

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2025
NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nursing at Pawling		STREET ADDRESS, CITY, STATE, ZIP CODE 9 Reservoir Road Pawling, NY 12564	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52261</p> <p>Based on record review and interview during an abbreviated survey (NY00348469, NY00349271) the facility did not ensure a resident was free from physical and verbal abuse from a staff member for 1 of 3 residents reviewed for abuse, neglect, or mistreatment was free from verbal abuse. Specifically, on 7/16/2024, Resident #2 reported that a Certified Nurse Aide #1 that provided care pulled their hair, hit and pulled their thumb. The incident was witnessed by the residents' roommate (Resident #3). In addition, Certified nurse Aide #5's statement revealed that when they walked into Resident #2's room, they found Resident #2 crying and Certified Nurse Aide #1 was telling Resident #2, I am a serious person, and you are racist.</p> <p>The Findings are:</p> <p>The Facility's Policy on Abuse Prevention dated 1/2025 documented that facility's residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.</p> <p>Resident #2 had diagnoses that included Major Depressive Disorder, Anxiety Disorder, Dysphagia, Cerebral Infarction and Dysphagia following Cerebral Infarction.</p> <p>The Minimum Data Set (MDS, an assessment tool) dated 2/8/2025, documented a Brief Interview for Mental Status (BIMS) score of 15/15 indicating that the resident was cognitively intact. Resident #2 required maximal assistance with personal hygiene and toileting and was dependent with all transfers and bed mobility with 2 person assistance. Resident was unable to speak clearly so they wrote everything down on a yellow pad.</p> <p>Review of the Behavior care plan dated 6/4/2024 documented that the Resident exhibited behavior symptoms such as (tapping on bedside table for staff response to needs). Resident taps on table repeatedly to get the attention of the staff even though she can use the call bell. The resident will ask the same questions repeatedly even though it has already been addressed. Interventions included to assess resident for signs and symptoms of abuse and/or neglect and report to appropriate resources, investigate all allegations of abuse and neglect promptly, provide support and ensure resident is free from abuse.</p> <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Behavior care plan dated 7/16/2024 documented Resident #2 alleged a Certified Nurse Aide pulled their hair, hit their right arm and twisted their thumb.</p> <p>Review of the Employee Disciplinary Action form dated 7/23/2024 documented status post investigation it was founded that Certified Nurse Aide #1 did verbally respond to the resident inappropriately, as per resident and witness.</p> <p>Review of a signed Employee Statement Form dated 7/16/2024 documented by Licensed Practical Nurse #3 documented that Resident #2 was found still crying and they asked the resident what happened. Resident #2 motioned by pulling their right thumb back, hitting their right arm and grabbing their hair and put up 2 fingers. Resident #2 was asked if it was Certified Nurse Aide #1, and the resident said yes. They looked at the resident's right arm and did not see any visible marks. They looked at the resident's right thumb which appeared red but Resident #2 was rubbing it as they said it hurts. Resident #2's head had no marks that could be seen. They told Resident #2 that that Certified Nurse Aide #1 would not be back in their room.</p> <p>Review of the Weekly Skin Monitoring dated 7/19/2024 documented that upon assessment, the resident had discoloration to right thumb palm area. Physician made aware. X-rays were ordered.</p> <p>Review of the X-ray results dated 7/19/2024 revealed no fracture to the right hand.</p> <p>Review of the Accident/Incident Report dated 7/16/2024 documented that the resident reported to staff and to resident's sibling that Certified Nurse Aide#1 pulled their right thumb backwards, hit my right arm and pulled my hair twice. The Administrator and Director of Nursing were notified. The Sheriff's office was called and given summary of incident and asked to come and see the resident and take report. The resident's sibling was contacted by the resident and floor nurse. Oncoming Supervisor made aware of the situation and staff in question was called and told not to return to work pending investigation per administration. Resident was not taken to the hospital. There were no obvious injuries.</p> <p>Resident #8 was admitted with diagnoses that included dementia, hearing loss and polymyelitis. The Minimum data set dated [DATE] docuemnted a Brief Interview for Mental Status (BIMS) score of 8/15 indicating the resident was cognitvely impaired. Resdient #8 was dependent with all cares and mobility.</p> <p>During an interview on 2/24/2025 at 9:28am with the Director of Social Work, they confirmed that the Resident #2 told them that it was a Certified Nurse Aide and not a nurse that to pulled their hair and thumb.</p> <p>During an interview with Licensed Practical Nurse #2 on 2/18/2025 at 3:33pm, they stated Certified Nurse Aide #1 was fired. Resident #2 informed them that after they called Certified Nurse Aide #1 a Nigger, Certified Nurse Aide #1 pulled their hair like a rag doll. A body audit was done and there was no discoloration was noted on the right thumb. There were no other visible injuries noted. Resident #2 was very distraught for hours, but Licensed Practical Nurse #2 was able to calm the resident down after a few hours. Licensed Practical Nurse #2 stated I know the resident well. Resident #2 can get a little dramatic but they would not make up a story like that.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Resident #2 on 2/19/2025 at 11:33am, they wrote on their yellow pad, I remember my thumb was pulled back. Certified Nurse Aide pulled my hair. I don't remember the name of the Certified Nurse Aide.</p> <p>During an interview on 2/24/2025 at 1:03pm, Certified Nurse Aide #1 stated when they went to help Certified Nurse Aide #5, Resident #2 was banging their phone on the table and they stood by the resident's door in the hallway. Certified Nurse Aide #5 was caring for another resident. Certified Nurse Aide #1 stated Resident #2 was calling them the N word and kept saying come change me now and they kept answering Resident #2, we have to wait for Certified Nurse Aide #5. They do not know why Resident #2 was so upset. Certified Nurse Aide #1 stated after providing care to Resident #2 they went back upstairs. An hour later, the supervisor called them at home and told them that they abused Resident #2 and they can't really recollect exactly what the supervisor said they did. They were taken off the schedule pending an investigation and was told the Director of Nursing and the Administrator will be in contact with them. Certified Nurse Aide #1 stated they were off the schedule for about 2 weeks. They were provided education on abuse. They were provided a re-orientation class and put back on shadowing for 10 shifts and they had to do a packet as well. Certified Nurse Aide #1 stated denied the allegation</p> <p>During an attempt to interview Resident #8(Resident #2's roommate) on 3/17/2025 at 11:01am, Resident #8 did not respond to questions and had their eyes closed.</p> <p>10 NYCRR 415.4(b)(1)(i)</p>