STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335540	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on observation, record review, and interview during the recertification survey, the facility did not ensure each resident was treated with respect and dignity and cared for in a manner that promotes maintenance or enhancement of quality of life for two (2) (Resident #s 39 and 61) of 32 residents reviewed. Specifically, Resident #s 39 and 61 were not cared for in a manner that promoted maintenance or enhancement of quality of life by staff providing care. This is evidenced by: The Policy and Procedure titled, Resident Rights, reviewed 1/2025, documented employees would treat all residents with kindness, respect and dignity. Federal and state laws guaranteed certain basic rights to all residents in the facility. These rights included the resident's right to a dignified existence and be treated with respect, kindness, and dignity. The Policy and Procedure titled, Quality of Life - Dignity, reviewed 1/2025, documented each resident would be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Residents would be treated with dignity and respect all times. Treated with dignity meant the resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth. Staff would speak respectfully to residents at all times. Resident #39 Resident #39 was admitted to the facility with diagnoses of congestive heart failure (a chronic condition in which the heart does not pump blood as well as it should), hypertension, and Parkinson's disease (a disorder of the central nervous system that affects movement, often including tremors). The Minimum Data Set (an assessment tool) dated 12/10/2024, documented the resident was cognitively intact., could be understood, and understand others. During an interview on 2/23/2025 at 2:45 PM, Resident #39 stated they had to wait for an hour or 2 hours for personal care. They stated that when the call light was answered some Certified Nurse Aides were rough. Resident #39 stated some Certified Nurse Aides would push and shove them when providing care to get them to turn over. Resident #39 stated, That to me is rough. Resident #39 stated one of the aides was ignoring their request for help one evening and threw a night gown on the side of the bed and then left the room. Resident #39 could not recall who the aide was. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #61 Resident #61 was admitted to the facility with diagnoses of fusion of spinal bones (a surgical procedure that permanently joins two or more vertebrae (bones) in the spine) , diabetes mellitus, and hypertension. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact, could be understood, and understand others. During an observation and interview on 2/24/2025 at 3:59 PM, Resident #61 stated some of the staff would answer their call light and just turn off the light and not do anything to help them. The staff member would tell them they had to wait. Resident #61 stated their arms and legs were partially paralyzed, and they were totally dependent on staff for eating, drinking and all care. Resident #61 was noted to have a call bell device that they had to blow in to activate the call light. They stated they put their call light on, and staff would come into the room and ask them if they needed water. The resident was noted to have 2 cups of water with a straw in each cup on the over the bed table that was next to the bed. Resident #61 stated that although they needed help with drinking, that was not their only need and staff would tell them in a harsh tone they had to wait. Resident #61 stated the only bed available to them was in this facility and they came here expecting to get the help they needed. During an interview on 3/07/2025 at 2:02 PM, the Registered Nurse Regional Clinical Director #1 stated they expected staff to treat residents with dignity and respect. When staff answered call bells, they expected staff to go into the room and greet the resident, ask them how they could assist them, and then turn the call light off. They would not expect staff to go in and turn the call light off without assisting the resident. 10 New York Codes Rules and Regulations 415.5(a) 51131 51958

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on observation, record review, and interview, during the recertification survey, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for 1 (Resident #23) of 1 resident reviewed. Specifically, Resident #23 was observed with topical steroid cream in their room and there was no assessment in the medical record and/or physician order for the resident to self-administer the medication. This is evidenced by: Cross-referenced to F656: Develop/Implement Comprehensive Care Plan Cross-referenced to F711: Physician Visits - Review Care/Notes/Order Resident #23 was admitted with the diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that cause 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, dated dated dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others. The Policy and Procedure titled, Self-Administration of Medications, reviewed ,d+[DATE], documented residents had the right to self-administer medications if the interdisciplinary team had determined that it was clinically appropriate and safe for the resident to do so. As part of their overall evaluation, the staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident. In addition to general evaluation of decision-making capacity, the staff and practitioner would perform a more specific skill assessment including but not limited to the resident's a) ability to read and understand medication labels, b) comprehension of the purpose and proper dosage and administration time for his or her medications, c) ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medications, and d) ability to recognize risks and major adverse consequences of his or her medications. The staff and practitioner would document their findings and the choices of residents who were able to self-administer medications. Self-administered medications must be stored in a safe and secure place, which was not accessible by other residents. If safe storage was not possible in the resident's room, the medications of residents permitted to self-administer would be stored on a central medication cart or in the medication room. Nursing staff would review the self-administered medication record on each nursing shift, and they would transfer pertinent information to the medication administration record kept at the nursing station, appropriately noting that the doses were self-administered. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that cause 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, dated dated dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others. Physician's Progress Note dated [DATE] at 10:49 AM by Physician #1, documented the resident was seen today [DATE] for rash. The rash was a fungal infection that frequently comes and goes, which previously responded to clotrimazole-betamethasone (Lotrisone Cream). Rash on the bilateral face. Plan: fungal skin rash; take regular shower, clotrimazole-betamethasone ,d+[DATE].05% ointment on the lesion twice daily. Medication Administration Record dated February 2025, documented Lotrisone Cream ,d+[DATE].05% (clotrimazole-betamethasone) apply to per additional directions topically two times a day for fungal skin rash. There were no instructions for where the medication was to be applied. Start date [DATE] at 5:00 PM and was discontinued following interview with Physician #1 on [DATE] at 3:48 PM. - Lotrisone Cream was administered several times from [DATE] to [DATE]. During an observation and interview on [DATE] at 12:40 PM, Resident #23 stated they were a Registered Nurse for [AGE] years. 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 bra that properly fit them and being sweaty under the breasts. The resident then 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 and pointed to their right breast. The surveyor asked about a rash that was noted on the resident's face which appeared red and blotchy across the forehead, nose, and cheeks. Resident #23 than 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 [DATE].5 % generic for Lotrisone. Apply to per directions topically every dayshift 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. They stated the nurse told them to look in the mirror and apply it to their face. 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 and the rash on their face 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 to affected area only. Resident #23 stated they were normally good at reading labels but does not always wear their glasses. Resident #23 stated they had no formal assessment to self-administer the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 3:48 PM, Physician #1 stated they saw the resident on [DATE] because of a rash on the face, nose, and forehead. Lotrisone cream was prescribed for the resident's face. They stated the rash comes and goes 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 on the face on the affected skin. They stated the order for the Lortisone had detailed instruction on where the nurse should apply it. They 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. They stated the resident only complained about the rash on their face when they saw them on [DATE]. They stated a fungal infection on the forehead could spread to the rest of the body. During an interview on [DATE] at 4:15 PM, Resident #23 stated the Lotrisone cream was removed from the room shortly after the surveyor left the room earlier that afternoon. The resident stated they told them the medication had expired. Upon further investigation, the surveyor identified a previous order dated [DATE], for Lotrisone Cream to be applied topically every dayshift for dermatitis (inflammation, redness, and itching) for 14 days, to be applied under the right breast. The order ended on [DATE]. During an interview on [DATE] at 2:02 PM, the Registered Nurse Regional Clinical Director #1, stated for self-administering medications, the physician would look at the resident's capacity and determine if they were able to safely administer the medications. A self-administration of medication form would then be completed. The physician would then write an order to leave medications at the bedside. 10 New York Codes Rules and Regulations 415.3(f)(1)(vi)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 21414 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. This is evidenced by: 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. During observations on 02/24/2025 from 9:45 AM through 11:39 AM: Strong urine odors were detected in the corridor outside rooms A01 through A05 and rooms B14 through B19. The ventilation grid by the emergency exit on the B-Wing was soiled with a heavy dust build-up. 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. 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, The nurse stations on the A-Wing, B-Wing and C-Wing were soiled with a brown dirt build-up. One ceiling tile was missing in the C-Wing outdoor patio. 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. The window blinds were caked with dust in rooms A02, A04, and A08. The lobby furniture upholstery was worn. In room B16, the floor was heavily soiled with dust behind the beds and the room door had chipped paint. Paint was chipped on the walls in room B13 and the B-wing soiled utility room. The plastic edge guards on the wall in the lobby area were chipped. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 10 New York Codes, Rules, and Regulations 415.5(h)(4)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48744 Based on interview and record review conducted during a recertification survey, the facility did not ensure residents were aware of the grievance process. Specifically, (1.) grievance forms were not readily available to residents; (2.) residents did not have the option to file a grievance anonymously; and (3.) 12 of 12 residents present at the Resident Council meeting reported they did not know the process by which to file a grievance. This is evidenced by: The facility policy, Filing A Grievance/Complaint dated 11/2016, documented any resident or resident representative may file a grievances and/or complaint regarding care, treatment, staff members etc. without fear of retaliation. Grievances could be made orally or in writing. The facility had a designated Grievance Officer who investigated grievances and/or complaints. During the Resident Council meeting held on 2/24/2025 at 10:34 AM, residents present did not know how to file a grievance and were unsure who the Grievance Officer was. Residents stated they would bring concerns to the Resident Council President or the Activity's Director. Some residents reported that they feared retaliation if they made a complaint. During an interview on 2/24/2025 at 10:34 AM, Activity's Director #1 stated that when they received a complaint or grievance, they informed the appropriate department and the social worker. They were not aware of a grievance form. During an interview on 2/24/2025 at 2:57 PM, Director of Social Work #1 stated they were the Grievance Officer and had grievance forms in their office. They believed there were forms in the supervisor's office, but they were not sure if forms were available on the units. Staff collected statements from residents, provided them to Director of Social Work 1, they collaborated with the appropriate department to resolve the complaint, and provided follow up to resident and/or resident representative. They had an open-door policy and received many informal complaints. Director of Social Work #1 reported they were not sure if there was anyway to file a grievance anonymously. During an interview on 3/07/2024 at 2:00 PM, Regional Clinical Director of Nursing #1, stated if a resident made a complaint, the staff would take down the grievance, have the Social Worker talk with the resident, then the complaint would be brought to the Administrator and Director of Nursing to have it addressed. They acknowledged that the facility had already taken corrective action to address the process for filing grievances. During an interview on 3/07/2025 at 2:41 PM, Administrator #1 stated that they were unaware of the issues surrounding grievances but as soon as the concern was raised during survey, the process was examined and the staff educated on officially filing grievances. Additionally, a locked box for grievances was installed outside the social work office in order to facilitate residents being able to file grievances anonymously. 10 New York Code Rules and Regulations 415.3(c)(1)(i) (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	51131 51958

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on record review and interviews during a recertification survey, the facility did not ensure that all alleged violations involving abuse were reported immediately, or no later than 2 hours after the allegation was made for 2 (Residents #68 and #113) for 6 reviewed for abuse. Specifically, an allegation of a resident-to-resident altercation was reported by Resident #113 on 12/13/2024. The incident was not reported to the New York State Department of Health. This is evidenced by: The policy and procedure titled, Abuse Prevention Program/Abuse and Neglect - Clinical Protocol/Abuse Investigation and Reporting reviewed 1/2023 documented all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and .federal agencies (as defined by current regulations). Resident #68 was admitted to the facility with the diagnoses of Alzheimer's disease, osteoarthritis, and thrombocytopenia (a condition characterized by abnormally low levels of platelets. The Minimum Data Set (an assessment tool) dated 1/28/2025 documented the resident was understood by others, able to understand others, and was severely cognitively impaired. Resident #113 was admitted to the facility with the diagnoses of alcoholic cirrhosis of the liver (a permanent scarring that damages your liver and interferes with its functioning. It can lead to liver failure), acute kidney failure, and hypotension. The Minimum Data Set, dated dated dated [DATE] documented the resident was understood by others, able to understand others and was cognitively intact. The Incident Report dated 12/13/2024 at 3:30 PM documented Resident #113 reported to staff that Resident #68 had entered their room, knocked off their hat and tapped them on their cheek. Both residents were assessed with no injury. The Summary of Investigation documented Resident #113 felt safe in the facility. It documented that Resident #68 was not malicious and had no intent to cause injury or harm to Resident #113. The facility declined to report the incident to the New York State Department of Health. During an interview on 03/07/25 at 2:30 PM, Administrator #1 stated Resident #113 had self-reported to staff that Resident #68 had taken off their hat and tapped them on the head. It was determined in the investigation that the incident was playful in manner and not malicious and was not reported to Department of Health because of that. 10 New York Codes, Rules, and Regulations 415.4(b)(2)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on interviews and record review during a recertification survey, the facility did not ensure that written notification was sent to the resident, the resident's representative, and to the Office of State Long-Term Care Ombudsman of the resident's transfer or discharge for 2 (Residents #112 and 123) of 2 residents reviewed for hospitalization . Specifically, (a.) for Resident #112, written notification of transfer to the hospital was not provided to the Ombudsman for 3 out of 4 hospital admissions; (b.) for Resident #123, written notification of transfer was not provided to the resident, the resident's representative, or the Ombudsman when the resident was admitted to the hospital from the facility on 12/27/2024 . This is evidenced by: The facility policy titled, Transfer or Discharge Notice revised on 10/2022, documented the resident and/or resident representative was to be notified in writing of the reason for the transfer or discharge, the effective date of transfer or discharge, location at which the resident was being transferred or discharged , and of the resident's appeal rights. When a resident was temporarily transferred to an acute care facility on an emergency basis, notice of the transfer may be provided to the resident or resident representative as soon as practicable according to 42 Code of Federal Regulations 483.15(c)(4)(ii)(D). Copies of notices of emergency transfers would also be sent to the Ombudsman when practicable, such as providing a list of residents to the Ombudsman on a monthly basis. Resident #112 Resident 112 was admitted to the facility with diagnoses of metabolic encephalopathy (a change in how your brain works due to an underlying condition), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), and end stage renal disease (the final stage of chronic kidney disease, where the kidneys have permanently lost most of their ability to function). The Minimum Data Set (an assessment tool) dated 1/26/2025, documented the resident was understood, understands others, and was cognitively intact. A physician progress note, dated 12/31/2024 at 11:55 AM, documented Resident #112 was sent to the hospital to receive dialysis because they had missed their previous dialysis appointment due to feeling lethargic and nauseous. A physician progress note, dated 1/05/2025 at 10:46 AM, documented Resident #112 was sent to the hospital per their request for pain control. A physician progress note, dated 1/11/2025 at 6:17 PM, documented Resident #112 was sent to the hospital due to unresponsiveness and low blood sugars. A nursing progress note, dated 2/25/2025 at 3:36 PM, documented Resident #112 was sent to the hospital due to a critical lab value. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/07/2025 at 10:10 AM, Director of Social Work #1, stated the transfer/discharge notices for Resident #112 for dates 12/31/2024, 1/05/2025, and 1/11/2025 were not documented as sent to the Ombudsman as they should have been. During an interview on 3/07/2025 at 2:24 PM, Regional Clinical Director of Nursing #1, reported that a paper copy of the transfer/discharge notice needed to be sent to the resident and Ombudsman anytime someone transfer/discharges. During an interview on 3/07/2025 at 2:25 PM, Administrator #1, stated that they believed that transfer/discharge notifications were sent to the Ombudsman monthly and was unaware that the notices were not being sent as expected. Resident #123 Resident #123 was admitted to the facility with diagnoses of acute kidney failure (a sudden decline in the functioning of kidneys), absolute glaucoma (increased intraocular pressure that results in permanent vision loss and blindness), and type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels). The Minimum Data Set, dated dated dated [DATE], documented that the resident was understood, could understand others, and had mild cognitive impairments. The resident required substantial/maximal assistance with most activities of daily living. A progress note dated 12/27/2024 at 5:13 AM, documented that Resident #123 was found on the floor during rounds facedown and reported a headache. The nurse practitioner ordered the resident be sent to the hospital. Family was made aware. A neurology consult note from the hospital, dated 12/28/2024 at 3:46 AM, documented Resident #123 was admitted to the hospital on 12/27/2024 status post fall. During an interview on 2/26/2025 at 4:10 PM, Director of Social Work #1 stated that a final discharge notification was never sent to Resident #123, the resident's representative, or the Ombudsman. They stated they did not provide the resident or resident representative with a transfer/discharge notice when they were sent to the hospital. They reported discharge notification forms were only sent to the Ombudsman for voluntary or against medical advice discharges, not for hospital transfers or discharges. During an interview on 2/27/2025 at 11:35 AM, Administrator #1 stated when a resident is sent to the hospital, they should be sent with the transfer/discharge form. Administrator #1 acknowledged the Ombudsman was not notified of Resident #123's transfer to the hospital. 10 New York Code of Rules and Regulations 415.3(i)(1)(iii)(a-c) 51131

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The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews during the recertification survey, the facility did not ensure written notice of the facility's bed hold policy was provided to the resident and/or representative upon transfer to the hospital for 2 (Residents #112 and 123) of 2 residents reviewed for hospitalization s. Specifically, a written notice of the facility's bed hold policy was not provided to the resident and/or their representative upon discharge to the hospital. This is evidenced by: The facility policy titled, Bed-Holds and Returns, dated 1/2022, documented residents or resident representatives would be informed in writing of the bed hold and return policy prior to transfers and therapeutic leave. Resident #112 Resident #112 was admitted to the facility with diagnoses of metabolic encephalopathy (a change in how your brain works due to an underlying condition), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), and end stage renal disease (the final stage of chronic kidney disease, where the kidneys have permanently lost most of their ability to function. The Minimum Data Set (an assessment tool), dated 1/26/2025, documented the resident was understood, understands others, and was cognitively intact. A physician progress note, dated 12/31/2024 at 11:55 AM, documented Resident #112 was sent to the hospital to receive dialysis because they had missed their previous dialysis appointment due to feeling lethargic and nauseous. A physician progress note, dated 1/05/2025 at 10:46 AM, documented Resident #112 was sent to the hospital per their request for pain control. A physician progress note, dated 1/11/2025 at 6:17 PM, documented Resident #112 was sent to the hospital due to unresponsiveness and low blood sugars. A nursing progress note, dated 2/25/2025 at 3:36 PM, documented Resident #112 was sent to the hospital due to a critical lab value. There was no documented evidence that a written notice of the facility's bed hold policy was provided to the resident or resident representative upon transfer to the hospital on 12/31/2024, 1/05/2025, 1/11/2025, and 2/25/2025. Resident #123 (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #123 was admitted to the facility with diagnoses of acute kidney failure (a sudden decline in the functioning of kidneys), absolute glaucoma (increased intraocular pressure that results in permanent vision loss and blindness), and type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels. The Minimum Data Set, dated dated dated [DATE], documented that the resident was understood, could understand others, and had mild cognitive impairments. The resident required substantial/maximal assistance with most activities of daily living. A progress note dated 12/27/2024 at 5:13 AM, documented that Resident #123 was found on the floor during rounds facedown and reported a headache. The Nurse Practitioner ordered the resident be sent to the hospital. Family was made aware. A neurology consult note from the hospital, dated 12/28/2024 at 3:46 AM, documented Resident #123 was admitted to the hospital on 12/27/2024 status post fall. The medical record did not include documentation that the resident and/or resident representative was provided with a copy of the bed hold policy upon their transfer to the hospital on 12/27/2024. During an interview on 2/26/2025 at 3:30 PM, Social Worker #1 stated that all bed hold notifications should be sent with the resident at the time of transfer. They acknowledged that Resident #123 was sent to the hospital on 12/27/2024 and reported the bed hold policy should have been sent with the resident to the hospital. During an interview on 2/26/2025 at 4:10 PM, Director of Social Work #1 stated on the 7:00 AM to 3:00 PM shift, the social work department was responsible for providing the bed hold policy to the resident and/or representative at the time of transfer. They reviewed the bed hold policy with the resident and/or representative and then documented the conversation in their progress notes. The Registered Nurse supervisor was responsible for providing and reviewing the bed hold policy with the resident and/or representative prior to transfer on the second and third shift. Director of Social Work #1 stated that there was no documentation to support that the bed hold policy was reviewed or provided to Resident #123 when transferred to the hospital on 12/27/2024. During an interview on 2/27/2025 at 11:35 AM, Administrator #1 stated when a resident was sent to the hospital, the Registered Nurse Supervisor was responsible for calling the resident ' s representative to review the bed hold policy and a notification of bed hold should be sent to the representative by mail. They acknowledged the bed hold procedure had not been followed for Resident #123. Review of the bed hold with the resident ' s representative was not documented in the progress notes and the bed hold notification was not uploaded to the chart as having been mailed. 10 New York Codes Rules Regulations 415.3(h)(4)(iii)(a) 51131

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews during the recertification survey, the facility did not ensure that each resident was screened for a mental disorder or intellectual disability prior to admission for 1 (Resident #47) of 32 residents reviewed. Specifically, the Preadmission Screening and Resident Review (PASARR, New York State Department of Health form 695) did not identify Resident #47 as having a serious mental illness when indicated, and a Level II referral was not made. This is evidenced by: The Policy and Procedure titled, Preadmission Screening and Resident Review (PASARR), dated 9/2021, documented the admissions coordinator would obtain a Preadmission Screening and Resident Review for all new residents admitted to the facility and a Level II Screen when required. The admission coordinator and/or social worker would review the screen to ensure completion, and that placement was appropriate for the resident. When a Level II is required based on the screen, the admission coordinator would notify the hospital, so that a Level II could be completed and obtained prior to admission to the facility. 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), generalized anxiety disorder (a mental health condition that causes fear, a constant feeling of being overwhelmed, and excessive worry about everyday things), and major depression disorder (mood disorder that causes a persistent feeling of sadness and loss of interest). The Minimum Data Set (an assessment tool), dated 10/01/2024, documented the resident was cognitively intact, could be understood, and understand others. The Preadmission Screen and Resident Review for Resident #47, dated 9/24/2024, Level 1 Review for Possible Mental Illness (MI) (question 23- does this person have a serious mental illness?) documented no, when the resident had a diagnosis of schizophrenia, prior to admission. A Level II referral (questions 33 and 35) were not completed. There was no documented evidence of a Level II referral for Resident #47. A hospital discharge summary dated 11/25/2024, documented Resident #47 was in the hospital from 10/30/2024 to 11/25/2024 for bacterial pneumonia, pleural effusion (a buildup of fluid between the tissues that line the lung and the chest), and acute exacerbation of chronic obstructive pulmonary disease. They transitioned to the Psychiatric unit on 11/21/2024 due to suicidal ideation and required 1 to 1 supervision for safety. Psychotropic medications were adjusted, and the 1 to 1 supervision was lifted prior to discharge back to the facility. A psychiatry note dated 11/27/2024, documented that Resident #47 had a history of Schizophrenia with confusion, paranoid delusions and auditory hallucinations. Resident #47 had multiple inpatient hospitalization s in their lifetime. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan dated 12/02/2024, documented Resident #47 displayed or reported the following moods; feeling down, depressed, hopeless, feeling tired or having little energy, isolates, little interested or pleasure in doing things. Resident #47 has a history of Suicidal Ideation (last statement 11/25/2024, no plan). Has a diagnosis of Schizophrenia. The Annual Minimum Data Set, dated dated [DATE], documented that Resident #47 received antipsychotics on a routine basis only. During an interview on 3/05/2025 at 9:50 AM, Director of Social Work #1 stated that the Preadmission Screen and Resident Review/Screen comes from the hospital or as part of the admission packet and gets reviewed. Director of Social Work #1 was not screen certified, but they would check the resident's diagnoses to see if the resident needed a level II referral. In the event that a Screen was found to be inaccurate upon a resident's arrival to the facility, they would reach out to the Regional Admissions Coordinator, who is Screen certified, for assistance. 10 New York Code of Rules and Regulations 415.11(e)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews during the recertification and abbreviated survey (Case #NY00363829), the facility did not ensure that the development and implementation of comprehensive person-centered care plans included measurable objectives and timeframes to meet residents' medical, nursing, mental, and psychosocial needs for eight (8) (Residents #12, 20, 23, 37, 47, 53, 110, and #231) of 32 residents reviewed for comprehensive care plans. Specifically, (a.) for Resident #12, there was no care plan developed and implemented for urinary tract infection with antibiotic treatment, diagnosed on [DATE]. (b.) for Resident #20, there was no comprehensive care plan in place to address podiatry issues; (c.) for Resident #23, there was no care plan for the use of Lotrisone Cream for fungal skin rash; (d.) for Resident #37, the comprehensive care plan did not include cultural information and interventions for the resident; (e.) for Resident #47, the comprehensive care plan for antibiotics was initiated after antibiotic therapy had been completed; (f.) for Resident #53, the comprehensive care plan did not address the presence of or interventions for a pressure ulcer; (g.) for Resident #110, there was no comprehensive care plan to address the presence of dentures; and (h.) for Resident #231, there was no comprehensive care plan to address the presence of a gastrostomy tube. This is evidenced by: The policy and procedure titled Care plans, Comprehensive Person-Centered, reviewed 1/2025, stated the comprehensive, person-centered would describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident #12 Cross-referenced to F711: Physician Visits - Review Care/Notes/Order Cross-referenced to: F760: Residents are Free of Significant Medication Errors 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 makes it harder for kidneys to filter waste and fluid from the blood), 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 (an assessment tool) dated 12/09/2024, documented the resident had severe cognitive impairment, could be understood, and sometimes understand others. Physician Progress Note dated 1/02/2025 at 12:28 PM, documented urinary tract infection results on 12/19/2024 showed Enterococcus faecalis in critically high amounts. The resident was prescribed Amoxicillin 500 milligrams by mouth; however, the resident had been spitting out the pills and refusing to take them, according to nursing staff. Based on the resident's behavior, the oral antibiotic was being changed to intravenous antibiotic. The resident was prescribed Ampicillin 2 grams intravenously every 6 hours x 7 days. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan did not document a care plan for the urinary tract infection with antibiotic treatment, diagnosed on [DATE]. Resident #23 Resident #23 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that cause 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, dated dated dated [DATE], documented the resident was cognitively intact, could be understood, and understand others. Physician's Progress Note dated 2/04/2025 at 10:49 AM by Physician #1, documented the resident was seen today for rash. The rash was a fungal infection that frequently comes and goes, which previously responded to clotrimazole-betamethasone (Lotrisone Cream). Rash on the bilateral face. Plan: fungal skin rash; take regular shower, clotrimazole-betamethasone 1-0.05% ointment on the lesion twice daily. 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. There were no instructions for where the medication was to be applied. Start date 2/04/2025 at 5:00 PM. Discontinued on 2/26/2025 at 8:57 PM. The medication was administered several times from 2/04/2025 to 2/26/2025. Review of the comprehensive care plan did not document a care plan for the use of Lotrisone Cream for fungal skin rash. Resident #231 Resident #231 was admitted to the facility with the diagnoses of dysphagia (difficulty swallowing), chronic obstructive pulmonary disease (a type of progressive lung disease characterized by chronic respiratory symptoms and airflow limitation), and gastro-esophageal reflux disease. The Minimum Data Set, dated dated dated [DATE] documented the resident could be understood, could understand others, and was moderately cognitively impaired. A Dietary Note dated 2/20/2025 at 12:03 PM documented the presence of a surgical gastrostomy site placed on 2/07/2025. A Physician's Progress Note dated 3/02/2025 at 10:01 AM documented the presence of a gastrostomy tube. A review of the resident's comprehensive care plan did not document a care plan to address the presence and use of a gastrostomy tube. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/2025 at 9:03 AM, Registered Nurse #2 stated that they have had to do the care plans for their unit, Unit A and sometimes the care plans on Unit B. They stated this could be a challenge at times for them. During an interview on 3/06/2025 at 9:56 AM, Licensed Practical Nurse #7 stated that the Director of Nursing sometimes had to update their care plans. Licensed Practical Nurse #7 stated that they could not update the care plans themselves so they did their part to update what they could and then told one of the Registered Nurses to finish it. When asked how they were assured the care plan would be completed, Licensed Practical Nurse #7 stated that once they reported to the registered nurse on duty, they moved on with their day. They stated they had too much to do to stay focused on things like that. During an interview on 3/07/2025 at 2:29 PM, Regional Director of Clinical Services #1 stated they would expect a care plan to be initiated for a gastrostomy tube. 10 New York Codes, Rules, and Regulations 415.11 (c)(1) 43805 48744

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record reviews and interviews during a recertification and abbreviated survey (Case #NY00363829) , the facility did not ensure comprehensive care plans were reviewed after each assessment and revised based on changing goals, preferences, and needs of the resident and in response to current interventions for eight (8) (Resident #'s 20, 23, 28, 47, 51, 84, 114, and 328) of 31 residents reviewed for comprehensive care plans. Specifically, for Resident #20, the care plan was revised to remove a medication that the resident was prescribed. Additionally, Resident #23's care plan for bladder incontinence with an intervention to monitor for signs and symptoms of urinary tract infection was not revised to include an infection diagnosed on [DATE]; Resident #28, the discharge planning care plan was not revised to reflect the resident's current status and goals; Resident #84, the impaired skin integrity care plan was not resolved after the wound was documented as healed in January 2025; Resident #114, the care plan was not updated to reflect the resident's falls; Residents #47, #51, and #328, medications that the residents were no longer prescribed were care planned for. This is evidenced by: The policy and procedure titled Care Plans, Comprehensive Person-Centered, reviewed 1/2025, stated care plans were to be revised as information about the residents and the residents' conditions change and must be reviewed and updated for a significant change in the resident's condition, when the desired outcome was not met, when the resident has been readmitted to the facility from a hospital stay, and/or at least quarterly. Cross-referenced to: F760: Residents are Free of Significant Medication Errors Resident #23 Resident #23 was admitted with the diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that cause 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, dated dated dated [DATE] documented the resident was cognitively intact. The resident made themselves understood and was able to understand others. The Care Plan for Resident has Bladder Incontinence related to disease process, revised 2/12/2025, documented the resident had bladder spasms and was on medication to help control signs and symptoms and maintain optimal bladder function. Interventions included to monitor and document signs and symptoms of urinary tract infection. Thesigns and symptoms were documented. A Nursing Progress Note dated 2/22/2025 at 5:22 PM by Registered Nurse #4 documented Resident #23's urine result came back positive for urinary tract infection. The Nurse Practitioner was aware and gave a new order for Augmentin (antibiotic) 875 milligrams twice daily for seven (7) days. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician Progress Note dated 2/22/2025 at 6:00 PM by Nurse Practitioner #3, On-call provider note documented a call from nursing staff reporting the resident's urinalysis and culture results that returned positive for a urinary tract infection that was sensitive to Augmentin. Resident #23 was prescribed Augmentin 875 milligrams twice daily. The resident's care plan was not revised to include the urinary tract infection diagnosed on [DATE]. Resident #28 Resident #28 was admitted to the facility with the diagnoses of dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgment), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The Minimum Data Set (an assessment tool) dated 12/26/2024 documented the resident was usually understood, could usually understand others, and was cognitively intact. The comprehensive care plan titled Discharge Planning stated the goal as long-term care placement. The interventions, including applications for community resources and durable medical equipment, were dated 8/2020 and were aimed at community discharge. During an interview on 3/7/2025 at 10:30 AM, Social Work #1 stated the resident's care plan for discharge to the community should have been resolved as the resident was long-term care. Resident #84 Resident #84 was admitted to the facility with the diagnoses of hyperlipidemia (high level of cholesterol in the blood), peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). The Minimum Data Set, dated dated dated [DATE] documented the resident was able to be understood, was able to understand others and was cognitively intact. A Physician's Order dated 1/21/2025 documented wound care to be provided to right above knee amputation site every Tuesday, Thursday, and Saturday. The comprehensive care plan for impaired skin integrity was revised on 2/23/2025 and documented the presence of a surgical wound. During an observation on 2/24/2025 at 10:48 AM, Resident #84 was wearing shorts and their amputation sites were easily visible. The amputation sites had no dressings on them and did not appear to have open areas. Well healed surgical scars were observed. During an interview on 2/24/2025 at 10:48 AM, Resident #84 denied they had need of any wound care. During an interview on 2/26/2025 at 3:00 PM, Director of Nursing #1 stated the area could be observed due to the resident's clothing choice and it was resolved. The Director of Nursing #1 stated they did not know why the care plan was updated to include a wound that was not there. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/2025 at 9:03 AM, Registered Nurse #1 stated they had to do all the care plans on their unit and sometimes the care plans on another unit and it was hard for them. Registered Nurse #1 stated the facility had a staff member to handle care plans a month ago, but they did not know who they were or where they went. During an interview on 3/7/2025 at 2:00 PM, Regional Director of Nursing #1 stated they would expect care plans to reflect the resident and their needs. The care plans should be updated to include falls, wounds, behaviors, any or all medications, and any new concerns for the residents. 10 New York Codes, Rules, and Regulations 415.11(c)(2)(i-iii) 43805 48744

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 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. This is evidenced by: Cross-referenced to F635: Admission Physician Orders for Immediate Care. 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. Resident #6 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 dated [DATE], documented the resident was able to be understood, understand others, with minimal cognitive deficits. 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). 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. ????? 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. 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. During an interview on 3/02/205 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. Resident #14 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 dated dated [DATE], documented the resident was usually able to understand and be understood by others, with significant cognitive impairment. 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. 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. 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. Resident #20 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 order (excessive, frequent, and unrealistic worry about everyday things). The Minimum Data Set, dated dated [DATE], documented the resident was usually able to understand others, usually able to be understood, and was cognitively intact. 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documented evidence of care plan related to foot care. A podiatry note dated 11/09/2024 documented all of Resident #20's toenails were elongated and there were no open areas noted. 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. 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. Resident #23 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 dated [DATE], documented the resident was cognitively intact, could be understood, and understand others. 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. 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. There were no documented evidence in the Nursing Notes about the resident's condition. 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: - 1/26/2025, blood pressure 132/68, temperature 97.4, pulse 68, respirations 17, oxygen saturation level 96. - 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. - 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/30/2025 and 1/31/2025, Licensed Practical Nurse #9 documented the same values for all vital signs as was documented on 1/26/2025, 1/27/2025, and 1/28/2025. - 2/01/2025, vital signs were not documented. All values were blank. There was no documented evidence in the nursing note that the medical provider was notified. - 2/02/2025, vital signs were not documented. Licensed Practical Nurse #4 documented 5 (hold/see nurses notes) and in a medication administration note dated 1/4/2025 at 11:37 AM, documented one time a day. Physician Progress Note, dated 2/04/2025 at 10:49 AM by Physician #1, documented Resident #23 had a cold and a moderate, non-productive cough. Plan was to complete vitals every shift for 3 days. Monitor and notify provider. There was no documented evidence in the in Nursing Notes that the resident's condition was monitored. Medication Administration Record dated February 2025, documented a physician's order for vital signs every shift for CIC (change in condition) monitoring for 3 days. Start date 2/04/2025 at 3:00 PM. Blood pressure, temperature, pulse, respiration, and oxygen saturation level documented: - 2/04/2025 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. - 2/05/2025 11:00 PM, Licensed Practical Nurse #18 documented NA for blood pressure and there was no documented evidence in the nursing note that the medical provider was notified. Physician Progress Note, dated 2/24/2025 at 4:45 PM by Physician #1, documented the resident was seen that day for a persistent cough and an abnormal chest x-ray finding that was highly suggestive of pneumonia. Plan included to give oxygen at 3 liters/minute, antibiotics, closely monitor the resident and notify the provider. There was no documentation in Nursing Notes that the resident's condition was monitored. Medication Administration Record dated February 2025, documented a physician order for vital signs every shift for 3 days to start 2/25/2025 at 3:00 PM. Blood pressure, temperature, pulse, respiration, and oxygen saturation level documented: - 2/25/2025 11:00 PM, Licensed Practical Nurse #11 documented NA for blood pressure, pulse, and respiration and there was no nursing note that the medical provider was notified. - 2/26/2025 11:00 PM, Licensed Practical Nurse #11 documented NA for all vital signs and there was no nursing note that the medical provider was notified. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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: - 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. Resident #77 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 dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others. 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. 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). 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. 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. There was no documented evidence in the in Nursing Notes that the resident's condition was monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. There was no documented evidence in the Nursing Notes that the resident's condition was monitored. 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: - 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. - 11/24/2024, blood pressure 124/60, temperature 97.8, pulse 60, respiration 18, oxygen saturation level 97, and pain level was 0. - 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. - 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. - 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. - 12/01/2024, blood pressure 115/56, temperature 97.4, pulse 94, respiration 17, oxygen saturation level 97, and pain level was 0. - 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. - 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. 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. There was no documented evidence in the Nursing Notes that the resident's condition was monitored. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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: - 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. - 12/07/2024, blood pressure 122/68, temperature 97.9, pulse 60, respiration 18, oxygen saturation level 96, and pain level was 0. - 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. - 12/09/2024, blood pressure 130/66, temperature 97.9, pulse 66, respiration 18, oxygen saturation level 97, and pain level was 0. - 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. 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. 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. (continued on next page)

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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 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. 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 48744 51958

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 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. This is evidenced by: 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 dated dated [DATE], documented the resident had moderate cognitive impairment. The resident made themselves understood and was able to understand others. 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. 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. 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. 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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-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. Treatment Administration Record dated February 2025: - 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. 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). - 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. 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. 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. -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. Treatment Administration Record dated February 2025: - 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. o Treatment was administered from 2/22/2025 to 2/25/2025. - 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. A care plan for the pressure ulcer on the left heel was not developed and implemented until 2/27/2025. - 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. 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. 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. 10 New York Codes Rules and Regulations 415.12(c)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that is in accordance with professional standards of practice, the comprehensive person-centered care plan and the residents' goals and preference for three (3) (Resident #'s 23, 51 and 231) of 5 residents reviewed for oxygen administration. Specifically, (a.) for Resident #s 23 and 231 who were ordered to have medications via nebulizer, the facility did not ensure documentation of nebulizer maintenance; and (b.) for Resident #51, supplemental oxygen was not provided as ordered by the physician. This is evidenced by: The Policy and Procedure titled, Nebulizer Treatment and Maintenance, effective 1/2025, documented to ensure safe and effective use of the nebulizer for medication administration, all staff and caregivers must follow proper procedures for its operation, cleaning, and maintenance. Regular maintenance of nebulizer tubing and components was required to prevent contamination and ensure optimal function. Nebulizer maintenance included daily cleaning after each use, weekly tubing replacement, filter maintenance per manufacturer's guidelines or when visibly dirty, and storage of the nebulizer. The facility policy titled, Oxygen Administration, date effective 10/1997 and last revised 10/2024, documented under Preparation, (1) verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration; (2) review the residents' care plan to assess for any special needs of the resident; (3) assemble the equipment and supplies as needed. The policy did not include instructions for the documentation of nebulizer maintenance. Resident #23 Resident #23 was admitted with the diagnoses of chronic obstructive pulmonary disease (a chronic lung disease that cause 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. The resident made themselves understood and was able to understand others. Care Plan for Resident #23 has an Alteration in Respiratory System related to Chronic Obstructive pulmonary disease and shortness of breath when lying flat, revised 2/12/2025. Interventions included administer treatments (nebulizer) and medications per physician orders. During an observation on 2/24/2025 at 12:08 PM, Resident #23's nebulizer was on the bedside table and was unplugged. There was no date on the nebulizer tubing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Administration Record dated February 2025, documented Ipratropium - Albuterol Solution 0.5-2.5 (3) milligrams/3 milliliters, 3 milliliters inhale orally every 4 hours as needed for shortness of breath or wheezing via nebulizer. Start date 1/3/2025 at 2:50 PM. -The medication was administered on 2/25/2025. During an observation on 2/24/2025 at 12:08 PM, Resident #23's nebulizer was on the bedside table and was unplugged. There was no date on the nebulizer tubing. During an interview on 2/26/2025 at 12:40 PM, Resident #23 stated they received Pulmicort and albuterol via the nebulizer. Treatment Administration Record dated February 2025 did not document nebulizer maintenance was performed. Resident #51 Resident #51 was admitted to the facility with the diagnoses of acute and chronic respiratory failure with hypercapnia (functional failure of the lungs that can result when there is too much carbon dioxide in the blood), chronic obstructive pulmonary disease (a progressive lung disease characterized by chronic respiratory symptoms and airflow limitation), and nondisplaced fracture of medical condyle of left femur (type of fracture where the bone remains in its original position but was still broken). The Minimum Data Set, dated dated [DATE] documented that the resident was able to understand others, be understood and was minimally cognitively compromised. The facility policy titled, Oxygen Administration, date effective 10/1997 and last revised 10/2024, documented under Preparation, (1) verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration; (2) review the residents' care plan to assess for any special needs of the resident; (3) assemble the equipment and supplies as needed. The Comprehensive Care Plan for Alteration in Respiratory System, date initiated 9/20/2024 and last revised 2/11/2025, documented under Focus: Resident #51 has an alteration in respiratory system related to shortness of breath when lying flat. Under Goal, the plan documented Resident #51 will receive adequate oxygenation as evidenced by resident's acceptable pulse oximetry level through the review date. Under Interventions include: administer treatments (nebulizer) and medications per medical doctor orders; elevate head of bed greater than 35 degrees to prevent shortness of breath; and provide oxygen per medical director orders. Maintain/change tubing per protocol. During an observation on 2/24/2025 at 11:15 AM, Resident #51's oxygen concentrator was set to 4 liters nasal cannula. During an observation on 3/06/2025 at 9:44 AM, Resident #51's portable oxygen flow rate was set for 2 liters nasal cannula. A Physician order dated 1/16/2025 at 11:00 PM documented Resident #51 should have oxygen via nasal cannula at 4 liters per minute to keep stats above 88%. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #231 Resident #231 was admitted to the facility with diagnoses of cerebral infarction (stroke), acute cough, and chronic obstructive pulmonary disease (a progressive lung disease characterized by chronic respiratory symptoms and airflow limitation). The Minimum Data Set, dated dated dated [DATE], documented the resident had moderate cognitive impairment. The resident usually made themselves understood and was usually able to understand others. Care Plan for Resident #231 has an Alteration in Respiratory System related to chronic obstructive pulmonary disease, shortness of breath, and acute laryngitis, revised 3/05/2025. Interventions included administer treatments (nebulizer) and medications per physician orders. Resident #231 observation on 2/26/2025 at 11:13 AM. The resident's nebulizer tubing was not dated. Medication Administration Record dated February 2025, documented Albuterol Sulfate Nebulization Solution (2.5 milligrams/3 milliliters) 0.083%, 3 milliliters inhale orally via nebulizer every 6 hours as needed for shortness of breath. Start date 2/18/2025 at 1:45 PM. - The medication was administered on 2/23/2025 and 2/24/2025. Treatment Administration Record dated February 2025 did not document nebulizer maintenance was performed. During an interview on 3/07/2025 at 11:56 AM, Licensed Practical Nurse #5 stated that when the nebulizer treatment was complete, they would clean the mask and leave it to dry on clean paper towels. When asked by what they meant as clean, Licensed Practical Nurse #5 stated that they ran it under hot water. Licensed Practical Nurse #5 stated that the tubing needed to be labeled and should be good for a week. When asked what they would do if the tubing wasn't labeled, or the Licensed Practical Nurse #5 would do if the tubing was not labeled. They stated that they would get new supplies. Anytime the tubing was changed, the mask should have been changed too. The changing of the tubing and supplied should be documented on the Treatment Administration Record and believed that the night shift changed the tubing. During an interview on 3/07/2025 at 2:00 PM, Regional Director of Nursing #1 stated that licensed staff was responsible for oxygen administration and well as the nebulizer treatments. Licensed staff were supposed to check the order for the set flow rate, document the administration time, how long the treatment took, and the assessment after the respiratory treatment. The tubing and mask should be covered when not in use and cleaned after the treatment was complete. Regional Director of Nursing #1 stated that they believed that was in an order set that was set up when the orders for nebulizer treatments were ordered. 10 New York Code of Rules and Regulations 415.12(k)(6) 48744

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 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. This is evidenced by: 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. Resident #11: 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. 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. There was no documented evidence of care plan intervention for assessing and/or monitoring the resident before and after dialysis. 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. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Dialysis Treatment Communication forms documented: - 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. - 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. - 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. - 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. - 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. - 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. - 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. - 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. - 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. 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. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. Resident #110 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 dated dated [DATE], documented the resident usually understood others, was usually able to be understood, and was minimally cognitively impaired. 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: - Monitor intake and output. - Monitor/document/report to medical director as needed any signs or symptoms of infection to access site redness, swelling, warmth or drainage. - 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. - Monitor/document/report to medical director as needed for signs or symptoms of the following: bleeding, hemorrhage, bacteremia, septic shock. - Obtain vital signs and weight per protocol. Report significant changes in pulse, respirations and blood pressure immediately. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. The sheets for 2/20/2025 and 2/22/2025 were not able to be located by facility staff. 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. 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. 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. 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. No communication log for 2/25/2025 was able to be located by facility staff. 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. 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. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 10 New York Code of Rules and Regulations 415.12 48744

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 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. This is evidenced by: Cross-referenced to F554: Resident Self-Administer Medications - Clinically Appropriate Cross-referenced to F760: Residents are Free of Significant Medication Errors Cross-referenced to F773: Laboratory Services Physician Order/Notify of Results Resident #23 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. 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. - There were no instructions on where the medication was to be applied and/or the duration of use. 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. - Lotrisone Cream was administered several times from 2/4/2025 to 2/26/2025. (continued on next page)

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	335540	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 Lortisone 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. Resident #77 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 dated dated [DATE], documented the resident was cognitively intact. The resident made themselves understood and was able to understand others. 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. 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. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. - 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). The resident's high potassium level was not evaluated by a provider until 12/21/2024 at 10:20 PM: - There was no documentation in Nursing Notes that the provider was notified of the critical/abnormal results on 12/17/2024. - 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. There was no documentation Nurse Practitioner #2 evaluated the high potassium level. - 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. - 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). 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. 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. 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. (continued on next page)

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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) 48744

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 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. This is evidenced by: Upon entrance to the facility on [DATE] there were 123 residents residing on 3 units. 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. 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). 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. A review of staffing sheets provided by the facility from 2/22/2025 through 3/06/2025 documented the following: 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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. 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. 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. A review of staffing sheets provided by the facility from 2/22/2025 through 3/06/2025 documented the following: Based on facility census, there were not the required number of Certified Nurse Aides any day between 2/22/2025 through 3/06/2025. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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. 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. 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. 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. 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. 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. During the resident council meeting on 2/24/2025 at 11:38 AM, residents present stated that there were not enough staff members. 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. 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. 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. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 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. 10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 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. This is evidenced by: 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. The Facility Assessment documented under Orientation, the following was required for licensed nurses and nurse aides: 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. The Facility Assessment documented under Annual the following was required for licensed nurses and nurse aides: 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. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 10 New York Code of Rules and Regulations 415.26(c)(1)(iv)

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The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744 Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for two (2) (Resident #s 47, and 67) of 11 residents observed during a medication pass for a total of 30 observations. This resulted in a medication error rate of 6.87 percent. This is evidenced by: The Facility's Policy and Procedure titled, Administering Medication, effective date: 10/1997 and revised 1/2025, documented medications shall be administered in a safe and timely manner, and as prescribed. Additionally, it documented medications must be administered in accordance with the orders, including any required time frame; the individual administering medication must check the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication; the following information must be checked/verified for each resident prior to administering medications: (a.) allergies to medications; and (b.) vital signs, if necessary. Resident #47 Resident #47 was admitted to the facility with diagnoses of metabolic encephalopathy (a condition in which brain function is disturbed due to underlying diseases or toxins in the body), type 2 diabetes mellitus without complications (a chronic condition characterized by insulin resistance and high blood sugars levels), and malignant neoplasm of upper-outer quadrant of right female breast (cancerous tumor in that specific location of breast). The Minimum Data Set (an assessment tool) dated 1/30/2025, documented that the resident was able to be understood, understand others, and was minimally cognitively compromised. During a medication observation on 2/28/2025 at 1:27 PM, Licensed Practical Nurse #9 attempted to give Resident #47 their Tylenol. Licensed Practical Nurse #9 poured Tylenol 650 milligrams, 2 tablets. Surveyor reviewed the order and told Licensed Practical Nurse #9 the order was for 500 milligrams, 2 tablets. Licensed Practical Nurse #9 acknowledged the error and apologized. Licensed Practical Nurse #9 stated the reason the error occurred was there were a lot of people who came to the cart and distracted them. Resident #67 Resident #67 was admitted with the diagnoses of diabetes (a disease that affects how the body uses blood sugar), stroke (a medical emergency that occurs when blood flow to the brain is interrupted, and hyperlipidemia (abnormally high levels of fat in the blood). The Minimum Data Set, dated dated dated [DATE], documented that the resident was usually able to be understood, usually able to understand others, and had significant cognitive impairments. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a medication observation conducted on 2/28/2025 at 1:46 PM, Licensed Practical Nurse #9 administered Resident #67's medications, which included Tylenol Extra Strength give 2 tablets by mouth three times a day for pain, no milligrams were noted to be on the order. Licensed Practical Nurse #9 crushed 2 extra strength Tylenol, mixed it with applesauce, and gave it to resident. The current physician orders on the Medication Administration Record dated 2/2025 revealed that the resident should have received Acetaminophen Extra Strength Tablet 500 milligrams. Give 2 tablet by mouth three times a day for pain. There was no documented order to crush medications for Resident #67. During an interview on 2/28/2025 at 1:46 PM, Licensed Practical Nurse #9 stated that they knew it was 500 milligrams of Tylenol that was ordered, because the previous order was to give 1000 milligrams by mouth every 8 hours as needed for pain. That order was discontinued. Licensed Practical Nurse #9 stated that there were several orders that were not specific and needed to be clarified. Licensed Practical Nurse #9 stated they had brought their concerns to the nurse manager. During an interview on 3/02/2025 at 2:00 PM, Administrator #1 stated that they have reached out to providers themselves to help figure out issues with medications. Administrator #1 stated they would expect that staff would call the pharmacy for missing doses and to find out when they can be delivered. Additionally, Administrator #1 would expect staff to call the medical provider to see if something else could be given and expect staff to monitor the resident and document whatever direction was given by provider. Administrator #1 stated that there was a medication error/missed dose sheet that should have been filled out for missing medications, however they had not received any in January or February. Administrator #1 stated that they did not run reports specific to medication issues but would expect that the nurses write a progress note that would be on the 24-hour report that gets reviewed daily. 10 New York Codes, Rules, and Regulations 415.12 (m)(1)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 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. This is evidenced by: 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #47 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 dated dated , 10/01/2024 documented the resident was cognitively intact, could be understood, and understand others. 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 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. Record review of manufacturer specification of Clozaril (clozapine), located at https://clozaril.com/important-safety-information/ 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. Medication Administration Record dated November 2024 documented, Clozapine 375 milligrams was to start on 11/25/2024 at 9:00 PM and documented: o 11/25/2024 was not given and documented: awaiting pharmacy delivery. o 11/26/2024 was not given and documented: medication was enroute from pharmacy, would administer upon arrival. Physician notified. o 11/27/2024 was documented as given. 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. Hospital Discharge Summary dated 11/25/2024, 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. A nursing note dated 11/29/2024 at 4:07 PM, documented the resident returned from the Emergency Department at 4:05 PM. 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. 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: 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. Per the report of what was available in the facility PYXIS (automated medication dispensing system), Clozapine was not stocked in the facility. The Medication Administration Record dated December 2024documented Clozapine 375 milligrams was to be given at bedtime and was scheduled for 9:00 PM. It documented: o 12/01/2024 was not given and documented: enroute from pharmacy. Physician notified. o 12/02/2024 was documented as given. o 12/03/2024 was documented as given. o 12/04/2024 was documented as given. o 12/05/2024 was not given and documented: awaiting pharmacy delivery. There was no documented evidence that Clozapine was delivered to the facility from 12/01/2024 to 12/05/2024. 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. 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. 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. The Medication Administration Record dated 12/7/2024 documented Clozapine 375 milligrams was given at 9:00 PM. 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. 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. 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. 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. The Emergency Department Clinical Summary, Discharge Information, documented the resident discharged on [DATE] at 2:26 AM with diagnosis of confusion. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. Resident #12 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. 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. 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. 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. 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. 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: o 1/03/2025 12:00 AM, 6:00 AM, and 12:00 PM doses were not given and there were no progress notes. 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. 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o 1/05/2025 6:00 PM dose was not given and there was no documented evidence why the medication was not given. o 1/06/2025 6:00 PM dose was not given and there was no documented evidence why the medication was not given. o 1/07/2025 12:00 PM dose was not given and there was no documented evidence why the medication was not given. 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. 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. 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. 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. A record review of the Medication Administration Record revealed the resident received the intravenous Levaquin on 1/10/2025. 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. Resident #23 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 dated dated [DATE] documented the resident was cognitively intact, could be understood, and understand others. 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. 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. 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. 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: o 2/22/2025 at 5:43 PM o 2/23/2025 at 7:12 AM o 2/24/2025 at 4:02 PM o 2/25/2025 at 3:34 PM Review of the Medication Administration Record dated February 2025 for Amoxicillin-potassium administration revealed the resident did not receive four (4) doses as follows: 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. o 2/24/2025 6:00 AM was not given and there was no documented evidence why the medication was not given. 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. 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. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. Resident #77 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 dated dated [DATE] documented the resident was cognitively intact. The resident made themselves understood and was able to understand others. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There was no documented evidence Resident #77 received sodium zirconium cyclosilicate on 12/21/2024, 12/22/2024, or 12/23/2024. 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. 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. 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. Resident #327 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 dated dated [DATE] documented the resident was able to understand and be understood by others. 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. 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. There was no documentation on the Medication Administration Record or in the progress notes for the missed dose on 4/17/2024. 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. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. 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. 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. 10 New York Codes Rules and Regulations 415.12(m)(2) 43805 48744

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48744 Based on observation, record review, and interviews, conducted during the recertification survey, the facility did not ensure drugs and biologicals were stored in accordance with professional standards of practice. This was evident for 3 (Unit A cart 2, Unit B cart 2, and Unit C cart 1) of 6 carts reviewed and 5 of 6 narcotic logbooks. Specifically, (1) medication cart on Unit A cart 2 contained multiple stock medications that were not dated, 2 bottles of resident specific eye drops that were not dated, a bottle of insulin with no label indicating resident ownership or date opened, and a bottle of mediation which required a biohazard bag that was open loose in the cart; (2) the medication cart on Unit B cart 2 contained a stock medication that was not dated; (3) the medication cart on Unit C cart 1, contained an insulin pen for a resident that should have been in Unit C cart 2; and 5 of 6 Units Narcotic Count books did not have two licensed nurses signatures consistently between shifts. This is evidenced by: The Policy and Procedure titled, Administering Medications, last revised 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: (3) Medications must be administered in accordance with the orders, including any required time frame; (9) The expiration/beyond use date on the medication label must be checked prior to administering. When opening a multi-dose container, the date opened should be recorded on the container; (10) Vials labeled as single dose, or single use will not be used on multiple residents. Such vials would be used only for one resident in a single procedure; (13) Insulin pens containing multiple doses of insulin are for single-resident use only; (14) Insulin pens would be clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse will verify that the correct pen is used for that resident. During an observation on 2/28/2024 at 10:24 AM, Unit A cart 2 contained multiple bottles of floor stock medications that were not labeled with dates that indicated when they were opened, mixed in with floor stock medication bottles that had been labeled with dates that indicated when they were opened. Additionally, 2 bottles of eye drops for one resident were in a bag labeled with the resident's name. There was no date on the bottles, the boxes the bottles were in, or the bag that both boxes were contained in. There was a sticker on the bag that indicated there should have been a date written down when the bottles were opened. There was also one bottle of Lispro insulin loose in the medication drawer that did not have a label on it indicating which resident the bottle belonged to, or when the bottle was opened. Additionally, there was an opened bottle of Valproic Liquid that was not contained in a biohazard bag next to another biohazard bag containing two bottles of the same liquid medication. During an observation on 2/28/2025 at 1:12 PM, Unit B cart 2 contained a bottle of floor stock Bisacodyl that was not dated. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/28/2025 at 11:30 AM, Unit C cart 1 contained a Lantus insulin pen for Resident #11. Per Licensed Practical Nurse #9, Resident #11's medications belonged in the Unit C cart 2. Licensed Practical Nurse #9 stated that the resident's insulin should have been moved to the other cart when the resident changed rooms. During medication cart observations on 2/28/2025, Narcotic Count Logbooks from carts on Units A, B and C were noted to not have two licensed nurse signatures to document a two-person narcotic count had been done on every shift consistently as required by law. The following dates provided were some examples of how the narcotic counts were not being signed off as done from shift to shift: For Unit A cart 1, (a) there was no signature for the on-coming nurse on 2/04/2025 at 3 PM; (b) there was no signature for the off-going nurse on 2/04/2025 at 11 PM; (c) there was no signature for the on-coming nurse on 2/07/2025 at 11 PM; and (d) there was no signature for the off-going nurse on 2/10/2025 at 7 AM. For Unit A cart 2, (a) there was no signature for the on-coming nurse on 2/18/2025 at 11 PM; (b) there was no signature for the on-coming nurse on 2/19/2025 at 11 PM; (c) there was no signature for the off-going nurse on 2/21/202 at 7 AM; and (d) there was no signature for the on-coming nurse on 2/22/2025 at 3 PM. For Unit B cart 1, (a) there was no signature for the on-coming nurse on 3/01/2025 at 3 PM; (b) there was no signature for the off-going nurse or on-coming nurse on 3/01/2025 at 11 PM; and (c) there was no signature for the off-going nurse or on-coming nurse on 3/02/2025 at 7 AM. For Unit B cart 2, (a) there was no signature for the off-going nurse on 2/15/2025 at 7 AM; (b) there was no signature for the on-coming nurse on 2/17/2025 at 7 AM; and (c) there was no signature for the on-coming nurse on 3/01/2025 at 1 PM. For Unit C, there was one book reviewed that (a) did not have a signature for the off-going nurse on 2/28/2024 at 11 PM; (b) there was no signature for the on-coming or off-going nurse on 2/29/2025 for any shift; and (c) there was no signature for the on-coming nurse on 3/01/2025 at 7 AM. During an interview on 2/28/2024 at 10:26 AM, Registered Nurse #2 stated that they did not know why the medications were not labeled with dates, why there was no label on the bottle of insulin, or why the one bottle of Valproic Medication did not require a biohazard bag if the other bottles did. Registered Nurse #2 stated that there were only 2 diabetics on the unit, so they knew who the insulin belonged to. Licensed Practical Nurse #9 (who was sitting nearby during the interview) stated that they also knew who the insulin belonged to but did not know why there was no date on the bottle. Additionally, Practical Nurse #9 stated that the facility pharmacist told them they did not need to label floor stock medications when they were opened anymore, only insulin and the rules had changed. Neither Registered Nurse #2 nor Licensed Practical Nurse #9 could state why the narcotic sheets were not signed consistently. It was noted that Licensed Practical Nurse #9 had signed for the end of their shift at the time of the interview. Licensed Practical Nurse #9 stated that they did that to ensure they did not forget to do the count. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/07/2025 at 02:00 PM, Regional Director of Nursing #1 stated that over the counter stock medications should have been dated when they were opened, and bottles of insulin should have been dated when they were opened with the expiration date. If a nurse were to pick up a bottle of opened medication that did not have a date on it, they would retrieve a new bottle and not use the bottle without a date on it. Regional Director of Nursing #1 also stated that narcotic count should be done shift to shift with two licensed nurses and they should have signed the narcotic count log sheet at the time of the count. There should never be missing signatures or just one signature. During an interview on 3/07/2025 at 2:15 PM. Administer #1 stated that issues regarding medication storage and nurses not signing narcotic count sheets were not on the list of concerns 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. 10 New York Code of Rules and Regulations 415.18(d)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48744 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. 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. Resident #103 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. 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. 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. 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. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 10 New York Code of Rules and Regulations 415.14(e)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 21414 Based on observation, record review, and interviews during the recertification survey, the facility did not store, prepare, distribute and serve food in accordance with professional standards for food service safety. Specifically, food was not cooled properly, the automatic dishwashing machine was not functioning, a test kit for checking sanitizing solution was not available, and food temperature thermometer were not in calibration. This is evidenced by: During observations of the main kitchen on 02/23/2025 at 12:48 PM: Purred vegetables stored in the walk-in refrigerator were 52 degrees Fahrenheit. During an interview on 2/23/2025 at 1:25 PM, cook #1 stated that they had prepared the purred vegetables yesterday (2/22/2025). The final rinse of the automatic dishwashing machine was 150 degrees Fahrenheit, and the water pressure gauge was not functioning (water was steaming while the automatic dishwashing machine was in operation). The information placard attached to the dishwashing machine stated that the final rinse is to be 180 degrees Fahrenheit at 15 to 25 pounds per square inch water pressure. The manufacture label directions on the concentrate of the quaternary ammonium compound used to manually sanitize food contact equipment state that the concentration is to be between 150 parts per million and 400 parts per million. The facility did not have test papers to check the concentration with graduations at 150 parts per million and greater than 400 parts per million. Two of 4 food temperature thermometers were found not in calibration when tested in a standard ice-bath method as follows: 27 degrees Fahrenheit and 25 degrees Fahrenheit. The document titled Cooling In-Service and dated 12/20/2024 documented that the dietary cooks received training on 1/15/2025 to cool foods to 41 degrees Fahrenheit within 6 hours. There was no documented evidence that dietary staff were trained on how to adjust/calibrate food temperature thermometers using the standard ice bath method. During an interview on 2/24/2025 at 11:16 AM, Administrator #1 stated that a corporate maintenance person would check the dishwashing machine, they would speak with the Food Service Director on the proper cooling of food, on the correct test papers to use for the sanitizing solution, and the calibration of thermometers, and the facility would order new test papers for the chemical sanitizing solution. 10 New York Codes, Rules, and Regulations 415.14(h) Chapter 1 State Sanitary Code Subpart 14-1

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. 21414 Based on observation and interview during the recertification survey, the facility did not dispose of garbage and refuse properly. Specifically, dumpsters were not kept closed to prevent the harborage and feeding of pests. This is evidenced by: During observations on 2/23/2025 at 1:58 PM, the lid to the garbage dumpster was propped open with a broom handle; kitchen and housekeeping waste was found inside the dumpster. During an interview on 2/24/2025 at 11:13 AM, Administrator #1 stated that the dumpster should be kept closed and that they would review keeping the dumpster closed with their staff. 10 New York Codes, Rules, and Regulations 415.14(h)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	428 State Route 146 Altamont, NY 12009

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 48744 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. This is evidenced by: Facility was cited F760: Residents are Free of Significant Medication Errors Cross-referenced to F684: Quality of Care 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. 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. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 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. Resident #12 received only 10 of 20 doses of antibiotics prescribed. Resident #23 received only 4 of 8 doses of antibiotics prescribed. Resident #77 was prescribed medication to lower their potassium level on 12/21/2024 and did not receive the medication until 12/25/2024. Resident #327 did not receive antibiotics for 2 days after prescribed. Resident #6 did not receive finger sticks to check the blood sugar level for over 12 hours after admission. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #14 was not offered personal care assistance. Resident #20's feet were not assessed regularly. Resident #23 and Resident #77 did not have vital signs as ordered and were not monitored for changes of condition. 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. 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. 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. (continued on next page)

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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. 10 New York Code of Rules and Regulations 415.26(b)(3)(1)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews conducted during a recertification survey, the facility did not ensure medical records were kept in accordance with accepted professional standards. Medical records were not complete and accurate for three of three units and two (2) (Resident #'s 23 and 53) of 31 residents. Specifically, (a.) narcotic count record books for 3 of 3 units were incomplete; (b.) Resident #23's documentation of vital signs was either incomplete or duplicated; and (c.) for Resident #53, wound care documentation was inaccurate. This is evidenced by: A review of the narcotic count record book for Unit A, there were no documented evidence of Nurses signatures for the following: - On-coming nurse on 2/04/2025 at 3:00 PM - Off-going nurse on 2/04/2025 at 11:00 PM - On-coming nurse on 2/07/2025 at 11:00 PM - Off-going nurse on 2/08/2025 at 7:00 AM - On-coming nurse on undated at 11:00 PM - Off-going nurse on 2/10/2025 at 7:00 AM - Off-going nurse on 2/11/2025 at 7:00 AM - On-coming nurse on 2/12/2025 at 11:00 PM - Off-going nurse on 2/13/2025 at 7:00 AM - On-coming nurse on 2/13/2025 at 11:00 PM - Off-going nurse on 2/14/2025 at 7:00 AM - Off-going nurse on 2/15/2025 at 3:00 PM - On-coming nurse on 2/17/2025 at 11:00 PM - Off-going nurse on 2/18/2025 at 7:00 AM - On-coming nurse on 2/19/2025 at 11:00 PM - Off-going nurse on 2/20/2025 at 7:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On-coming nurse on 2/20/2025 at 11:00 PM - Off-going nurse on 2/21/2025 at 7:00 AM - On-coming nurse on an unreadable date at 7:00 AM - Off-going nurse on 2/22/2025 at 3:00 PM A review of the narcotic count record book for Unit B Team 1 there were no documented evidence of Nurses signatures for the following: - On-coming nurse on 1/12/2025 at 11:00 PM - Off-going nurse on 1/13/2025 at 7:00 AM - On-coming nurse on 1/14/2025 at 11:00 PM - Off-going nurse on 1/15/2025 at 7:00 AM - Off-going nurse on 1/16/2025 at 3:00 PM - On-coming nurse on 1/17/2025 at 11:00 AM - Off-going nurse on 1/18/2025 at 7:00 AM - On-coming nurse on 1/31/2025 at 11:00 PM - Off-going nurse on 2/01/2025 at 7:00 AM - Off-going nurse on 2/03/2025 at 3:00 PM - On-coming nurse on 2/04/2025 at 7:00 AM - Off-going nurse on 2/04/2025 at 3:00 PM - On-coming nurse on 2/05/2025 at 7:00 AM - Off-going nurse on 2/05/2025 at 3:00 PM - On-coming nurse on 2/07/2025 at 7:00 AM - Off-going nurse on 2/07/2025 at 3:00 PM - On-coming nurse on 2/08/2025 at 7:00 AM - Off-going nurse on 2/08/2025 at 3:00 PM - On-coming nurse on 2/09/2025 at 7:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Off-going nurse on 2/09/2025 at 3:00 PM - On-coming nurse on 2/10/2025 at 7:00 AM - Off-going nurse on 2/10/2025 at 3:00 PM -On-coming nurse on 2/12/2025 at 7:00 AM - Off-going nurse on 2/12/2025 at 3:00 PM - On-coming nurse on 2/13/2025 at 7:00 AM - Off-going nurse on 2/13/2025 at 3:00 PM - On-coming nurse on 2/14/2025 at 7:00 AM - Off-going nurse on 2/14/2025 at 3:00 PM - On-coming nurse on 2/14/2025 at 11:00 AM - Off-going nurse on 2/15/2025 at 7:00 AM - On-coming nurse on 2/15/2025 at 7:00 AM - Off-going nurse on 2/15/2025 at 3:30 PM - On-coming nurse on 2/16/2025 at 7:00 AM - Off-going nurse on 2/16/2025 at 3:00 PM - On-coming nurse on an undated date and time - Off-going nurse on 2/17/2025 at 3:00 PM - On-coming nurse on 2/18/2025 at 7:00 AM - Off-going nurse on 2/18/2025 at 3:00 PM - On-coming nurse on 2/19/2025 at 7:00 AM - Off-going nurse on 2/19/2025 at 3:00 PM - On-coming nurse on 2/20/2025 at 7:00 AM - Off-going nurse on 2/20/2025 at 3:00 PM - On-coming nurse on 2/21/2025 at 7:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Off-going nurse on 2/21/2025 at 3:00 PM - Off-going nurse on 2/23/2025 at an unknown time - On-coming nurse on 2/26/2025 at 7:00 AM Photocopies of the narcotic count record book for Unit B Team 2 were provided to the surveyor on 2/28/2025. Review of the photocopies documented blank spaces for the following dates: - On-coming nurse on 1/20/2025 at 7:00 AM - Off-going nurse on 1/20/2025 at 3:00 PM - On-coming nurse on 1/21/2025 at 7:00 AM - Off-going nurse on 1/21/2025 at 3:00 PM - On-coming nurse on 1/24/2025 at 7:00 AM - Off-going nurse on 1/24/2025 at 3:00 PM - On-coming nurse on 1/25/2025 at 7:00 AM - Off-going nurse on 1/25/2025 at 3:00 PM - On-coming nurse on 1/26/2025 at 7:00 AM - Off-going nurse on 1/26/2025 at 3:00 PM - On-coming nurse on 1/29/2025 at 7:00 AM - Off-going nurse on 1/29/2025 at 3:00 PM - On-coming nurse on 1/30/2025 at 7:00 AM - Off-going nurse on 1/30/2025 at 3:00 PM - On-coming nurse on 1/31/2025 at 7:00 AM - On-coming nurse on 1/31/2025 at 11:00 PM - Off-going nurse on 2/01/2025 at 7:00 AM - On-coming nurse on 2/09/2025 at 7:00 AM - Off-going nurse on 2/09/2025 at 3:00 PM - On-coming nurse on 2/10/2025 at 7:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Off-going nurse on 2/10/2025 at 3:00 PM - On-coming nurse on 2/14/2025 at 11:00 PM - Off-going nurse on 2/15/2025 at 7:00 AM - On-coming nurse on 2/17/2025 at 7:00 AM - Off-going nurse on 2/17/2025 at 3:00 PM - On-coming nurse on an unknown date at 3:00 PM - Off-going nurse on 2/20/2025 at 11:00 PM - On-coming nurse on 2/24/2025 at 11:00 AM - Off-going nurse on 2/24/2025 at 3:00 PM - On-coming nurse on 2/25/2025 at 7:00 AM - Off-going nurse on 2/25/2025 at 3:00 PM In addition, review of the provided photocopies of the narcotic count record book documented a crossed out signature without a corresponding signature for the off-going nurse on 1/31/2025 at 3:00 PM. An additional copy of Unit B Team 2 narcotic count record book was provided to the surveyor via secure file transfer on 3/02/2025. The following discrepancies were noted: Dates that were previously blank on copies provided on 2/28/2025 were now signed on 3/2/2025: - On-coming nurse on 1/20/2025 at 7:00 AM - Off-going nurse on 1/20/2025 at 3:00 PM - On-coming nurse on 1/21/2025 at 7:00 AM - Off-going nurse on 1/21/2025 at 3:00 PM - On-coming nurse on 1/24/2025 at 7:00 AM - Off-going nurse on 1/24/2025 at 3:00 PM - On-coming nurse on 1/25/2025 at 7:00 AM - Off-going nurse on 1/25/2025 at 3:00 PM - On-coming nurse on 1/26/2025 at 7:00 AM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Off-going nurse on 1/26/2025 at 3:00 PM - On-coming nurse on 1/29/2025 at 7:00 AM - Off-going nurse on 1/29/2025 at 3:00 PM - On-coming nurse on 1/30/2025 at 7:00 AM - Off-going nurse on 1/30/2025 at 3:00 PM - On-coming nurse on 2/09/2025 at 7:00 AM - Off-going nurse on 2/09/2025 at 3:00 PM - On-coming nurse on 2/10/2025 at 7:00 AM - Off-going nurse on 2/10/2025 at 3:00 PM - On-coming nurse on 2/25/2025 at 7:00 AM - Off-going nurse on 2/25/2025 at 3:00 PM A review of the narcotic count record book for Unit C documented blank spaces for: - On-coming nurse on an unknown date at 11:00 PM - Off-going nurse on 2/2/2025 at 7:00 AM - Off-going nurse on 2/4/2025 at 7:00 AM - On-coming nurse on an unknown date at 11:00 PM - Off-going nurse on 2/6/2025 at 7:00 AM - On-coming nurse on 2/11/2025 at 11:00 AM - Off-going nurse on 2/12/2025 at 7:00 AM - On-coming nurse on 2/23/2025 at 11:00 PM - Off-going nurse on 2/24/2025 at 7:00 AM - On-coming nurse on 2/25/2025 at 7:00 AM - Off-going nurse on an unknown date at 3:00 PM - On-coming nurse on 2/27/2025 at 11:00 PM (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In addition, review of the narcotic count record book for Unit C documented the following dates with signatures crossed out and no corresponding signature in its place: - On-coming nurse on 2/2/2025 at 3:00 PM - Off-going nurse on 2/3/2025 at 7:00 AM - On-coming nurse on 2/3/2025 at 11:00 PM - On-coming nurse on an unknown date at 11:00 PM - On-coming nurse on an unknown date at 7:00 AM - On-coming nurse on 2/15/2025 at 11:00 PM During an interview on 3/03/2025 at 10:36 AM, Director of Nursing #1 stated that staff should not back sign any documentation. The narcotic count record book should be signed when the nurses are performing the count and there should not be any blanks on the signature page. During an interview on 3/03/2025 at 10:46 AM, Licensed Practical Nurse #2 stated if they saw a blank signature space in the book and knew they worked that shift, they would sign it, even if it were days later. They acknowledged the book should be signed by both the on-coming and off-going nurses at the time of the narcotic count. During an interview on 3/7/2025 at 2:02 PM, Regional Clinical Director #1 stated that narcotic counts required 2 nurses, the on-coming and the off-going nurse, to count the narcotics and sign the narcotic count book at the time of the count. Resident #23 Resident #23 was admitted to the facility with the diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), pneumonia (an infection that inflames air sacs in one or both lungs, which may fill with fluid), and chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body). The Minimum Data Set, dated dated dated [DATE], documented the resident was understood, able to understand others, and was cognitively intact. The Treatment Administration Record for January 2025 documented the following repeated vital signs: - 1/06/2025 and 1/07/2025: Blood pressure 122/70, Temperature 97.7, Pulse 80, Respirations 17, Oxygen saturation 99% - 1/16/2025, 1/17/2025, and 1/18/2025: Blood pressure 139/78, Temperature 97.9, Pulse 71, Respirations 17, Oxygen saturation 99% - 1/20/2025 and 1/21/2025: Blood pressure 132/66, Temperature 97.9, Pulse 78, Respirations 18, Oxygen saturation 96% (continued on next page)

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	335540	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Guilderland	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)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 1/22/2025, 1/23/2025, 1/25/2025, 1/26/2025, 1/27/2025, 1/28/2025, 1/30/2025, and 1/31/2025: Blood pressure 132/68, Temperature 97.4, Pulse 68, Respirations 17, Oxygen saturation 96% There were no vital signs documented for the following dates: 1/08/2025, 1/13/2025, and 1/24/2025. The Treatment Administration Record for February 2025 documented the following repeated vital signs: - 2/03/2025 and 2/04/2025: Blood pressure 144/81, Temperature 97.4, Pulse 95, Respirations 17, Oxygen saturation 92% - 2/06/2025, 2/08/2025, 2/10/25, and 2/12/2025: Blood pressure 130/68, Temperature 97.9, Pulse 77, Respirations 18, Oxygen saturation 95% - 2/13/2025 and 2/16/2025: Blood pressure 137/76, Temperature 98.2, Pulse 71, Respirations 16, Oxygen saturation 97% - 2/22/2025 and 2/23/225: Blood pressure 127/73, Temperature 97.7, Pulse 100, Respirations 21, Oxygen saturation 93% - 2/24/2025 and 2/25/2025: Blood pressure 139/78, Temperature 98.1, Pulse 86, Respirations 18, Oxygen saturation 98% There were no vital signs documented for the following dates: 2/01/2025, 2/05/2025, 2/07/2025, 2/11/2025, 2/14/2025, 2/15/2025, 2/18/2025, 2/19/2025, 2/20/2025, and 2/21/2025 The Treatment Administration Record for March 2025 documented the following repeated vital signs: - 3/01/2025 and 3/02/2025: Blood pressure 127/71, Temperature 97.8, Pulse 71, Respirations 15, Oxygen saturation 96%. There were no vital signs documented for 3/04/2025. During an interview on 3/06/2025 at 2:39 PM, Licensed Practical Nurse #5 stated they would not expect a resident to have the same vital signs multiple days in a row. They could not explain the duplicate vital signs multiple days in a row for Resident # 23. During an interview on 3/06/2025 at 3:05 PM, Nurse Practitioner #1 stated that duplicate vital signs over several days would be highly unusual. During an interview on 3/7/2025 at 2:02 PM, Regional Clinical Director #1 stated staff should not be documenting that care was provided when it was not, and documentation should not be falsified. Resident #53 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335540	A. Building B. Wing	03/07/2025

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #53 was admitted to the facility with the diagnoses of polyosteoarthritis (a condition where pain and inflammation occur in multiple joints at once), obstructive sleep apnea (a condition that occurs when airflow is intermittently blocked during sleep), and hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 12/29/2024, documented the resident was understood, able to understand others, and was cognitively intact. A physician's order dated 12/27/2024, documented to apply collagen into wound on left buttocks, cover with foam dressing every Monday, Wednesday, and Friday. A wound assessment note dated 1/14/2025, documented the wound on the left buttocks was healed. A physician's progress note dated 2/11/2025, documented there were no rashes or lesion noted. The March 2025 Treatment Administration Record documented the dressing was completed on 3/05/2025. A provider's note dated 3/05/2025, documented the resident's skin was dry and intact. During an interview on 3/06/2025 at 2:30 PM, Resident #53 denied they had any open areas requiring a dressing. During an interview on 3/06/2025 at 2:39 PM, Licensed Practical Nurse #5 stated there were no open areas on the Resident #53's skin that required a dressing. They were unable to state why they had documented they completed the dressing in the Treatment Administration Record During an interview on 3/07/2025 at 2:02 PM, Regional Clinical Director #1 stated staff should not be documenting that care was provided when it was not, and documentation should not be falsified. 10 New York Codes, Rules, and Regulations 415.22(a)(1-4) 43805 48744 51131

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on observations, record reviews, and staff interviews during the recertification survey, the facility did not ensure infection prevention control practices were followed to help prevent the spread, development, and transmission of communicable diseases and infections for three (3) (Residents #s 110, 115, and 231) of 31 residents reviewed for infection control. Specifically for Residents #s 110, 115, and 231, the facility did not implement and maintain enhanced barrier precautions for residents with indwelling medical devices. This is evidenced by: The policy and procedure titled Barrier Enhanced Precautions reviewed 1/2025 documented nursing home resident with wounds and indwelling medical devices were at especially high risk for multi drug resistant organisms and the use of gown and gloves for high contact resident care activities was indicated. Resident #110 Resident #110 was admitted to the facility with the diagnoses of osteoarthritis (degenerative disease that worsens over time, often resulting in chronic pain in the joints), end stage renal disease (a severe and irreversible condition where the kidneys lose their ability to function adequately), and gastro-esophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and the stomach called the esophagus). The Minimum Data Set (an assessment tool) dated 1/24/2025 documented the resident was usually understood, could usually understand others, and was cognitively intact. During an observation on 3/6/2025 at 10:29 AM, Resident #110's room did not have signage or set up for enhanced barrier precautions. A record review of physician's orders did not have documented evidence of orders for enhanced barrier precautions. The comprehensive care plan for hemodialysis revised 11/20/2024 documented the presence of a hemodialysis catheter (an indwelling medical device used for hemodialysis services). Resident #115 Resident #115 was admitted to the facility with the diagnoses of gastro-esophageal reflux disease, hypertension (high blood pressure), and hyperlipidemia (high level of cholesterol in the blood). The Minimum Data Set, dated dated dated [DATE] documented the resident was understood, was understood by others, and was moderately cognitively impaired. During an observation on 3/06/2025 at 10:25 AM, Resident #115's room did not have signage or set up for enhanced barrier precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician's Order dated 2/27/2025 documented the presence of an indwelling urinary catheter with orders to change the catheter monthly and as needed. A Physician's Order dated 3/01/2025 documented treatment orders for a wound on the right lateral ankle daily. A record review of physician's orders had no documented evidence of orders for enhanced barrier precautions. Resident #231 Resident #231 was admitted to the facility with the diagnoses of dysphagia (difficulty swallowing foods and liquids), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breath), and gastro-esophageal reflux disease. The Minimum Data Set, dated dated dated [DATE] documented the resident could be understood, could understand others, and was moderately cognitively impaired. During an observation on 3/06/2025 at 10:25 AM, Resident #231's room did not have signage or set up for enhanced barrier precautions. A Dietary Note dated 2/20/2025 at 12:03 noted the presence of a surgical gastrostomy site placed on 2/7/2025. A Physician's Progress Note dated 3/02/2025 at 10:01 AM noted the presence of a gastrostomy tube. A record review of physician's orders had no documented evidence of orders for enhanced barrier precautions. During an interview on 3/06/2025 at 10:01 AM, Registered Nurse # 2 stated enhanced barrier precautions should be initiated when the resident had an organism that required infection control. They stated that an indwelling medical device such as a urinary catheter or gastrostomy tube would not need to be on enhanced barrier precautions. They stated that a hemodialysis catheter would not require enhanced barrier precautions because the dressing would be changed at the hemodialysis center and not at the facility. During an interview on 3/06/2025 at 10:10 AM, Licensed Practical Nurse #7 stated enhanced barrier precautions should be initiated when a resident had a wound or external medical devices such as urinary catheters, intravenous access, or gastrostomy tubes. They stated a nurse could initiate the precautions if needed but would require a doctor's order. During an interview on 3/06/2025 at 3:30 PM, Registered Nurse #1 stated they would expect any residents with indwelling device like a urinary catheter, hemodialysis catheter, or gastrostomy tube to also be on enhanced barrier precautions. During an interview on 3/07/2025 at 2:29 PM, Regional Clinical Director #1 stated they would expect residents with indwelling medical devices and wounds to be placed on enhanced barrier precautions. New York Codes, Rules, and Regulation 415.19(a)(1-3)