STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335386	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Mohawk	99 Sixth Avenue Ilion, NY 13357

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews during the abbreviated (IQIES #2600078) survey the facility did not implement a comprehensive person-centered to meet a resident's medical, nursing, and mental and psychosocial needs identified in the comprehensive assessment for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 was left in the dining room after the lunch meal ended, and staff did not assist with toileting as planned. Findings include: The facility policy Care Plans, Comprehensive Person-Centered, reviewed 1/2025, documented the comprehensive care plan would describe the services furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being and reflect currently recognized standards of practice for problem areas and conditions. The facility policy Resident Care with Activities of Daily Living, reviewed 1/2025, documented residents on a toileting program will be offered assistance every 2-4 hours and as needed. Staff would document resident toilet use in the certified nurse aide accountability record. Preparation included to review the resident's care plan to assess for any special needs. Resident #1 had diagnosis including aspiration pneumonia (inhaling matter into the lungs), progressive hyperphagia (insatiable hunger) and dysphagia (difficulty swallowing). The Minimum Data Set assessment had not been completed.The 8/20/2025 admission Evaluation completed by Registered Nurse #20 documented the resident had intact cognition, was incontinent of bladder related to acute condition, and required substantial/maximal assistance with toileting.The 08/23/2025 at 11:10 AM Incident Report documented Resident #1 was witnessed sliding out of their wheelchair and landing on the floor. The resident did not strike their head. The resident was assessed by Registered Nurse #15 to have no injuries. The resident was soaked in urine and incontinence care was provided at the time. Interventions to prevent reoccurrence included to check and change every two hours, report any refusals, document the resident was checked every two hours and whether the resident was wet or dry. A 08/23/2025 at 12:00 PM verbal order documented check and change the resident every two hours to maintain skin integrity. The 8/23/2025 Comprehensive Care Plan documented to check and change every two hours and as needed, document if resident was wet/dry and any refusals for incontinence care.The Kardex (care instructions) as of 8/28/2025 documented check and change every two hours and as needed, document if resident is wet/dry and any refusal for incontinence care. The Certified Nurse Aide Activities of Daily Living Report documented on 08/23/2025 Resident #1 was provided bathing and personal hygiene activities at 9:45 AM and toileting at 11:36 AM, by Certified Nurse Aide #9.The Treatment Administration Record documented beginning on 08/23/2025 at 12:00 PM to check and change the resident every two hours. At 12:00 and 2:00 PM, Licensed Practical Nurse #2 documented the resident was checked and wet.The facility's 08/23/2025 surveillance videos from the second-floor dining room from 12:00 PM through 3:30 PM was reviewed. The following was observed:-From 12:10 PM - 3:15 PM, Resident #1 was seated in the dining room. No staff checked or provided care to the resident. At 3:15 PM, Certified Nurse Aide #14 entered the dining room and found the resident unresponsive. There was no documented evidence the resident was toileted every two hours as planned from 12:10 PM-3:15 PM. During an interview on 08/28/2025 at 1:45 PM Licensed Practical Nurse #2 stated on 8/23/2025 at around 1:30 PM, they went into the dining room to refill their water pitcher and Resident #1 was still sitting at the table. They told the resident they would let someone know to come get them, as residents were not supposed to be left in the dining room after they ate. They went back to their medication cart and told the certified nurse aides at the desk to make sure everyone was out of the dining room. During an interview on 8/29/2025 at 11:00 AM Certified Nurse Aide #7 stated on 8/23/2025 during the day shift there were four certified nurse aides, and they split the two hallways, two assigned to the Northside and two to the Southside. The were assigned the Northside with Certified Nurse Aide #9 and they were both assigned to Resident #1. They toileted Resident #1 around 11:00 AM when the resident slipped out of their wheelchair but did not provide any care prior to that. The last time they saw the resident was at 1:45 PM. They did not provide the resident any care after lunch and took over doing a one to one for another resident at 2:00 PM. During an interview on 8/29/2025 at 11:20 AM Certified Nurse Aide #8 stated earlier in the day on 8/23/2025 they assisted with cleaning the resident's chair pad after they slid out of their wheelchair, as it was soaked in urine. During an interview on 8/29/2025 at 11:35 AM Certified Nurse Aide #9 stated on 8/23/2025 they left the dining room around 1:20 PM to do afternoon care on other residents and Resident #1 was still eating. They did not provide any afternoon care to Resident #1 as they were helping other aides. They usually checked and changed the resident but the last time they changed Resident #1 on 8/23/2025

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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 0678 Level of Harm - Actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the abbreviated (IQIES 2600078) survey, the facility did not ensure provision of emergency basic life support immediately when needed, for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 was found in the dining room unresponsive and without a pulse and staff did not initiate cardiopulmonary resuscitation (chest compressions and rescue breathing) immediately and moved the resident to their room to start cardiopulmonary resuscitation.Findings include: The facility policy Cardiopulmonary Resuscitation. revised 02/2024, documented the facility would ensure personnel completed training on the initiation of cardiopulmonary resuscitation and basic life support, including defibrillation, for victims of sudden cardiac arrest. If a resident was found unresponsive and not breathing a licensed staff member who was cardiopulmonary resuscitation certified shall initiate cardiopulmonary resuscitation unless there is a do not resuscitate order and there are obvious signs of irreversible death.Resident #1 was admitted to the facility on [DATE] and had diagnoses including aspiration pneumonia, progressive hyperphagia (excessive hunger) and dysphagia (difficulty swallowing). The [DATE] physician admission orders documented Full Code (perform cardiopulmonary resuscitation). The [DATE] facility surveillance videos from the second floor dining room from 12:00 PM through 3:30 PM was reviewed. The following was observed:-From 3:15:56 PM - 3:16:15 PM, Certified Nurse Aide #14 entered the dining room toward Resident #1. They looked at the resident, bent over to look closer and walked out of the dining room toward the nursing station.-At 3:16:36 PM Certified Nurse Aide #14 returned with Licensed Practical Nurse #13, who appeared to examine Resident #1. At 3:16:57 PM, Licensed Practical Nurse #13 left the dining room walked toward the nursing station and returned to the resident at 3:17:58. They pushed the table away from the resident and along with Certified Nurse Aide #14 bent over the resident. Certified Nurse Aide #8 and Licensed Practical Nurse #17 entered the dining room. Licensed Practical Nurse #17 talked on a cellphone. At 3:18: 34, they wheeled the resident out of the dining room. The [DATE], Change in Condition Evaluation documented Resident #1 was found unresponsive in the dining room, cardiopulmonary resuscitation and code blue were initiated. Emergency Medical Services was called at 3:19 PM and arrived at 3:25 PM. Resident #1 was pronounced deceased at 3:29 PM after Emergency Medical Services called the hospital. During an interview on [DATE] at 2:45 PM Registered Nurse #3 stated on [DATE] they arrived at the facility at 2:45 PM. They received a text from Licensed Practical Nurse #17 to call them, they called back at 3:21 PM and the call was not answered. They headed to the resident's floor and received a call back the resident was unresponsive. When they arrived, the resident was on their bed on a backboard and Licensed Practical Nurse #13 was doing chest compressions. Registered Nurse Unit Manager #15 was present in the room. Certified Nurse Aide #14 was getting the crash cart and Licensed Practical Nurse #17 called Emergency Medical Services at about 3:19 PM. Emergency Medical Services arrived at approximately 3:25 PM. When they arrived, they inspected the resident's legs and stated the resident was cold to the touch, called the hospital, and the physician in the Emergency Department called time of death at 3:29 PM.During an interview with the Director of Nursing #10 on [DATE] at 11:55 AM they stated staff should have done cardiopulmonary resuscitation right there in the dining room, but they did not. During an interview with Licensed Practical Nurse #13 on [DATE] at 2:15 PM they stated when they started their shift on [DATE] at 2:15 PM they were given report. Around 3:00 PM Certified Nurse Aide #14 told them Resident #1 was in the dining room and was not responding. They entered the dining room and the resident's head was to the side. The resident did not have a pulse. The left the dining room to look at the resident's Medical Orders for Life-Sustaining Treatment Form, but the resident did not have one, but they knew the resident was a Full Code as they checked their orders the night before and again checked at the time. They returned to the dining room and was going to put the resident on the floor but there were residents coming in and out of the dining room, so they decided to take the resident to their room. The resident's legs were cold, but their upper body was warm. Licensed Practical Nurse #17 was instructed to call the supervisor, call 911 and get the crash cart. Once they got the resident in the bed, they put the board behind the resident and started chest compression. Emergency Medical Services arrived shortly after that, and said the resident had been dead a long time. Emergency Medical Services went to make a call to the hospital and got an order to stop cardiopulmonary resuscitation and they called the time of death. Licensed Practical Nurse #13 did not believe moving the resident to their room to do cardiopulmonary resuscitation caused a delay in emergency

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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 - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the abbreviated (IQIES 2600078) survey, the facility failed to ensure a resident received adequate supervision and assistance devices for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 required supervision at meals due to hyperphagia (insatiable hunger) and dysphagia (difficulty swallowing) and was on aspiration precautions (inhaling food into the lungs). Specifically, the resident was left unattended in the dining room on 08/23/2025 with access to inappropriate food consistency and the Resident began choking, showed signs of distress, and staff did not intervene to assist the resident. The resident was discovered unresponsive approximately 90 minutes later and was pronounced deceased after cardiopulmonary resuscitation was attempted. This resulted in Immediate Jeopardy to Resident #1 and placed 29 residents requiring supervision at meals at risk for the likelihood of serious harm, serious impairment, serious injury, or death.Findings include: The facility policy Aspiration Precautions, revised 03/2025 documented a dietitian, speech language pathologist or licensed nurse would be present during meals and consumption of intake to monitor for signs of choking or aspiration. Resident #1 was admitted to the facility on [DATE] and had diagnoses including aspiration pneumonia, progressive hyperphagia, and dysphagia. The Minimum Data Set assessment had not yet been completed. The 08/20/2025 physician admission orders documented Full Code (perform cardiopulmonary resuscitation) and a diet of regular ground texture, honey consistency liquids with aspiration precautions. The 08/21/2025 at 08:21 AM Speech Language Pathologist #4 screening documented the resident had loss of liquids/solids from mouth, was holding food in their mouth/cheeks and had pain with swallowing. The current diet order was ground, honey thick liquids with aspiration precautions. The 08/21/2025 Speech Language Pathologist #4 progress note documented aspiration precautions, maroon spoon (adaptive utensil), 1:1 supervision to implement strategies, out of bed for all meals, maintain upright position for 30 minutes after meals, encourage small bites/sips, reduce rate, alternate liquids/solids, double swallow, lingual sweep, and throat clear with swallow. The 08/21/2025 Diet Technician #18 dietary progress note documented the resident perseverated (to recur or repeat continually) about food. Speech Therapy recommended aspiration precautions, maroon spoon for pacing along with feeding techniques. The Comprehensive Care Plan initiated on 08/21/2025 documented the resident required a mechanically altered diet and perseverated on, food/eating/feeling hungry. Interventions included to provide diet as ordered and maroon spoons for pacing. The Comprehensive Care Plan did not include documentation related to aspiration precautions or specialized feeding techniques. The undated Kardex (care instructions) documented a ground diet with honey thick liquids, and aspiration precautions. The resident's assistance with feeding was not included in the Kardex. The 08/21/2025 Nurse Practitioner #19 progress note documented the resident was dependent on a feeding tube but tolerated a modified diet with supervised oral intake.The 08/25/2025 Investigative Summary completed by the Director of Nursing documented that on 08/23/2025 at 3:15 PM, Resident #1 was found in the dining room unresponsive with no signs of life. A Code Blue (emergency response) was called, the resident was taken to their room and cardiopulmonary resuscitation was initiated. Emergency Medical Services arrived, immediately called the hospital and received an order to cease cardiopulmonary resuscitation, and the resident was pronounced deceased . The conclusion of the investigation documented the meal consistency served to the resident during lunch was accurate. Review of the camera footage showed the resident waving their arm and pounding on their chest, which went unnoticed by Dietary Aide #11 and Housekeeper #5 who were present in the dining room at the time. The investigation documented, it was not seen and could not be determined on video footage the resident consumed anything prior to the event, and it was the facility's belief the resident regurgitated and choked on their vomit.The 08/23/2025 lunch meal tickets documented: -Resident #1 received a ground diet with honey thick liquids, required two maroon spoons, and was on aspiration precautions. The resident received mashed potatoes, ground cauliflower, yogurt, and ground mixed fruit.-Resident #4, who was seated next to Resident #1 during the meal was given a regular diet of Swedish meatballs, brown gravy, noodles, cauliflower and mixed fruit. The facility's 08/23/2025 surveillance videos from the second-floor dining room from 12:00 PM through 3:30 PM and the Nursing Station from 2:40 PM to 2:50 PM was reviewed. The following was observed:-From 12:10 PM to 1:23 PM, Resident #1 was in the dining room seated to the right of Resident #4 and across from Resident #3. Certified Nurse Aides #7, #8, and #9 served residents' lunch. There were no licensed nurses in