 two-bedded rooms, numbered 1, 3-10, 15, 23, 26, 27, 29, 32 and 34-65 provide 75 square feet per bed in lieu of 80 square feet per	F 458		

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F 458	Continued From page 21 bed. 711.5(c)(7)	F 458		
F 465 SS=D	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Physical environment. The nursing home shall be designed, constructed, equipped and maintained to provide a safe, healthy, functional, sanitary and comfortable environment for residents, personnel and the public. (f) Water supplies. Water supplies of nursing homes shall be operated in conformance with the following requirements: (6) the hot water supply used by residents or the public shall be regulated to maintain hot water temperature within the range of 90 degrees to 120 degrees F. Based on observation and interview it was determined that the facility did not ensure that a safe, functional and comfortable environment is provided for residents in that hot water temperatures that exceeded 120F was observed; also, hot water supply was lacking in certain sink faucets. This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy. The findings are: During the annual survey conducted on 09/22/08	F 465		11/24/08

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F 465	Continued From page 22 between 9:00am and 3:30pm, hot water that was supplied in resident use areas (hand washing sinks in resident rooms and bath rooms) were observed with temperatures that exceeded120F. Examples of locations where observations were made include rooms 306 (124F), 309 (125F), the main shower room (122F), the bathroom by room 307 (124F). In an interview on the same day at 12:05pm, the Director of Maintenance stated that the hot water temperatures were being adjusted from the boiler room. Also, the hand wash sinks in resident bathrooms (314/315 and 316/317) were observed to lack the supply of hot water. In an interview at approximately 12:10, the Director of Maintenance stated that the issue would be addressed. Further inspection of resident units conducted on the same day from 12:30pm to 3:30pm, revealed hot water temperatures ranging between 90F and 119F. 415.29(f)(6)	F 465		
F 514 SS=D	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514		11/24/08

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F 514	Continued From page 23	F 514		

Continued From page 23

This REQUIREMENT is not met as evidenced by:
Based upon staff interviews and record reviews it was determined that the facility did not ensure that medical records are complete and systematically organized. This was evidenced by absence of renewal orders for finger stick blood glucose determinations.These findings were noted for one of 24 residents. (Resident # 11). This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

Findings include:

Resident #11 is a 50 year old female with the following medical conditions: Diabetes mellitus, paraplegia, multiple sclerosis, pressure ulcer, previous history of sepsis, osteoporosis, PVD (peripheral vascular disease), right CVA (cerebrovascular accident), anemia, chronic urinary catheterization, status post urinary tract infection.

The quarterly Minimum Data Set (MDS) 2.0 assessment completed on 7/27/08 documented in section B2, short term and long term "memory OK." Section B4 (cognitive skills for daily decision making) documented: "independent."

On 4/24/08 the medical record documents the following physician's orders:
"Fingerstick for glucose before meals and at bed with regular insulin coverage as directed:

Novolin - R/Humulin for coverage.
200 - 250 = 2 units.
251 - 300 = 4 units.
301 - 350 = 6 units

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F 514		F 514		

Continued From page 24
351 - 400 = 8 units
> 400 = 10 units.
< 60 call MD."

On 9/3/08 the physician's monthly orders include the following:
"Novolin - R/Humulin 10ml vial.
Inject for coverage
150 - 200 = 2 units.
200 - 251 = 3 units.
251 - 300 = 4 units.
301 - 350 = 6 units.
351 - 400 = 8 units.
Units less than 60 or greater than 400 MD."

However on 9/3/08 there are no orders for finger stick blood glucose testing and the orders do not specify the time of day for the finger stick blood glucose testing with insulin coverage.

The medication administration record from 9/4/08 to 9/23/08 documents "Novolin R - /Humulin 10ml vial inject for coverage 6:30AM, 11:30AM.
150 - 200 = 2 units.
200 - 251 = 3 units.
251 - 300 = 4 units.
301 - 350 = 6 units.
351 - 400 = 8 units.
Units less than 60 or greater than 400 MD."

The medication administration record also documents: "Finger stick at 4:30PM and 9PM."

On 9/23/08 at 10:30AM the nursing supervisor was interviewed. She reviewed the orders and confirmed that the time of finger stick glucose testing is not specified in the 9/3/08 physician

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F 514	Continued From page 25 orders. On 9/24/08 at 3:30PM the director of nursing was interviewed. She reviewed the orders and stated that the timing of the finger stick blood glucose determinations is based upon an order in May 2008. This information is supposed to be printed by the pharmacist on every monthly physician's orders. However, the pharmacist "dropped it" from the orders. On 9/25/08 at 1:15PM the physician was interviewed and stated that the resident's finger stick glucose determinations are supposed to be performed 4 times a day as is being done. From 9/4/08 to 9/23/08 the medication administration record indicated that finger stick blood glucose determinations were to be obtained at 6:30AM, 11:30AM, 4:30PM and 9PM. However, the monthly orders on 9/3/08 did not include an order for finger stick blood glucose determinations as well as the frequency and timing for finger stick blood glucose determinations and insulin coverage. 415.22	F 514		

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335154	A. Building B. Wing	1/21/2009

Name of Facility	Street Address, City, State, Zip Code
WATERVIEW NURSING HOME	119 15 27TH AVENUE FLUSHING, NY 11354

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0323 Reg. # 483.25(h) LSC	01/19/2009	ID Prefix F0490 Reg. # 483.75 LSC	01/19/2009	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
9/25/2008			

Form Approved
OMB NO. 0938-0390

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335154	A. Building B. Wing	12/9/2008

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WATERVIEW NURSING HOME	119 15 27TH AVENUE FLUSHING, NY 11354

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	11/14/2008	ID Prefix F0253 Reg. # 483.15(h)(2) LSC	11/14/2008	ID Prefix F0333 Reg. # 483.25(m)(2) LSC	11/24/2008
ID Prefix F0371 Reg. # 483.35(i) LSC	11/14/2008	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	11/24/2008	ID Prefix F0428 Reg. # 483.60(c) LSC	11/24/2008
ID Prefix F0441 Reg. # 483.65(a) LSC	11/24/2008	ID Prefix F0458 Reg. # 483.70(d)(1)(ii) LSC	11/14/2008	ID Prefix F0465 Reg. # 483.70(h) LSC	11/14/2008
ID Prefix F0514 Reg. # 483.75(l)(1) LSC	11/24/2008	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency				
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/25/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335154	A. BUILDING 01 B. WING	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WATERVIEW NURSING HOME	**119 15 27TH AVENUE FLUSHING, NY 11354**

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I310 SS=D	415.29 Physical Environment This Regulation is not met as evidenced by: NYCRR 415.29 (j)(6) Waste: (ii) facilities shall manage regulated medical waste in accordance with the provisions of Part 70 of this Title. 70-2.2 (g) (2) Each storage area shall: (a) display prominent signage indicating the space is used to store regulated medical waste. Based on observation and interview, the facility did not store regulated medical waste in accordance with the requirements of Part 70 10NYCRR as evidenced by medical waste main storage area lacking a displayed prominent signage indicating the space is used to store regulated medical waste. The finding is: On 09/22/08 between 9:00am and 3:30pm, the main regulated medical waste storage area located outside of the facility building was observed to lack a displayed prominent signage that indicates that the space is used to store regulated medical waste (the universal warning sign or the word " biohazard"). In an interview on the same day at approximately 2:40pm, the Life Safety Director stated that the signage that was up was water damaged and that it would be replaced. 10 NYCRR Part 70-2.2	I310		11/24/08
I560 SS=D	713-1 Standards of Construction for New Existing NH	I560		11/24/08

Office of Health Systems Management / Office of Long Term Care

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

New York State Department of Health

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I560	Continued From page 1	I560		

This Regulation is not met as evidenced by:
Physical Plant Violations- State Only
NCYRR 713-1.19 Electrical Requirements
(g) Nurse's calling system (1) General. In general patient areas, each room shall be served by at least one calling station and each bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. Calls shall register with the floor staff and shall activate a visible signal in the corridor at the patients' door, in the clean workroom, in the soiled workroom, and in the nourishment station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at the corridor intersections. In rooms containing two or more calling stations, and remain lighted as long as the voice circuit is operating.

Based on observation and staff interview, it was determined that the facility did not maintain the resident call system as required in 713-1.19(g)(1) in that calls failed to activate a visible signal in the soiled utility rooms.

The findings are:

During the annual survey on 09/22/08 and 09/23/08 between 9:00am and 3:00pm it was observed that the soiled utility rooms located on the 1st floor in the east and north wings did not activate a visible signal when the nursing call system was tested using call buttons from resident rooms.

In an interview with the Maintenance Director on 09/23/08 at approximately 1:55am, he stated that the call panels in the soiled utility rooms would be

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I560	Continued From page 2 repaired. NYCRR 713-1.19(g). 415.29	I560		

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K 000	INITIAL COMMENTS 42 CFR 483.70(a) The facility must meet the applicable provisions of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: REPEAT DEFICIENCY Based on observation, it was determined that the facility did not ensure that corridor doors are kept free of impediments to closing and are maintained to close tight and positively latch to resist the passage of smoke. This resulted in no actual harm with potential for greater than	K 018		11/24/08

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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K 018	Continued From page 1 minimal harm that is not immediate jeopardy. The findings are: During the annual survey conducted on 09/22/08 and 09/23/08 doors were observed: 1) Held open with unapproved door hold open devices. For example the 1st floor east exit door by the kitchen section was held open using a shovel; also, the 1st floor day room door was held open using a garbage can. When the door was tested, it did not close tight, the door did not fit into its frame. At approximately 2:00pm on 9/22/08 the Life Safety Director stated that this door would be replaced. 2) Not maintained to close tight to resist the passage of smoke. For example the corridor door to the storage by room 216 (equipped with a self closer) did not close tight, corridor door to the kitchen (equipped with a self closer) did not also close tight when tested; this door did not fit into its frame. The corridor doors to room 21 (east wing), the main fire alarm equipment room as well as the kitchen chemical storage room door did not close tight when tested (examples not all inclusive). In an interview with the Maintenance Director on 9/22/08 at 2:10pm, he stated these doors would be fixed. Other doors which were also not maintained to properly close are the main maintenance storage, main house keeping storage rooms located outside the facility building. These doors are noted to be equipped with self closers that were not maintained to ensure that the doors close properly. In an interview with the Life Safety Director at 2:30pm on 9/22/08 he stated that those were ' free standing ' doors.	K 018		

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K 018	Continued From page 2 711.2 (a) (1)	K 018		
K 064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Section 5-2, NFPA 10, standard for portable fire extinguishers, states that at intervals not exceeding those specified in Table 5-2, fire extinguishers shall be hydrostatically-retested. The hydrostatic retest shall be conducted within the calendar year of the specified test interval. In no case shall an extinguisher be recharged if it is beyond its specified retest date. Based on observation, interview and record review, it was determined that the facility did not ensure that the stored pressure water type portable fire extinguishers installed are hydrostatically retested at 5 years intervals as per Table 5-2, NFPA10. This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy. The findings are: On 9/22/08 and 9/23/08 between 9:00am and 3:30pm, it was observed that the facility was equipped with stored pressure water type portable fire extinguishers in numerous locations in the facility. Extinguishers were noted that were last	K 064		11/24/08

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K 064	Continued From page 3 retested hydrostatically in April, 2000; examples include extinguishers mounted by the 3rd floor day room, rooms 32 (east wing) and 314 (examples not all inclusive). The fire extinguishers by room 28 (east wing) was last retested hydrostatically in July, 2002. Furthermore, it was observed that fire extinguishers were made inaccessible; for example, the fire extinguisher mounted by room 314 was blocked with a wheel chair, the fire extinguisher mounted by the kitchen door was blocked with a cart (examples not all inclusive). In an interview with the Director of Maintenance on 9/22/08 at approximately 11:45am, he stated that the water type extinguishers would be replaced with new ones and that they will ensure to in-service staff to not block fire extinguishers with items. 711.2 (a) (1)	K 064		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe	K 066		11/24/08

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K 066	Continued From page 4 design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: REPEAT DEFICIENCY Based on observation and interview it was determined that the facility: 1) Did not ensure that a metal container with self-closing cover device in to which ash trays are emptied was provided in the smoking area. 2) Did not ensure that the foot pedal metal container provided in the smoking area (for the disposal of cigarette butts) was of safe design in that it was lined with plastic. This resulted in no actual harm with potential for greater than minimal harm that is not immediate jeopardy. Findings are: During the LSC inspection conducted on 9/23/08 between 9:00am and 3:30pm, the outdoor patio smoking area was observed not equipped with a metal container with self-closing cover device; however, a foot pedal metal bin was provided. This foot pedal metal bin was lined with plastic. This practice is not safe and is not in accordance with the requirements of NFPA 101 19.7.4 In an interview with the Life Safety consultant he	K 066		

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K 066	Continued From page 5 stated that the foot pedal metal bin (lined with plastic) serves as the required metal container with self-closing cover device into which ash trays could be emptied. 711.2 (a) (1)	K 066		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility did not continuously maintain the means of egress free of all obstructions or impediments to full use in the case of fire or other emergency as evidenced by the storage of unattended resident and nursing equipment on exit access corridors. This resulted in no actual harm with the potential for minimal harm. The findings are: During the LSC inspection conducted on 9/22/08 and 9/23/08 between 9:00am and 3:30pm, resident and nursing equipment were observed stored and unattended in the exit access corridors of the resident nursing units and in the basement. Examples of unattended storage noted on the corridor include: a) By room 314 (2 wheel chairs stored). b) Between rooms 317 and 318 (three wheel	K 072		11/24/08

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K 072	Continued From page 6 chairs and four soiled linen bins stored). c) Basement corridor (storage of housekeeping equipment which include but are not limited to buffers and burnishers). Examples not all inclusive. In an interview with the Life Safety consultant on 9/23/08 at approximately 2:35pm, he stated that the items would be relocated. 711.2 (a) (1)	K 072		

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{F 323} SS=E	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	{F 323}		
{F 490} SS=E	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	{F 490}		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 323} SS=K	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to consistently supervise unsafe smokers who had cigarettes in their possession and who exhibited unsafe smoking practices. Additionally, the facility failed to ensure that residents identified as safe smokers were consistently supervised. The facility did not reevaluate all smokers to determine if the residents smoking ability had changed and implement interventions to address the residents unsafe smoking practices. This was evident for 15 of 16 sampled residents and 5 of 5 out of sample residents. (Residents #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #66, #67, #68, #69, #70 and #71) This resulted in Immediate Jeopardy to resident health or safety and Substandard Quality of Care. The findings include but are not limited to: 1) Resident #57 diagnoses include Dementia and Schizoaffective Disorder. The Minimum Data Set (MDS) 2.0 dated 8/25/08 documented that the resident is identified with long and short term memory problems and moderately impaired in cognitive skills for daily decision making.	{F 323}		

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{F 323}	Continued From page 1	{F 323}		

The facility's Plan of Correction dated 11/12/08 documented "...All residents will be required to surrender their cigarettes......to the social service department, who will in turn give same to the smoking monitor to be locked and secured in the smoking cart..."

The comprehensive care plan dated 11/17/08 documented that the resident is an unsafe smoker.

The smoking assessment dated 11/17/08 documented that the resident is a safe smoker and must wear "...apron to prevent burns to clothing. Cigarettes distributed by S.S. (Social Service) to ensure compliance."

On 12/3/08 from 6:25pm to 6:45pm, the resident was observed smoking in the courtyard smoking tent along with Residents #55, #70 and #71. There was no smoking attendant or staff member supervising the smoking area. Resident #57 (who was wearing a smoking apron) was observed flicking ashes on the ground. The resident did not use any of the three ashtrays that were available in the courtyard smoking tent.

On 12/9/08 at 8:55am, a search of the resident's room was conducted by facility staff and the resident was observed wearing a sweater with 3 cigarette burn holes at the bottom of her sweater. The resident's closet contained two sweaters that had burn holes at the elbow and the bottom of the sweater. It was also observed that a full package of cigarettes (20) were in the resident's purse.

On 12/09/08 at 2:20pm, the resident was observed in the courtyard smoking tent (wearing

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{F 323}	Continued From page 2 an apron) with a bag of chips in one hand and a lit cigarette in her other hand. The lit cigarette was resting on the smoking apron and smoke was observed rising from the cigarette. During the observation, the resident did not use the ashtray. A smoking monitor was in the vicinity at the time of the observation but did not intervene to re-direct the resident's unsafe smoking practice. On 12/09/08 at 4:45pm, the resident was observed in the courtyard smoking tent, smoking a cigarette. The facility's "smoking regulations" documented that the designated smoking times are 3pm to 4:30pm. Social Worker #1 and the DON (Director of Nursing) were observed in the courtyard smoking tent at the time of the observation and did not intervene or redirect the resident from smoking. The "Residents' Smokers" list dated 12/3/08 documented that the resident's name was highlighted. According to the Director of Nurses on 12/3/08 at 10am, when a resident's name is highlighted on the "Resident's Smoking" list this means that the resident is an unsafe smoker. The Comprehensive Care Plan updated 11/17/08 documented "Smoking material now distributed and monitored by smoking monitor. Continue to assess for safety quarterly and resident will be monitored for unsafe smoking practices." The smoking assessment dated 11/17/08 was not the revised smoking assessment documented in the plan of correction dated 11/12/08. The smoking assessment dated 11/17/08 documented "... Wears apron to prevent burns to clothing. Cigarettes distributed by Social Service to ensure compliance." This assessment	{F 323}		

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	335154	A. BUILDING ______ B. WING ______	R 12/09/2008

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{F 323}	Continued From page 3 documented that the resident is "...capable of using the ash trays and extinguishing cigarettes in ash trays..." The CNA (Certified Nursing Assistant) Accountability Record dated August, 2008 documented that the resident is a smoker and there is no documentation of special directives for the resident's smoking safety. The facility's plan of correction dated 11/12/08 documented "...CNA accountability records were reviewed to ensure that each resident who smokes has specific directives for the CNA's to follow to ensure resident's safety and compliance..." An interview was conducted with CNA #1 on 12/9/08 at 12:25pm and stated "...I check resident #57's room about two times a shift and I ask another aid or a nurse to go with me." On 12/9/08 at 1pm, an interview was conducted with the Licensed Practical Nurse (LPN #1) responsible for Resident #57's unit and stated that she does not conduct room searches for either safe or unsafe smokers. 2) Resident #66 has diagnoses that include Seizure Disorder, Traumatic Brain Injury, Hypothyroidism, Diabetes Mellitus, Psychotic Disorder, and Intermittent Explosive Disorder. The Minimum Data Set (MDS) 2.0 dated 9/10/08 documented that the resident is cognitively intact and is moderately dependent in cognitive skills for daily decision making. This MDS documented that the resident has slurred speech. The "Residents Smoking" list dated 12/3/08, the comprehensive care plan dated 9/11/08 and the	{F 323}		

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{F 323}	Continued From page 4	{F 323}		

smoking assessment dated 9/11/08 documented that the resident is a safe smoker.

On 12/3/08 at 1pm, the resident was observed in the courtyard smoking tent, hunched over his wheelchair tray with paper that he utilizes to write notes to communicate with people. The resident was observed smoking a cigarette directly over the paper on his tray and flicking ashes, some of which landed on his papers and the ground. The resident extinguished his cigarette by crushing the lit butt on the railing along side of the courtyard smoking tent. During this observation, the resident did not use an ashtray. The Social Worker supervising the courtyard smoking tent did not re-direct or counsel the resident regarding this unsafe smoking practice.

There was no evidence of a Smoking Agreement in the resident's medical record.

The Smokers Comprehensive Care Plan (CCP) dated 9/1/08 documented "...Staff will monitor unsafe smoking habits..."

The Certified Nursing Aide Accountability Record dated 8/08 does not document that the resident is a smoker.

The facility's plan of correction dated 11/12/08 documented "...CNA accountability records were reviewed to ensure that each resident who smokes has specific directives for the CNA's to follow to ensure resident's safety and compliance..."

3) Resident #59 has diagnoses that include Psychosis, Hypertension and is deaf.

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{F 323}	Continued From page 5 The Minimum Data Set 2.0 dated 9/29/08 documented that the resident has short term memory problem and is moderately impaired for cognitive skills for daily decision making. The smoking assessment dated 10/3/08 and the comprehensive care plan reviewed on 10/2/08 documented that the resident is a safe smoker. The "Resident Smokers" list dated 12/3/08 and the Certified Nursing Assistant Assignment/Accountability Record documented that the resident is an unsafe smoker and must wear a smoking apron. On 12/3/08 at 1:55pm, the resident was observed in his room. The resident was wearing gray sweatpants that contained 5 small to medium size burn holes on the thigh area of the pants. The resident's white shirt had one medium size burn hole near the resident's waist. The Licensed Practical Nurse (LPN #1) was present during this observation and stated that these areas resemble holes from cigarette burns. The Licensed Practical Nurse went to the resident's closet and it was observed that a black pair of sweat pants had 6 to 8 small to medium sized burn holes in the pants thigh area. The LPN #1 stated that the resident is deaf and in order to communicate with the resident, you must stand in front of the resident for him to read your lips. The LPN #1 further stated that the staff also communicates with the resident by using gestures. On 12/9/08 at 9:00am, the resident was observed wearing a smoking apron and was smoking in the outside courtyard smoking tent. The resident was observed to flick his ashes on the ground and did not use the ashtray. The social worker stated to	{F 323}		

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Continued From page 6

the resident that he should use the designated ashtray. The social worker was not observed to use gestures or stand in front of the resident to communicate. The resident continued to smoke his cigarette, flicking his ashes to the ground and then threw the lit butt to the ground. The social worker did not intervene again to address this unsafe smoking practice.

The comprehensive care plan (CCP) dated 4/22/08 and revised 7/7/08 and 10/2/08 documented "Smoker- Resident smokes and has been assessed as demonstrating safe smoking habits." This CCP further documented interventions "...Staff will monitor for any unsafe smoking habits..." On 10/2/08, the CCP documented "Continue to smoke, but no noted episodes of smoking in facility. Continue quarterly smoking assessment + (and) continue CCP."

The smoking assessment dated 10/3/08 documented that the resident is a safe smoker and "...is able to call for help if lit smoking item falls on self or others..."

4) Resident #55 has diagnoses that include Cerebrovascular Accident, Depression and Psychosis.

The Minimum Data Set 2.0 dated 8/11/08 documented that the resident has short term memory problem and is moderately impaired for cognitive skills for daily decision making.

The resident was observed on 12/3/08 at 1:40PM with a smoking apron, smoking in the courtyard. The resident was observed sitting in a chair with his back to the smoking attendant. The resident

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was observed putting the ashes of the cigarette on the ground. The smoking attendant did not encourage the resident to use the ash trays in the courtyard smoking tent.

On 12/3/08 from 6:25PM to 6:45PM, it was observed that the resident was smoking in the courtyard along with Residents #57, #70 and #71. It was observed that there was no smoking attendant or staff member monitoring the smoking area. Resident #55 was observed to have a smoking apron and flicked the cigarette ashes on the ground. The resident did not use any of the 3 ashtrays that were in the courtyard smoking tent.

The comprehensive care plan (CCP) dated 5/27/08 documented "Smoker - Resident smokes and has been assessed as demonstrating safe smoking habits". The interventions documented were: "Resident wears apron when smoking to prevent burns to clothing and resident...Staff will monitor for any unsafe smoking habits..." The CCP revised on 8/11/08 documented "No changes. Continue CCP." There is no documented evidence in the medical record that the CCP for smoking was reviewed after 8/11/08.

The smoking assessment dated 8/12/08 documented that the resident is a safe smoker and "Wears smoking apron when smoking to prevent burns to clothes." This smoking assessment further documented that "Residents who smoke will be assessed on admission, quarterly and episodically for their ability to smoke safely". There is no documented evidence in the medical record of a smoking assessment after 8/12/08.

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The smoking log comment section dated 12/20/08 at 1:20pm documented "Was smokin a joint in smokin area. Refuse to leave area. Later left."

There is no documented evidence that there was follow-up or an investigation concerning the 12/20/08 comment.

The assigned social worker #1 was interviewed on 12/3/08 at 5:30PM and stated that when the resident's smoking assessment and care plan was due for review, he was on vacation. The social worker further stated that usually when a social worker is on vacation, the other social worker will cover and complete the necessary assessments and care plans.

Social worker #2 was interviewed on 12/3/08 at 5:35PM and stated that when a social worker is going on vacation, one would complete the assessment and care plan prior to your planned time off.

The Director of Nurses was interviewed on 12/24/08 at 6pm and stated that there should have been documentation in the medical record concerning the 12/20/08 smoking log comment.

The smoking monitor was interviewed on 12/24/08 at 6:06pm and stated that someone told him on 12/20/08 that Resident #55 was smoking a "joint". The smoking monitor stated that he did not inform nursing until 12/24/08.

5) On 12/3/08 at 8:10am, Resident #67 and Resident #68 were observed smoking in the courtyard smoking tent. There was no monitoring by staff observed either in the court yard tent or at

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the inside station that serves as a smoking attendant monitoring desk. Cigarette butts were observed strewed on the gravel and grass of the smoking tent. During this observation, Resident #67 was asked by the surveyor where she obtained the cigarette she then stated "I kept it" and refused to say anything else. Resident #68 did not respond to the surveyor. Both residents were observed flicking their ashes on the ground and neither residents utilized the 3 ashtrays that were present in the courtyard smoking tent.

The facility's plan of correction dated 11/12/08 documented that their smoking regulations were revised to include "...All smoking materials will be held by the facility's smoking monitors who will monitor the smoking area during smoking area (times)... The smoking monitor will be on duty during smoking hours from 10:00am - 10:30pm, after which the smoking area will be closed. The Social Worker/designee will distribute cigarettes from 9:00am - 10:00am. The Security Officer will be responsible for monitoring the area from 10:30pm - 9:00am and report any non-compliance to the RNS (Registered Nurse Supervisor) on duty..."

On 12/9/08 at 8:35am an interview was conducted with night shift security guard regarding her responsibilities and knowledge of smoking regulations. "I start at 1:00 am and my shift ends at 9:00am, My break is between 3:00am and 3:30am and the Registered Nurse Supervisor in the building covers for me, I also call her if I have to go to the bathroom. There is only one supervisor at night."

On 12/9/08 at 2:00pm an interview was conducted with the smoking monitor. When

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questioned about smoking times and his individual break times he stated "The smoking hours are from 9:00am to 12:00pm, 1:00 to 4:40pm and from 6:00pm until 10:15pm." He went on to state that Swk #1 covers the smoking cart from 9:00 am until 10:00am as that is when he gets to work. As for the monitors break coverage he stated " I have lunch between 12:00pm and 1:00pm and my dinner break is 4:40pm until 6:00pm, I don't have to inform anyone as they know those are my times. Nobody else covers at those times because nobody is suppose to be smoking then. If I need a bathroom break I call SW #1."

6) Resident #62 has diagnoses that include Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Hypertension and a history of depression.

The Minimum Data Set 2.0 documented that the resident is cognitively intact and independent in cognitive skills for daily decision making.

The CCP dated 10/28/08 documented that the resident is a safe smoker.

On 12/3/08 at 8:50am, the resident was observed in his room with an unlit cigarette in his hand. When the surveyor attempted to question the resident, he refused to respond.

The facility's plan of correction dated 11/12/08 documented "...All residents will be required to surrender their cigarettes......to the social service department, who will in turn give same to the smoking monitor to be locked and secured in the smoking cart..."

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{F 323}	Continued From page 11 7) Resident #61 has diagnoses that include Traumatic Brain Injury, Seizure Disorder, Schizophrenia, Psychosis, Spasticity and Hypertension. The Minimum Data Set (MDS) 2.0 dated 10/27/08 documented that the resident has short and long term memory problems and is moderately impaired in cognitive skills for daily decision making. The resident's smoking assessment dated 9/1/08 documented that the resident was not able to "...comprehend, sign and follow smoking contract..." This smoking assessment further documented "Cigarettes distributed by Social Service. Purchased by family, smoking apron on when smoking and resident's lighters and/or matches to be confiscated." The Comprehensive Care Plan last updated 9/1/08 documented "Smoker- Resident smokes and has been assessed as demonstrating un-safe smoking habits if not monitored closely by staff. Resident is un-counselable due to TBI (Traumatic Brain Injury) Dx (diagnosis)." The facility's plan of correction dated 11/12/08 documented "... In the event that a resident does not have capacity to understand smoking contract, the resident's responsible party will be contacted to ascertain whether or not the resident should be permitted to smoke..." There is no documented evidence in the medical record that a family member was contacted regarding permission for the resident to smoke and there is no documented family member's signature on the smoking agreement.	{F 323}		

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On 12/3/08 at 7:05PM, the Director of Social Service (DSS), SW #1 and SW#2 were interviewed and stated that "We thought it was better to have a signature on something than not have one ...We don't see any of the family that often."

8) The medical records of Residents #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #62, #63, #64, #66 did not contain the residents' smoking agreement.

The facility's plan of correction dated 11/12/08 documented "...A copy of the contract will be kept in the resident's medical record..."

The Director of Nurses was interviewed on 12/3/08 at 5:00PM and stated that it was her understanding that the revised smoking agreement was to be in effect immediately for each resident that smokes.

SW #1 was interviewed on 12/3/08 at 5:15PM and stated that the new smoking agreement was given to SW #1 to be used at the next care plan meeting for each smoker. SW#1 further stated that in speaking with SW #2, the new smoking agreement was to be used when the residents' next annual review would be done. SW #1 further stated that when the form was given, no one stated when the form should be completed.

SW#2 and the Director of Social Services were interviewed on 12/3/08 at 5:35PM and both stated that the new smoking agreement would be done on the next quarterly review of each resident.

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{F 323}	Continued From page 13 415.12(h)(2)	{F 323}		
F 490 SS=K	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the Administrator failed to ensure that the facility operated in a manner in which the safety of all residents is maintained. Specifically, the Administrator did not implement the accepted plan of correction to ensure the residents' safety. The Administrator failed to ensure that all residents were supervised while smoking and re-evaluated to determine if their smoking ability had changed. This was evident for 15 of 16 sampled residents and 5 of 5 out of sampled residents. (Residents #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #61, #62, #63, #64, #66, #67, #68, #69, #70 and #71). This resulted in Immediate Jeopardy to residents health and safety and Substandard Quality of Care. Refer to F 323 The finding is: The medical records of Residents' #51, #52, #53, #54, #55, #56, #57, #58, #59, #60, #62, #63, #64, #66 did not contain the residents' smoking	F 490		

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F 490	Continued From page 14 agreement. The facility's plan of correction dated 11/12/08 documented "...A copy of the contract will be kept in the resident's medical record..." The Administrator was interviewed on 12/9/08 at 9:40am and stated that it was his understanding that the revised smoking regulations and agreements documented in the 11/12/08 plan of correction were to be implemented by 11/24/08. 415.26	F 490		

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335154	A. Building B. Wing 01 - MAIN BUILDING 01	11/26/2008

Name of Facility	Street Address, City, State, Zip Code
WATERVIEW NURSING HOME	119 15 27TH AVENUE FLUSHING, NY 11354

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0018	11/24/2008	ID Prefix Reg. # NFPA 101 LSC K0064	11/24/2008	ID Prefix Reg. # NFPA 101 LSC K0066	11/24/2008
ID Prefix Reg. # NFPA 101 LSC K0072	11/24/2008	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/25/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO