

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 06/17/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the recertification and abbreviated (NY00356909, NY00339190) surveys from 6/10/25 to 6/17/25, the facility did not ensure resident's right to a safe, clean, comfortable, and homelike environment. Specifically, 1) Maintenance Care Logs dated January 2024 to present documented more than five hundred (500) reports of television and television remote controls not working properly and many not repaired timely. Additionally, Resident #314's family reported during April and September 2024 visits Resident #314 did not have a functioning television in their room, and 2) the closet door in Resident #39's room had broken hinges which prevented proper attachment.</p> <p>The findings are:</p> <p>The Policy dated January 2025 titled Maintenance Service, documented the maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner.</p> <p>During an interview on 06/10/25 at 11:51 AM, Resident #46 stated every time they moved to a different room, the television did not work.</p> <p>The Maintenance Care Logs reviewed from January 2024 to the present date documented more than five hundred (500) reports of televisions and television remote controls not working properly and many not repaired timely, with some lag times up to several days.</p> <p>During a telephone interview on 6/12/25 at 1:08 PM, a family member of Resident #314 (room [ROOM NUMBER]) stated during visits they observed the resident's television was not working.</p> <p>The Maintenance Logs dated 4/11/24, 4/12/24, and 9/10/24 documented install a new television in room [ROOM NUMBER], as the family was upset about the situation.</p> <p>During an interview on 06/11/25 at 03:02 PM, the Director of Maintenance reviewed the Maintenance Log reports of televisions and television remote controls not working. They stated all staff are responsible for reporting broken items via the computer on Maintenance Care. When reviewing lag times for repairing televisions and television remotes, they stated sometimes they run out of batteries for the infrared channel changers. They stated they must prioritize leaks and other safety issues over television issues. They stated they have only one helper, and no other staff can replace the batteries besides the maintenance staff.</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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. During an interview and observation on 06/11/25 at 9:17 AM, Resident #39 stated their closet door had been broken for over two years and they told multiple staff members. They stated they hold the door closed with a chair as it falls if not propped. Resident #39 was observed moving the chair. The chair was propped against the closet door. The closet door was not attached at the hinges.</p> <p>During an observation in room [ROOM NUMBER] B on 6/12/25 at 9:38 AM a chair was observed propped against the closet door to prevent it from falling.</p> <p>There were no documented work orders in the Maintenance Repair logs to address the closet door,</p> <p>During an interview on 6/12/25 at 3:07 PM, the Director of Maintenance assessed the closet door in room [ROOM NUMBER] B and stated the door needed repair and removed it from the room. They stated when a repair is needed, staff enter the work order in the computer program used for reporting needed repairs, but they had not received a recent work order for this closet. When work orders are received, they prioritize them, complete the work, and mark the work completed. They stated a broken wardrobe door would be prioritized for repair because it is a safety hazard. They stated they have not been auditing the rooms routinely to assess for safety issues.</p> <p>During an interview on 06/17/25 at 09:00 AM the Administrator stated there is a maintenance program that should be used for reporting any needed repairs. They stated maintenance and housekeeping both round on the units, but there is no formal tool in use to audit the rooms for safety.</p> <p>10 NYCRR 415.5(h-i)(1-3)</p>

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review conducted during the recertification and abbreviated surveys (NY00364897) from 6/10/25 to 6/17/25, the facility did not ensure each resident's right to file a grievance and/or that prompt efforts were made to resolve a grievance for one of six residents (Resident #14) reviewed for Personal Property. Specifically, there was no documented evidence that a grievance was filed an investigation conducted and/or a grievance was resolved when Resident 14 reported to staff they were missing a bag that contained their license, gift cards, and some cash and multiple clothing items.</p> <p>The findings include:</p> <p>The Policy titled Grievances, complaints, and filing, which was revised in January 2025, documented residents and their representatives have the right to file grievances either orally or in writing with the facility staff. The administrator and staff are committed to making prompt efforts to resolve grievances to the satisfaction of the resident and /or representative. Individuals filing a grievance will be informed verbally and in writing about the outcome. A written summary of the investigation will also be provided to the resident.</p> <p>The Policy titled Missing Items reviewed January 2025 documented residents are permitted to retain and use personal possessions and appropriate clothing, as space permits. The residents belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.</p> <p>Resident #14 had diagnoses that included, but not limited to, heart failure, chronic kidney disease, and lymphedema.</p> <p>The Annual Minimum Data Set, dated [DATE] and 5/6/2025 Quarterly Minimum Data Set documented Resident #14 had intact cognition, and had no behaviors.</p> <p>During an interview on 6/12/25 at 9:51 AM, Resident #14 stated when they purchased new items of clothing, they did not think the facility recorded the clothing on an inventory sheet. They stated the facility sent clothing to an outside launderer some time in the last year and may have lost some of their items. They stated they have receipts for all the missing clothing. They stated they had not seen the Social Worker or Administration regarding the missing items, just housekeeping staff. They stated they spoke with the housekeeping manager again last week but was not offered a grievance form.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/25 at 12:27 PM the Director of Housekeeping stated when a new resident is admitted their personal items should be listed on an inventory sheet and clothing is taken to be labeled. They stated if a resident acquires new items during their stay, housekeeping should be informed, and the items should be labeled and inventoried. They stated when missing clothing items are reported, staff often notify them so they can look for the item. They stated if they can't find the missing items, they let the Social Worker know. There stated there was a time when clothing was removed from the facility and sent to an outside launderer. They stated when clothing was sent out, they did not re-inventory the clothing. They stated they had spoken with Resident #14 many times about missing items and contacted the outside launderer. They stated they had not located the described items. They stated they had discussed this with the resident for the last couple of months but did not inform the Social Worker.</p> <p>During an interview on 6/16/25 at 12:04 PM, the Director of Social Work stated if there were reports of missing personal items, staff should look for the item first and if not found, contact the Social Worker. They stated laundry may be contacted to check for the item if it is clothing. They stated if the missing item was listed on the inventory form and not found they would request reimbursement from the facility. They stated any items newly purchased for a resident already living at the facility should be added to the inventory form. They stated if items were not on the inventory form, but the resident had receipts, they would need approval from administration for reimbursement. They stated all staff should be aware of the process. They stated they were not made aware of missing clothing reported by Resident #14.</p> <p>During an interview on 6/16/25 at 3:45 PM, Resident #14 stated that they had also been missing a bag since February which contained their license, gift cards, and some cash. They stated the items had not been added to their inventory form, but the Unit Manager acknowledged that they had the bag. They stated the Social Worker told them they had no proof of the bag, so they never wrote the item up.</p> <p>During an interview on 6/17/25 at 9:34 AM the Administrator stated when a resident is missing an item, a missing item form should be completed. Any staff member can complete the form and the Unit Manager should be made aware. They stated they were not certain how the Social Worker is involved but they should be notified. They stated they were not certain who kept the inventory forms but believed they may be in the paper chart. They stated if clothing is missing, housekeeping/laundry should investigate and if the item/s are not found, the resident should be reimbursed. They stated the Assistant Administrator typically handles reimbursement. They stated if an item was never added to the inventory form, staff could not verify that the item existed. They stated if the resident had receipts that would help. They stated a reasonable amount of time to investigate missing items would be 7-14 days. They stated the process is a little unclear right now.</p> <p>During an interview on 6/17/25 at 10:13 AM, the Director of Social Work stated they were not aware that Resident #14 was missing a bag, but stated they would follow up to investigate.</p> <p>During an interview on 6/17/25 at 11:01 AM, Registered Nurse Unit Manager #10 stated when an item is missing, they looked for the item first and then informed the Social Worker. They stated Resident #14 reported a missing bag and the Social Worker was made aware. They stated the bag had not been found. They stated housekeeping was working on Resident #14's missing clothing and the investigation is ongoing but never resolved.</p> <p>10NYCRR 415.3 (d)(1)(ii)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the Recertification and Abbreviated Surveys (NY00339190, NY00364897, NY00368159, NY00372669, NY00377396, NY00356909, and NY00373290) from 6/10-6/17/2025, the facility did not ensure that residents unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 9 of 9 residents (Residents #46, #14, #74, #216, #364, #214, #78, #314, #165, and 13) reviewed for Activities of Daily Living and 3 additional residents (Residents #61, 76, and 6) observed during the sufficient staffing task. Specifically, 1) Resident # 46 was not provided timely incontinence care and was not gotten out of bed daily. 2) Resident #14 was not provided consistent incontinence care and showers. 3) Resident #74 was observed with long dirty finger nails, clothes soiled with food and a noticeable urine odor. Additionally, Residents #78 and #13 were not showered as planned; Residents #214, #216, #165, #364 and #314's Certified Nurse Aide Accountability Records were noted with multiple omissions over multiple day for activity of daily living that included showers, personal hygiene, and toileting; and on 6/15/25, a Sunday afternoon at 12:45 PM, Resident #6 was in bed, stated they had urinated and had not been changed since 5:00 AM; Resident #76 was in bed and their sheets and hospital gown were soaked with urine; Resident #61 was out of bed in a chair with a strong odor of urine and rings of dried urine were observed on the bedsheet.</p> <p>Findings include:</p> <p>The Facility Policy Activities of Daily Living reviewed 1/2025 documented the purpose of this procedure is to accurately assist with the residents need for support for basic ADL(activities of daily living) function. The procedures included those for toileting for ambulatory and non-ambulatory residents, hair care, dressing and undressing, skin inspection and cleanliness, oral care, peri care, personal care and infection prevention. Documentation should be completed after the care is provided.</p> <p>1. Resident #46 had diagnoses including severe morbid obesity, anxiety, and depression.</p> <p>The 3/12/25 annual Minimum Data Set (resident assessment) documented the resident's cognition was intact. Resident #46 had an impairment to lower extremity on one side and was dependent on staff for toileting hygiene and transfers.</p> <p>The 6/4/25 Care Plan, at risk for functional decline in mobility and self-care, documented intervention included to provide dependent assistance with footwear/toileting hygiene, and chair to bed transfers with 2-person mechanical lift.</p> <p>The 6/12/25 Kardex documented the resident required a mechanical lift with 2 staff for transfers. The resident wore incontinence brief and used a urinal.</p> <p>During a resident interview on 6/10/25 at 12:55 PM, Resident #46 stated when there was not enough staff, it was hard to get someone to assist them to get their brief changed, to get washed and dressed, and to be transferred out of bed. They stated they frequently called the corporate main office number to ask for assistance. The corporate office would call the facility to get a staff member to wash, dress, and get them out of bed. They stated they felt afraid to have a bowel movement because they might have to stay soiled for long periods of time. They stated on weekends, the staff told them they could not get them out of bed due to short staffing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and resident interview, on 6/15/25 at 12:45 PM, Resident #46 was observed visibly soiled through the sheets. The resident stated they told the Certified Nurse Aide 30 minutes ago and was still dirty.</p> <p>During a follow-up observation and resident interview, on 6/15/25 at 2:29 PM, Resident #46 was observed clean and dry, but was still in bed. The resident stated they had requested to get out of bed when they were cleaned earlier.</p> <p>During a follow-up resident interview, on 6/16/25 at 10:41 AM, Resident #46 stated that sometimes the Certified Nurse Aide told the resident there were not enough staff to get the resident out of bed that day. They only washed and changed the resident, but did not take the resident out of bed those days. They stated they need two staff for transfers with the mechanical lift. They stated they had a bowel movement yesterday morning around 9:00 AM and was not changed until after 12:00 PM. They stated they had rung the bell after having the bowel movement and a Certified Nurse Aide answered the call bell but did not come to change their brief until later. Resident #46 stated they told the Assistant Administrator that they want to get out of bed every day and the Assistant Administrator told them to tell the head nurse. Resident #46 stated they told the unit manager, and the unit manager tried but often stated there were not enough staff to get them out of bed.</p> <p>When interviewed on 6/16/25 at 10:59 AM, Certified Nurse Aide #5 stated they were assigned to Resident #46 and was told the resident got out of bed every day and required a 2-person assist and mechanical lift. They stated they worked the night shift and Resident #46 had a large bowel movement around 2:00 AM and they changed the resident with the assistance of another Certified Nurse Aide. They stated they planned to get resident out of bed this morning.</p> <p>During a follow-up resident interview on 6/16/25 at 2:52 PM, Resident #46 stated that on 12/17/24 and 12/25/24 (Christmas Day) they could not get out of bed when their family came to visit, which made them feel angry. They stated they felt depressed and anxious every morning, not knowing if they would be able to get out of bed that day.</p> <p>2. Resident #14 had diagnoses including heart failure, chronic kidney disease, and lymphedema.</p> <p>The Quarterly Minimum Data Set, dated [DATE] documented intact cognition, no behaviors, and dependent on staff assistance for all activities of daily living except eating and oral hygiene, which were documented as set up assistance.</p> <p>The Annual Minimum Data Set, dated [DATE] documented intact cognition, no behaviors, dependent on staff assistance for most activities of daily living except eating and oral hygiene which were documented as set up assistance, and maximal assistance for personal hygiene and upper body dressing.</p> <p>The Care Plan for at risk for functional decline in mobility and self-care, initiated 10/5/2023 and reviewed 2/27/2025, documented the resident was dependent on assistance from staff for all activities of daily living except oral hygiene and eating. Their shower days were Sunday and Thursday.</p> <p>The Care Plan for bowel incontinence, initiated 1/5/2023 and revised on 3/6/2025, documented the resident's incontinence would be managed in a timely manner. Interventions included checking the resident every 2-4 hours and assisting with toileting as needed.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Care Plan for bladder incontinence, initiated 1/7/2023 and revised on 3/6/2025, documented a goal that the resident would remain free from skin breakdown due to incontinence and brief use. Interventions included brief check and change every 3-4 hours and apply incontinence devices as appropriate.</p> <p>The May 2025 Certified Nurse Aide Accountability Record for Resident #14 contained no documented evidence that toileting hygiene was completed on 5/18 and 5/25/2025. Toileting hygiene was documented for one shift only on 5/4-5/6, 5/11, 5/17, 5/22, 5/27, and 5/29/2025. There was no documented evidence that personal hygiene was completed on 5/18 or 5/25/2025. Personal hygiene every shift was documented for one shift only on 5/4-5/6, 5/11, 5/17, 5/22, 5/27, and 5/29/2025. There was no documented evidence that showers were completed on 5/1, 5/5, 5/19, and 5/29/2025.</p> <p>The June 2025 Certified Nurse Aide Accountability Record for Resident #14 documented the resident was given a shower on 6/9/25 for the first time that month.</p> <p>During an interview and observation on 6/10/25 at 1:39 PM, Resident #14 was observed in bed with messy, unkept hair, and poor grooming. Resident #14 stated that they did not receive enough assistance with activities of daily living. There was rarely enough staff to get them out of bed and they usually receive incontinence care once a day. They stated showers were rarely given.</p> <p>During an interview and observation on 6/12/25 at 10:18 AM, Resident #14 was in bed and stated they were changed last around 5:00 AM and were waiting to be changed. They stated they used to get out of bed, but it was a rare occurrence now as there was not enough staff.</p> <p>During an observation on 6/12/25 at 10:33 AM, two Certified Nurse Aides arrived to provide care for Resident #14 and get them out of bed. At 6/12/25 at 11:16 AM, Resident #14 was observed out of bed.</p> <p>During an interview and observation on 6/13/25 at 12:56 PM, Resident #14 was observed in bed. Resident #14 stated they had not been changed since 4:00 AM and were waiting to be changed. They stated they did not know who their assigned aide was.</p> <p>During an interview on 6/13/25 at 1:14 PM Registered Nurse Unit Manager #10 stated the nurse would have to assist with cares for Resident #14 if there were only 2 Certified Nurse Aides assigned to the unit. Residents should be checked every 2-3 hours even with only 2 Certified Nurse Aides. They stated that they also assisted with cares as needed. Resident #14 did not call for assistance much, but since they were incontinent, they should have been checked every 2-3 hours.</p> <p>During an interview on 6/16/25 at 9:24 AM Resident #14 stated that the staff told them they would get them up yesterday and Friday, but never did.</p> <p>During an interview on 6/16/25 at 9:35 AM, Registered Nurse Unit Manager #10 stated of the 40 residents on Unit 300, approximately 18 were independent or required limited assistance. The remaining residents on the unit required 1-2 assist, with many requiring a mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/16/25 at 9:45 AM Certified Nurse Aide #12 stated that the information for the residents' level of care was on the Kardex (care instructions) in the computer. They were supposed to document on the Certified Nurse Aide Accountability record in all the sections for the care provided. The tasks that they did not complete should be documented as not attempted or not available if the resident was out of the facility. If a shower was not given, they would document not attempted with a reason. They stated that not all residents were gotten out of bed when there were only 2 Certified Nurse Aides on the unit for the shift. They stated there were times when they were the only Certified Nurse Aide and they were not able to complete all tasks. They need 2 people to provide Resident #14 care. During the day shift, they usually checked and changed Resident #14 after breakfast or before lunch. They tried to provide care at least one time for them during their eight-hour shift. They stated sometimes Resident #14 they refused to get out of bed, but sometimes they did not have enough help to get them out of bed. They stated they prefer to have a third person when getting them out of bed. They were not sure when Resident #14 was showered and had not showered them.</p> <p>During an interview on 6/17/25 at 3:04 PM, the Director of Nursing stated that the Licensed Practical Nurse and Unit Manager oversee the Certified Nurse Aides and should ensure that the activities of daily living are met according to the tasks assigned for each resident. Residents get showers twice a week and as requested. They are aware that they have gotten bed baths instead of showers. They were not aware that the showers were not being given consistently twice a week. They stated they do review the Certified Nurse Aide documentation and are aware that there are a lot of omissions. Three signatures should be there for 3 shifts when a task is indicated every shift. However, the care takes priority over the documentation. Residents have the right to get out of bed when they want. Their preference should be followed for dressing and getting out of bed. Certified Nurse Aides should be making rounds to check and change the residents every 2-4 hours and as needed.</p> <p>3. Resident #74 was admitted to the facility with diagnoses including non-Alzheimer's dementia, diabetes mellitus and depression.</p> <p>The Minimum Data Set (MDS) dated [DATE] documented the Resident #74 had moderately impaired cognition and needed substantial staff assistance with personal hygiene and shower/bathe self.</p> <p>The Comprehensive Care Plan for Resident Requires Assist with Activities of Daily Living last updated on 09/13/2024, documented cut fingernails weekly.</p> <p>The Comprehensive Care Plan last updated on 3/20/25, documented the resident required substantial assistance with personal hygiene and shower/bathing.</p> <p>During observation on 6/10/25 at 1:07 PM Resident #74 was sitting in their wheelchair. The resident had long and dirty fingernails on both hands. The resident stated that the staff took care of their fingernails and did not remember when they were clipped last time.</p> <p>During observation on 6/11/25 at 12:16 PM Resident #74 was sitting at the overbed table in front of untouched lunch meal tray. The resident's clothes were soiled with food, and noticeable urine odor.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/17/25 at 10:16 AM Certified Nurse Aide #7 stated that they provide all personal care assistance for Resident #74, which included facial hair care, clipping and trimming of fingernails. Certified Nurse Aide #7 stated that they believed the resident was not diabetic that was why when the resident's fingernails were long, they clipped and filed them. Certified Nurse Aide #7 stated that they did not remember when they clipped the resident's fingernails last time. They stated that they did not remember what the resident's appearance and clothes were before lunch on 6/11/25.</p> <p>During an interview on 6/17/25 at 10:34 AM Licensed Practical Nurse Unit Manager #1 stated that Resident #74 was diabetic and that was why they clipped their fingernails on 6/11/25. Licensed Practical Nurse Unit Manager #1 stated nurses took care of fingernails for diabetic residents. They stated that they did not remember when the resident's fingernails were clipped previously, and it was not documented.</p> <p>10NYCRR 415.12 (a)(3)</p>		

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 06/17/2025
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 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, record review and interviews during the recertification and abbreviated surveys (NY00351988), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (1) of four (4) residents (Resident #217) reviewed for pressure ulcers. Specifically, Resident #217 reported ongoing loose bowel movements and there was no documented evidence of clinical monitoring and collection of stool for Clostridium Difficile as planned in the 7/22/2024 Nurse Practitioner progress note, and no documented evidence that stool for Clostridium Difficile (a bacterium that causes an infection of the colon) and a Complete Blood Count/Comprehensive Metabolic Panel were collected as planned in the 7/24/2024 Nurse Practitioner progress note. Additionally, Docusate Sodium (stool softener) 100 milligrams was not held for loose stools as per physician order on 7/24/2024, 7/25/2024 and 7/27/2024. Subsequently Resident #217 was transferred to the hospital on 7/29/2024 due to lethargy and slurred speech and was admitted to the hospital with a diagnosis of septic shock. This resulted in actual harm that is not immediate jeopardy for Resident #217.</p> <p>The findings are:</p> <p>The Policy and Procedure titled Lab and Diagnostic Test Results-Clinical Protocol last revised 1/2022, documented the physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. The staff will process test requisitions and arrange for tests. The Laboratory, diagnostic radiology provider, or other testing source will report test results to the facility.</p> <p>The Policy and Procedure titled Medication and Treatment Orders, last revised 1/2025, documented verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order. Verbal orders must be signed by the prescriber at their next visit.</p> <p>Resident #217 was admitted to the facility with diagnoses which included diabetes mellitus, dehiscence of the amputation stump (surgical complication where a closed incision opens) and morbid obesity.</p> <p>The Minimum Data Set (resident assessment) dated 6/7/2024 documented Resident #217 had intact cognition, was dependent on staff assistance with toileting hygiene, had an indwelling catheter and was frequently incontinent of bowel.</p> <p>The Comprehensive Care Plan titled Risk for Fluid and Electrolyte Imbalance, dated 6/8/2024, documented monitor labs and report abnormal findings to the medical doctor.</p> <p>The 6/17/2024 Physician's Order documented administer Imodium A-D Capsule 2 milligrams, 1 capsule by mouth every 6 hours as needed for diarrhea.</p> <p>The 7/3/2024 Physician's Order documented Docusate Sodium 100 milligrams, give 1 capsule by mouth in the morning for constipation, hold for loose stools.</p> <p>The 7/21/2024 at 6:25 PM Nursing Progress Note documented the resident complained of having loose stools all day and requested and received Imodium.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The 7/21/2024 at 8:19 PM Nursing Progress Note documented the Imodium was ineffective.</p> <p>The 7/22/2024 at 1:34 PM Nurse Practitioner Progress Note documented the resident was seen for reports of loose stool after each meal. The resident reported it had been occurring for a few weeks. The plan was to order stool test for Clostridium Difficile, start Metamucil and monitor clinically.</p> <p>Review of the resident's electronic medical record revealed no documented evidence the stool test was ordered, or clinical monitoring was started as planned in the Nurse Practitioner's progress note on 7/22/2024.</p> <p>The 7/24/2024 at 7:04 PM Nurse Practitioner Progress Note documented the resident was seen for follow up to complaints of loose stools after meals. The resident reported the loose stools continued. The resident has been recently started on Metamucil and the plan was to order a stool test for Clostridium Difficile, continue Metamucil, and order Complete Blood Count/Comprehensive Metabolic Panel (blood work) for monitoring.</p> <p>Review of the resident's electronic medical record revealed no documented evidence of laboratory results for the stool test or blood work planned in the Nurse Practitioner's progress notes on 7/24/2024.</p> <p>The July 2024 Bowel Movement Record documented on 7/21/2024 Resident #217 had one small loose bowel movement, on 7/23/2024 one large and one medium loose bowel movement, on 7/24/2024 one large loose bowel movement, on 7/25/2024 one small loose bowel movement, on 7/27/2024 one large loose bowel movement, and on 7/28/2024 one small and one large loose bowel movement. The bowel movement record had no documentation on day and evening shifts for 7/22/2024 and 7/26/2024.</p> <p>The July 2024 Medication Administration Record documented Docusate Sodium 100 milligrams was given 1 capsule by mouth every morning and to be held for loose stools. The medication was not held as ordered for loose stool on 7/22/2024, 7/24/2024, 7/25/2024, 7/26/2024 and 7/27/2024. There was no documentation on 7/28/2024 as to if it was administered or held.</p> <p>The July 2024 Medication Administration Record and physician orders revealed no documented evidence the Metamucil was ordered or started as planned in the Nurse Practitioner progress notes.</p> <p>The 7/29/2024 at 12:58 PM Nursing Progress Note documented the resident had slurred speech, the Nurse Practitioner assessed the resident and gave new orders. New orders included to obtain Complete Blood Count/Comprehensive Metabolic Panel/Ammonia level, intravenous hydration and a chest x-ray. An intravenous saline lock was placed, and the staff would continue to monitor.</p> <p>The 7/29/2024 at 4:17 PM Nurse Practitioner Progress Note documented the resident was seen for follow up to complaints of fatigue and slurred speech. The plan was to order Complete Blood Count/Comprehensive Metabolic Panel/Ammonia, start intravenous hydration, order chest x-ray and monitor clinically.</p> <p>There was no nurse progress notes or evidence of monitoring on 7/29/2024 between 12:58 PM and 8:21 PM. There was no evidence the laboratory blood tests, or chest x-ray were completed.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The July 2024 Medication Administration Record documented intravenous fluid was administered at 6:38 PM.</p> <p>The 7/29/2024 at 8:21 PM Nursing Progress Note documented Registered Nurse #16 was notified by the assigned Licensed Practical Nurse #17 that the resident was increasingly lethargic. The nurse notified the on-call medical doctor of the findings due to the resident's significantly drastic decline. The Medical Doctor instructed to send the resident to the emergency room for medical work up. The Registered Nurse #16 called 911, and at 9:00 PM the resident was taken to the hospital via ambulance.</p> <p>The 7/30/2024 at 6:18 AM Nursing Progress Note documented the resident was admitted to the hospital for septic shock.</p> <p>During an interview on 6/17/2025 at 2:09 PM, Licensed Practical Nurse #14 stated any registered nurse, or licensed practical nurse could accept orders from the medical doctor or nurse practitioner and process test requisitions and arrange for tests.</p> <p>During an interview on 6/16/2025 at 10:37 AM, Nurse Practitioner #18 stated they followed up with Resident #217 on 7/22/2024 for episodes of loose stool and ordered a stool test for Clostridium Difficile, to start Metamucil and to monitor clinically. The orders on 7/22/2024 were given verbally to the Nurse Manager. The Nurse Practitioner stated they met with the resident again on 7/24/2024 and noted the stool test for Clostridium Difficile was not completed as planned. They ordered the stool test for Clostridium Difficile again, to continue Metamucil, and ordered Complete Blood Count /Comprehensive Metabolic Panel (blood work) for monitoring. Nurse Practitioner #18 stated these orders were communicated with the nurse and put into the electronic medical record. Nurse Practitioner #18 stated they assessed the resident again on 7/29/2024 and noted at that time the laboratory tests were not completed and ordered Complete Blood Count /Comprehensive Metabolic Panel, an ammonia level, to start intravenous (IV) hydration, and a chest x-ray. Nurse Practitioner #18 stated they gave all these orders verbally to the nurse unit manager. Nurse Practitioner #18 stated they were new to the facility and may not have been clear how to order and check the laboratory results. They stated they were an independent practitioner and did not talk to the Medical Director about the condition of the resident. Nurse Practitioner #18 stated since laboratory tests such as stool for Clostridium Difficile, Complete Blood Count /Comprehensive Metabolic Panel and ammonia were not completed, they were unable to diagnose and treat the resident, which resulted in actual harm to the resident.</p> <p>During an interview on 6/17/2025 at 1:50 PM, the Medical Director stated a nurse practitioner can work independently, but in the nursing home setting, a nurse practitioner provides care under a physician. They stated they were not aware of the resident's condition or that the laboratory tests were not completed. They stated Nurse Practitioner #18 should have notified the Medical Director of changes in the resident's condition.</p> <p>10 NYCRR 415.12</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on record review and interviews conducted during the Recertification and Abbreviated surveys (NY00339190) from 06/10/25 to 06/17/25, the facility did not ensure there was sufficient nursing staff to attain or maintain the highest practicable physical and psychosocial well-being of each resident. Specifically, the facility did not provide adequate nurse staffing per the Facility Assessment Staffing Plan to meet the needs of the residents on sixty-nine of ninety days reviewed. This was evidenced by the nurse staffing schedules dated April 26, 2024, May 7, 2024, December 1 through December 31, 2024, weekends from January 1, 2025 through March 31, 2025, and May 10-June 10, 2025. Additionally, residents expressed concerns that there were not enough nurse aides to provide them with necessary care and assistance, residents were observed in bed late into the day shift, and nursing staff expressed concerns about low staffing.</p> <p>The findings included:</p> <p>The July 2024 Facility Assessment Staffing Plan documented: Unit 100: Day shift: one (1) Licensed Practical Nurse Unit Manager, two (2) Licensed Practical Nurses, two (2) Certified Nurse Aides. Evening shift: two (2) Licensed Practical Nurses, two (2) Certified Nurse Aides. Night shift: 0.33 Supervisor, one (1) Licensed Practical Nurse, two (2) Certified Nurse Aides. Unit 200: Day shift: one (1) Registered Nurse Unit Manager, two (2) Licensed Practical Nurses, two (2) Certified Nurse Aides. Evening shift: two (2) Licensed Practical Nurses, two (2) Certified Nurse Aides. Night shift: 0.33 Supervisor, one (1) Licensed Practical Nurse, two (2) Certified Nurse Aides. Unit 300: Day shift: one (1) Registered Nurse Unit Manager, two (2) Licensed Practical Nurses, two (2) Certified Nurse Aides. Evening shift: one (1) Licensed Practical Nurse, two (2) Certified Nurse Aides. Night shift: 0.33 Supervisor, one (1) Licensed Practical Nurse, two (2) Certified Nurse Aides.</p> <p>The Nurse Staffing Schedules reviewed documented the facility did not meet facility minimum staffing 4/26/2024 and 5/7/2024 (two of two days), December 1, 2024 through December 31, 2024 (twenty-eight of thirty-one days), January 1, 2025 through March 30, 2025 (twenty-three of twenty-six weekend days), and May 10, 2025 through June 10, 2025 sixteen of thirty-one days.</p> <p>During interview on 06/10/25 at 10:15 AM Resident #13 stated if the unit is short staffed, they don't get a shower. They stated in April and May they only received one shower per week.</p> <p>During observation and interview on 06/10/25 at 11:36 AM Resident #6 stated they had not been washed yet and had a soiled brief since 5:00 AM. They stated the night Certified Nurse Aide knew they were soiled but told them they did not have time to change their brief.</p> <p>During a resident interview on 6/10/25 at 12:55 PM, Resident #46 stated when there was not enough staff, it was hard to get someone to assist them to get their brief changed, to get washed and dressed, and to be transferred out of bed. They stated they frequently call the corporate main office number to ask for assistance. The corporate office would call the facility to get a staff member to wash, dress, and get them out of bed. They stated they felt afraid to have a bowel movement because they might have to stay soiled for long periods of time. They stated on weekends, the staff told them they could not get them out of bed due to short staffing.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During interview on 06/10/25 at 01:12 PM, Resident # 57 stated there was not enough staff at the facility.</p> <p>During the Resident Council meeting on 06/11/25 at 10:58 AM, Resident #78 stated their roommate waited three hours for their overfilled colostomy bag to be emptied, and many times there was only one Certified Nurse Aide for forty residents. Resident #39 stated their roommate waited six hours for their adult brief to be changed. Resident #89 stated staff was overworked. Resident #13 stated showers were canceled when staff was low and not rescheduled. They stated residents go several weeks without a shower.</p> <p>During interview on 06/11/25 at 12:42 PM, the Administrator stated the Assistant Administrator who had been the Acting Administrator in July 2024 had reviewed the July 2024 Facility Assessment Staffing Plan based on resident needs, and stated the Staffing Plan accurately documented the minimum staffing requirement for the facility</p> <p>During interviews on 06/11/25 at 03:53 PM, 06/11/25 at 04:38 PM, and 06/13/25 at 11:06 AM, the Staffing Coordinator reviewed the Facility Assessment Staffing Plan and the Nurse Staffing Schedules for 4/26/24 and 5/7/24, December 1 through 31 2024, weekends from January 1, 2025 through March 30, 2025 and daily staffing schedules from May 10, 2025 through June 10, 2025. They stated the facility did not provide the minimum staffing required for the shifts/units per the Facility Assessment Staffing Plan. They stated there were a lot of callouts and vacations, and majority of the facility staff are per diem staff who only work when they want to work.</p> <p>During interview on 06/12/25 at 09:31 AM Registered Nurse Unit Manager #6 stated they scheduled resident showers two times a week, they do the best they can to get them done but they are not always able to get them done. They stated they should have three Certified Nurse Aides on day shift but most of the time they have one or two.</p> <p>During interview on 06/12/25 at 11:30 AM, Certified Nurse Aide #2 stated often there was only one Certified Nurse Aide on the unit. They stated residents had to wait hours to be changed and got frustrated because they had to wait so long. They stated nurses tried to help when they could but they had to give medications and administer treatments and document notes. They stated the facility did not pay extra to Certified Nurse Aide who worked alone, and the facility did not send out texts to offer extra money or a bonus to get staff to come in like some other facilities do.</p> <p>During interview on 06/12/25 at 11:37 AM, Licensed Practical Nurse #3 stated they were usually the only nurse on the unit and frequently work with one Certified Nurse Aide, so the residents wait a long time for assistance with activities of daily living. They stated they tried to help with resident care, but they were responsible for administering medications and treatments and had to document everything, so they did not have a lot of extra time to help with cares.</p> <p>During interview on 06/13/25 at 11:48 AM, the Assistant Administrator and Administrator stated they were aware of low staffing. They stated they had trouble hiring new staff and had trouble getting staff to come in to work. They stated they rarely offered bonuses for staff to come in last minute and only as a last resort. They stated they did not provide extra pay to staff who worked alone, such as when only one of two Certified Nurse Aides or when only one of two Licensed Practical Nurses works on a unit. When asked if they have considered decreasing new admissions, they stated they would not be able to stop taking new admissions without corporate directive.</p> <p>(continued on next page)</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During observation on 06/15/25 at 12:40 PM, Resident #19 was still in bed, and not dressed.</p> <p>During observation and interview on 6/15/25 at 12:42 PM, Resident #6 stated they had their brief changed at 4:00 or 5:00 AM, and had not been changed since then. They stated they urinated and needed to be changed.</p> <p>During observation and interview on 6/15/25 at 12:44 PM, Resident #19's family member was observed feeding Resident #19 in bed. They stated they would like their mother to be out of bed but stated the low staffing ratio caused this issue.</p> <p>During interview on 6/15/25 at 01:21 PM, the Director of Nursing stated they wanted to hire more staff, but no one wants the job. They stated they were doing the best they can with the staff they have.</p> <p>During follow-up observation and interview on 06/15/25 at 02:29 PM, Resident #6 was observed in bed, and had not had a brief change. They stated they had a bowel movement, and their adult brief was soiled and wet.</p> <p>During a follow-up interview, on 6/16/25 at 10:41 AM, Resident #46 stated sometimes the Certified Nurse Aide told the resident there was not enough staff to get them out of bed and only washed and changed the resident on those days. They stated they need two staff for transfers with the mechanical lift. They stated they had a bowel movement yesterday morning around 9:00 AM and was not changed until after 12:00 PM. They stated they had rung the bell after having the bowel movement and a Certified Nurse Aide answered the call bell but did not come to change their brief until later. Resident #46 stated they told the Assistant Administrator that they want to get out of bed every day and the Assistant Administrator told them to tell the head nurse. Resident #46 stated they told the unit manager, and the unit manager tried but often stated there were not enough staff to get them out of bed.</p> <p>During interview on 6/16/25 at 10:59 AM, Certified Nurse Aide #5 stated they have often worked at the facility without another Certified Nurse Aide and do not like to be the only Certified Nurse Aide working on a unit because they do not feel it is safe for the residents and very difficult to meet all the resident's care needs. They stated if they transfer a resident without the sufficient assistance, there could be an accident.</p> <p>During follow-up interview on 6/16/25 at 3:07 PM, Licensed Practical Nurse Unit Manager #1 stated that to have more staff in the facility would be much better for the residents. There would be less wait time for resident cares to be completed such as toilet hygiene, brief changes, and getting out of bed.</p> <p>During interview on 6/16/25 at 3:16 PM, Certified Nurse Aide #7 stated if the staffing were better, the resident care would be better. Stated they have worked as the only Certified Nurse Aide on duty and the residents had to wait longer for cares to be provided and some residents did not get out of bed that day.</p> <p>During follow-up interview on 6/17/25 at 1:12 PM, the Assistant Administrator and Administrator stated that after reviewing the Facility Assessment Staffing Plan, they determined that it does not document a sufficient number of staff to provide care to the residents.</p> <p>(continued on next page)</p>		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10 NYCRR 415.13