

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335540	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/30/2024
NAME OF PROVIDER OR SUPPLIER  The Grand Rehabilitation and Nrsq at Guilderland		STREET ADDRESS, CITY, STATE, ZIP CODE  428 State Route 146 Altamont, NY 12009	

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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</b></p> <p>Based on record review and interview during the recertification and abbreviated survey (Case #NY00329958) from 1/22/2024 to 01/30/2024, the facility did not ensure a copy of discharge notice was sent to a representative of the Office of the State Long-Term Care Ombudsman for 1 (Resident # 52) of 1 resident reviewed. Specifically, Resident #52 received a 30-day discharge termination notice on 11/7/2023, and a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman was not sent until 12/4/2023.</p> <p>This is evidenced by:</p> <p>Resident #52 was admitted on [DATE] with diagnoses of diabetes mellitus type 2, depression, and bladder cancer. The Minimum Data Set (an assessment tool), dated 11/2023, documented that the resident was able to understand, be understood by others, and was cognitively intact.</p> <p>The facility Notice of Transfer/Discharge policy dated 3/2018 documented the facility provided residents with a thirty (30) day written notice of an impending transfer or discharge. A representative of the administration would provide resident and family member (representative/sponsor) with a written 30-day advance notice of transfer or discharge. Facility would provide the Ombudsman a copy of the notice at the time of the discharge.</p> <p>Review of Resident #52's 30-day transfer/discharge termination notice documented the resident received notification on 11/7/2023, and the Ombudsman was notified on 12/04/2023.</p> <p>During a record review of facility-initiated discharges from 9/1/2023 to 1/30/2024, there was only one 30-day notice of discharge issued.</p> <p>During an interview on 1/25/2024 at 9:31 AM, Director of Social Work #1 stated the resident owed the facility a significant amount of money and refused to relinquish any social security benefits and or pension funds. They stated a 30-day notice of discharge was issued to Resident #52 on 11/07/2023. The Ombudsman Office was notified of the discharge on 12/04/2023. The Director of Social Work stated it was the Social Work Department's responsibility to send out discharge notification letters. Director of Social Work #1 stated it was an oversight that the Ombudsman's office did not receive the notification on the same day as the resident. Director of Social Work #1 stated they had a policy in place which included same day notification and would adhere to their policy going forward.</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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F 0623  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	10 New York Codes, Rules and Regulations 415.3(h)(1)(iii)(a-c)		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>33538</p> <p>Based on observations, record review, and interviews conducted during the recertification survey from 1/22/2024 to 1/30/2024, the facility did not ensure the facility had sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, there was not sufficient staff to meet the needs of residents at any given time.</p> <p>This is evidenced by:</p> <p>The Facility Assessment, dated 7/27/2023, documented the facility capacity was 127 and the average daily census was 123-125. The Facility Assessment documented that based on the resident population and their needs for care and support, the facility's general approach to staffing to ensure there was sufficient staff to meet the needs of the residents at any given time were the following by position and ranges based on shift needs:</p> <ul style="list-style-type: none"> <li>-Nurse Aides- Day shift: 3-12; Evening shift: 3-9; Night shift: 3-6</li> <li>-Licensed Nurses providing direct care- Day shift: 3-6; Evening shift: 3-6; Night shift: 2</li> <li>-Other nursing personnel (e.g., those with administrative duties)- 4-5</li> </ul> <p>During Resident council meeting on 1/22/2024 at 2:03 PM, Resident #'s 43 and 70 stated that they had not been provided a shower in four weeks due to low staffing levels.</p> <p>During an interview on 1/22/2024 at 10:45 AM, Licensed Practical Nurse #3 stated that staffing had always been an issue since they had been employed at the facility now for 2 years. They stated that they were told that there were no ratios of staff to residents but felt that they had a need for additional staff. They stated that on their unit, there were 43 residents and only 2 aides and 1 nurse not including them. Licensed Practical Nurse #3 further stated that they only very rarely had 3 aides and 2 nurses on the unit, and sometimes only had one aide and one nurse.</p> <p>During an interview on 1/23/2024 at 10:48 AM, Certified Nursing Aide #1 stated staffing was a problem at the facility, that they had too many residents to care for and not enough staff to accomplish everything they needed to do. They stated that they could remember when they had 4 to 5 aides on their unit and all activities of daily livings for the residents were accomplished with residents and staff happier. They stated that they needed more staff and there were times when residents did not get out bed and did not receive showers since staff could only do so much with the amount of residents.</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 - Some</p>	<p>During an interview on 1/24/2024 at 12:39 PM, Certified Nursing Aide #2 stated that mostly there were only two aides working on the unit, which meant they could not usually provide showers to the residents. Certified Nursing Aide #2 stated that if there were three aides working, then the residents would be able to receive showers. They stated that if showers were not provided then they would inform the nurse, document it, provide a bed bath to the resident, and hoped that staff working the next shift would be able to provide the shower.</p> <p>During an interview on 1/26/2024 at 10:40 AM, Certified Nursing Aide #1 stated that every 2 hours for care was impossible with the current staffing they had. They stated that with two aides working on a unit, it was very hard to get everything needed done. They stated that sometimes residents were dressed, bed bathed and gotten up for the day. They stated that sometimes residents were not gotten out of bed because of the limited staff in the facility. Certified Nursing Aide #1 stated that Residents who require 2-staff person assists for care take away the time that was available for aides to complete all tasks. They stated that resident care would be delayed because if one aide was taking care of another resident, they may have to ask the nurse to assist which may or not be available since much of the time there was only one nurse on the unit and they would be busy, too. They stated that for most of the time, they would stay extra on days to make sure residents received showers, but that not everyone in the facility would do this. They stated that there were more agency staff then facility staff providing aide care so there was no consistency in resident care.</p> <p>During an interview on 1/29/2024 at 2:25 PM, Licensed Practical Nurse #1 stated three residents did not receive their shower that day because these residents were all 2-staff person assists and the staffing level did not allow staff to provide the showers to the residents at their time.</p> <p>During an interview on 1/29/2024 at 2:26 PM, Certified Nursing Aide #3 stated they were supposed to give two residents showers that day but were unable to because they only had two aides on duty at that time.</p> <p>During an interview on 1/29/2024 at 3:08 PM, Certified Nursing Aide #4 stated they did not give resident #27 their shower because there were only two aides on the unit and the resident was a 2-staff person assist.</p> <p>During an interview on 1/30/2024 at 12:27 PM, Certified Nursing Aide #5 stated the documentation in the electronic medical record was changed a few months ago and there was no differentiation between a bed bath and a shower. They stated that there was no way to look at the documentation and determine if the resident had been showered or given a bed bath.</p> <p>During an interview on 1/30/2024 at 1:00 PM, Staffing Coordinator #1 stated they, along with the Director of Nursing, Assistant Director of Nursing, and Administrator determined what the minimum and maximums in staffing levels should be based on census. They stated that since being employed, the staffing level had not changed for the facility. They stated that the minimum level of staffing for each unit was 1 nurse and 2 aides during the day, 1 nurse and 2 aides on the evening shifts, and 1 aide on the night shift. They stated that the units should have more staff and they should have at least three staffers. They stated if staffing levels dropped below minimums, there were several staff individuals who were cross trained as aides to fill spots when needed. Staffing Coordinator #1 state that this had not happened since they had been employed at the facility.</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 - Some</p>	<p>During an interview on 1/30/2024 at 1:30 PM, Registered Nurse #1 stated that the facility had just recently updated their pay rates for aide staff and were getting more individuals. They stated that they had to compete with a lot of agencies in the area, and the facility was a not on a major roadway, which would possibly decrease the number of individuals being employed. They stated that they were recently approved by New York State to have their own in-house Nurse Aide Training Program, which may boost the number of employees.</p> <p>During an interview on 1/30/2024 at 4:00 PM, Administrator #1 stated they were not currently doing staffing audits but followed the weekly hiring and staff schedules. They stated the facility offered open shifts with bonuses to staff but it was too costly and had to stop, which resulted in less staff. Administrator #1 stated they had identified staffing issues and were now offering increased pay rates, so it was getting better.</p> <p>10 New York Codes, Rules and Regulations 415.13(a)(1)(i-iii)</p>