

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  03/07/2025
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</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>Based on observation, record review, and interviews conducted during the recertification and abbreviated survey (Case # NY00347964), the facility did not provide effective housekeeping and maintenance services on 3 (A, B, and C) of 3 resident units. Specifically, floors, walls, window blinds, ceilings, and dining tables were not clean or maintained and obnoxious odors were detected.</p> <p>This is evidenced by:</p> <p>During observations on 2/23/2025 at 1:52 PM, a urine and fecal odor was detected on the B-Wing corridor, an unwashed body odor was detected by room B13, and trash was found on the floor in room B19.</p> <p>During observations on 02/24/2025 from 9:45 AM through 11:39 AM:</p> <ul style="list-style-type: none"> <li>&amp;bull;</li> <li>Strong urine odors were detected in the corridor outside rooms A01 through A05 and rooms B14 through B19.</li> <li>&amp;bull;</li> <li>The ventilation grid by the emergency exit on the B-Wing was soiled with a heavy dust build-up.</li> <li>&amp;bull;</li> <li>Stained ceiling tiles were found in the corridor by the Activity Room, the C-Wing Soiled Utility room, the employee dining room, and rooms B22 and C21.</li> <li>&amp;bull;</li> <li>The floors were soiled with a brown build-up where the corridor door frames meet the floor, and next to the walls in the Rehabilitation room,</li> <li>&amp;bull;</li> <li>The nurse stations on the A-Wing, B-Wing and C-Wing were soiled with a brown dirt build-up.</li> <li>&amp;bull;</li> </ul> <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 - Some</p>	<p>One ceiling tile was missing in the C-Wing outdoor patio.</p> <p>&amp;bull;</p> <p>Chewing gum was found stuck to the underside of the dining tables in the main dining room, A-wing Day Room, and B-Wing Day room.</p> <p>&amp;bull;</p> <p>The window blinds were caked with dust in rooms A02, A04, and A08.</p> <p>&amp;bull;</p> <p>The lobby furniture upholstery was worn.</p> <p>&amp;bull;</p> <p>In room B16, the floor was heavily soiled with dust behind the beds and the room door had chipped paint.</p> <p>&amp;bull;</p> <p>Paint was chipped on the walls in room B13 and the B-wing soiled utility room.</p> <p>&amp;bull;</p> <p>The plastic edge guards on the wall in the lobby area were chipped.</p> <p>During an interview on 2/24/2025 at 2:02 PM, Administrator #1 stated that they would speak with the housekeeping and maintenance departments regarding the cleaning, maintenance, and ventilation (odor) issues found.</p> <p>10 New York Codes, Rules, and Regulations 415.5(h)(4)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, observations, and interviews during the recertification survey and an abbreviated survey (Case #s NY00369042 and NY00363829), the facility did not ensure residents received treatment and care in accordance with professional standards of practice for five (5) (Resident #s 6, 14, 20, 23, and 77) of 32 residents reviewed. Specifically, [a.] Resident #6 who was newly admitted on [DATE] with diagnoses of diabetes, was to have blood sugar checks 3 times a day, per discharge paperwork. The facility did not check the resident's blood sugar until 1/11/2025 at 4:55 PM; [b.] Resident #14's clothes and bedding were not changed effectively; [c.] Resident #20 did not receive proper footcare; and [d.] for Resident #s 23 and 77, vital signs ordered daily and for changes in condition were not obtained, and did not monitor the resident's condition.</p> <p>This is evidenced by:</p> <p>Cross-referenced to F635: admission Physician Orders for Immediate Care.</p> <p>The facility Policy and Procedure titled, Change in a Resident's Condition or Status, reviewed 1/2025, documented the nurse would record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.</p> <p>Resident #6</p> <p>Resident #6 was admitted to the facility with the diagnoses of acute respiratory failure (lungs cannot release enough oxygen into the blood), type 2 diabetes (an endocrine system dysfunction when the body cannot use insulin correctly and sugar builds up in the blood), and chronic obstructive pulmonary disease (lung disease causing restricted airflow and breathing problems). The Minimum Data Set, dated [DATE], documented the resident was able to be understood, understand others, with minimal cognitive deficits.</p> <p>The Licensed Nurse: Admission/readmission Evaluation dated 1/10/2025 at 9:48 PM, documented the most recent admission was 1/10/2025 at 9:40 PM. Reason for admission was acute hypoxic respiratory failure due to pneumonia and hyperglycemia (high blood sugar).</p> <p>Discharge paperwork from hospital documented need to check finger sticks 3 times a day daily. The resident was an insulin dependent diabetic who required Insulin Degludec daily and Insulin Lispro before meals. ?????</p> <p>Physician Progress Note dated 1/11/2025 at 12:09 PM by the Nurse Practitioner, documented the resident was seen and evaluated that morning for medical follow-up, given they were a new admission to the facility. The resident arrived yesterday evening. The resident had poorly controlled diabetes. The medication regimen that was available was reviewed, which they believed was the most accurate documentation that they were able to obtain at the moment. Plan included monitor blood glucose levels, avoid hyperglycemia. Would adjust therapy if needed.</p> <p>Medication Administration Record dated January 2025, documented an order to monitor blood sugar before meals and at bedtime for diabetes. The order was to start on 1/11/2025 at 4:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Blood Sugar Summary Report printed 3/01/2025 at 10:46 AM, documented the resident's blood sugar was 286 on 1/11/2025 at 4:55 PM. The report did not have documented evidence of blood sugar levels prior to that date/time.</p> <p>During an interview on 3/02/2025 at 11:55 AM, Director of Nursing #1 stated for admissions that were off shift admissions, staff would follow the admission check list which included things like diets, advanced directives, and medication orders. Director of Nursing #1 stated staff would need to verify the physician orders in order to treat the resident, but there was always a physician on call 24 hours a day. When asked if the staff would be expected to assess the resident upon arrival, Director of Nursing #1 stated that they did not know if the Registered Nurse assessment had to be done within a certain time limit, but it would be expected to be done during the shift that the resident was admitted . Vital signs and a finger sticks would be a part of that assessment. Doing the assessment 12 hours later would not be acceptable.</p> <p>Resident #14</p> <p>Resident #14 was admitted to the facility with diagnoses of dementia (a group of conditions that cause a progressive decline in cognitive abilities), iron deficiency (a state where the body's iron stores are depleted), and diverticulitis (inflammation of irregular bulging in the large intestine). The Minimum Data Set, dated [DATE], documented the resident was usually able to understand and be understood by others, with significant cognitive impairment.</p> <p>Resident #14's Comprehensive Care Plan for Assistance with Self-care and mobility, dated 10/2023, documented that the resident required supervision or touching assistance for all personal care.</p> <p>Resident #14's Comprehensive Care Plan for Impaired Skin Integrity, dated 1/06/2023 and revised 1/09/2023, listed the interventions of applying moisturizer as needed to skin, apply protective/preventative skin care, keep skin dry, clean, and well lubricated, and monitor skin condition daily during care and report changes.</p> <p>During an observation on 2/24/2025 at 11:30 AM, Resident #14's bed clothes had not been changed effectively and when the sheets were removed the mattress was covered with dead skin.</p> <p>Resident #20</p> <p>Resident #20 was admitted to the facility with the diagnoses of schizoaffective disorder (mental health condition that combines symptoms of schizophrenia with mood disorders such as depression), chronic obstructive pulmonary disease, and generalized anxiety disorder (excessive, frequent, and unrealistic worry about everyday things). The Minimum Data Set, dated [DATE], documented the resident was usually able to understand others, usually able to be understood, and was cognitively intact.</p> <p>Resident #20's comprehensive care plan for being at risk of being a victim due to inability to understand their surroundings related to dependence on others for activities of daily living, documented interventions to assess the resident for signs and symptoms of abuse and/or neglect and provide assistance with activities of daily living as needed.</p> <p>During an observation on 2/24/2025 at 9:30 AM, Resident #20 showed surveyor that their toenails were so long they wrapped around the resident's toes and the resident had blisters on multiple toes.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documented evidence of care plan related to foot care.</p> <p>A podiatry note dated 11/09/2024 documented all of Resident #20's toenails were elongated and there were no open areas noted.</p> <p>During an interview on 2/28/2025 at 2:28 PM, Licensed Practical Nurse #17 was made aware of Resident #20's feet. Licensed Practical Nurse #17 stated that they did not know about the resident's feet. Resident #20 stated they had told staff and named Registered Nurse #2 as the person they told. Licensed Practical Nurse #17 stated to the resident, Next time tell me. You know I'll get something done. Licensed Practical Nurse #17 thanked surveyor for showing Resident #20's feet to them.</p> <p>During an interview on 3/07/2025 at 2:00 PM, Regional Director of Nursing #1 stated that care plans needed to reflect the resident. It should have been updated for falls, wounds, behavior, something new for the resident and any or all medications.</p> <p>Resident #23</p> <p>Resident #23 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease, acute on chronic systolic congestive heart failure (a sudden worsening of symptoms of a pre-existing condition of weakened heart muscles), and type 2 diabetes mellitus. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and understand others.</p> <p>Physicians Progress Note, dated 1/26/2025 at 11:01 AM by Nurse Practitioner #1, documented a lab review for Resident #23 with urinary symptoms. Results were completed and showed positive for urinary tract infection. Would order Levaquin 250 milligrams daily for 5 days.</p> <p>There was no documented evidence in Nursing Notes that the resident's condition was monitored until 1/30/2025. The Infection/Antibiotic Note dated 1/30/2025 at 11:38 AM by Licensed Practical Nurse #9, documented the resident started Levaquin today and was tolerating well with no signs and symptoms of discomfort, upset stomach or nausea. No signs and symptoms of allergy.</p> <p>There were no documented evidence in the Nursing Notes about the resident's condition.</p> <p>Treatment Administration Record dated January and February 2025, documented a physician's order for vital signs daily and to report any findings outside of the resident's baseline to the medical provider. Start date 4/06/2024 at 9:00 AM. There was no end date. The resident's vital signs: blood pressure, temperature, pulse, respiration, and oxygen saturation level documented:</p> <ul style="list-style-type: none"> <li>- 1/26/2025, blood pressure 132/68, temperature 97.4, pulse 68, respirations 17, oxygen saturation level 96.</li> <li>- 1/27/2025 and 1/28/2025, Licensed Practical Nurse #5 documented the same values for all vital signs as was documented on 1/26/2025.</li> <li>- 1/29/2025, Licensed Practical Nurse #8 documented NA for all vital sign values and there was no documented evidence in the nursing note that the medical provider was notified.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Progress Note dated 2/26/2025 at 9:08 AM by Nurse Practitioner #2, documented acute care visit for pneumonia follow up. Resident #23 has not had much improvement in their symptoms. The resident had poor appetite, general malaise (a feeling of weakness, overall discomfort, illness, or simply not feeling well), cough, congestion and profound fatigue. The resident continued to require supplemental oxygen. Plan included vitals every shift for 3 days, monitor for changes, and notify provider.</p> <p>Medication Administration Record dated February 2025, documented a physician order for vital signs every shift for pneumonia monitoring for 3 days, to start 2/26/2025 at 7:00 AM. Blood pressure, temperature, pulse, respiration, and oxygen saturation level documented:</p> <p>- 2/26/2025 11:00 PM, Licensed Practical Nurse #11 documented NA for all vital sign values and there was no documented evidence in the nursing note that the medical provider was notified.</p> <p>Resident #77</p> <p>Resident #77 was admitted to the facility with diagnoses of chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood effectively), cerebral infarction (stroke), and chronic obstructive pulmonary disease. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others.</p> <p>Physician Progress Note, dated 11/18/2024 at 12:40 PM by Nurse Practitioner #2, documented the resident was seen that day for constipation. There was no bowel movement x5 days per documentation. The resident reported they had a large bowel movement last evening. Plan: upon chart review, the resident's blood pressures were noted to be soft. The resident has had no symptoms. Would discontinue Amlodipine 5 milligrams (lowers blood pressure). Continue to monitor blood pressure daily - current order for daily vitals. Notify provider of abnormal values.</p> <p>Medication Administration Record dated 11/18/2024, documented the resident's blood pressure was 105/51 (normal is between 90/60 and 120/80 mmHg).</p> <p>Nursing Note dated 11/19/2024 at 10:15 AM by Registered Nurse #7, documented they obtained an order for the resident to receive intravenous fluids for decreased oral intake and the fluids were infusing at that time.</p> <p>Physician Progress Note dated 11/19/2024 at 12:15 PM by Physician #2, documented the resident was seen that day for decreased meal and fluid intake for the past 3 days. Plan included, intravenous fluid x1 liter, monitor for changes, and notify the provider.</p> <p>There was no documented evidence in the in Nursing Notes that the resident's condition was monitored.</p> <p>Physician Progress Note dated 11/22/2024 at 12:12 PM by Nurse Practitioner #2, documented the resident was seen that day for chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The resident wanted to resume their Spiriva inhaler instead of Advair, since they had less chronic obstructive pulmonary disease exacerbations and less shortness of breath. Resident #77 reported they had been laying in bed more as of late and reported their shortness of breath made it hard for them to ambulate or participate in activities and caused extreme fatigue. Plan included monitor for changes and notify the provider.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documented evidence in the Nursing Notes that the resident's condition was monitored.</p> <p>Medication Administration Record dated November and December 2024, documented a physician's order for vital signs every dayshift to start 1/30/2024 at 7:00 AM. There was no end date on the order. The resident's vital signs: blood pressure, temperature, pulse, respiration, oxygen saturation level, and pain level documented:</p> <ul style="list-style-type: none"> <li>- 11/23/2024, Licensed Practical Nurse #16 documented NA for all vital sign values and there was no nursing note that the medical provider was notified.</li> <li>- 11/24/2024, blood pressure 124/60, temperature 97.8, pulse 60, respiration 18, oxygen saturation level 97, and pain level was 0.</li> <li>- 11/25/2024 and 11/26/2024, Licensed Practical Nurse #17 documented the same values for the blood pressure, temperature, and pulse as were documented on 11/24/2024.</li> <li>- 11/27/2024, vital signs were not documented. Licensed Practical Nurse #18 documented 5 (hold/see nurses notes) and in a medication administration note dated 11/27/2024 at 2:31 PM, documented not able to complete, only nurse on unit. There was no documentation the medical provider was notified.</li> <li>- 11/28/2024, 11/29/2024, and 11/30/2024, Licensed Practical Nurse #17 documented the same values for the blood pressure, temperature, and pulse as was documented on 11/24/2024, 11/25/2024, and 11/26/2024.</li> <li>- 12/01/2024, blood pressure 115/56, temperature 97.4, pulse 94, respiration 17, oxygen saturation level 97, and pain level was 0.</li> <li>- 12/2/2024, vital signs were not documented. Licensed Practical Nurse #16 documented NA for all vital sign values and there was no nursing note that the medical provider was notified.</li> <li>- 12/3/2024, Licensed Practical Nurse #17 documented NA for blood pressure, temperature, pulse, and respirations. A Medication Administration Note dated 12/3/2024 at 10:50 AM, documented did not get full vital signs due to being the only nurse on floor. There was no documentation the medical provider was made aware.</li> </ul> <p>Physician Progress Note dated 12/3/2024 at 4:21 PM by Physician #2, documented the resident was seen that day for laboratory review related to chronic illness. Repeat chest x-ray still showed pulmonary edema). Plan included, monitor for changes and notify provider.</p> <p>There was no documented evidence in the Nursing Notes that the resident's condition was monitored.</p> <p>Medication Administration Record dated 12/04/2024, Licensed Practical Nurse #17 documented NA for blood pressure and temperature. There was no nursing note that the medical provider was notified.</p> <p>Physician Progress Note dated 12/6/2024 at 9:32 AM by Nurse Practitioner #2, documented the resident was seen that day for medical follow up. The chest x-ray showed prominent lung markings that may be due to pulmonary edema or atypical pneumonia. Continue daily vitals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medication Administration Record dated December 2024, documented a physician's order for vital signs every dayshift to start 1/30/2024 at 7:00 AM. There was no end date on the order. The resident's vital signs: blood pressure, temperature, pulse, respiration, oxygen saturation level, and pain level documented:</p> <ul style="list-style-type: none"> <li>- 12/06/2024, no vitals were documented. Licensed Practical Nurse #18 documented 5 (hold/see nurses notes) and in a Medication Administration Note dated 12/06/2024 at 1:49 PM, documented unit short.</li> <li>- 12/07/2024, blood pressure 122/68, temperature 97.9, pulse 60, respiration 18, oxygen saturation level 96, and pain level was 0.</li> <li>- 12/08/2024, Licensed Practical Nurse #3 documented the same values for the blood pressure, temperature, and pulse, as were documented on 12/7/2024.</li> <li>- 12/09/2024, blood pressure 130/66, temperature 97.9, pulse 66, respiration 18, oxygen saturation level 97, and pain level was 0.</li> <li>- 12/10/2024, Licensed Practical Nurse #3, documented the same values for the blood pressure, temperature, and pulse, as were documented on 12/9/2024.</li> </ul> <p>During an observation on 2/24/2025 at 10:05 AM, Licensed Practical Nurse #19 was standing in the hall at the medication cart with a resident and placed the blood pressure cuff on the resident in front of surveyor. The blood pressure cuff was on backwards with the bladder of the cuff filling outwardly. Licensed Practical Nurse #19 told the resident they could not understand why the blood pressure cuff was not reading. Licensed Practical Nurse #19 again pushed the button on the blood pressure machine to inflate the cuff. Surveyor asked Licensed Practical Nurse #19 why they thought the cuff was not reading properly. Licensed Practical Nurse #19 stated, I don't know, these don't read right sometimes. Surveyor explained that the cuff was on incorrectly. Licensed Practical Nurse #19 stared at the inflated bladder on the outside and then deflated the cuff and turned the cuff around. Licensed Practical Nurse #19 reapplied the cuff to the same arm they had been using and re-inflated the cuff again. The blood pressure reading was obtained.</p> <p>During an interview on 3/02/2025 at 11:15 AM, Director of Nursing #1 stated they had never been told something could not be done because there was a staffing problem. They stated it would be expected that basic care including vital signs, skin assessments, and finger sticks would be done on the shift that the resident arrived.</p> <p>During an interview on 3/07/2025 at 12:38 PM, Registered Nurse #2 reviewed Resident #77's electronic medical record. They stated they saw the documentation about the vitals not being completely done due to staffing issues and immediately called Licensed Practical Nurse #17 into the room. At 12:43 PM, Surveyor asked Licensed Practical Nurse #17 about their documentation of the resident's vital signs, and they stated, I have done that. They stated they made sure the oxygen and blood pressure were ok and stated they were not able to get the full set of vitals because they were the only nurse on the unit. They stated they notified the Registered Nurse supervisor and the provider. License Practical Nurse #17 stated they had to provide care to both sides of the unit and had both medication carts and were unable to get the full set of vital signs.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	During an interview on 3/07/2025 at 2:02 PM, Regional Clinical Director #1 was asked why nurses were documenting vital signs the same as was documented the previous day(s). They stated the surveyor would have to ask the nurse.  10 New York Codes Rules and Regulations 415.12		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews and interviews during the recertification survey , the facility did not ensure a resident with pressure ulcers received necessary treatment and services consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for one (1) (Resident #115) of three (3) residents reviewed. Specifically, for Resident #115, the wound care treatment ordered by provider not was followed. Specifically, on 2/11/2025, when the resident was assessed with a pressure on their left heel and on 2/18/2025, when the resident was seen by the wound care provider for further assessment of the wound. Additionally, the facility failed to ensure a care plan was developed timely and implemented to promote healing of the wound and to prevent infection. A care plan was not developed until 2/27/2025.</p> <p>This is evidenced by:</p> <p>Resident #115 was admitted to the facility with diagnoses of urinary tract infection, acute kidney failure and age-related physical disability. The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment. The resident made themselves understood and was able to understand others.</p> <p>The facility policy and procedure titled Pressure Ulcers/Injuries Overview and reviewed 1/25 documented the purpose of the policy was to provide information regarding clinical identification of pressure ulcers/injuries and associated risk factors, which were derived from definitions in the Code of Federal Regulations 483. 25(b)(1) Pressure Ulcers (F686). The policy documented definitions of medical terms related to pressure ulcers.</p> <p>The facility policy and procedure titled Wound Care and reviewed 1/25 documented the purpose of the policy was to provide guidelines for the care of wounds to promote healing. Preparation for wound care documented to verify there was a physician's order for the procedure. The type of wound care given was to be recorded in the resident's medical record.</p> <p>Care Plan for Resident documented Impaired Skin Integrity related to fragile skin which was initiated 2/5/2025 and revised 2/12/2025. The goals of the care plan dated 2/12/2025 documented the resident's impaired skin area would show signs of improvement/healing and the resident would not develop additional sites of impaired skin integrity. The sites of impairment were not documented. Interventions included apply treatment per physician order and refer to appropriate medical specialist as needed for evaluation and treatment.</p> <p>Wound Assessment and Plan dated 2/11/2025 by the wound care provider documented a stage 3 (F/Thk, Depth to SubQ) (full thickness loss of skin in which subcutaneous fat may be visible in the ulcer and granulation tissue (pink-red moist tissue that fills an open wound when it starts to heal) on the left heel. The wound onset date was documented as 2/11/2025 and measured 7 centimeters length x 8 centimeters width x 0.1 centimeters depth. The wound bed tissue composition was 50% epithelial (superficial pink or white tissue that migrates across the wound and occurs in the final stage of healing)/50% granulation. There were no signs of infection.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Wound care provider treatment order dated 2/11/2025, documented that every Tuesday, Thursday and Saturday: cleanse the wound with normal saline or sterile water and apply to alginate (absorbs wound fluid while creating a moist environment) to wound bed. Cover with dry clean dressing and as instructed. Specialized foam dressing: foam - follow manufacturer recommendations.</p> <p>Treatment Administration Record dated February 2025:</p> <p>- The wound care provider's treatment order for the left heel dated 2/11/2025 was not documented as ordered on the administration record. There was an order dated 2/12/2025 for the left heel: clean area with normal saline/sterile water, apply calcium alginate and cover with dry protective dressing and wrap, every dayshift for wound care. The order did not include the foam dressing and that it was to be done on Tuesday, Thursday, and Saturday.</p> <p>o Treatment was administered from 2/12/2025 to 2/16/2025, was not administered on 2/17/2025 (was blank), was administered on 2/18/2025 to 2/20/2025, and was not administered on 2/21/2025 (was blank).</p> <p>- Additionally, there was a previous physician order dated 2/5/2025 that documented left heel open blister cover with Optifoam (foam dressing) heel dressing every day for wound care.</p> <p>o From 2/11/2025 to 2/18/2025, it was documented that this treatment for the left heel continued to be administered concurrently with the order dated 2/12/2025, except for 2/17/2025, when it was documented as not administered.</p> <p>The Wound Assessment and Plan dated 2/18/2025 by the wound care provider documented a stage 3 wound on the left heel. The onset date of the wound was 2/11/2025, and measured 5 centimeters length x 6 centimeters width x 0.1 centimeters depth on 2/18/2025. The wound bed tissue composition was 70% granulation/30% eschar (dead or devitalized tissue that is hard or soft in texture and usually black, brown, or tan in color and may appear scab-like). Healing status: same/stable. There were no signs of infection.</p> <p>-The wound care provider's treatment order for the left heel dated 2/18/2025 documented no changes from the order dated 2/11/2025.</p> <p>Treatment Administration Record dated February 2025:</p> <p>- The wound care provider's treatment order for the left heel dated 2/18/2025 was not documented as ordered on the administration record. There was an order dated 2/22/2025 for the left heel: clean area with normal saline/sterile water, apply calcium alginate and cover with dry protective dressing and wrap, every dayshift for wound care. The order did not include the foam dressing and that it was to be done on Tuesday, Thursday, and Saturday.</p> <p>o Treatment was administered from 2/22/2025 to 2/25/2025.</p> <p>- Additionally, there was a previous physician order dated 2/5/2025, that documented left heel open blister cover with Optifoam (foam dressing) heel dressing every day for wound care.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>o From 2/22/2025 to 2/25/2025, it was documented that this treatment for the left heel continued to be administered concurrently with the order dated 2/22/2025, except for 2/24/2025, when it was documented as not administered.</p> <p>A care plan for the pressure ulcer on the left heel was not developed and implemented until 2/27/2025.</p> <p>- The Care Plan for Resident had Alteration in Skin Integrity related to pressure injury to left heel (5x8), initiated 2/27/2025 and revised 3/03/2025. Interventions included assess the wound weekly and document wound measurements, wound bed appearance, odor, drainage, and surrounding tissue and refer to the wound care specialist as needed.</p> <p>During an interview on 3/06/2025 at 2:37 PM, Licensed Practical Nurse #8 stated if a resident refused a treatment, they would write a note and would notify the manager or charge nurse and call the provider if needed. They stated wound treatment orders were documented on the treatment administration record and there should not be blanks on the treatment record, which indicated it was not done. They stated wound care should be done per the physician order. Licensed Practical Nurse #8 was aware that Resident #115 was ordered to have wound care treatments.</p> <p>During an interview on 3/07/2025 at 3:08 PM, Registered Nurse Regional Clinical Director #1 stated if the nurse did not have enough time to complete a treatment during their shift, they should notify the provider and provide a hand off to the next shift.</p> <p>10 New York Codes Rules and Regulations 415.12(c)(1)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and interviews during a recertification and abbreviated survey (Case # NY00347964), the facility did not ensure that residents who required dialysis received such services, consistent with professional standards of practice, for two (2) (Resident #s 11, and 110) of 3 residents reviewed for dialysis. Specifically, (a) the facility did not ensure nursing consistently completed, reviewed, and logged dialysis communication sheets for Resident #110 on between 2/18/2025 and 2/26/2025; (b) for Resident #11, there was no ongoing communication and collaboration with the dialysis facility and ongoing assessments in January 2025 and February 2025.</p> <p>This is evidenced by:</p> <p>The facility policy titled, Dialysis, effective date 10/1997 and last revised 1/2024, documented that the facility shall seek to have a written agreement with all Dialysis Center providers who service residents in the facility. The facility would also maintain a communication log with the respective centers on all its residents who go out for Dialysis. In Procedures, the policy documented the following: (1) The administrator would be kept abreast of all the Dialysis Centers who treated facility residents; (2) An agreement with vendor would be sought and effectuated, listing the necessary requirements and services to be rendered; (3) Executed copies of the various agreements would be maintained by the Administrator; (4) A Communications Log would be used for each resident who leaves the building for Dialysis, in order to communicate the residents needs and response to the Dialysis treatments; and (5) Inter-facility communications will be tracked and followed up on.</p> <p>Resident #11:</p> <p>Resident #11 was admitted to the facility with diagnoses of end stage renal disease (loss of kidney function to the point where they no longer work), dependence on renal dialysis (dependence on mechanical filtration of the blood due to kidney failure), and type 2 diabetes mellitus with unspecified complications (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels). The Minimum Data Set (an assessment tool) dated 11/23/2024, documented the resident was cognitively intact. The resident made themselves understood and was able to understand others.</p> <p>The Care Plan for Resident needs dialysis related to end stage renal disease, revised 12/09/2024, documented the resident attends dialysis at a facility on Monday, Wednesday, and Friday at 2:30 PM. Care plan interventions included encourage the resident to go to scheduled dialysis appointments and monitor/document/report to physician signs and symptoms of depression.</p> <p>There was no documented evidence of care plan intervention for assessing and/or monitoring the resident before and after dialysis.</p> <p>The Order Summary Report for order date range 12/01/2024 to 3/31/2025 documented orders dated 12/6/2024 for (a.) book was to be completed for the resident's dialysis treatment one time a day every Monday, Wednesday and Friday for pre (before dialysis, and (b.) book was to be collected, and post notes were to be charted in the evening every Monday, Wednesday, and Friday for post (after) dialysis.</p> <p>Review of the Dialysis Treatment Communication forms documented:</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> <li>- On 1/06/2025, the Prior to Treatment section; the resident's name and vital signs was not completed (was blank) and was not signed by a nurse. The Return from Treatment section was not completed (was blank) and was not signed and dated by the Registered Nurse.</li> <li>- On 1/13/2025, the Return from Treatment section; review and acknowledgement of dialysis communication/recommendations was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> <li>- On 1/15/2025, the Dialysis Center section; treatment prior to discharge from treatment was not completed (was blank). The Return from Treatment section was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> <li>- On 1/29/2025, the Dialysis Center section; treatment prior to discharge from treatment was not completed (was blank). The Return from Treatment section was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> <li>- On 2/03/2025, the Return from Treatment section; review and acknowledgement of dialysis communication/recommendations was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> <li>- On 2/05/2025, the Prior to Treatment section; the resident's name and vital signs was not completed (was blank) and was not signed by a nurse. The Return from Treatment section was not completed (was blank) and was not signed and dated by the Registered Nurse.</li> <li>- On 2/10/2025, the Dialysis Center section; treatment prior to discharge from treatment was not completed (was blank). The Return from Treatment section was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> <li>- On 2/12/2025, the Return from Treatment section; was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> <li>- On 2/17/2025, the Return from Treatment section; was not completed with the resident's vital signs (was blank) and was not signed and dated by the Registered nurse.</li> </ul> <p>During an interview on 2/28/2025 at 3:19 PM, Resident #11 stated they went out of the facility for hemodialysis treatments three times a week on Monday, Wednesday, and Friday. They stated they usually took the communication book with them because it was important documentation that was an important part of their care.</p> <p>During an interview on 3/07/2025 at 11:50 AM, Licensed Practical Nurse #8 stated it was expected that the dialysis communication book be filled out by the nurse prior to a resident leaving for dialysis. This includes full vital signs and any concerns or medication changes. It was also expected that upon return from dialysis, any communication from the dialysis center would be entered into the electronic medical record. They stated the unit clerk would scan the individual sheets into the electronic medical record every Monday. They stated there was a section in the Medication Administration Record for the nurse to sign off that vital signs were taken before the resident left for dialysis. They did not know why it would not be filled out.</p> <p>(continued on next page)</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/07/2025 at 11:50 AM, Licensed Practical Nurse #8 stated it was expected that the dialysis communication book be filled out by the nurse prior to a resident leaving for dialysis. This includes full vital signs and any concerns or medication changes. It was also expected that upon return from dialysis, any communication from the dialysis center would be entered into the electronic medical record. They stated the unit clerk would scan the individual sheets into the electronic medical record every Monday. They stated there was a section in the Medication Administration Record for the nurse to sign off that vital signs were taken before the resident left for dialysis. They did not know why it would not be filled out.</p> <p>Resident #110</p> <p>Resident #110 was admitted to the facility with the diagnoses of end stage renal disease (loss of kidney function to the point where they no longer work), generalized arthritis (cartilage of several joints has slowly broken down, leading to joint pain and stiffness), and acute respiratory failure (lungs were unable to release enough oxygen to the blood). The Minimum Data Set, dated [DATE], documented the resident usually understood others, was usually able to be understood, and was minimally cognitively impaired.</p> <p>The Comprehensive Care Plan for Dialysis, dated initiated 7/30/2024 and last revised on 11/20/2024, documented the focus of Resident #110 would attend dialysis 3 times a week (Tuesday, Thursday, and Saturday), and that Resident #110 had a dialysis catheter. The documented goals were Resident #110 would have immediate intervention should any signs or symptoms of complications from dialysis occurred through the review date; and Resident #110 would have no signs or symptoms of complications from dialysis through the review date. The interventions documented were as follows:</p> <ul style="list-style-type: none"> <li>- Monitor intake and output.</li> <li>- Monitor/document/report to medical director as needed any signs or symptoms of infection to access site redness, swelling, warmth or drainage.</li> <li>- Monitor/document/report to medical director as needed for signs or symptoms of renal insufficiency: changes in level of consciousness, changes in skin turgor, oral mucosa, changes in heart and lung sounds.</li> <li>- Monitor/document/report to medical director as needed for signs or symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock.</li> <li>- Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure immediately.</li> </ul> <p>During an observation on 2/24/2025 at 10 AM, Resident #110's dialysis binder, which was to have the communication sheets between the facility and the dialysis center, contained only an incomplete sheet dated 2/18/2025. The Prior to Treatment section; the resident's name and vital signs was not completed (was blank) and was not signed by a nurse. The Return from Treatment section was not completed (was blank) and was not signed and dated by the Registered Nurse.</p> <p>The sheets for 2/20/2025 and 2/22/2025 were not able to be located by facility staff.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/26/2025 at 9:37 AM, Resident #110's dialysis book contained only the previously observed incomplete communication sheet dated 2/18/2025.</p> <p>During an interview on 2/24/2025 at 9:30 AM, Resident #110 stated that their dialysis book had been lost. They had last seen it when they went to dialysis and then they did not see it again. The resident was unable to speak to which dialysis trip was the trip that they saw their book. Resident #110 stated that the staff always checked their vitals and weight when they went and came back from dialysis.</p> <p>There were no progress notes documenting resident's condition before or after dialysis on 2/18/2025, no progress note documenting resident's condition after dialysis on 2/20/2025, and no progress note documenting the resident's condition before or after dialysis on 2/24/2025.</p> <p>During a follow up interview on 2/26/2025 at 9:48 AM, Resident #110 stated that they had a communication sheet from the dialysis center on 2/25/2025, which they had given to staff when they returned.</p> <p>No communication log for 2/25/2025 was able to be located by facility staff.</p> <p>During an interview on 3/01/2025 at 8:00 AM, Licensed Practical Nurse #10 stated that they were going to fill out the dialysis communication sheet before Resident #110 left because the resident's blood pressure was a little low.</p> <p>During an interview on 3/03/2025 at 11 AM, Licensed Practical Nurse #9 stated that they always filled out their piece of the dialysis sheet and could not speak to why the older sheets were not able to be found. When asked what they would do if an incomplete communication log sheet was handed to them, Licensed Practical Nurse #9 stated that they would call the dialysis center and ask for the information. Additionally, they would document in the electronic medical record the resident's condition upon return to the facility.</p> <p>During an interview on 3/07/2025 at 2:02 PM, Regional Registered Nurse Clinical Director #1 stated that a dialysis communication binder was sent with the resident when they went out to the dialysis center for treatment. They stated the nurse would do their assessment prior to treatment and document on the dialysis communication form in the binder. The nurse would then send the binder with the resident. Upon return from dialysis treatment, the nurse would assess the resident and document the findings in the binder and notify the physician if necessary. They stated the nurse should contact the dialysis center if the dialysis treatment section was not completed. They stated if the facility side was blank, hopefully dialysis would contact the facility. They stated that if a resident goes to treatment without an assessment and then came back with a subpar report from dialysis, they should assess the resident and then call the dialysis center for more information. They stated the nurse could document in a note or in the binder or both places.</p> <p>During an interview on 3/07/2025 at 2:15 PM, Administer #1 stated that issues regarding dialysis documentation and nurses not filling out the communication sheets were not on the list of concerns being discussed during the Quality Assurance meetings. These issues were brought to light through the survey process and going forward would be a part of the meetings with unit managers.</p> <p>10 New York Code of Rules and Regulations 415.12</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews during the recertification and abbreviated survey (Case # NY00363829), the facility did not ensure the physician reviewed the resident's total program of care, including medications and treatments, at each visit for 2 (Resident #s 23 and 77) of 3 residents reviewed. Specifically, Resident #23 was ordered a topical medication for fungal infection that did not indicate where the medication was to be applied and/or the duration of use. For Resident #77, the provider did not evaluate a high potassium level on 12/17/2024, when the result was reported, and on 12/18/2024, when the provider saw the resident.</p> <p>This is evidenced by:</p> <p>Cross-referenced to F554: Resident Self-Administer Medications - Clinically Appropriate</p> <p>Cross-referenced to F760: Residents are Free of Significant Medication Errors</p> <p>Cross-referenced to F773: Laboratory Services Physician Order/Notify of Results</p> <p>Resident #23</p> <p>Resident #23 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that causes progressive and irreversible damage to the airways in the lungs), acute on chronic systolic congestive heart failure (a sudden worsening of symptoms of a pre-existing condition of weakened heart muscles), and type 2 diabetes mellitus (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels). The Minimum Data Set (an assessment tool) dated 1/24/2025, documented the resident was cognitively intact, could be understood, and understand others.</p> <p>Order Audit Report dated 2/04/2025 at 11:50 AM, documented an order for Lotrisone Cream 1-0.05% (clotrimazole-betamethasone), apply to per additional directions topically two times a day for fungal skin rash. The order was entered and signed by Physician #1 on 2/04/2025 at 11:52 AM and was confirmed by Licensed Practical Nurse #7 on 2/04/2025 at 4:33 PM.</p> <p>- There were no instructions on where the medication was to be applied and/or the duration of use.</p> <p>Medication Administration Record dated February 2025, documented Lotrisone Cream 1-0.05% (clotrimazole-betamethasone) apply to per additional directions topically two times a day for fungal skin rash. Start date 2/4/2025 at 5:00 PM and was discontinued following interview with Physician #1 on 2/26/2025 at 3:48 PM.</p> <p>- Lotrisone Cream was administered several times from 2/4/2025 to 2/26/2025.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During observation and interview on 2/26/2025 at 12:40 PM, Resident #23 stated they were a Registered Nurse. When asked about the fungal skin rash, the resident stated they had a rash under their right breast that was caused from not having a proper fitting bra and from sweat under the breasts. The resident picked up a bottle of antifungal powder that was on their nightstand and stated they had been using it regularly for the rash under their breast. The surveyor asked about the rash that was observed on the resident's face which was red and blotchy across the forehead, nose, and cheeks. Resident #23 reached in a bag and handed the surveyor a tube of cream that was in a clear plastic bag with a pharmacy label on it. The facility pharmacy label documented Clotrim/Beta cream 1-0-0.5 % generic for Lotrisone. Apply to per directions topically every day shift for 14 days. Apply under the breast. Resident #23 stated the nurse left it for them (the resident) to apply themselves. The resident stated they had applied it to the rash on their face as instructed by the nurse. The surveyor told the resident that the directions on the cream stated to apply it under the breast. The resident was not aware it was for the breast and stated they had applied the cream once yesterday afternoon to their face and the rash was gone. There was a red label on the prescription bag that read, for external use only: keep out of the eyes, inside of nose or mouth. Resident #23 stated they read the label and thought it said apply to affected area only. They stated they were normally good at reading labels but do not always wear their glasses. They reported they had no formal assessment to self-administer the medication.</p> <p>During an interview on 2/26/2025 at 3:48 PM, Physician #1 stated they saw Resident #23 on 2/04/2025 because of a rash on their face, nose, and forehead. Lotrisone cream was prescribed for the resident's face. They stated the rash would come and go because the resident was not following proper hygiene. When they saw the resident, they told the resident the plan was for the resident to shower every day and for the Lotrisone cream to be applied to the face on the affected skin. They stated the order for the Lotrisone had detailed instructions on where the nurse should apply it. Physician #1 stated they would not expect the patient to use it themselves. They stated, the instructions were for the nurse, not the patient. They stated they were not aware the resident had a fungal infection under their breast and could not explain why the prescription from the pharmacy documented to apply under the breast. The resident only complained about the rash on their face when they saw them on 2/04/2025. Physician #1 stated a fungal infection on the forehead could spread to the rest of the body.</p> <p>Resident #77</p> <p>Resident #77 was admitted to the facility with diagnoses of chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), cerebral infarction (stroke), and chronic obstructive pulmonary disease. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others.</p> <p>Laboratory Results Report for a basic metabolic profile collected on 12/12/2024 and reported on 12/13/2024 at 2:36 AM, documented critical/abnormal test list: Glucose, B-type natriuretic peptide, Creatinine, Chloride, Calcium, Calculated Osmolality, and estimated Glomerular Filtration Rate.</p> <p>Physician Progress Note dated 12/13/2024 at 9:10 PM by Nurse Practitioner #4, documented they were notified by the facility to review laboratory results. Labs collected on 12/12/2024 had notable results for the resident's kidney function and the plan was for a repeat basic metabolic profile laboratory test to be done on 12/16/2024.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Laboratory Results Report for a basic metabolic profile collected on 12/16/2024 and reported on 12/17/2024 at 3:05 AM, documented critical/abnormal test list: b-type natriuretic peptide, Creatinine, Chloride, Calculated Osmolality, and estimated Glomerular Filtration Rate, as was previously noted on results reported on 12/13/2024.</p> <p>- In addition, a potassium level of 5.2 was documented as high and was in the list of critical/abnormal tests (potassium helps nerves and muscles work properly and too much can be dangerous and cause serious heart problems).</p> <p>The resident's high potassium level was not evaluated by a provider until 12/21/2024 at 10:20 PM:</p> <p>- There was no documentation in Nursing Notes that the provider was notified of the critical/abnormal results on 12/17/2024.</p> <p>- Physician Progress Note dated 12/18/2024 at 9:09 AM by Nurse Practitioner #2, documented the resident was seen for follow up. The resident's basic metabolic profile lab test dated 12/16/2024 was reviewed. The providers had been following the resident's kidney function following acute kidney injury and estimated Glomerular Filtration Rate was slowly improving. Labs were discussed with the resident that day. Plan documented to repeat the basic metabolic profile on 12/30/2024.</p> <p>There was no documentation Nurse Practitioner #2 evaluated the high potassium level.</p> <p>- Laboratory Results Report for a basic metabolic profile collected on 12/20/2024 and reported on 12/21/2024 at 6:39 AM, the potassium level was 5.2, high.</p> <p>- Physician Progress Note dated 12/21/2024 at 10:20 PM by Nurse Practitioner #5, documented the resident was seen by the provider on 12/18/2024 and ordered a repeat basic metabolic profile. Nurse Practitioner #5 ordered Lokelma 10 grams x1 for hyperkalemia (too much potassium in the blood).</p> <p>During an interview on 3/07/2025 at 12:38 PM, Registered Nurse #2 stated laboratory results were accessible on the provider's dashboard. They stated if the potassium result was 5.2 on 12/17/2024, the provider would have been in the facility and would have seen it. Registered Nurse #2 stated nurses were not responsible for monitoring test results because providers could look up results themselves. They stated the providers should watch for the results because they ordered the tests. They stated the provider should have ordered something for the potassium level of 5.2 on 12/17/2024. Registered Nurse #2 reviewed the progress note dated 12/18/2024 by Nurse Practitioner #2 and stated there was nothing ordered for the high potassium. They stated there was another result on 12/21/2024 that the potassium was 5.2.</p> <p>During an interview on 3/03/2025 at 11:46 AM, Medical Director #1 stated that 90% of the orders were entered by the provider. They stated that when the provider evaluated a resident, they should be looking at the resident's clinical picture, meaning the lab results, orders, and progress notes.</p> <p>During an interview on 3/07/2025 at 2:02 PM, Registered Nurse Regional Clinical Director #1 stated labs were done Monday, Wednesday, and Friday unless they were stat orders. They stated the laboratory results were automatically uploaded into the electronic medical record and the provider was able to see the results on the dashboard. Administrator #1 was present and stated the nurse would see the results and notify the provider.</p> <p>(continued on next page)</p>		

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F 0711  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	10 New York Codes Rules and Regulations 415.15(b)(2)(iii)

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews during a recertification and abbreviated survey (Case #NY00347964), the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility's minimum staffing levels were not met each day from 2/22/2025 through 3/06/2025 per facility assessment and New York State Nursing Home Minimum Staffing and Direct Resident Care.</p> <p>This is evidenced by:</p> <p>Upon entrance to the facility on 2/22/2025 there were 123 residents residing on 3 units.</p> <p>Nursing Homes are required by New York State Public Health Law and Regulations to meet minimum staffing standards. These minimum standards required every nursing home to maintain daily staffing hours equal to 3.5 hours of care per resident per day by a certified nurse aide, licensed practical nurse, or registered nurse. Of the 3.5 hours required, at least 2.2 hours of care per resident per day must be provided by a certified nurse aide and at least 1.1 hours of care per resident per day must be provided by a licensed nurse.</p> <p>The Facility assessment dated [DATE] documented, under Part 3 listed Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies. Licensed nurses providing direct care: Average Days 3-6; Evenings 3-6; Nights 3. Nurse aides: Average Days 3-12; Evenings 3-9; Nights 3-6. Other nursing personnel (e.g., those with administrative duties) Director of Nursing, Assistant Director of Nursing, Nurse Manager, Nurses (Licensed Practical Nurses, Minimum Data Set, Quality Assurance Performance Initiative, Education).</p> <p>Other nursing personnel did not account for the Director of Nursing as a licensed nurse on any unit. Additionally, there was no Assistant Director of Nursing in the facility at the time of the survey. Nurse Managers were counted as being floor staff for the purposes of counting staff working on the units. All Licensed Practical Nurses were counted as working staff on the units; however, the Minimum Data Set, Quality Assurance and Education positions were not counted as working staff unless they were documented as working on as assigned unit per the staffing sheets provided by the facility.</p> <p>A review of staffing sheets provided by the facility from 2/22/2025 through 3/06/2025 documented the following:</p> <p>Based on facility census, there were not the required number of Registered Nurses or Licensed Practical Nurses on 2/22/2025, 2/23/2025, 2/28/2025, 3/03/2025, and 3/06/2025.</p> <p>On 2/22/2025, the facility census was 123. There were 16 licensed nurses (Licensed Practical Nurses and Registered Nurses) scheduled to work on that day. The required hours of licensed care for the facility were 135.3 hours based on the census. The licensed staff scheduled accounted for 128 hours of care.</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>On 2/23/2025, the facility census was 122. There were 14 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 134.2 hours based on the census. The licensed staff scheduled accounted for 112 hours of care.</p> <p>On 2/28/2025, the facility census was 124. There were 16 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 136.4 hours based on the census. The licensed staff scheduled accounted for 128 hours of care.</p> <p>On 3/03/2025, the facility census was 125. There were 16.5 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 137.5 hours based on the census. The licensed staff scheduled accounted for 132 hours of care.</p> <p>On 3/06/2025, the facility census was 125. There were 15 licensed nurses scheduled to work on that day. The required hours of licensed care for the facility were 137.5 hours based on the census. The licensed staff scheduled accounted for 120 hours of care.</p> <p>A review of staffing sheets provided by the facility from 2/22/2025 through 3/06/2025 documented the following:</p> <p>Based on facility census, there were not the required number of Certified Nurse Aides any day between 2/22/2025 through 3/06/2025.</p> <p>On 2/22/2025, the facility census was 123. There were 23 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 301.35 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 184 hours of care.</p> <p>On 2/23/2025, the facility census was 122. There were 22 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 298.9 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 176 hours of care.</p> <p>On 2/24/2025, the facility census was 121. There were 22 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 296.45 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 176 hours of care.</p> <p>On 2/25/2025, the facility census was 120. There were 24 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 294 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 192 hours of care.</p> <p>On 2/26/2025, the facility census was 121. There were 21 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 296.45 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 168 hours of care.</p> <p>On 2/27/2025, the facility census was 123. There were 21 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 301.35 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 168 hours of care.</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>On 2/28/2025, the facility census was 124. There were 21 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 303.8 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 168 hours of care.</p> <p>On 3/01/2025, the facility census was 125. There were 28 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 306.25 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 224 hours of care.</p> <p>On 3/02/2025, the facility census was 125. There were 21 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 306.25 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 168 hours of care.</p> <p>On 3/03/2025, the facility census was 125. There were 22 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 306.25 hours based on the census. The licensed staff scheduled accounted for 176 hours of care.</p> <p>On 3/04/2025, the facility census was 125. There were 20 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 306.25 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 160 hours of care.</p> <p>On 3/05/2025, the facility census was 125. There were 21 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 306.25 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 168 hours of care.</p> <p>On 3/06/2025, the facility census was 125. There were 23 Certified Nurse Aides scheduled to work on that day. The required hours of Certified Nurse Aide care for the facility were 306.25 hours based on the census. The Certified Nurse Aide staff scheduled accounted for 184 hours of care.</p> <p>During the resident council meeting on 2/24/2025 at 11:38 AM, residents present stated that there were not enough staff members.</p> <p>During an interview on 2/24/2025 at 3:59 PM, Resident #61 stated that they had been at the facility since January, 2025. Resident #61 stated that they had 2 showers since they arrived but were supposed to have at least 1 per week, on Fridays on the 3-11 PM shift. Staff had told Resident #61 they were short staffed, and the resident had to wait.</p> <p>During an interview on 2/27/2025 at 9:03 AM, Registered Nurse #2 stated that the unit was short staffed, and they had never worked with such low staffing numbers. There was no real effective staff appreciation. The facility had monthly staff appreciation days but there's no bonuses for people that pick-up shifts, there's no app to communicate where the staffing holes were in case someone wanted to pick up or trade shifts. Registered Nurse #2 additionally stated that they have had to do all the care plans for unit A and sometimes some of the care plans on unit B. It was very hard to run two units.</p> <p>During an interview on 3/02/2025 at 11:54 AM, Administrator #1 stated that the facility did have agency staff but not a lot. Administrator #1 stated that they did not think that they were significantly understaffed.</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 an interview on 3/02/2025 at 1:48 PM, Director of Nursing #1 stated that they had never been told something could not be done because of no staff.</p> <p>During a subsequent interview on 3/02/2025 at 2:00 PM, Administrator #1 stated that they had never heard that there were not enough staff at the facility to administer medications or resident care done.</p> <p>10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview during the recertification survey, the facility did not ensure licensed nurses and Certified Nurse Aides had the specific competencies and skills necessary to care for resident's need. Specifically, based on the facility assessment of required education, (a.) education records reviewed for Certified Nurse Aides #3 and #4 were incomplete; (b.) Licensed Practical Nurses #s 11 and 12 education were incomplete; (c.) Registered Nurse #4's education record was incomplete, and (d.) Registered Nurse #2 did not possess the knowledge needed to complete the tasks being assigned to their position.</p> <p>This is evidenced by:</p> <p>The Facility assessment dated [DATE], documented under Staff Training/Education, Competencies, and Skill Sets, All NA/R's (Nurse Aides/Resident Assistants) would receive at least 12 hours of Training per year - including all the mandatory trainings, along with basic ADL (Activities of Daily Living) care, dementia training, and areas of weakness as defined by annual performance reviews and as needed.</p> <p>The Facility Assessment documented under Orientation, the following was required for licensed nurses and nurse aides:</p> <p>Topic: Maltreatment, [NAME] of Rights, Resident Rights, Emergency Disaster Plan, Hazardous substances, Health Insurance Portability Accountability Act, Medicaid Fraud, Waste, and Abuse, Job description, Orientation to the resident, Advanced Directives, Infection Control, Quality Assurance Performance Improvement, Principles of person centered care and service delivery, Infection Control, Compliance and Ethics, Behavioral Health, Elder Justice Act, Centers for Medicaid and Medicare Services, Medicare Fraud Waste and Abuse, Trauma-Informed Care, Communication and Conflict Resolution, Cultural Competency, Safe Patient Handling, Explanation Alzheimer's Disease and other Dementia, Assistance with Activities of Daily Livings, Problem solving with challenging behavior, Communication skills, Person-centered planning and service delivery, and Documentation requirements for services provided.</p> <p>The Facility Assessment documented under Annual the following was required for licensed nurses and nurse aides:</p> <p>Topic: [NAME] of Rights, Resident Rights, Emergency/Disaster Plan, Hazardous substances, Health Insurance Portability Accountability Act, Medicaid Fraud, Waste and Abuse, Policies and Procedures, Job description, Orientation to the resident, Advanced Directives, Infection Control, Quality Assurance Performance Improvement, Principles of person centered care and service delivery, Infection Control, Compliance and Ethics, Behavioral Health, Elder Justice Act, Centers for Medicaid and Medicare Services, Medicare Fraud Waste and Abuse, Trauma-Informed Care, Communication and Conflict Resolution, Cultural Competency, Safe Patient Handling, Explanation Alzheimer's Disease and other Dementia, Assistance with Activities of Daily Living, Problem solving with challenging behavior, Communication skills, Documentation requirements for services provided, Emergency and Disaster Preparedness Plan (required 2 times per year), Cognitive Impairment, and Training Program in Rehabilitation for nursing personnel.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Facility Assessment documented under Infection Control Program Evaluation: (Infection Risk Assessment) that all staff were trained in basic infection control on hire and annually. Staff conducted random skill audits such as hand hygiene, glove use, peri cares, wound cares.</p> <p>Certified Nurse Aide #3's education file from the facility did not contain evidence that annual educations had been done after 1/09/2024, one year after Certified Nurse Aide #3 had been employed at the facility.</p> <p>Certified Nurse Aide #4's education file from the facility revealed that Certified Nurse Aide #4's General Orientation Mandatory Checklist dated 1/14/2025, was not signed by an instructor, the Doffing and Donning Personal Protective Equipment competency dated 1/14/2025 was not signed by an Evaluator, the Mechanical Lift Competency dated 1/15/2025 was not signed by a Validator, and the Handwashing Competency was not signed at all.</p> <p>Licensed Practical Nurse #11's education file from the facility did not contain evidence of annual educations done after 9/26/2024 which was one year after the last documented educations.</p> <p>Licensed Practical Nurse #12's education file from the facility did not contain documentation that Licensed Practical Nurse #12 received annual educations after 3/10/2024.</p> <p>Registered Nurse #4's education file from the facility revealed that the Code of Conduct was never signed by the Registered Nurse, and there was no name or date on the Posttest for Abuse Prevention. Additionally, there was no documented evidence that Registered Nurse #4 received annual educations or competencies after 8/22/2024.</p> <p>During an interview on 2/27/2025 at 9:03 AM, Registered Nurse #2 stated that the orientation was 2 days long and the instructors read to them. Registered Nurse #2 stated that they had told administration that the training provided was not sufficient, that the staff turnover rate was terrible, and the staff was made up of mostly new people.</p> <p>When discussing updating care plans as a part of the job of the Registered Nurses in the building, Registered Nurse #2 stated that they had to do all the care plans for Unit A and sometimes some of the care plans on Unit B. Registered Nurse #2 stated it was very hard for them to run two units. Registered Nurse #2 stated that they were not proficient in updating care plans. Additionally, Registered Nurse #2 asked what the rules were regarding hand washing before giving resident care and after. After the surveyor stated the expectation of washing one's hands both before and after giving resident care, Registered Nurse #2 put their head down and stated that the staff were not washing their hands and that they had seen it happen.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/06/2025 at 3:45 PM, Licensed Practical Nurse #13 stated that they had been the facility educator for 2 weeks but used to be the person responsible for educating the staff on the Point Click Care program (electronic record system used in the facility). Additionally, they were just getting settled into their position. Licensed Practical Nurse #13 stated that competencies were done with shadowing and in a classroom. They had not yet had to orient any floor staff in their position. Licensed Practical Nurse #13 stated that competencies would be reviewed annually and that focused competencies were done a few times a year based on what happened in the building and what was apparent that the staff required education on. Licensed Practical Nurse #13 stated that orientation was on average around 4 days in the classroom and then 10 days on the floor, depending on the performance of the new hire. Licensed Practical Nurse #13 stated that they were planning to do a Point Click Care training when the survey started. When asked to describe how staff were tested for competency, Licensed Practical Nurse #13 stated that there was a group discussion with posttests or visual competencies if the education was skill-based. Additionally, there would be a review of skills if it was reported that staff did not know how to perform functions of their jobs.</p> <p>When asked if a staff member would be allowed to work on the floor and with residents without completing their orientation educations and competencies, Licensed Practical Nurse #13 stated that they would not let anyone loose without being signed off and could not account for why there would be holes in orientation paperwork.</p> <p>During an interview on 3/07/2025 at 2:00 PM, Regional Director of Nursing #1 stated that it was their expectation that the staff would be fully trained before working on the units, that education should be continuous and as often as possible for important topics like infection control. Regional Director of Nursing #1 stated that they were looking to improve and was able to speak to policies of the facility but not the specifics of residents or staff because they just changed from another corporate facility to this one 5 days prior.</p> <p>During an interview on 3/07/2025 at 2:30 PM, Administrator #1 stated that they were not aware of the multitude of issues brought up by the survey team. Administrator #1 stated that they intended to improve on their processes and with guidance from corporate and other resources, they would be more active in the day-to-day operations of the facility and audit the staff for compliance.</p> <p>10 New York Code of Rules and Regulations 415.26(c)(1)(iv)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interview during the recertification survey and abbreviated survey (Case # NY00363829), the facility did not ensure that it provided pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of the residents for two (2) (Resident #s 47 and 77) of 5 residents reviewed. Specifically, [a.] for Resident #47 with diagnoses of schizophrenia, the facility did not ensure Clozapine (atypical antipsychotic) was available to administer on 11/25/2024 to 12/26/2024 and, [b.] for Resident #47, the facility did not ensure Lokelma was available on 12/21/2024, when ordered for a high potassium level. The resident did not receive the medication until 12/25/2024.</p> <p>This is evidenced by:</p> <p>Cross-referenced to F760: Residents are Free of Significant Medication Errors</p> <p>Resident #47</p> <p>Resident #47 was admitted to the facility with diagnoses of schizophrenia (a mental condition characterized by thoughts or experiences that seem out of touch with reality), chronic obstructive pulmonary disease with acute exacerbation (a chronic lung disease that cause progressive and irreversible damage to the airways in the lungs), and type 2 diabetes mellitus without complications (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident made themselves understood and was able to understand others.</p> <p>Order Summary Report for order date range 11/01/2024 to 3/07/2025, documented an order dated 11/25/2024 for Clozapine oral tablet give 375 milligrams by mouth at bedtime for schizophrenia.</p> <p>Medication Administration Record dated November 2024 documented Clozapine 375 milligrams was to start on 11/25/2024 at 9:00 PM and documented:</p> <ul style="list-style-type: none"> <li>- 11/25/2024 was not given and documented awaiting pharmacy delivery.</li> <li>- 11/26/2024 was not given and documented medication enroute from pharmacy, will administer upon arrival. Physician notified.</li> <li>- 11/27/2024 was documented as given.</li> <li>- 11/28/2024 was not given and documented the medication was on order and awaiting arrival from the pharmacy. Skilled nursing would follow up.</li> </ul> <p>Pharmacy report for Clozapine, dispense date range 2/01/2024 to 3/03/2025, did not document Clozapine was dispensed in November 2024 for Resident #47. The report documented the medication was dispensed on 12/6/2024.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Pharmacy Packing Slip Proof of Delivery documented Clozapine was delivered to the facility for Resident #47 on 12/06/2024 at 9:49 PM.</p> <p>Resident #77</p> <p>Resident #77 was admitted to the facility with diagnoses of chronic kidney disease (chronic kidney damage that makes it harder for kidneys to filter waste and fluid from the blood), cerebral infarction (a medical condition where the blood flow to the brain is interrupted, leading to the death of brain cells), and chronic obstructive pulmonary disease (a chronic lung disease that cause progressive and irreversible damage to the airways in the lungs). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others.</p> <p>Laboratory Report dated 12/21/2024, documented the results of a basic metabolic panel that was collected on 12/20/2024. The potassium result was 5.2 (reference range 3.5 - 5.1) and was flagged as being high.</p> <p>Order Summary Report for order date range 11/1/2024 to 3/31/2025, documented an order dated 12/21/2024 for Lokelma oral packet 10 grams (sodium zirconium cyclosilicate), give 1 packet by mouth for hyperkalemia (high level of potassium in the blood often caused by kidney disease).</p> <p>Nursing Note dated 12/21/2024 at 10:54 PM by the Registered Nurse documented they received a call from the provider regarding Resident #77 having a potassium level of 5.2. The provider placed a new order for Lokelma. The Registered Nurse contacted the pharmacy, and they reported they would not be able to get the medication in the facility until the following afternoon. The provider was made aware and confirmed it was ok that the medication would not be available until the following afternoon.</p> <p>Medication Administration Record dated December 2024, did not have documented evidence that Lokelma was given on 12/22/2024 and there was no documented evidence in a Nursing Progress Note that the provider was notified.</p> <p>There was no documented evidence the resident received Lokelma on 12/21/2024, 12/22/2024, 12/23/2024, or 12/24/2024. There was no documented evidence in Nursing Notes that the medical provider was notified.</p> <p>Physician Progress Note dated 12/24/2024 at 3:45 PM by Physician #2, documented the resident's potassium level had increased, and the resident had received 1 dose of Lokelma on 12/21/2024. Plan documented to give Lokelma 2 times a day for 1 day.</p> <p>Order Summary Report for order date range 11/1/2024 to 3/31/2025, documented an order dated 12/24/2024 for Lokelma oral packet 10 grams (sodium zirconium cyclosilicate), give 1 packet by mouth two times a day for hyperkalemia.</p> <p>Order Note dated 12/25/2024 at 2:16 AM by Registered Nurse, documented the order for Lokelma oral packet 10 grams, give 1 packet two times a day for hyperkalemia was outside of the recommended dose or frequency. The frequency of 2 times a day exceeded the usual frequency of every 2 days to daily. It documented the provider was aware.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Medication Administration Record dated December 2024 documented Lokelma oral packet 10 grams was given on 12/25/2024 at 9:00 AM.</p> <p>During an interview on 3/02/2025 at 1:48 PM, Director of Nursing #1 stated that they were aware that there were medications missing from pharmacy. They have been looking into it. Haven't run into any reports of missing medications or medication errors, had just been told by staff that pharmacy didn't send medications. Director of Nursing #1 stated they would expect that staff who discovered medications weren't in house would check the PYXIS to see if there was any here already, get vitals, contact Medical Doctor to tell them what was available for substitution, document in the Electronic Medical Record that the medication was not available and that the dose was missed, and call pharmacy to make sure that medication would come on next run. Missed medications should be reported to the supervisor. Director of Nursing #1 stated they were unaware that there was a medication error form and stated that documentation of missed medications should be in the shift to shift 24-hour report that was they reviewed every day. Director of Nursing #1 stated Nurse Managers were also supposed to check. Quality Assurance Plan Initiative had met once with them as a Director of Nursing, and they were having night nurses review carts and medications to ensure that everything was where it needed to be. Pharmacy made 3 deliveries a day early in the morning on the overnight shift, afternoon on day shift, and on the evening shift around 8-9 PM.</p> <p>During an interview on 3/02/2025 2:00 PM, Administrator #1 stated in the past they had reached out to providers themselves to help figure out issues. They stated they would expect that staff would call pharmacy for missing doses and to find out when they could be delivered. The Administrator stated they would expect that staff would call Medical Director to see if something else could be given. They stated they would expect staff to monitor the resident and document whatever direction was given by provider. They stated the medication issues in the building just came to light over the last week.</p> <p>During an interview on 3/02/2025 at 3:11 PM, Administrator #1 stated they had started a house wide education regarding what was available in the Pyxis ( and what to do when something was not available. Supervisors and unit managers had been reeducated on the policy of checking their reports, checking the clinical dashboard for late and/or missing medications. Daily reports would be run regarding medication errors and missed doses and if the providers were notified. Administrator #1 stated they would be checking reports for yellow and red colors (indicated late or missed doses) daily and try to correct inconsistencies in real time.</p> <p>During an interview on 3/07/2025 at 12:38 PM, Registered Nurse #2 stated Resident #77 had a result on 12/21/2024 that the potassium was 5.2. When asked about the Lokelma ordered on 12/21/2024 for the high potassium, they stated they had lots of problems with the pharmacy that was located out-of-state. They stated they had issues with medications received in the facility because of the pharmacy location. They stated the facility did not utilize a local pharmacy.</p> <p>During an interview on 3/07/2025 at 2:02 PM, Registered Nurse Regional Clinical Director #1 stated that recently during the survey, they came across the problem with receiving medications from the pharmacy. Administrator #1 was present and stated they reached out to the pharmacy representative and now had access to a pharmacy dashboard.</p> <p>10 New York Codes Rules and Regulations 415.18(a)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, record review, and interviews during a recertification and abbreviated survey (Case #'s NY00363829, NY00364424, and NY00347964), the facility failed to ensure residents were free of any significant medication errors for five (5) (Resident #s 12, 23, 47, 77, and 327) of 10 residents reviewed for medication administration. Specifically, (a.) Resident #47 was not administered 12 days-worth of psychiatric medication from 11/25/2024 to 12/06/2024. Over the 12 days, the resident decompensated psychiatrically, and on 11/29/2024 at 9:00 AM, the resident requested to be sent to the hospital. (b.) Resident #12 was not administered their antibiotics (medication to treat active infections) 10 of 20 times as prescribed. (c.) Resident #23 was not administered antibiotics as prescribed, receiving only four (4) of eight (8) doses prescribed. (d.) Resident #77 was not administered prescribed medication to lower their high potassium level on 12/21/2024 and did not receive the medication until 12/25/2024, after it was noted that Resident #77's potassium level was further elevated. (e.) Resident #327 was not administered antibiotics until two (2) days after the order was prescribed, causing a delay in treatment for an active infection. This resulted in actual harm for Resident #47 which was Immediate Jeopardy and Substandard Quality of Care with the likelihood of risk for harm to the health and safety of Residents #12, #23, #77, and #327.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Administering Medications, effective 10/1997 and reviewed on 1/2025, documented that Medications should be administered in a safe and timely manner, and as prescribed. The policy Interpretation and Implementation documented the following: Medications must be administered in accordance with the orders, including any required time frame; medications must be administered within one (1) hour of their prescribed time, unless otherwise specified; if a dosage was believed to be inappropriate or excessive for a resident, or an education had identified consequences, the person preparing or administering the medications should contact the resident's Attending Physician or the facility's Medical Director to discuss the concerns. The following information must be checked/verified for each resident prior to administering medications: allergies to medications; vital signs, if necessary; for residents not in their rooms or otherwise unavailable to receive medication on the pass, the Electronic Medication Administration Record may be flagged. After completing the medication pass, the nurse would return to the missed resident to administer the medication; if a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication should document the same in the Electronic Medication Administration Record for that drug and dose. The person withholding, receiving the refusal, or administering medication at a different time would notify the attending/covering physician. The individual administering the medication must sign the resident's Electronic Medication Administration Record as indicated by the software after giving each medication and before administering the next one. As required or indicated for medication, the individual administering the medication would record in the resident's medical record: (a.) the date and time the medication was administered; (b.) the dosage; (c.) the route of administration; (d.) the injection site (if applicable); (e.) any complaints or symptoms for which the drug was administered; (f.) any results achieved and when those results were observed; and (g.) the signature and title of the person administering the drug; topical medication used in treatment must be recorded on the resident's treatment record; and residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, had determined that they have the decision-making capacity to do so safely.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #47</p> <p>Resident #47 was admitted to the facility with diagnoses of schizophrenia (a mental condition characterized by thoughts or experiences that seem out of touch with reality), chronic obstructive pulmonary disease with acute exacerbation (a chronic lung disease that causes progressive and irreversible damage to the airways in the lungs), and type 2 diabetes mellitus (a chronic condition where the body does not use insulin properly or does not produce enough insulin to regulate blood sugar levels). The Minimum Data Set, dated , 10/01/2024 documented the resident was cognitively intact, could be understood, and understand others.</p> <p>The Care Plan for Resident Displays/Reports the following moods: feeling down, depressed, hopeless, feeling tired or having little interest or pleasure in doing things, revised 12/02/2024, documented the resident had a history of suicidal ideation and their last statement was on 11/25/2024, when they had suicidal ideation, no plan. Interventions included administer psychotropic medications as ordered, assess for suicidal ideation if needed, no cords per statement of suicidal ideation, and psychological services as needed</p> <p>Order Summary Report for order date range 11/01/2024 to 3/07/2025, documented an order dated 11/25/2024 for Clozapine oral tablet, give 375 milligrams by mouth at bedtime for schizophrenia. There was no end date on the order.</p> <p>Record review of manufacturer specification of Clozaril (clozapine), located at <a href="https://clozaril.com/important-safety-information/">https://clozaril.com/important-safety-information/</a> documented the following: Important Safety Information, Discontinuing Treatment documented to reduce the dose gradually over a period of 1 to 2 weeks if termination of clozapine therapy was planned and there was no evidence of moderate to severe neutropenia (low number of neutrophils (a type of white blood cell) in the bloodstream). For abrupt clozapine discontinuation for a reason unrelated to neutropenia, continuation of the existing ANC (absolute neutrophil count) monitoring was recommended. It documented to monitor all patients carefully for the recurrence of psychotic symptoms.</p> <p>Medication Administration Record dated November 2024 documented, Clozapine 375 milligrams was to start on 11/25/2024 at 9:00 PM and documented:</p> <ul style="list-style-type: none"> <li>o 11/25/2024 was not given and documented: awaiting pharmacy delivery.</li> <li>o 11/26/2024 was not given and documented: medication was enroute from pharmacy, would administer upon arrival. Physician notified.</li> <li>o 11/27/2024 was documented as given.</li> <li>o 11/28/2024 was not given and documented: the medication was on order and awaiting arrival from the pharmacy. Skilled nursing would follow up.</li> </ul> <p>Hospital Discharge summary dated [DATE], Hospital Course documented the resident was found to have a lung infection and was also seen by psychiatry services. The resident was on one-to-one observation for suicidal ideation. Prior to discharge, the resident was cleared by psychiatry services and was taken off one-to-one observation. Discharge diagnosis/plan included schizophrenia and suicidal ideation.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Behavioral Health Services Note dated 11/26/2024 documented the resident recently returned for a hospitalization for medical reasons, but then required additional time on the psychiatric unit for suicidal ideation. The resident currently was reporting feeling more stable, with no thoughts of suicidal ideation. The resident reported continued thoughts of mild depression and confusion. Target symptoms that would be the focus of treatment: depression, psychosis.</p> <p>A nursing note dated 11/29/2024 at 8:36 AM by Registered Nurse #5 documented Resident #47 stated, I want to die. I want to go to the hospital. Registered Nurse #5 informed the provider and social work and assigned a staff member to sit with the resident. 911 was called and the resident was sent to the Emergency Department. The resident was sent to the hospital at 9:00 AM.</p> <p>A nursing note dated 11/29/2024 at 4:07 PM, documented the resident returned from the Emergency Department at 4:05 PM.</p> <p>The Medication Administration Record dated November 2024 documented Clozapine 375 milligrams was given on 11/29/2024 and 11/30/2024 at 9:00 PM.</p> <p>Surveyors were unable to determine how/why Clozapine was documented as given on 11/27/2024, 11/29/2024, and 11/30/2024. There was no documented evidence Clozapine was delivered to the facility in November 2024:</p> <p>Pharmacy report for Clozapine for Resident #47, dispense date range 2/01/2024 to 3/03/2025, did not document Clozapine was dispensed in November 2024. The medication was not dispensed until 12/6/2024.</p> <p>Per the report of what was available in the facility PYXIS (automated medication dispensing system), Clozapine was not stocked in the facility.</p> <p>The Medication Administration Record dated December 2024 documented Clozapine 375 milligrams was to be given at bedtime and was scheduled for 9:00 PM. It documented:</p> <ul style="list-style-type: none"> <li>o 12/01/2024 was not given and documented: enroute from pharmacy. Physician notified.</li> <li>o 12/02/2024 was documented as given.</li> <li>o 12/03/2024 was documented as given.</li> <li>o 12/04/2024 was documented as given.</li> <li>o 12/05/2024 was not given and documented: awaiting pharmacy delivery.</li> </ul> <p>There was no documented evidence that Clozapine was delivered to the facility from 12/01/2024 to 12/05/2024.</p> <p>A Physician Progress Note dated 12/06/2024 at 3:38 PM by Nurse Practitioner #2, documented Resident #47 was prescribed Clozapine for schizophrenia. Clozapine level was less than 10. (therapeutic range 350-600 nanograms/milliliter) It documented questionable medication adherence. The medication administration report showed 5 times the resident did not receive medication, unclear why.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A nursing note dated 12/06/2024 at 4:01 PM documented the nurse was informed by the pharmacy that the resident's clozapine was waiting for approval, and as soon as it was approved, it would be sent on the next delivery. Provider was made aware.</p> <p>The Medication Administration Record dated December 2024 documented Clozapine 375 milligrams was not given on 12/06/2024 at 9:00 PM. A Medication Administration Note dated 12/06/2024 at 8:51 PM, documented: awaiting pharmacy delivery.</p> <p>The Pharmacy Packing Slip Proof of Delivery documented Clozapine 375 milligrams was delivered to the facility for Resident #47 on 12/06/2024 at 9:49 PM.</p> <p>There was no documentation on the Medication Administration Record dated 12/06/2024 that the clozapine was administered on 12/06/2024 after it was received in the facility at 9:49 PM.</p> <p>The Medication Administration Record dated 12/7/2024 documented Clozapine 375 milligrams was given at 9:00 PM.</p> <p>A nursing note dated 12/08/2024 at 4:24 PM by Registered Nurse #6 documented at 3:35 PM Registered Nurse #6 and the unit nurse entered the resident's room and found Resident #47 flailing their arms around and flipping their body over continuously and putting themselves onto their knees and attempting to stay on the floor. Resident #47 was not speaking normally, oriented to self, and unable to say the name of the facility. Typically, the resident could say the name of the facility. Resident #47 has also known Registered Nurse #6's name for months but could not recall their name. Resident #47 stated they wanted to go to the hospital. Resident #47 has not received their psychiatric medication in a week and the resident was not functioning safely.</p> <p>A nursing note dated 12/08/2024 at 5:19 PM by Registered Nurse #documented they called 911 and report was given to the Emergency Medical Technicians. Resident #47 appeared to understand they were going to the hospital and wanted to go.</p> <p>The Hospital Emergency Documentation documented the resident was seen on 12/8/2024 at 7:36 PM. Chief complaint: The resident was brought in by ambulance from the nursing home for altered mental status. The resident had a history of schizophrenia and has not been given their clozapine for unknown time/unreason.</p> <p>The Emergency Department Course/Medical Decision Making documented resident presents with altered mental status. Differential diagnosis included but not limited to medication side effect, medication withdrawal, urinary tract infection, or metabolic abnormality. Basic labs, urinalysis, and chest x-ray were obtained. Urinalysis was not suggestive of urinary tract infection. Chest x-ray and computed tomography did not show any significant findings. On reevaluation, the resident was arousable and was able to have a conversation. The resident stated they remembered feeling somewhat confused that afternoon but now felt back to normal. The resident was discharged and transported back to the facility by ambulance.</p> <p>The Emergency Department Clinical Summary, Discharge Information, documented the resident discharged on 12/09/2024 at 2:26 AM with diagnosis of confusion.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A Physician Progress Note dated 12/09/2024 at 3:39 AM by Nurse Practitioner #6 documented they received a call from the facility for admission medication reconciliation. The resident returned from the hospital after hallucinating.</p> <p>During an interview on 3/2/2025 at 12:12 PM, Nurse Practitioner #2 stated Resident #47 missed several doses of Clozapine and ended up going to the hospital because they were suicidal.</p> <p>Resident #12</p> <p>Resident #12 was admitted to the facility with diagnoses of severe intellectual disabilities (a developmental delay that limits a person's ability to function in social and practical ways), chronic kidney disease stage 3 (a moderate level of kidney damage that would make it harder for kidneys to filter waste and fluid from the blood), and type 2 diabetes mellitus. The Minimum Data Set (an assessment tool) dated 12/09/2024 documented the resident had severe cognitive impairments, could be understood, and sometimes understand others.</p> <p>A Physician Progress Note dated 1/02/2025 at 12:28 PM documented Resident #12 was diagnosed with a urinary tract infection on 12/19/2024, with enterococcus faecalis bacteria in critically high amounts. It documented they were prescribed an antibiotic, Amoxicillin 500 milligrams by mouth; however, according to nursing staff, the resident had been spitting out the pills and refusing to take them. Based on the resident's behavior, the oral antibiotic was changed to intravenous antibiotic (administered into a vein). The resident was prescribed the antibiotic Ampicillin, 2 grams intravenously every 6 hours for 7 days.</p> <p>A Physician Order dated 1/02/2025 at 11:56 AM documented Resident #12 was to receive Ampicillin Sodium Solution, reconstituted 2 grams, starting 1/02/2025 at 6:00 PM, administered intravenously every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM for 7 days.</p> <p>Registered Nurse Orders Administration Report dated 1/02/2025 6:00 PM dose was not given. The record was blank. There was no documented evidence why the medication was not given.</p> <p>A Physician Order dated 1/03/2025 at 1:10 PM documented Ampicillin Sodium Solution reconstituted 2 grams, intravenously every 6 hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM for 7 days. Start date 1/3/2025 at 6:00 PM.</p> <p>A Registered Nurse Orders Administration Report dated January 2025 documented Ampicillin Sodium Solution Reconstituted 2 grams, use intravenously every 6 hours for urinary tract infection for seven (7) days. The medication was scheduled to be given at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. The resident did not receive 10 out of 20 scheduled doses as follows:</p> <ul style="list-style-type: none"> <li>o 1/03/2025 12:00 AM, 6:00 AM, and 12:00 PM doses were not given and there were no progress notes.</li> </ul> <p>Physician Progress Note dated 1/03/2025, documented the resident missed three (3) doses due to a delay in delivery by the pharmacy and a staff shortage.</p> <ul style="list-style-type: none"> <li>o 1/04/2025 12:00 AM, 6:00 AM, and 6:00 PM doses were not given and there was no documented evidence why the medication was not given.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>o 1/05/2025 6:00 PM dose was not given and there was no documented evidence why the medication was not given.</p> <p>o 1/06/2025 6:00 PM dose was not given and there was no documented evidence why the medication was not given.</p> <p>o 1/07/2025 12:00 PM dose was not given and there was no documented evidence why the medication was not given.</p> <p>A Physician Progress Note dated 1/07/2025 at 4:50 PM by Nurse Practitioner #2 documented they were notified that several doses of intravenous Ampicillin had been missed. Ampicillin was ordered to treat enterococcus faecalis urinary tract infection. The intravenous medication was specifically ordered as the resident had been refusing all medications by mouth. This was brought to the physician's attention on 1/02/2025 and as a result, was started on Ampicillin 2 grams intravenously every six (6) hours. Order changed to Levaquin 250 milligrams intravenously once a day at 2:00 PM, for better medication compliance.</p> <p>The Medication Administration Record dated January 2025 documented Levofloxacin (Levaquin) intravenous solution, use 250 milligrams intravenously in the afternoon for urinary tract infection for three (3) days, to start on 1/07/2025 at 2:00 PM.</p> <p>A record review of the Medication Administration Record revealed the resident did not receive the Levaquin on 1/09/2025. There was no documented evidence why the medication was not given.</p> <p>A Physician Progress Note dated 1/10/2025 at 11:50 AM by Nurse Practitioner #2 documented the resident was prescribed intravenous Levaquin for urinary tract infection. The resident did not receive the last dose yesterday afternoon (1/09/2025). Plan: would give the last dose of intravenous Levaquin 250 milligrams now. The provider would follow up to ensure the dose was received.</p> <p>A record review of the Medication Administration Record revealed the resident received the intravenous Levaquin on 1/10/2025.</p> <p>During an interview on 3/02/2025 at 12:12 PM, Nurse Practitioner #2 stated they had to alter orders to account for no staffing. It had been something they had to do since about October 2024. They could not recall other resident names, but they knew missed medication doses for other residents had happened in the past. They stated nurses were documenting medications were not available but were not notifying providers. Providers had to double cover infections with more than one (1) antibiotic because they were unsure if residents had received all the doses. They stated Resident #12 was ordered to have Ampicillin intravenously every six (6) hours to treat urinary tract infection. They did not have enough nurses on the unit to administer the medication as ordered and the resident missed doses of Ampicillin. They had to think of a way to provide medication to the resident and ordered Levaquin intravenously once daily for three (3) days for better medication compliance by nursing staff. They stated that even with the Levaquin being a once daily medication, the resident did not get it for three (3) consecutive days as ordered. They stated the resident missed the third dose and they had to order a one-time dose of Levaquin intravenously.</p> <p>Resident #23</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Resident #23 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that causes progressive and irreversible damage to the airways in the lungs), acute on chronic systolic congestive heart failure (a sudden worsening of symptoms of a pre-existing condition of weakened heart muscles), and type 2 diabetes mellitus. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact, could be understood, and understand others.</p> <p>A Physician Progress Note dated 2/22/2025 at 6:00 PM by Nurse Practitioner #3 documented they received a call from nursing staff reporting the resident's urinalysis and culture results returned positive for urinary tract infection and was sensitive to Augmentin (antibiotic). The resident was prescribed Augmentin 875 milligrams twice daily.</p> <p>A Physician Order dated 2/22/2025 documented Amoxicillin-potassium clavulanate (Augmentin) tablet 875-125 milligrams, give 1 tablet by mouth every 12 hours for urinary tract infection for seven (7) days. Start date 2/22/2025.</p> <p>The Medication Administration Record dated February 2025 documented Amoxicillin-potassium clavulanate tablet 875-125 milligrams, give one (1) tablet every 12 hours for urinary tract infection for seven (7) days, to start on 2/22/2025 at 6:00 PM. It was scheduled to be given at 6:00 AM and 6:00 PM. The order was discontinued on 2/26/2025 at 8:29 AM, for a total of eight (8) doses to be given.</p> <p>The facility printed a report from the automated medication dispensing system on 2/27/2025 for Resident #23, for date range 2/21/2025 to 2/25/2025, documented Augmentin (four (4) doses) were removed from the automated medication dispensing system on:</p> <ul style="list-style-type: none"> <li>o 2/22/2025 at 5:43 PM</li> <li>o 2/23/2025 at 7:12 AM</li> <li>o 2/24/2025 at 4:02 PM</li> <li>o 2/25/2025 at 3:34 PM</li> </ul> <p>Review of the Medication Administration Record dated February 2025 for Amoxicillin-potassium administration revealed the resident did not receive four (4) doses as follows:</p> <ul style="list-style-type: none"> <li>o 2/23/2025 6:00 PM documented Augmentin was given. There was no record that it was removed from the automated medication dispensing system.</li> <li>o 2/24/2025 6:00 AM was not given and there was no documented evidence why the medication was not given.</li> <li>o 2/25/2025 6:00 AM documented Augmentin was not given. The medication administration notes documented: did not come from pharmacy and not available in automated medication dispensing system. Supervisor aware.</li> <li>o 2/26/2025 6:00 AM was not given. The medication administration notes documented: not available from pharmacy and none in automated medication dispensing system. Supervisor notified.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 12:40 PM, Resident #23 stated they missed two or three doses of antibiotics because they were not available.</p> <p>During an interview on 3/02/2025 at 12:12 PM, Nurse Practitioner #2 stated Resident #23 developed pneumonia while being treated for urinary tract infection. They stated the Augmentin that was ordered would have taken care of the urinary tract infection and pneumonia if the nurses had given the medication as ordered. They stated they had to order intravenous antibiotic for Resident # 23's pneumonia because of the missed doses of Augmentin. They stated Resident #47 missed several doses of Clozapine and ended up going to the hospital because they were suicidal.</p> <p>Resident #77</p> <p>Resident #77 was admitted to the facility with diagnoses of chronic kidney disease (chronic kidney damage that makes it harder for kidneys to filter waste and fluid from the blood), cerebral infarction (a medical condition where the blood flow to the brain is interrupted, leading to the death of brain cells), and chronic obstructive pulmonary disease. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact. The resident made themselves understood and was able to understand others.</p> <p>A Laboratory Report dated 12/21/2024 documented the results of a basic metabolic panel (helps doctors check the body's fluid balance and levels of electrolytes) that was collected on 12/20/2024. The potassium result was 5.2 (reference range 3.5 - 5.1) and was flagged as being high.</p> <p>An Order Summary Report for 11/01/2024 to 3/31/2025 documented an order dated 12/21/2024 for sodium zirconium cyclosilicate, give one (1) packet by mouth for hyperkalemia (high level of potassium in the blood often caused by kidney disease) for one (1) day.</p> <p>A nursing note dated 12/21/2024 at 10:54 PM by the Registered Nurse #3 documented they received a call from the provider regarding Resident #77 having a potassium level of 5.2. The provider placed a new order for sodium zirconium cyclosilicate. Registered Nurse #3 contacted the pharmacy, and they reported they were not able to get the medication to the facility until the following afternoon. The provider was made aware and confirmed it was okay that the medication was not available until the following afternoon.</p> <p>The Medication Administration Record dated December 2024 did not document sodium zirconium cyclosilicate was given on 12/22/2024, and there was no documented evidence in a Nursing Progress Note that the provider was notified.</p> <p>A Laboratory Report dated 12/24/2024 documented the results of a basic metabolic panel that was collected on 12/23/2024. The potassium result was 5.4 (reference range 3.5 - 5.1) and was flagged as being high.</p> <p>A Physician Progress Note dated 12/24/2024 at 3:45 PM by Physician #2 documented the resident was seen for routine lab review related to chronic illness. It documented resident received one (1) dose of the sodium zirconium cyclosilicate for potassium of 5.2 on 12/21/2024, and on that day the potassium level was 5.4.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>There was no documented evidence Resident #77 received sodium zirconium cyclosilicate on 12/21/2024, 12/22/2024, or 12/23/2024.</p> <p>An Order Summary Report for order date range 11/01/2024 to 3/31/2025, documented an order dated 12/24/2024 for sodium zirconium cyclosilicate oral packet 10 grams (sodium zirconium cyclosilicate), give one (1) packet by mouth two (2) times a day for hyperkalemia for one (1) day.</p> <p>An Order Note dated 12/25/2024 at 2:16 AM by Registered Nurse documented the order for sodium zirconium cyclosilicate oral packet 10 grams, give one (1) packet two (2) times a day for hyperkalemia was outside of the recommended dose or frequency. The frequency of two (2) times a day exceeded the usual frequency of every two (2) days to daily. It documented the provider was aware.</p> <p>The Medication Administration Record dated December 2024 documented sodium zirconium cyclosilicate oral packet 10 grams was given on 12/25/2024 at 9:00 AM.</p> <p>Resident #327</p> <p>Resident #327 was admitted to the facility with fracture of upper and lower end of the right fibula (when the smaller bone in the lower leg is broken at both the knee and the ankle regions), atrial fibrillation (a common heart rhythm disorder where the upper chambers of the heartbeat irregularly and rapidly), and dementia (a chronic generative condition characterized by progressive or persistent memory impairment). The Minimum Data Set, dated [DATE] documented the resident was able to understand and be understood by others.</p> <p>A Physician's Order dated 4/16/2024 documented the resident was to receive Azithromycin (an antibiotic) 500 milligrams intravenously one time a day for pneumonia for two (2) administrations.</p> <p>The Medication Administration Record documented the resident did not receive either dose of the antibiotic. The progress note dated 4/16/2024 documented the nurse was unable to establish intravenous access, the provider was called and did not give any new orders.</p> <p>There was no documentation on the Medication Administration Record or in the progress notes for the missed dose on 4/17/2024.</p> <p>On 4/18/2024, Resident #327 was transferred to the hospital by family request and admitted overnight. The resident was treated for pneumonia and received intravenous antibiotics.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/02/2025 at 1:48 PM, Director of Nursing #1 stated that they were aware there were medications missing from the pharmacy. They had been looking into it. They stated they had not run into any reports of missing medications or medication errors but had just been informed by staff that pharmacy did not send medications. Director of Nursing #1 stated they would expect staff who discovered medications were not in-house to check the automated medication dispensing system to see if there were any available, contact the Medical Doctor to tell them what was available for substitution, document in the Electronic Medical Record that the medication was not available and that the dose was missed, and call the pharmacy to make sure the medication would come on the next run. Missed medications should be reported to the supervisor. Director of Nursing #1 stated they were unaware that there was a medication error form, and that documentation of missed medications should be in the shift-to-shift 24-hour report that was reviewed every day. Director of Nursing #1 stated Nurse Managers were also supposed to check the 24-hour shift to shift report for discrepancies on their units. The Quality Assurance Plan Initiative meeting had occurred one time since they have been a Director of Nursing, and they were having night nurses review carts and medications to ensure that everything was where it needed to be. The pharmacy made three (3) deliveries a day, early in the morning on the overnight shift, in the afternoon on day shift, and on the evening shift around 8:00 PM or 9:00 PM.</p> <p>During an interview on 3/02/2025 2:00 PM, Administrator #1 stated in the past they had reached out to the providers to help figure out issues. They stated they would expect staff to call the pharmacy for missing medication doses and to find out when they could be delivered. Administrator #1 stated they would expect staff to call the Medical Director to see if something else could be given. They stated they would expect staff to monitor the resident and document whatever direction was given by provider. They stated the medication issues in the building just came to light over the last week. The facility completed medication error/missed dose sheets when there was an error or missed medication. Administrator #1 stated they had not received any sheets in January or February 2025 unless they were on the Director of Nursing's desk, and they did not know it. They stated they did not run reports specific to medication issues, but they would expect the nurses would write a progress note that would be on the 24-hour report that gets reviewed daily. They stated they had never heard that there were not enough staff at the facility to get medications passed or resident care done.</p> <p>During an additional interview on 3/02/2025 at 3:11 PM, Administrator #1 stated they had started a house-wide education regarding what was available in the automated medication dispensing system and what to do when something was not available. Supervisors and unit managers had been reeducated on the policy of checking their reports, checking the clinical dashboard for late and/or missing medications. Daily reports would be run regarding medication errors and missed doses and if the providers were notified. Administrator #1 stated they will be checking reports for yellow and red colors (indicated late or missed doses) daily and trying to correct inconsistencies in real time.</p> <p>10 New York Codes Rules and Regulations 415.12(m)(2)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>Based on record review and interview during the recertification and abbreviated survey (Case #NY00363829), the facility did not ensure laboratory services were provided timely to meet the needs of the resident for 1 (Resident #77) of 3 residents reviewed. Specifically, Resident #77 [a.] provider ordered to have laboratory tests completed on 11/27/2024. The tests were not completed, and the provider was not notified; [b.] provider reordered the tests again on 12/03/2024. The tests were not completed, and the provider was not notified; and [c.] provider reordered the tests again on 12/06/2024 and the specimen was collected and resulted on 12/09/2024.</p> <p>This is evidenced by:</p> <p>Resident #77</p> <p>Resident #77 was admitted to the facility with diagnoses of chronic kidney disease (longstanding disease of the kidneys leading to renal failure), cerebral infarction (stroke), and chronic obstructive pulmonary disease (a lung disease characterized by chronic respiratory symptoms). The Minimum Data Set (an assessment tool) dated 2/6/2025, documented the resident was cognitively intact, could be understood and understand others.</p> <p>Physician Progress Note dated 11/25/2024 at 1:31 PM by Nurse Practitioner #2, documented the resident was seen that day for review of a chest x-ray that was done on 11/22/2024. Plan documented questionable pneumonia. Furosemide (diuretic - water pill) 20 milligrams for 5 days and laboratory tests: complete blood count, procalcitonin (a protein that is produced in the body in response to inflammation, particularly bacterial infections), and B-type natriuretic peptide (a hormone secreted by the heart ventricles in response to increased blood volume or pressure) to be done on the next laboratory draw date, 11/27/2024 were ordered. Provider to follow up after laboratory tests. If the B-type natriuretic peptide was elevated, Furosemide was to be continued daily.</p> <p>Order Audit Report dated 11/25/2024 at 1:29 PM, documented an order for laboratory tests: complete blood count, B-type natriuretic peptide, and procalcitonin one time only for 1 day. The order was entered and signed by Nurse Practitioner #2 on 11/25/2024 at 1:30 PM and was confirmed by Registered Nurse #2 on 11/25/2024 at 11:04 PM. The order was reviewed and signed by Nurse Practitioner #2 on 11/27/2024 at 2:44 PM.</p> <p>There were no documented laboratory results for November 2024 and there was no documented evidence in Nursing Notes that the provider was notified that the laboratory tests were not completed as ordered.</p> <p>Physician Progress Note dated 12/03/2024 at 4:21 PM by Physician #2, documented the resident was seen that day for laboratory review related to chronic illness. Resident #77 was on Furosemide 20 milligram for 5 days. Repeat chest x-ray still shows pulmonary edema (a condition caused by too much fluid in the lungs). Plan documented Furosemide 20 milligrams once daily and laboratory tests: complete blood count, comprehensive metabolic profile, B-type natriuretic peptide, and procalcitonin.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Order Audit Report dated 12/03/2024 at 4:35 PM, documented an order for laboratory tests: complete blood count, comprehensive metabolic profile, B-type natriuretic peptide, and procalcitonin one time only for 1 day. The order was entered and signed by Physician #2 on 12/03/2024 at 4:37 PM and was confirmed by the Registered Nurse on 12/04/2024 at 9:28 PM.</p> <p>There was no documented evidence of laboratory test results dated 12/03/2024 to 12/6/2024 and there was no documentation in Nursing Notes the provider was notified that the laboratory tests were not completed as ordered.</p> <p>Physician Progress Note dated 12/06/2024 at 9:32 AM by Nurse Practitioner #2, documented the resident was seen that day for medical follow up. Resident #77 had an abnormal chest x-ray on 11/25/2024 with questionable findings given the resident's symptoms and laboratory tests were ordered for confirmation. The resident was started on Furosemide. The laboratory tests had never resulted to the chart. Resident #77 had a repeat chest x-ray on 12/03/2024 with similar findings and laboratory tests were reordered again for confirmation and to assess kidney function and electrolytes given the new diuretic. Laboratory tests again had not resulted to the chart. Plan documented follow up after laboratory tests back for review. Notified Director of Nursing of laboratory issue.</p> <p>Order Audit Report dated 12/06/2024 at 9:31 AM, documented an order for complete blood count, comprehensive metabolic profile, B-type natriuretic peptide, and procalcitonin one time only for 1 day. The order was entered and signed by Nurse Practitioner #2 on 12/6/2024 at 9:31 AM and was confirmed by Registered Nurse #2 on 12/06/2024 at 4:01 PM.</p> <p>Laboratory Report dated 12/09/2024, documented the results of a complete blood count, comprehensive metabolic profile, B-type natriuretic peptide, and procalcitonin that were collected on 12/9/2024 at 4:40 AM and reported on 12/09/2024 at 6:05 PM.</p> <p>During an interview on 3/02/2025 at 12:12 PM, Nurse Practitioner #2 stated there were several residents who had orders for laboratory tests that were not done on the day they were ordered. They stated they did not recall who the residents were. They stated they talked to the former Director of Nursing about the issues.</p> <p>During an interview on 3/07/2025 at 12:38 PM, Registered Nurse #2 stated if Nurse Practitioner #2 entered an order for labs, they (Registered Nurse #2) would have to confirm the order. Once confirmed, it went right to the lab and then the lab comes and draws. They stated if the provider did not enter the order correctly or if they did not sign it, the order would just sit there pending signature. They stated they could not confirm an order that was not signed.</p> <p>During an interview on 3/07/2025 at 2:02 PM, Registered Nurse Regional Clinical Director #1 stated labs were done Monday, Wednesday, and Friday unless they were stat orders.</p> <p>10 New York Codes Rules and Regulations 415.20</p>		

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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	

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.</p> <p>Based on record review and interview during the recertification survey, the facility did not promptly notify the ordering nurse practitioner of laboratory results that fall outside of clinical reference ranges for 1 (Resident #77) of 3 residents reviewed. Specifically, the facility did not promptly notify Nurse Practitioner #2 or the on-call provider of an abnormal laboratory result for Resident #77 on 12/17/2024 at 3:05 AM.</p> <p>This is evidenced by:</p> <p>Cross-referenced to F711: Physician Visits - Review Care/Notes/Order</p> <p>Resident #77</p> <p>Resident #77 was admitted to the facility with diagnoses of chronic kidney disease, cerebral infarction (stroke), and chronic obstructive pulmonary disease (a lung disease characterized by chronic respiratory symptoms). The Minimum Data Set (an assessment tool) dated 2/06/2025, documented the resident was cognitively intact, could be understood, and understand others</p> <p>Physician Progress Note dated 12/13/2024 at 9:10 PM by Nurse Practitioner #4, documented they were notified by the facility to review laboratory results. Labs collected on 12/12/2024 had notable results for the resident's kidney function and the plan was for a repeat basic metabolic profile laboratory test to be done on 12/16/2024.</p> <p>Laboratory Results Report for a basic metabolic profile collected on 12/16/2024 and reported on 12/17/2024 at 3:05 AM, documented critical/abnormal test list: b-type natriuretic peptide (a hormone secreted by the heart ventricles in response to increased blood volume or pressure), Creatinine (a measure of how well the kidneys are filtering waste from the blood), Chloride (helps maintain proper balance of fluids inside and outside of cells), Calculated Osmolality (checks the fluid-to-particle balance in the blood), and estimated Glomerular Filtration Rate (measures level of kidney function and determines stage of kidney disease) , as was previously noted on results reported on 12/13/2024.</p> <p>-</p> <p>In addition, a potassium level of 5.2 was documented as high and was in the list of critical/abnormal tests (potassium helps nerves and muscles work properly and too much can be dangerous and cause serious heart problems).</p> <p>There was no documented evidence in the Nursing Notes that the provider was notified of the critical/abnormal results on 12/17/2024.</p> <p>During an interview on 3/2/2025 at 12:12 PM, Nurse Practitioner #2 stated there was a problem with getting the laboratory tests done as ordered. They stated they would put laboratory orders in for residents and the tests would not get done. They stated they would put the orders in again when they did not get done. They stated they spoke to the former Director of Nursing about the problem. They could not recall the names of the residents that had the laboratory issues.</p> <p>(continued on next page)</p>

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<p>F 0773</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/3/2025 at 11:46 AM, Medical Director #1 stated that 90% of the orders were entered by the provider. They stated when the provider evaluated a resident, they should be looking at the resident's clinical picture, meaning the lab results, orders, and progress notes.</p> <p>During an interview on 3/07/2025 at 12:38 PM, Registered Nurse #2 stated laboratory results were accessible on the provider's dashboard. They stated if the potassium resulted 5.2 on 12/17/2024, then the provider would have been in the facility and would have seen it. They stated it was not up to the nurse to watch for results because providers could look it up themselves. They stated the providers should be watching for the results because they ordered the test. They stated the provider should have ordered something for the potassium level of 5.2 on 12/17/2024. Registered Nurse #2 reviewed the progress note dated 12/18/2024 by Nurse Practitioner #2 and stated there was nothing ordered for the high potassium. They stated there was another result on 12/21/2024 that the potassium was 5.2.</p> <p>During an interview on 3/07/2025 at 2:02 PM, Registered Nurse Regional Clinical Director #1 stated labs were done Monday, Wednesday, and Friday unless they were stat orders. They stated the laboratory results were automatically uploaded into the electronic medical record and in the provider was able to see the results on the dashboard. Administrator #1 was present and stated the nurse would see the results and notify the provider.</p> <p>10 New York Codes Rules and Regulations 415.20</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>Based on observation, interview, and record review during the recertification survey, the facility did not ensure residents were provided a therapeutic diet as prescribed by a physician for one (1) (Resident #103) of 2 reviewed for diet consistencies. Specifically, Resident 103 did not receive the correct diet consistency per the physician order for meat during a lunch observation.</p> <p>The Policy and Procedure, Food Consistencies and Definitions, revised 3/2022, documented all diet modifications would print on the meal tickets. A regular diet was unrestricted. A chopped diet was foods that were nearly regular' textures, not including hard or crunchy foods. A chopped diet texture required the ability to chew and have tongue control. Foods should be softer and easy to break into pieces with a fork. Foods should be chopped, including tender vegetables such as broccoli and cauliflower. A ground diet consisted of foods that are moist and soft textured. Meats needed to be ground. On a pureed diet, food would be pureed to a cohesive, smooth texture without lumps. No bread products were included in this diet.</p> <p>Resident #103</p> <p>Resident #103 was admitted to the facility with diagnoses of cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die), dysphagia (difficulty swallowing), and malnutrition (a serious health condition that develops when someone doesn't have enough nutrients to meet their body's needs). The Minimum Data Set (an assessment tool) dated 11/29/2024, documented that Resident #103 was usually able to be understood, usually able to understand others, and was significantly cognitively compromised.</p> <p>The Comprehensive Care plan titled, At Risk for Malnutrition' revised 2/24/2025, documented Resident #103 was at risk for malnutrition related to need for mechanically altered diet due to history of stroke. Interventions included provide diet and consistency per physician order: regular diet, chopped texture, thin consistency, and ground meat.</p> <p>During a lunch observation on 2/27/2025 at 12:15pm, Resident #103's meal ticket read: regular, chopped; ground meats with chopped sides. On Resident #103's plate, whole portions of chicken parmesan were observed. The meat was not ground. When asked, Resident #103 was unsure if the meat should have been ground. They were attempting to cut the meat with a fork. Resident 103's roommate was also seated at the table. The roommate explained that staff had cut up the meat, so that Resident #103 would not choke. The roommate stated that trays served to Resident #103 in their room, usually consisted of pureed foods.</p> <p>During an interview on 2/27/2025 at 12:28 PM, Nurse Educator #1 stated, oh and removed Resident #103's plate when asked to review their meal ticket and the food that was served to the resident.</p> <p>During an interview 2/27/2025 at 12:34PM, Director of Food Service #1 stated, Resident #103 was seen by speech therapy, and it was determined they should have ground meats. When they looked at the whole portions of chicken served to Resident #103, they stated the meat should have been ground and a mistake was made. The person who passed the tray to the resident was responsible for reviewing the ticket with the meal for accuracy.</p> <p>(continued on next page)</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/07/2025 at 2:00 PM, Regional Director of Nursing #1 stated that they could speak to general facility policies, but not specific resident issues as they had just been transferred from another facility 5 days prior. Regional Director of Nursing #1 stated that nurses and Certified Nurse Aides should have checked the trays prior to giving them to the residents.</p> <p>10 New York Code of Rules and Regulations 415.14(e)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility.</p> <p>Based on observation, record review, and interviews during the recertification and abbreviated survey (Case #s NY00343930, NY00347964, NY00354057, NY00363829, NY00364424, NY00364701, and NY00369042) , it was determined the facility and governing body failed to ensure that residents received appropriate quality of care by allowing the following deficient practices to exist, placing residents at risk for serious injury, serious harm, serious impairment, or death: F760: Residents are Free of Significant Medication Errors and F684 Quality of Care. Specifically, the facility's governing body did not ensure established policies regarding the management and operation of the facility were implemented. Subsequently, resident care was compromised.</p> <p>This is evidenced by:</p> <p>Facility was cited F760: Residents are Free of Significant Medication Errors</p> <p>Cross-referenced to F684: Quality of Care</p> <p>The undated document titled, Quality Assurance Performance Improvement Plan, documented the purpose of the Quality Assurance Performance Improvement Plan was to evaluate residents' experience of the services provided to determine how the experience could be improved, to realize the facility's vision of innovation and continuous improvement in the delivery of care. To accomplish that purpose, the facility engaged all members of each service to evaluate the quality of care provided to residents and held themselves to the highest standard by continually improving the care on the resident's behalf. Guiding Principles documented Quality Assurance Performance Improvement guided the facility's daily operation, included all members of each service, was encouraged by holding each individual accountable for their performance (professional or otherwise), and the facility was committed to encouraging all members on any level of the organization to identify system breakdowns/deficits in an effort to improve performance.</p> <p>Element II: Governance and Leadership documented the Governing Body and Administration potentiated high quality resident care by developing and leading the Quality Assurance Performance Improvement program. Quality Assurance Performance Improvement would be adequately resourced and promote an atmosphere that encouraged the reporting of quality problems as well as opportunities for improvement. The Quality Assurance Performance Improvement coordinator would utilize systems thinking and assist departments in the methodology and selection of priority concerns impacting resident care safety. The facility would provide in house training/in-service for all employees on Quality Assurance Performance Improvement as well as posters with information specific to Quality Assurance Performance Improvement. The training would be provided by members of the Steering Committee. The facility would designate members of the steering committee to attend training programs/seminars specific to Quality Assurance Performance Improvement. Technical training would be provided by the Nursing Department.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Element III: Feedback, Data Systems, and Monitoring documented (1) pertinent resident care information would be reviewed daily by the Interdisciplinary Team, (2) daily morning minutes (running log or needed follow up for each unit) would be reviewed and revised on an ongoing basis by the Interdisciplinary Team, (3) any areas that needed immediate Process Improvement would be identified and followed up by Quality Assurance Steering Committee as indicated, (4) the facility would utilize multiple data sources to monitor performance including Quality Measures, State and National benchmarks as well as tracking and investigating any adverse events affecting residents, (5) feedback from staff would be encouraged and welcomed via Unit Quality Improvement rounds, regular meetings and open door policy by Department Heads and administration, and (6) Quality Improvement alert would be distributed to each Department Head for staff education as indicated.</p> <p>Element IV: Performance Improvement Projects documented (1) focus areas of Performance improvement would be identified by Administration based upon input from staff, residents, and families, (2) for each focus area Root Cause analysis would be used to identify systems, processes and procedures that need revision; (3) for each area a Performance Improvement team would be identified, (4) performance improvement teams would meet weekly, (5) the team was responsible to educate, monitor, and collect data and plan improvement as indicated, (6) the data collection would be reviewed monthly by team members and quarterly by the Quality Assurance Performance Improvement Steering Committee, (7) compliance with Performance Improvement established goals would be evaluated against a benchmark and decision to continue, revise or close Performance Improvement area would be made by Steering Committee, (8) all staff members, residents, and families would be educated regarding performance improvement areas on a regular basis to include but not limited to unit conferences, resident council meetings and comprehensive care plan meetings as indicated, (9) visible signage would be posted to alert all resident, staff, and families of facility progress with Performance Improvement Areas.</p> <p>Element V: Systemic Analysis and Systemic Action documented (1) actions taken would be linked to the root cause and lead to a system or process change, (2) all staff members would receive ongoing education regarding systemic changes, (3) feedback from all staff as well as residents and families would be welcomed and encouraged, (4) residents and families would be educated regarding systemic changes, (5) the Quality Assurance Steering Committee would monitor sustainability of systemic changes on a quarterly basis or more frequently as indicated.</p> <p>Resident #47 did not receive prescribed psychiatric medication to be given at bedtime at 9:00 PM from 11/25/2024 to 12/6/2024 (12 days). On 11/29/2024 at 9:00 AM, the resident decompensated and was sent to the hospital upon their request.</p> <p>Resident #12 received only 10 of 20 doses of antibiotics prescribed.</p> <p>Resident #23 received only 4 of 8 doses of antibiotics prescribed.</p> <p>Resident #77 was prescribed medication to lower their potassium level on 12/21/2024 and did not receive the medication until 12/25/2024.</p> <p>Resident #327 did not receive antibiotics for 2 days after prescribed.</p> <p>Resident #6 did not receive finger sticks to check the blood sugar level for over 12 hours after admission.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #14 was not offered personal care assistance.</p> <p>Resident #20's feet were not assessed regularly.</p> <p>Resident #23 and Resident #77 did not have vital signs as ordered and were not monitored for changes of condition.</p> <p>During an interview on 3/2/2025 at 1:48 PM, Director of Nursing #1 stated they were aware that there were medications missing from pharmacy and had been looking into it. Director of Nursing #1 stated they would expect staff who discovered a medication was not in-house, would check the Pyxis to see if the medication was available, obtain vital signs, and contact the Medical Director to inform them of an available substitution. They would expect staff to document in the Electronic Medical Record that the medication was not available, and the dose was missed. They would expect staff to call the pharmacy to ensure the medication would come on next pharmacy delivery. They stated missed medications should have been reported to the supervisor. Director of Nursing #1 stated there was no missed medication form, but it would be documented in the shift to shift 24-hour report that they reviewed every day. They stated nurse managers were responsible for checking the report. They stated Quality Assurance Performance Improvement had met once since their promotion to Director of Nursing and one of the things they were doing was having night nurses review carts and medications to ensure that everything was where it needed to be.</p> <p>During an interview on 3/2/2025 at 2:00 PM, Administrator #1 stated they have reached out to providers to help to determine and resolve issues. They would expect that staff would call the pharmacy for missing doses and to find out when they could be delivered. They would expect that staff would call the Medical Director to see if something else could be given. They would expect staff to monitor the resident and document directions given by the provider. Administrator #1 stated the medication issues in the building just came to light over the last week during survey. They stated there were medication error/missed dose sheets, but the Administrator had not received any in January or February 2025. Administrator #1 stated they would expect the nurses to write a progress note about the missed doses that would be included on the 24-hour report that was reviewed daily. Administrator #1 stated that they had never heard there were not enough staff to get medications administered or resident care done.</p> <p>During an interview on 3/02/2025 at 3:11 PM, Administrator #1 stated they started house- wide education regarding what was available in the Pyxis and what to do when medications were not available. Supervisors and unit managers were reeducated on the policy of checking their reports and checking the clinical dashboard for late and/or missing medications. Daily reports would be run regarding medication errors and missed doses and to if the providers were notified. Administrator stated they would be checking reports for yellow and red colors (indicated late or missed doses) daily and would try to correct inconsistencies in real time.</p> <p>(continued on next page)</p>		

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<p>F 0837</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/03/2025 at 11:22 AM, Medical Director #1 stated they were only here to monitor the physicians. Medical Director #1 stated they attended all Quality Assurance Performance Improvement meetings. They stated communication breakdown was a big part of the problems seen during survey. They stated they were only notified of significant problems. Medical Director #1 stated they became aware of the facility's issues this week and going forward it would be discussed every day. When asked if they would be present in the facility more often to ensure provider and staff compliance, Medical Director #1 stated they believed that because they had talked to the girls they would be compliant, and did not intend to increase visits unless it was needed.</p> <p>During an interview on 3/07/2025 at 2:00 PM, Registered Nurse Regional Clinical Director #1 stated they were able to speak to the general facility and corporate policies, but not resident specific issues. They stated they had just transferred from another facility 5 days prior. They stated they were looking to make immediate improvements.</p> <p>During an interview on 3/07/2025 at 2:30 PM, Administrator #1 stated that they meet with the department heads daily during morning meeting and monthly with the Quality Assurance committee. Administrator #1 stated they were unaware of the multitude of problems that had come to light during the survey. They stated they became the administrator of the facility in the summer of 2024. Administrator #1 stated they intended to be more present on the units and more closely manage the day-to-day operations of the facility.</p> <p>10 New York Code of Rules and Regulations 415.26(b)(3)(1)</p>		