STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335202	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Batavia	257 State St Batavia, NY 14020

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 36415 Based on observation, interview, and record review conducted during a Standard survey completed on 2/20/25, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medication if clinically appropriate for one (1) (Resident #54) of one (1) resident reviewed. Specifically, Resident #54 was observed with medication in their room and had stated they self-administered the medication without being evaluated as to whether they could safely do so. In addition, the comprehensive care plan did not include the resident's ability to self-administer medications. The finding is: The policy and procedure titled Self Administration of Medications, last revised 01/2025, documented residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate. In addition to general evaluation decision making capacity, the staff and practitioner will perform a more specific skill assessment including but not limited to the resident's ability to read and understand medication labels: Comprehension of the purpose and proper dosage and administration time for the medication: Ability to remove medications from the container: The ability to recognize risks and major consequences of the medication. Self-administered medications must be stored in a safe and secure place, which is not accessible to other residents. Resident #54 had diagnoses that included end stage renal disease, diabetes mellitus, and depression. The Minimum Data Set (a resident assessment tool) dated 11/10/24 documented Resident #54 was understood, understands, and was moderately cognitive impaired. The comprehensive care plan, revised 08/20/24, did not reflect Resident #54's ability to self-administer medications including Sevelamer (medication used to remove phosphate in the blood). The Visual/Bedside Kardex Report (guide used by staff to provide care) with an as of date 2/18/25 documented Resident #54 was independent for activities of daily living. Review of the Order Summary Report (recap of physician's orders) documented an active physician's order dated 9/30/24 for Sevelamer Carbonate 800 milligrams with instructions to give two tablets by mouth three times a day for end stage renal disease unsupervised self-administration with meals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335202	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: The Grand Rehabilitation and Nursing at Batavia		STREET ADDRESS, CITY, STATE, ZIP CODE: 257 State St Batavia, NY 14020	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of progress notes dated 08/12/24 to 11/12/24 revealed there was no documented evidence that Resident #54 was assessed by the interdisciplinary team to self-administer medications. There was no documented evidence that self-administration of medication was clinically appropriate or safe. Review of the physician's progress notes from 8/12/24 to 11/12/24 revealed there was no documented evidence that Resident #54 could self-administer their own medications. During an observation and interview on 2/13/25 at 12:04 PM, on the over the bed table, Resident #54 had a blue tinged medication bottle with approximately fifteen large white pills. There was a specimen label fixed to the bottle and had Resident #54's last name and Sevelamer written on the label in black permanent marker. Resident #54 stated the Sevelamer had to be ingested within 15 minutes of eating food and administered the medication themselves during meals. During an observation and interview on 2/18/25 at 9:17 AM, Registered Nurse #2 entered Resident #54's room with a medication cup and administered Resident #54 their morning medications. Resident #54's personal supply of the Sevelamer was on the over the bed table. Registered Nurse #2 after administering the morning medications, went to the unit B medication cart and stated that they administered the Sevelamer to Resident #54 earlier with their breakfast from the bottle kept in the unit B medication cart. At 9:20 AM Registered Nurse #2 opened the top drawer of the unit B medication cart and removed an additional bottle of Sevelamer 800 milligrams supplied from the pharmacy. Resident #54 was alert and oriented and would take the Sevelamer themselves when we couldn't get to their room in time during meals. Resident #54 could give themselves their own medication, therefore kept their own personal supply at their bedside. Registered Nurse #2 stated that keeping a bottle of medications was unsafe because other residents could potentially take them. The Sevelamer should have been kept in a locked drawer and was dangerous if other residents had access to the medication. During an interview on 2/18/25 at 1:59 PM, Licensed Practical Nurse #2 stated they were unaware Resident #54 had the Sevelamer in their possession. The Sevelamer should have been stored in a locked drawer for other residents' safety. Licensed Practical Nurse #2 stated there was no documented evidence by the interdisciplinary team or on the care plan whether that Resident #54 was physically or cognitively safe to self-administer the Sevelamer, therefore should not be taking it on their own. During a telephone interview on 2/19/25 at 11:26 AM, the Consultant Pharmacist stated the interdisciplinary team assessed and determined residents who were clinically safe and requested to do so, they could self-administer medications. The Consultant Pharmacist was not included in the process. During an interview on 2/19/25 at 12:02 PM, the Director of Nursing stated for Resident #54 to self-administer the Sevelamer there should have been an evaluation in the electronic medical record to determine cognition, dexterity and whether the resident was physically capable to administer medications and were safe to do so on their own and addressed in their care plan. Nurses should be documenting whether they administered the medication from the pharmacy supply or Resident #54's own supply to avoid potentially overmedicating. Resident #54 should be storing the Sevelamer in a safe locked drawer away from other residents. The Director of Nursing was unsure where Resident #54 was getting their own supply from. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 10:32 AM, the Administrator stated when a resident expressed interest in self-medicating, they would need to be deemed appropriate. A Registered Nurse initiated the process by obtaining a physician's order, collaborated with the interdisciplinary team and ensured the resident was clinically appropriate and safe. Without the assessment the resident should not be self-medicating. 10 NYCRR 415.3 (f)(1)(vi)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review conducted during a Standard survey completed on 2/20/25, the facility did not ensure the residents' environment remained as free from accident hazards as possible, and each resident receives adequate supervision for one (Resident #54) of four residents reviewed. Specifically, the privacy curtain was not securely mounted to the ceiling track and the curtain fabric was lying directly on the floor. The finding is: The policy and procedure titled Falls Prevention Program, revised 1/2024, documented the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Identifying causes or fall risks included whether any environmental risk factors were involved (slippery floor, poor lighting, furniture, or objects in the way). When a resident falls the following individuals will be notified: The resident's family; The attending Physician; The Director of Nursing; and the Nursing Supervisor on duty. Resident #54 had diagnoses including end stage renal disease, diabetes mellitus, and depression. The Minimum Data Set (a resident assessment tool) dated 11/10/24 documented Resident #54 was understood, understands, and was moderately cognitive impaired. The comprehensive care plan, revised on 2/10/25, documented Resident #54 tripped over a rug and fell on [DATE]. The plan included to initiate fall prevention interventions, provide a clutter free environment, and ensure the call bell was within reach, and assistive devices within reach. The Visual/Bedside Kardex (guide used by staff to provide care) with an as of date 2/18/25 documented Resident #54 ambulated independently with a cane, educate on safety precautions, and call for help if needed. Review of the Fall Risk Evaluation with an effective date of 1/12/25 documented Resident #54 had a history of falls, exhibited loss of balance while standing, and was categorized as a low risk for falls. During observation and interview on 2/13/25 at 10:24 AM, Resident #54 was lying on their bed. They stated they had walked to their bathroom from the bed and tripped over the privacy curtain two months ago and was helped up by Certified Nurse Aide #4 and Licensed Practical Nurse #3. Resident #54 stated they had been waiting for the privacy curtain to be fixed and did not want to fall again. At this time a portion of the privacy (eight inches by six inches) curtain fabric was lying directly on the floor. There were six grommets at the top of the privacy curtain were not secured and dangled from the ceiling track. Review of the nursing progress notes from 8/12/24 through 2/13/25 revealed there was no documented evidence of a fall related to Resident # 54's privacy curtain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Work Order Request Forms from 12/1/24 through 2/16/25 revealed there was no documented evidence Resident #54's broken privacy curtain was reported to maintenance. During intermittent observations on 2/14/25 and 2/18/25 between 9:00 AM and 3:00 PM the privacy curtain fabric remained directly on the floor and was not securely mounted to the ceiling track. During observation and interview on 2/18/25 at 9:50 AM, Registered Nurse #2 stated they had never noticed the privacy curtain was on the floor. It was a tripping hazard and an accident waiting to happen. The concern should have been reported to maintenance. During an observation and interview on 2/18/25 at 9:52 AM, Housekeeping Aide #2 stated the privacy curtain was dangling and dangerous. They should have identified the broken privacy curtain when they mopped the floor. The repair should have been documented on their Housekeeping Daily Room Cleaning Checklist form and turned into the Assistant Environmental Services Director. Housekeeping Aide #2 stated, they should have told the Environmental Service Director as well incase their form turned up missing. Review of the Housekeeping Daily Room Cleaning Checklists from 1/1/25 through 2/16/25 revealed Resident #54's privacy curtains were checked daily for holes/stains. However, there was no evidence the broken privacy curtain was reported to the Maintenance Supervisor. During observation and interview on 2/18/25 at 9:53 AM, Maintenance Assistant #1 stated the privacy curtain was a fall hazard, needed to be replaced, and should have been documented on a work order form in the maintenance log. During observation and interview on 2/18/25 at 9:58 AM, the Director of Nursing stated the privacy curtain was six hooks shy and needed to be repaired. On 2/18/25 at 9:59 AM, Resident #54 stated to the Director of Nursing that Certified Nurse Aide #4 and Licensed Practical Nurse #3 helped them off the floor after they had tripped over the privacy curtain about two months ago. The Director of Nursing stated Certified Nurse Aide #4 and Licensed Practical Nurse #3 should have reported the broken hooks to maintenance immediately after and prevented further falls. The Director of Nursing stated the resident's fall should have been immediately reported to them. During an interview on 2/18/25 at 10:15 AM, Certified Nurse Aide # 4 stated Resident #54 fell a few weeks ago, with the help of Licensed Practical Nurse #3 they assisted Resident #54 off the floor and they did not realize they fell over the curtain or would they have reported it to maintenance that the privacy curtain needed to be fixed. Certified Nurse Aide #4 thought Licensed Practical Nurse #3 would take care of it. Resident #54 wanted us to forget it even happened. During an interview on 2/18/25 at 10:22 AM, the Assistant Environmental Services Director stated the privacy curtain was not dangling during the house audit that was completed in January 2025. There was no documented evidence a house audit had been completed. The Housekeepers were responsible to inspect for rips, tears, or soiling daily when cleaning the room. They could have replaced the hooks or the privacy curtain. During an interview on 2/18/25 at 1:51 PM, Certified Nursing Aide #3 stated they verbally reported the broken privacy curtain on 2/14/25 to Maintenance Assistant #1. Resident #54 or the roommate could have fallen. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 10:25 AM, the Environmental Services Director stated Housekeeping Aide #1 & #2 should have documented they inspected the privacy curtains, brought it to their attention, and they would have arranged to have it replaced. During an interview on 2/20/25 at 9:06 AM, Housekeeping Aide #1 verified they had completed the housekeeping daily room cleaning checklist on 2/15/25 and 2/16/25; and must have overlooked the Resident #54's privacy curtain. A portion of the privacy curtain on the floor could cause Resident #54 to fall. During an interview on 2/20/25 at 10:32 AM, the Administrator stated the privacy curtain could have caused Resident #54 to trip and was avoidable. 10 NYCRR 415.12 (h)(1)

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F 0742

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 36415

Based on interviews and record review conducted during a Standard survey completed on 2/20/25, the facility did not ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being for one (Resident #21) of five resident reviewed. Specifically, Resident #21 did not have a follow up Psychiatry consult as recommended and the facility was not aware the resident was not being provided with those Psychiatry services.

The finding is:

The policy and procedure titled Consultations with a revised date of 1/24, documented the facility is responsible to provide consultation services for any residents as needed. The facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility, and the timeliness of the services. If consultation services cannot be provided in-house, the facility will obtain services at appropriate outside offices. The policy documented that a designated facility staff will schedule the consult. Nursing will notify physician of consultation and any recommendations if physician is not at facility. Physician will approve any orders they agree with on the consult and documented a reason if they disagree. The consultation report will be added to the resident's medical record.

Resident #21 had diagnoses that included Schizophrenia, major depressive disorder and developmental disorder of scholastic skills. The Minimum Data Set, dated dated dated [DATE] documented Resident #21 was cognitively intact, was understood, and understands.

The Comprehensive Care Plan revised date 7/11/24, documented Resident #21 had a history of false accusations, providing inaccurate or conflicting information, multiple episodes of verbal outbursts due to a history of schizophrenia and major depressive disorder. Interventions included to initiate psychiatric evaluation as needed.

Review of the Order Summary Reported 2/20/25, documented Resident #21 had an active order with start date of 4/14/21 for psychiatry consults as needed.

Review of a (local hospital) Department of Telepsychiatry note dated 10/27/23 and signed by Nurse Practitioner #1 (of psychiatry) documented they had been seeing Resident #21 in video consultant since 6/26/23 for their paranoid schizophrenia diagnosis. Recommendations included to follow-up in four months.

Review of the Resident #21's electronic medical record from 10/28/23 through 2/19/25 revealed there was no documented evidence of psychiatric follow up or visit was completed.

During an interview on 2/14/25 at 9:25 AM, Resident #21 asked surveyor if they were safe because the walls were talking to them.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing progress notes revealed the following: -2/14/25 at 1:56 PM Licensed Practical Nurse #1 documented they were approached by Resident #21, and they had stated they overhead staff say they were going to kill them, and they do not feel safe at that the facility. Resident stated staff had been having secret meetings and were planning to execute them. Licensed Practical Nurse #1 documented they reassured Resident #21 they were safe, and staff had no intention of causing harm. -2/18/25 at 11:44 AM Licensed Practical Nurse #2 documented that Resident #21 confided in them that a staff member stated, someone put a hit on their head. Licensed Practical Nurse #2 documented that Resident #21 also stated I have visions of the [NAME] and God and things that happen. -2/18/25 at 2:24 PM Licensed Practical Nurse #1 documented that Resident #21 appeared to be having delusional behaviors. The Resident stated they believe staff is actively trying to harm them and that they are going to be executed. During an interview on 2/19/25 at 11:37 AM, Social Worker #1 stated Resident #21 was under the psychiatric care of Physician Assistant #1. They stated they could not locate any further psychiatry progress notes in Resident #21 medical record since the 10/27/23 visit. During a telephone interview on 2/19/25 at 12:25 PM, Physician Assistant #1 (of Psychiatry) stated Resident #21 was not an active patient of theirs. Resident #21's insurance company approved the resident for psychology visits but denied the resident for psychiatry visits about a year or two ago. During an interview on 2/19/25 at 12:37 PM, Social Worker #1 stated they were not aware the Resident #21 was not seeing Physician Assistant #1, and did not know their insurance company denied psychiatric visits and stated Physician Assistant #1 did not notify them of this. During an interview on 2/19/25 at 12:38 PM, Medical Doctor #1 stated they were unsure if Resident #21 was under the care of a psychiatrist. They stated if a previous psychiatry consult recommended a follow-up visit in four months, then it was not appropriate if that did not occur. Medical Doctor #1 stated that Resident #21 should have been seeing a psychiatrist because Resident #21 was on psychotropic medications. During an interview on 2/19/25 at 3:35 PM, the Medical Director stated that if Resident #21 had a recommendation to follow up with psychiatry in four months, then the resident should have had a follow up visit. The Medical Director stated that a person with the diagnosis of schizophrenia should be followed by psychiatry, if the resources where available. During a telephone interview on 2/19/25 at 5:37 PM, the Phycologist stated they were not aware that Resident #21 was not under the care of psychiatry. They stated they would have expected Resident #21 to have had a follow up appointment with psychiatry if that was the recommendation. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 9:46 AM, Social Worker #1 stated that the lack of psychiatry visits for Resident #21 slipped through the radar and they were not aware they were not seeing the psychiatrist until it was brought to their attention on 2/19/25. They stated when Physician Assistant #1 came on board at the facility they attempted to switch the company that Resident #21 was using for psychiatry care from telepsychiatry visits with Nurse Practitioner #1 to in-house visits with Physician Assistant #1. They stated the company that the Psychologist and Physician Assistant #1 work for would make their own schedule and follow-up appointments for their residents. Social Worker #1 stated Resident #21 would benefit from having someone else to talk with. During an interview on 2/20/25 at 8:55 AM, Licensed Practical Nurse Unit Manager #2 stated Resident #21 main behaviors consisted of delusions, hallucinations and seeing visions of future events. They stated they assumed Resident #21 was being followed by psychiatry but that was the responsibility of Social Worker #1. After view of Nurse Practitioner #1's progress note dated 10/27/23 they stated they did not know why Resident #21 did not have a follow up appointment but should have. They stated the importance of maintaining psychiatry appointments for Resident #21 was for their mental health and keeping them stable. During a follow up interview on 2/20/25 at 10:09 AM, Licensed Practical Nurse #2 stated they could not locate any documentation for Resident #21 regarding a follow-up visit for psychiatry after 10/27/23. During an interview on 2/20/25 at 11:00 AM, the Director of Nursing stated Resident #21 was schizophrenic with a lot of active hallucinations and delusions. They stated they do not know if Resident #21 was supposed to see psychiatry and that all mental health visits were handled by Social Worker #1. After review of Nurse Practitioner #1 note on 10/27/23 they stated their expectation would be that Resident #21 would have had a follow up visit in four months as recommended. During a telephone interview on 2/20/25 at 1:23 PM, the Referral Coordinator for the (local hospital) Department of Telepsychiatry stated that Resident #21 was last seen for a psychiatry visit on 10/27/23 and was to have a follow up visit on 3/6/24. They stated that Resident #21 was a now show by the home for the 3/6/24 visit. During an interview on 2/20/25 at 1:48 PM, Resident #21 stated they were happy that they would be following up with Nurse Practitioner #1 (psychiatry) again. During an interview on 2/20/25 at 2:05 PM, the Administrator stated they expected if the psychiatrist recommended a follow up visit that one would occur. They stated Social Worker #1 was responsible for ensuring psychiatry visits took place. 10 NYCRR 415.12(f)(1)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on interview and record review conducted during a Standard survey completed on 2/20/25, the facility did not ensure that the pharmacist reported irregularities to the Attending physician and the facility's Medical Director, and that these reports were acted upon for two (Residents #12 and #21) of five residents reviewed for drug regimen reviews. Specifically, irregularities identified by the Consultant Pharmacist were not sent to the Attending physician and Medical Director and they were not signed, addressed, or acted upon by a medical provider (Residents #12 and #21). The findings are: The policy and procedure titled Medication Regimen Reviews, review date 1/25, documented the consultant pharmacist performs a medication regimen review for every resident in the facility receiving medication. The policy documented that within 24 hours of the review, the consultant pharmacist provides a written report to the attending physician for each resident identified as having a non-life-threatening medication irregularity. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, the consultant contacts the medical director or the administrator. The policy documented that the attending physician documents in the medical record that the irregularity has been reviewed and what action was taken to address it. Copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record. 1. Resident #12 had diagnoses which included anxiety, depression, and dementia. The Minimum Data Set (a resident assessment tool) dated 1/5/25 documented that Resident #12 was severely cognitive impaired, sometimes understands, sometimes understood and received antidepressant and antipsychotic medications. Review of the comprehensive care plan dated 11/19/24 documented Resident #12 used psychotropic medications related to dementia, depression, and anxiety. Target behaviors included pacing, wandering, and inappropriate response to verbal communication towards others. The Order Summary Report dated 2/19/25 documented an active physician's order dated 1/9/25 for Xanax (antianxiety medication) oral tablet 0.5 milligrams by mouth every twenty-four hours as needed for panic attacks. There was no stop date. Review of the Consultant Pharmacist's Medication Regimen Review dated 1/23/25 documented an irregularity was identified during their medication review. Review of the Note to Attending Physician/Prescriber form dated 1/23/25, revealed the Consultant Pharmacist identified that Resident #12 had an as needed order for the psychotropic medication Xanax without a stop date. The Consultant Pharmacist recommended adding a stop date to the order and that if the Xanax could not be discontinued, regulations required that the prescriber documented the indication for use, the intended duration of therapy, and the rationale for the extended use. The Physician/Prescriber response section was not addressed, not signed, and was blank. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 2/19/25 at 11:26AM, the Consultant Pharmacist stated they emailed recommendations to the Director of Nursing after their review on 1/23/25. They could not see where the provider reviewed the Xanax, and it should have been evaluated on or before 1/23/25. There was no documentation that supported an indication for use or continued use of the Xanax past fourteen days. They would have expected the Director of Nursing to have printed the recommendation on 1/23/25 to give to Licensed Practical Nurse #2 who should have contacted the provider immediately as the recommendation was time sensitive. Other recommendations they'd expected to be signed and addressed by the medical providers within thirty days. During an interview on 2/19/25 at 12:26PM, Licensed Practical Nurse #2 (Unit Manager) stated the Director of Nursing printed the pharmacy recommendations and placed them in the medical provider's folder. The medical provider signed and addressed the recommendations when they would come in next. Licensed Practical Nurse #2 was responsible and ensured that the pharmacy recommendations were completed with the provider timely. A copy of the physician's order was attached to the recommendation for verification and placed in a binder when completed. Licensed Practical Nurse #2 stated they missed that the Xanax was ordered as needed with no stop date. During an interview on 2/19/25 at 12:31PM, the Director of Nursing stated they printed two copies of the pharmacy recommendations on 1/23/25. One copy was placed in their binder and the other placed in the medical provider's folder. Licensed Practical Nurse #2 was responsible to review new physician's orders and should have caught the Xanax had no stop date on 1/9/25. Therefore, they should have immediately contacted the medical provider for a stop date for the Xanax. Psychoactive medications ordered as needed should not be ordered for more than fourteen days. The Director of Nursing stated they printed off a report with the previous days new orders and the Xanax was overlooked and didn't know how. During an interview on 2/19/25 at 3:39PM, the Medical Director stated they had not seen the pharmacy recommendations, was not included in the emails from the Consultant Pharmacist, and wished they were. 2. Resident #21 had diagnoses that included diabetes, schizophrenia, major depressive disorder. The Minimum Data Set, dated dated dated [DATE] documented Resident #21 was cognitively intact, was understood, understands, and received hypoglycemic medication (used to lower blood sugar). Review of the Consultant Pharmacist report titled Note to Attending Physician/Prescriber dated 10/18/24, documented Resident #21 received Metformin Extended Release (a medication that lowers blood sugar over a 24-hour period) 500 milligrams two tablets twice a day. The Consultant Pharmacist recommended to considerer administering the medication once a day, 500 milligrams four tabs to simplify their regimen. There was no documented follow up, signature or date on the report by a medical provider. There also was no follow up documented by the Consultant Pharmacist. Review of the physician's Order Summary Report dated 2/20/25, documented Resident #21 had an active order for Metformin ER 500 milligrams two tablets twice a day with order start date of 1/9/22. Review of the Physicians Progress Notes from 10/18/24-11/27/24 revealed there was no documented evidence that the Consultant Pharmacist recommendation on 10/18/24 was reviewed or addressed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Grand Rehabilitation and Nursing at Batavia		STREET ADDRESS, CITY, STATE, ZIP CODE: 257 State St Batavia, NY 14020	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the nursing Progress Notes from 10/18/24-2/19/25 revealed there was no documented evidence of a discussion with a medical provider about the Consultant Pharmacist recommendation dated 10/18/24. During an interview on 2/19/25 at 3:35PM, the Medical Director stated hey were not provided any pharmacy recommendations when they started at the facility in November 2024 and could not speak on what providers prior to them should have done with the medication regimen review recommendations. The Medical Director stated the recommendations should also go to the other providers in the facility and not themselves. During a telephone interview on 2/19/25 at 4:25PM, the Consultant Pharmacist stated they would expect the medical provider to address their recommendation by signing, dating, and provided a rationale if the recommendation had been declined within 30 days of the recommendation being completed. They stated they would review their previous recommendations to see if they were addressed by a medical provider at the gradual dose reduction meetings that are held monthly at the facility. The Consultant Pharmacist stated if the medication regimen review forms were not scanned into the electronic medical record, then the Director of Nursing had them filed in a binder. They stated as a general rule if recommendations were not addressed by a medical provider, then they would reissue the recommendation again. They stated they do not have any documentation from Resident #21's 10/18/24 recommendation being addressed. The Consultant Pharmacist stated they probably did not follow up with the medical provider because Resident #21's recommendation was more for the convenience for the staff by only needing to do one medication pass versus two. During an interview on 2/20/25 at 11:00AM, the Director of Nursing stated they received the medication regimen review recommendations via email from the Consultant Pharmacist. They stated they printed two copies giving one to the medical provider and putting the second into their binder. They stated once the recommendation had been addressed by the provider, they replaced the copy in their binder with the addressed version. The Director of Nursing stated they were unsure what happened to Resident #21's 10/18/24 recommendation, but they should have been able to present documented evidence that the recommendation was addressed by the medical provider, but they could not. During an interview on 2/20/25 at 2:05PM, the Administrator stated their expectation would be that a medical provider address, sign and date the Consultant Pharmacist medication regimen review recommendations. The Administrator stated they had identified that only the Director of Nursing received the recommendations via email and that they would need to be expending that process, so more staff are receiving the recommendations. 10 NYCRR 415.18(c)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415 Based on observation, interview, and record review conducted during a Standard survey completed [DATE], the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Specifically, one of one kitchen had issues with foods and beverages being either unlabeled or outdated in the refrigerators; kitchen had a grease laden hood with dusty, fuzzy debris, greasy black floor beneath the stove and oven, and thick greasy build up alongside the oven next to the stove/grill top; lack of [NAME] #1 wearing a facial hair covering in food preparation areas and during serving of food. Additionally, the pH (potential of hydrogen) test paper strips utilized to test the three-compartment sink were expired. The findings are: The undated policy and procedure titled Food Receiving and Storage documented food shall be stored in a manner that complies with safe food handling practices. All foods stored in the refrigerator will be covered, labeled and dated (use by date). Beverages must be dated when opened and discarded after twenty-four hours. The undated policy and procedure titled Sanitation documented the food service area shall be maintained in a clean and sanitary manner. Kitchen areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. Manual washing and sanitizing will employ a three-step process for washing, rinsing and sanitizing: quaternary ammonium compound ,d+[DATE] parts per million for time designated by the manufacturer. The Food Service Manger will be responsible for scheduling staff for regular cleaning of kitchen. The manufacturer manual for the kitchen hood documented they suggested having a certified hood cleaning company inspect and professionally clean hood system. Recommended guidelines based on use included hoods over non-grease applications/low volume cooking had a one-year cleaning requirement and typical hospital kitchens had a 90-day requirement. Exhaust fan cleaning was recommended monthly and heavy grease build up could be a fire hazard. Review of outside vendor receipts kitchen exhaust hood cleaning service was provided on [DATE] and [DATE] Review of Kitchen Cleaning List Monthly or When Needed 2025 provided by the Food Service Director on [DATE], documented stove burners and grill cleaning was completed on [DATE]. Hood Vents cleaning was handwritten as due in March. 1. During an observation of the kitchen on [DATE] between 9:22AM and 10:04AM, the following was observed: (continued on next page)

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-the cooks cooler contained a plastic container of prepared egg salad with use by date of ,d+[DATE]; a deep stainless steel dish labeled ,d+[DATE], no use by date indicated, contained the following lunch meat: a clear plastic bag of bologna that felt slimy with date on twist tie of ,d+[DATE], one opened undated package of sliced turkey, and one unopened, undated package of sliced turkey; a shallow stainless steel pan with label dated ,d+[DATE] and use by date of ,d+[DATE] contained two packages of thawed raw chicken. An opened package of raw chicken dated ,d+[DATE] with no use by date, and an additional unopened package of raw chicken was present without a label or date.

- the milk cooler contained one gallon of chocolate milk dated [DATE], use by [DATE] with a sell by date of [DATE]; one 46 fluid ounce honey consistency water labeled as opened on ,d+[DATE], use by date not indicated; one 46 fluid ounce of nectar consistency orange juice labeled as opened on ,d+[DATE], use by date was not indicated; one 46 fluid ounce tomato juice labeled as opened on ,d+[DATE], use by ,d+[DATE].

-the hood over the stove/grill and ovens were observed grease laden with dusty, fuzzy debris.

-the floor beneath the oven was soiled with a large area of blackened greasy debris; black thick debris buildup, and/or grease buildup on the outside of the oven next to the stove/grill top.

-Cook #1 was observed with facial hair approximately a quarter of an inch long cooking and preparing food in the kitchen without a facial hair covering.

During an observation and interview on [DATE] at 9:41AM to 9:50AM, [NAME] #1 stated the cooks were responsible for checking use by dates everyday and tossing anything after 3 days. [NAME] #1 stated the prepared egg salad should have been used or tossed out by [DATE]. Upon checking the plastic bag of bologna, [NAME] #1 stated they did a smell test to see if it was still good. They opened the bag of bologna, smelled the inside of the bag, then with an ungloved hand removed a slice of bologna from the plastic bag to feel the texture. [NAME] #1 stated the bologna needed to be thrown away, because it did not feel right. They stated it was important to check expiration and use by dates, so food did not sit too long. They stated it could grow bacteria and they would not want it consumed. [NAME] #1 stated the opened package of raw chicken was opened on [DATE] and should still be good. They stated some food was still good for ,d+[DATE] days.

During an observation and interview on [DATE] at 10:09AM to 10:13AM, the Food Service Director stated food, and beverages were supposed to be labeled with the date opened and the date to be discarded, if it was not dated and labeled, they should be discarded. They stated the cooks, and the dietary staff utilizing the food and beverages should be checking dates. The Food Service Director stated after three days of use, food should be thrown away due to bacterial growth. The Food Service Director inspected and threw out the opened package of raw chicken dated ,d+[DATE], stating it could cause salmonella. They stated the gallon of chocolate milk should have been thrown out as it was past the expiration date.

2. During an observation of the kitchen on [DATE] at 7:54AM-8:17AM the following was observed:

- [NAME] #1 still had facial hair and plated breakfast from the steam table without a facial hair covering and pureed a banana without a facial hair covering.

- the hood over the stove/grill and ovens was observed grease laden with dusty, fuzzy debris.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- the floor beneath the oven was soiled with large area of blackened greasy debris; black thick debris buildup, and/or grease buildup on the outside of the oven next to the stove/grill top. - the pH (potential of hydrogen) test paper utilized by staff for testing the three-compartment sink, had an expiration date of [DATE]. During an observation and interview on [DATE] at 8:18AM, the Food Service Director stated the hood over the stove/grill and oven were cleaned by a company every six months. They stated the hood was dusty with grease present and was do for cleaning the beginning of March. The Food Service Director identified the large area of blackened debris on the floor beneath the oven and black build up on the outside of oven as grease build up. They stated the floor, and the outside of the oven were supposed to be cleaned at least daily to prevent grease buildup that could start a fire and to prevent rodents. The Food Service Director stated dust should not be present in the area where food is being prepared for health reasons, did not want dust debris getting into the food being prepared and served to residents. The Food Service Director stated facial hair coverings should be worn so hair did not get into any food. They stated utilizing expired pH (potential of hydrogen) test paper may not give an accurate reading, or false reading when testing for proper sanitation levels. During an interview on [DATE] at 8:20AM, [NAME] #1 stated they did not realize their facial hair was that long. They stated they did not need a facial hair covering until facial hair was over a quarter of an inch long. [NAME] #1 stated facial hair coverings were worn for sanitation, so hair did not get into the food. 3. During an observation and interview in the kitchen on [DATE] at 11:02 AM-11:21AM, [NAME] #1 pureed spinach, chicken and macaroni and cheese wearing a face mask below their nose with their mustache facial hair exposed. [NAME] #1 utilized the pH (potential of hydrogen) test strips with expiration date of [DATE] to check the pH (potential of hydrogen) level of the three-compartment sink. [NAME] #1 stated they did not even think to check the pH (potential of hydrogen) paper for an expiration date. [NAME] #1 stated that utilizing the pH (potential of hydrogen) paper after the expiration date, degraded the value. They stated they may not get a proper rating and there could still be bacteria on the dishes. During an interview on [DATE] at 11:35AM, Registered Dietician stated they expected everything that was opened to be labeled and dated. They stated after the third day, food should be thrown out as food spoils and residents can get sick. The Registered Dietician stated maintaining a clean kitchen was important for food safety, protecting residents from getting sick; and that grease should be cleaned to prevent fire hazards. The Registered Dietician stated any facial hair should be covered so no hair got into the food and contaminated it. During an interview on [DATE] at 3:55PM, the Administrator stated that kitchen cleanliness should be maintained for infection control and hoods should be maintained for fire safety. They stated code required that food must be labeled and dated when opened. The Administrator stated that all expired food should be removed, as it could be spoiled, growing bacteria and cause illness. They stated it was a requirement to wear a hair covering so food did not become contaminated with hair. 10 NYCRR 415.14(h)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. 36415 Based on observation, interview, and record review during the Standard survey completed on 2/20/25, the facility did not operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes. Specifically, the facility was not in compliance with Section 915 of the 2020 Fire Code of New York State, which requires carbon monoxide detection in all rooms and sleeping areas with fuel-burning appliances, and on-going preventative maintenance of carbon monoxide detectors. This affected two (Unit A and Unit B) of two resident units and the basement. The finding is: According to the 2020 Fire Code of New York State, patient rooms in nursing homes are defined as sleeping units. In residential and commercial buildings that contain a fuel burning appliance, carbon monoxide detection shall be installed in all rooms, occupiable space, dwelling units, sleeping areas, and sleeping units that contain a fuel-burning appliance. Additionally, the 2020 Fire Code of New York State stated carbon monoxide detectors shall be maintained in good working order in accordance with Section 915 of this code, National Fire Protection Association (NFPA) 720 (Standard for the Installation of Carbon Monoxide Detection and Warning Equipment), and the manufacturer's instructions/recommendations. Observations on 2/13/25 between 9:10 AM and 3:30 PM revealed battery powered carbon monoxide alarms were installed on the first floor and in the basement. Further observation during these times revealed resident sleeping rooms were located on the first floor and fuel burning appliances were located on the first floor and in the basement. During an interview on 2/18/25 at 3:30 PM, the Environmental Services Director stated there were two different models of carbon monoxide detectors in the facility and both models were from the same manufacturer. The Environmental Services Director further stated the carbon monoxide detectors were tested and cleaned monthly. Review of carbon monoxide detectors logs documented that carbon monoxide detectors were located on the first floor and in the basement and the detectors had been tested and cleaned monthly from dated 5/13/23 through 2/15/25. Review of the Carbon Monoxide Alarm User Guide for carbon monoxide alarm (Model A) documented, Maintenance Tips. To keep your alarm in good working order, you must follow these steps: Test the alarm once a week by pressing the Test/Reset button. Review of the Carbon Monoxide Alarm User Guide for carbon monoxide alarm (Model B) Maintenance Tips. To keep your alarm in good working order, you must follow these steps: Test the alarm once a week by pressing the Test/Reset button. 42 CFR 483.70(b) (continued on next page)

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F 0836 Level of Harm - Potential for minimal harm Residents Affected - Many	10NYCRR: 415.29(a)(2), 711.2(a)(1) 2020 Fire Code of New York State, Section 915: 915.3.1, 915.6