STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 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 record review and interviews during an abbreviated survey (Case# NY00333575), the facility did not ensure it treated each resident with respect and dignity and care for 2 (Resident #s 2 and 6) of 10 residents reviewed. Specifically, Resident #2, who had severe cognitive impairment, and was asking where their room was, was spoken to in a disrespectful and undignified manner by Certified Nurse Aide #8 on 2/10/2024. For Resident #6, they stated during interview on 4/2/2024 at 9:41 AM, they felt scared when they overheard a loud verbal altercation between Certified Nurse Aide #8 and Licensed Practical Nurse #4, during the night shift on 2/6/2024. This is evidenced by: Refer to F609. The Policy and Procedure titled, Resident Rights, reviewed 1/2024, documented employees would treat all residents with kindness, respect, and dignity. It documented federal and state laws guaranteed certain basic rights to all residents of the facility. These rights included: a dignified experience; be treated with respect, kindness, and dignity; and be free from abuse. Resident #2: Resident #2 was admitted to the facility with diagnoses of sequelae of cerebral infarction (complications after a stroke), anxiety disorder, and recurrent major depressive disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood, and usually understood others. The Comprehensive Care Plan for Exhibits Behavior Symptoms initiated 10/26/2023 and revised 2/09/2024, documented socially inappropriate/verbally aggressive/abusive; physically aggressive/abusive; wandering behavior; wandered around the unit at times and easily redirected. A care plan intervention initiated on 10/26/2023, documented staff were to distract the resident from wandering by offering pleasant diversions. The Comprehensive Care Plan for At Risk for Being a Victim, initiated on 12/28/2023 and last revised on 2/14/2024 after the incident, documented the inability to understand their surroundings related to cognitive impairment and dementia. A care plan intervention initiated on 12/29/2023 documented for staff to provide support and ensure the resident was free from abuse. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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(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	The General Statement form (a document used by the facility as part of their investigation) dated 2/14/2024 by Licensed Practical Nurse Manager #3, documented Resident #12 approached them and reported that during the 11:00 PM - 7:00 AM shift on 2/9/2024 or 2/10/2024, they overheard a Certified Nurse Aide #8 tell Resident #2, I don't like you. Get the fuck away from me. Resident #12 stated the Certified Nurse Aide was yelling at the resident loud enough for them to hear while they were in their room. When asked, Resident #12 stated the Certified Nurse Aide who was yelling was Certified Nurse Aide #8, and they knew it was them because they knew their voice. Resident #12 stated Certified Nurse Aide #8 yelled for about 10 to 15 minutes. Resident #12 stated all Resident #2 asked was where their room was, and Certified Nurse Aide #8 went off on Resident #2. They stated Certified Nurse Aide #8 was cursing at Resident #2, and Resident #2 just kept asking where their room was. The General Statement, dated 2/14/2024 by Licensed Practical Nurse Manager #3, documented a statement from Resident #7. It documented Resident #7 reported to Licensed Practical Nurse Manager #3 that they heard over the weekend, on overnights, a Certified Nurse Aide yelling and cursing at a resident, I don't fucking like you. I can't deal with you. Resident #7 stated this went on for a few minutes. The General Statement dated 2/14/2024 by Director of Nursing #1, documented while they were interviewing Resident #12, their roommate (Resident #8) spoke up and stated they heard it too. Resident #8 stated Resident #8 heard screaming and yelling at a resident, telling them to go back to their room. They stated they were heard swearing and it was at the resident and was just really nasty. Resident #8 stated they did not see who it was because the door was closed but it sounded like it was right outside their door. Resident #8 stated they had heard the voice before but could not say a name. The General Statement dated 2/14/2024 at 2:00 PM by Certified Nurse Aide #5, documented they worked on unit 6 from 7:00 AM - 3:00 PM. They were in a resident's room and heard yelling coming from the nurse's station. Certified Nurse Aide #8 was screaming at Resident #2, who was a new resident on the unit. Certified Nurse Aide #8 told the resident (yelling at the top of their lungs), Get into your room and stop walking around with your dick outside your brief. I'm tired of you and I don't fucking like you. It documented they repeated this verbal assault several times before they stopped. It documented it was disgusting and disgraceful to have to endure this. The General Statement dated 2/14/2024 at 2:30 PM by Director of Nursing #1, documented a phone interview was completed with Certified Nurse Aide #8 and was witnessed by Assistant Director of Nursing #2. Certified Nurse Aide #8 stated Resident #2 kept coming out of their room, was up all night, and they tried to get them to go to sleep. When asked if they ever yelled or swore at the resident when redirecting them, Certified Nurse Aide #8 stated No. I can hardly yell because of my mouth hurting. They were asked if they heard yelling between 7:00 AM and 8:00 AM from a staff member yelling at a resident and Certified Nurse Aide #8 stated no. When asked who was on the unit at that time, Certified Nurse Aide #8 stated they knew Certified Nurse Aide #5 and an unnamed nurse were there. The General Statement dated 2/15/2024 by Resident Assistant #9, documented that between 7:00 AM and 8:00 AM, they heard someone yelling, Get back to your fucking room. They approached the nurse's station and Certified Nurse Aide #8 was sitting and charting, and Resident #2 was there. Certified Nurse Aide #8 then proceeded to follow the resident into the dining room, yelling at the resident and swearing at them, Go to your fucking room. Certified Nurse Aide #8 kept yelling at the resident in a nasty way. Resident #2 was looking for coffee and Resident Assistant #9 sat them down and gave them a cup. Certified Nurse Aide #8 then left the dining room. (continued on next page)

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The facility investigation report, dated 2/16/2024 by the Director of Nursing #1, documented an incident between resident and staff on 2/10/2024 at approximately 7:00 AM. It documented staff were notified about the incident on 2/14/2024 at 2:30 PM. The incident documented Resident #12 reported to Licensed Practical Nurse Manager #3 on 2/14/2024 that over the weekend they overheard a Certified Nurse Aide tell a resident, I don't like you. Get the fuck away from me. I can't deal with you. The report conclusion documented that upon interview, Resident #12 stated they were in their room with the door closed when they overheard a Certified Nurse Aide yelling at a resident and knew who was yelling because they were familiar with their voice. They stated that although they did not see the incident, they overheard Certified Nurse Aide #8 say Resident #2's name during the altercation. It further documented the facility's investigation revealed multiple witnesses overheard and saw Certified Nurse Aide #8 being verbally abusive to Resident #2. It documented other residents in rooms adjacent to Resident #12 were interviewed and statements were consistent with overhearing a staff member yelling and swearing at a resident to get away from them and go back to their room:

During an interview on 3/28/2024 at 10:53 AM, Licensed Practical Nurse Manager #3 stated Resident #2 was cognitively impaired, liked to walk around the unit, and always asked where the bathroom was. They stated Resident #2 was easily redirected. They stated that on 2/14/2024, Resident #12 reported there was an incident with Certified Nurse Aide #8 and Resident #2 on 2/10/2024 between 7:00 AM and 8:00 AM. They stated Resident #12 overheard Certified Nurse Aide #8 screaming at Resident #2. Resident #12 told them that Resident #2 was looking for the bathroom and Certified Nurse Aide #8 told them to Put their dick away, I don't want to see it and said I can't look at it right now. Licensed Practical Nurse Manager #3 stated Resident #2 probably got out of bed, looking for the bathroom and all the Certified Nurse Aide #8 had to do was point Resident #2 in the right direction. Licensed Practical Nurse Manager #3 reported the incident to Assistant Director of Nursing #1, and then it was then reported to Director of Nursing #1. They would expect the incident to get reported immediately by staff to the nursing supervisor that the abuse occurred.

During an interview on 3/29/2024 1:51 PM, Certified Nurse Aide #5, stated they witnessed an incident with Certified Nurse Aide #8 and Resident #2 on Saturday, 2/10/2024, between 7:00 AM and 7:15 AM. They stated Certified Nurse Aide #8 was sitting at the front desk charting when Resident #2 came out of their room with nothing on. They stated Certified Nurse Aide #8 just got up out of their chair, and went straight for Resident #2, and told them to get the fuck in your room multiple times and stated they told the resident that more than once. They stated Certified Nurse Aide #8 had been thrown off every nursing unit and it was no surprise that they did that to Resident #2. They stated they did not report the incident because with Certified Nurse Aide #8, yelling and swearing at residents was a common occurrence, and it was nothing abnormal for them.

During an interview on 3/29/2024 2:17 PM, Resident Assistant #9 stated they were familiar with Resident #2. There was an incident on a Saturday 2/10/2024 morning involving Resident #2 and Certified Nurse Aide #8. They stated Certified Nurse Aide #8 was at the desk doing computer books when Resident #2 wandered out of their room towards them. They stated Certified Nurse Aide #8 told Resident #2 to get the F to their room. They stated the aide was screaming at the resident and stated Certified Nurse Aide #8 was always loud. They stated they witnessed the incident as they were coming off the elevator to start their shift. They stated residents heard Certified Nurse Aide #8 yell at Resident #2. They stated Certified Nurse Aide #8 was not whispering but screaming. They stated Resident #2 did not respond to Certified Nurse Aide #8 when they screamed at them. Resident Assistant #9 stated they brought Resident #2 to the dining room and gave them breakfast.

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During an interview on 4/1/2024 at 10:11 AM, Certified Nurse Aide #8 stated the allegation about Resident #2 was not true at all. They stated they were not around Resident #2 and the facility was trying to put it on me. They stated they were familiar with Resident #2 but never said those things to the resident. They stated at the time of the alleged incident they had a really bad toothache and could not open their mouth and was not able to yell. They stated they never yelled at Resident #2 and would never yell at a resident. They stated Resident #2 wandered around the unit. They stated they would not redirect the resident because they would walk right back out of their room. They stated they did not know who reported the incident and stated they were told a resident complained about a week later. They stated the resident reported that they heard them (Certified Nurse Aide #8) yelling at the resident. Certified Nurse Aide #8 stated that they let Resident #2 do whatever they wanted to that night. They stated they did not speak to residents in a disrespectful manner. When asked if they talked to the supervisor on 2/10/2024, they stated no and stated no one told them and said anything about an incident.

During an interview on 4/5/2024 at 1:55 PM, Registered Nurse Supervisor #2 (night shift) stated they were familiar with Certified Nurse Aide #8. They stated, Instead of fixing the problem they [the facility] move the problem. They stated they had multiple issues with Certified Nurse Aide #8 on unit 2, and Certified Nurse Aide#8 was moved off the unit. They stated Certified Nurse Aide #8's tone was nasty and they would swear at residents. They stated they have personally sent Certified Nurse Aide #8 home for the way they spoke to residents. They stated they wrote several disciplinary actions for Certified Nurse Aide #8 and provided Director of Nursing #1 and Human Resources with copies of them.

Resident #s 12 and 8 were not in the facility and were not interviewed.

Resident #6:

Resident #6 was admitted to the facility with diagnoses of cerebral infarction (stroke), recurrent major depressive disorder, and anxiety disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact.

During an interview on 4/1/2024 at 10:11 AM, Certified Nurse Aide #8 stated they had an altercation with Licensed Practical Nurse #4 during the night shift on 2/6/2024. They stated it occurred in the later part of the shift, in the early morning hours. They stated they were taking antibiotics and Licensed practical Nurse #4, took offense to them dozing off for a minute. They stated Licensed Practical Nurse #4 came to the resident's room that they (Certified Nurse Aide #8) were in and started yelling in my face. They stated they told the nurse if they had a problem with them, they could take it outside, meaning outside the facility, and told the nurse they needed to get out of their face. They stated they were accused of abusing Resident #2 after the altercation with nurse.

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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	During an interview on 4/2/2024 at 9:41 AM, Resident #6 (unit 6) stated they did not hear Certified Nurse Aide #8 yell at Resident #2, but their roommate (Resident #12), who was currently in the hospital, heard something and reported it. They stated that a few days prior to the incident, they heard Certified Nurse Aide #8 yelling and arguing with Licensed Practical Nurse #4. They stated, They were really going at it. They stated they heard Certified Nurse Aide #8 say over and over to Licensed Practical Nurse #4, Get out of my face, as Licensed Practical Nurse continued to talk to them. They stated both staff were using loud voices. When asked how it made them feel, they stated, I was scared. I didn't know which one was going to hit the other because both are feisty. They stated the incident happened early in the morning and lasted a few minutes. They stated they did not report the incident. During an interview on 4/2/2024 at 12:37 PM, Licensed Practical Nurse Manager #3, stated they were made aware of an altercation with Certified Nurse Aide #8 and Licensed Practical Nurse #4, after the fact. They stated they did not know exactly what happened. They stated Licensed Practical Nurse #4 told them It was an uncomfortable situation, which made it an uncomfortable work situation. They stated the details of the incident were not shared with them and they did not ask them about the details. They stated they did not know when it occurred, and they did not report it. They stated Certified Nurse Aide #8 had an attitude and a mouth and stated, Some aides just had that personality, and you can't change personality. They stated Certified Nurse Aide #8 was a float aide. They stated Licensed Practical Nurse #4 was confrontational, meaning if they saw staff doing something they should not be doing, they would say something to them and tell them what they should be doing. The Surveyor asked them if them if Certified Nurse Aide #8 was dozing off prior to the altercation with Licensed Practical Nurse #4. Licensed Practical Nurse Charge #1, then walked over to the Surveyor and stated Certified Nurse Aide #8 was sleeping and stated Certified Nurse Aide #5 was working at the time of the incident and was a witness. During an interview on 4/2/2024 at 1:01 PM, Certified Nurse Aide #5 stated the altercation with Certified Nurse Aide #8 and Licensed Practical Nurse #4 happened during the overnight shift in the middle of the week. They stated they were doing rounds and saw Certified Nurse Aide #8 asleep at the nurse station, with their head down on a pillow. They stated when Certified Nurse Aide #8 finally woke up they came to the room where Certified Nurse Aide #5 needed help with a resident who was a 2-person assist and was the last resident they needed to provide care to. They stated it was at that time when Licensed Practical Nurse #4 approached Certified Nurse Aide #8 and told them they should consider their coworkers because they were doing all the work while they were sleeping. They stated Certified Nurse Aide #8 then started screaming at the top of their lungs and was fuck you at Licensed Practical Nurse #4. They stated Certified Nurse Aide #8 was in a resident's room at the doorway and Licensed Practical Nurse #4 was outside the room during the incident. They stated they argued because Licensed Practical Nurse #4 called them out on it, meaning about the sleeping. They stated they argued for a few minutes and then they ended up leaving the room and waved Licensed Practical Nurse #4 to get away from the room. They stated the Certified Nurse Aide #8 had been asleep from 1:00 AM - 5:30 AM and the incident happened around 6:00 AM. They stated they did not report the incident. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/3/2024 at 2:41 PM, Licensed Practical Nurse #4 stated they had one altercation with another staff member, and it was with Certified Nurse Aide #8. They stated [Certified Nurse Aide #8] has been a menace to that facility, for I don't know how long. They stated the Certified Nurse Aide #8 was sleeping and all they said to them was they needed to be considerate. They stated they were not in a resident's room at the time but were very close to it. They stated that it was reasonable to believe that any resident in the vicinity could have heard them. They stated that when they first started to talk to Certified Nurse Aide #8, their voice went from zero to one thousand in terms of loudness. They stated Certified Nurse Aide #8 kept saying, get out of my face, as they tried to talk to them. They stated Certified Nurse Aide #8 had issues and the facility was aware of them. They stated they did not like the way Certified Nurse Aide #8 interacted with the residents and stated the same way they got loud during their altercation was the same way they interacted with residents. They stated they had witnessed Certified Nurse Aide #8 talking inappropriately to residents and had spoken to the aide about it. They stated the conflict between Certified Nurse Aide #8 and themselves was caused because they saw the aide sleeping and they addressed it with them. 10 New York Codes, Rules and Regulations 415.5(a)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34630 Based on record review and interviews during an abbreviated survey (Case # NY00331916), the facility failed to protect residents' rights to be free from abuse for 2 (Resident #s 1 and 2) of 3 residents reviewed for abuse. Specifically, the facility failed to ensure the residents' safety and provide adequate supervision to prevent abuse on 1/21/2024, when Certified Nurse Aide #1 observed Residents #s 1 and 2, both of whom had severe cognitive impairment, sitting next to each other on Resident #1's bed. Resident #2 was not redirected out of the room and Certified Nurse Aide #1 left the room, with the residents unsupervised. Subsequently, Certified Nurse Aide #1 returned to the room [ROOM NUMBER] to 8 minutes later and observed Resident #s 1 and 2 engaging in inappropriate sexual behavior. Additionally, during an interview with Certified Nurse Aide #3 on 3/20/2024 at 1:51 PM, they reported they had observed Resident #s 1 and 2 engaging in inappropriate touching prior to the incident on 1/21/2024, it was reported to the Nurse Manager, and they could not recall when it happened or who they told. This resulted in, or had the likelihood for, psychosocial harm that is Immediate Jeopardy and Substandard Quality of Care for Resident #s1 and 2 and had the likelihood to affect 106 vulnerable residents in the facility who are cognitively impaired. This was evidenced by: The Policy and Procedure titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program reviewed 1/2024, documented residents had the right to be free from abuse. It documented this included but was not limited to freedom from sexual abuse. The resident abuse prevention program consisted of a facility-wide commitment and resource allocation to support the following objectives: protect residents from abuse by anyone including other residents, develop and implement policies and protocols to prevent and identify abuse of residents, and ensure adequate staffing and oversight/support to prevent burnout, stressful working situations and high turnover rates. The Policy and Procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating reviewed 1/2024, documented all reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property would be reported to local, state, and federal agencies (as required by current regulations) and thoroughly investigated by facility management. It documented findings of all investigations were documented and reported. Upon receiving any allegations of abuse, the administrator was responsible for determining what actions (if any) were needed for the protection of the residents. The Incident and Accident Statement Form: Supervisor Statement/Summary of Investigation for Resident #s 1 and 2 dated 1/21/2024 at 3:45 PM, summary of investigation documented inappropriate sexual interaction. Contributing factors documented dementia and impaired decision making. Actions taken documented separated and 15-minute checks. Conclusion documented the incident was witnessed; a sexual interaction occurred between two cognitive deficit residents unable to give consent. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's investigation report dated 1/26/2024, for date of incident 1/21/2024 at 3:45 PM, documented a resident-to-resident altercation between Resident #s 1 and 2. It documented a Certified Nurse Aide observed Resident #2 naked from the waist down, standing in front of Resident #1, who was sitting on the bed with their clothes on. It documented a Certified Nurse Aide observed the residents engaging in inappropriate sexual behavior. Interventions documented the residents were immediately separated and both residents were placed on 15-minute checks until the room change was completed for Resident #2. The investigation conclusion documented sexual interaction occurred between two residents that due to cognitive deficits were unable to give consent. Resident #1: Resident #1 was admitted to the facility with diagnoses of dementia with psychotic disturbance, delusional disorders, and hallucinations. The Minimum Data Set (an assessment tool) dated 12/28/2023, documented the resident had severe cognitive impairment, usually could be understood, and sometimes understood others. The Comprehensive Care Plan for Exhibits Behavior Symptoms, initiated on 12/18/2023 and revised 1/23/2024, documented resident socially inappropriate/verbally aggressive/abusive; hallucinations; delusions; wandering behavior; belief that other residents were their husband and was easily redirected. A care plan intervention initiated 12/22/2023, documented all day hourly checks. The Comprehensive Care Plan for At Risk for Being a Victim, initiated 1/22/2024, documented resident's inability to understand their surroundings related to cognitive impairment and dementia. It documented a resident-to-resident altercation on 1/21/2024. The Nursing Progress Note dated 1/21/2024 at 3:45 PM written by Registered Nurse Supervisor #1, documented they were called to the unit and staff reported that Resident #1 was observed with Resident #2, performing inappropriate sexual interactions. The residents were immediately separated. It was documented Resident #1 stated they were spending time with their husband. The resident was placed on 15-minute checks and the on-call Nurse Practitioner #1, and the Director of Nursing were notified. The Physician's Progress Note dated 1/21/2024 at 5:34 PM by the Nurse Practitioner #1, documented a late entry note. They were notified by the nurse that Resident #1 and another resident were having inappropriate sexual relations with each other. It documented the nurse notified the Director of Nursing and facility protocols followed. The Physician's Progress Note dated 1/23/2024 at 10:53 AM by the Physician #1, documented the nurse notified them that Resident #1 and another resident were having inappropriate sexual relations with each other. It documented the nurse notified the Director of Nursing and facility protocols followed. It documented the resident was getting monitored for sexual behaviors. The assessment/plan documented to monitor for sexual behaviors. Resident #2: Resident #2 was admitted to the facility with diagnoses of sequelae of cerebral infarction (complications after a stroke), anxiety disorder, and recurrent major depressive disorder. The Minimum Data Set, dated dated dated [DATE], documented the resident had severe cognitive impairment, could be understood, and usually understood others. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Comprehensive Care Plan for Exhibits Behavior Symptoms, initiated 10/26/2023 and revised 2/9/2024 after the incident, documented socially inappropriate/verbally aggressive/abusive; physically aggressive/abusive; wandering behavior; wandered around the unit at times and easily redirected. A care plan intervention initiated on 10/26/2023, documented staff were to distract the resident from wandering by offering pleasant diversions. There was no documented evidence of new interventions, until 3/23/2024; staff were to intervene when the resident became agitated with the following interventions: coffee, snacks, enjoys reminiscing about their past. The Comprehensive Care Plan for At Risk for Being a Victim, initiated on 12/28/2023 and revised on 1/21/2024 after the incident, documented the inability to understand their surroundings related to cognitive impairment and dementia. It documented a resident-to-resident altercation on 1/21/2024. A care plan intervention initiated on 12/29/2023, documented for staff to provide support and ensure the resident was free from abuse. An intervention initiated on 1/22/2024, documented room change off unit. An intervention for 15-minute checks for safety was initiated on 3/22/2024. The Comprehensive Care Plan for Abuse, Neglect related to altered mental status, initiated 3/23/2024, after the incident, documented care plan interventions: 15-minute checks for safety and resident to be offered food and/or activities of interest while wandering to help keep the resident occupied. The Nursing Progress Note dated 1/21/2024 at 3:45 PM by Registered Nurse Supervisor #1, documented they were called to the unit. It documented staff stated Resident #2 was observed in Resident #1's room having inappropriate sexual interactions. Resident #2 was immediately removed from the room and taken to their room. Resident #2 was unable to state the incident and when asked if there was any incident with another resident they stated no. The Director of Nursing, the resident representative and the on-call Nurse Practitioner were notified. It documented the resident was placed on 15-minute checks. There was no documented evidence the care plan was updated to include 15-minute checks until 3/22/2024. The Physician's Progress Note dated 1/21/2024 at 5:36 PM by Nurse Practitioner #1, documented a late entry note. It documented they were notified by the nurse that Resident #2 and another resident were involved in inappropriate sexual behavior. It documented the residents were separated, the Director of Nursing was notified, and facility protocols were followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/20/2024 at 12:31 PM, Certified Nurse Aide #1 stated they saw Resident #s 1 and 2 sitting next to each other on Resident #1's bed on 1/21/2024. They stated the bathroom door was open and they could see feces on the floor. They stated they left Resident #1's room to gather cleaning supplies and returned approximately 7 to 8 minutes later. Certified Nurse Aide #1 stated when they returned the room, the door was closed, they knocked on the door and called out Resident #1's name. They stated no one said anything so they just walked in. They stated they saw Resident #1 sitting on the bed with their clothes on and Resident #2's pants were off and were placed on the sink, about 5 to 7 feet away from the bed. They stated Resident #2 was naked from the waist down and the Residents were engaged in an inappropriate sexual interaction. They stated they did not try to get Resident #2 out of the room earlier, because they were coming right back, and thought Resident #2 would be alright for those few seconds. They stated they were totally wrong on that note. and stated the supervisor asked them same thing. They stated they did not feel any cause for alarm because both residents wandered and would go in and out of other resident rooms. They stated they thought they would escort Resident #2 out of the room when they got back. They stated they had no knowledge of Resident #2 being sexually inappropriate with any other resident. They stated they called out for Certified Nurse Aide #3 to help them get Resident #2 out of the room. They stated Resident #1 told them they were going to prison because they interrupted their marital affairs. During an interview on 3/20/2024 at 1:51 PM, Certified Nurse Aide #3 stated they were familiar with the incident between Resident #s 1 and 2. They stated Resident #1 had been on the unit 1 for a couple of months. They stated they saw Resident #2 go into Resident #1's room on occasion and they stated it was a daily thing. When asked if the residents were ever sexually inappropriate prior to the incident, they stated there was one time when Resident #1 was sitting on their bed and Resident #2 was standing in front of them and Resident #1 was inappropriately touching Resident #2. They stated they removed Resident #2 from the room and told the manager. They stated they did not recall when it happened or who they told. They stated they had not received formal training about what to do for a wandering resident prior to or after the incident. They stated they had received abuse training and if they saw something related to abuse, they would report to the manager or a nurse on the unit. During an interview on 3/21/2024 at 11:22 AM, Licensed Practical Charge Nurse #1 stated they were aware of an incident of a sexual nature that occurred prior to Resident #2 coming to their unit 6. They stated they had not received any training after the incident. They stated Resident #2 was on 15-minute checks and was still being monitored. They stated male residents were not allowed in female resident rooms. They stated Certified Nurse Aide #1 should have removed the resident from the room before they left the room. They stated Resident #s 1 and 2 should never have been left in a room unsupervised. During an interview on 3/21/2024 at 2:05 PM, Director of Nursing #1 stated they personally trained Certified Nurse Aide #1 specifically for redirecting residents following the incident. They stated Certified Nurse Aide #1 observed Resident #s 1 and 2 sitting on Resident #1's bed. They stated Certified Nurse Aide #1 saw feces on the floor and went to get something to clean it up. They stated when Certified Nurse Aide #1 got back to the room, they saw Resident #2 was naked and Resident #1 was engaged in inappropriate sexual behavior with Resident #2. Director of Nursing #1 stated it was a dementia unit and residents wandered around and mingled with each other. They stated Certified Nurse Aide #1 received dementia training upon hire, annually, and as needed. They stated there was no abuse training following the incident. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/21/2024 at 2:14 PM, Staff Educator #1 stated they were not aware of an incident between Residents #1 and #2. They stated when there was stuff going on in the facility they were not informed about the details. They stated they would just be told to educate staff and was told what the need was. They stated they did abuse training for the facility in January 2024. They stated they did orientation for new staff coming in and stated dementia training was done at that time. They stated they provided no individual training for Certified Nurse Aide #1 following the incident. During an interview on 3/21/2024 at 2:34 PM, Registered Nurse Manager #1 stated they knew briefly about what happened over the weekend between Resident #s 1 and 2 by reading about it. They talked to Certified Nurse Aide #1 who had witnessed the incident and Certified Nurse Aide #1 said they were checking residents and walked by Resident #1's room. The Certified Nurse Aide then walked into the room and Resident #2 had their pants down and Resident #1 was engaged in a sexual act with Resident #2. Registered Nurse Manager #1 stated they were aware Certified Nurse Aide #1 was in Resident #1's room several minutes prior to the incident and that the aide saw both residents fully clothed and sitting on the bed together. They stated whenever they saw two residents in a room together, they would separate them immediately out of dignity and safety of the residents. Registered Nurse Manager #1 stated both residents had a diagnosis of dementia and were unable to give consent for sexual relations. They stated based on their the brief interview for mental status score, Resident #s 1 and 2 were not formally assessed to be unable to give consent. They stated they were responsible for the care planning on that unit. Registered Nurse Manager #1 stated it was on Resident #1's care plan that the resident believed other residents were their husband and stated Resident #1 would say that's my husband when referring to residents on the unit. They stated they would have to redirect Resident #1 constantly and remove them from the male residents' rooms. They stated there was no relationship between Residents #1 and #2. Registered Nurse Manager #1 stated Resident #2 looked like Resident #1's husband, who would visit the resident. They were not aware that Resident #2 was in Resident #1's room daily and stated Resident #2 wandered into everyone's room. Registered Nurse Manager #1 stated they were not aware that Resident #1 had touched Resident #2 inappropriately as was witnessed by Certified Nurse Aide #3. They stated all staff were to report any inappropriate contact between residents. Registered Nurse Manager #1 stated hourly checks meant staff needed to put their eyes on Resident #1 and try to keep them in the common area where they could see the resident. They stated that after the incident both residents were placed on 15-minute checks and now they were on hourly checks. The Registered Nurse Manager #1 stated they did not update the residents' care plan following the incident. They stated with any resident-to-resident altercation, they usually updated the care plan. They stated the Registered Nurse Supervisor should have updated the care plan at the time of the incident. They stated Resident #2 was moved to unit 6 on the Monday 1/22/2024 following the incident. They stated the facility had abuse training in January 2024, however, there was no specific training regarding the incident. Registered Nurse Manager #1 stated they were not sure if Certified Nurse Aide #1 was educated following the incident. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 3/22/2024 at 1:00 PM, Assistant Administrator #1 stated they were made aware of the incident with Resident #s 1 and 2 on Monday, following the allegation of sexual abuse incident. Assistant Administrator #1 stated the residents should have been separated when the Certified Nurse Aide saw Resident #2 in Resident #1's room sitting on the bed and documentation should have been placed in the record. Assistant Administrator #1 stated the facility addressed everything right away and reported it right away. Assistant Administrator #1 stated Resident #2 had been previously moved because the resident was wandering and disruptive and was care planned for this. They stated Resident #2 was moved to yet another unit after the incident and was kept on 15-minute checks. Assistant Administrator #1 stated there was documentation in the electronic medical record about Resident #1, but it was not placed in the care plan. During an interview on 3/25/2024 at 9:55 AM, Administrator #1 stated they were made aware of the incident with Resident #s 1 and 2 at the time it occurred by the Director of Nursing. They stated they were not aware that Certified Nurse Aide #1 left both residents in the room and was not aware that this incident was not the residents' first sexual encounter together. During an interview on 3/28/2024 at 2:50 PM, Medical Director #1 stated the incident with Resident #s 1 and 2 sounded familiar but were not familiar with the residents because Medical Director #1 only provided oversight to the providers for clinical issues. They stated that normally, the protocol was to put resident safety first and stated the Certified Nurse Aide should have never left Resident #s 1 and 2 unattended. They stated there was no going around this and the incident should never have happened. During an interview on 4/1/2024 at 2:15 PM, Certified Nurse Aide #2 stated it was around 3:00 PM or 4:00 PM on 1/21/2024, when Certified Nurse Aide #1 walked into Resident #1's room and started screaming their (Certified Nurse Aide #2's) name. They stated Resident #1 was on the bed and Resident #2 was standing with their pants down. They stated Resident #1 had their clothes on and Resident #2 was noted with an erect penis and was yelling and cursing at the Certified Nurse Aides, saying give me one more minute. They stated they gave both residents a shower that evening and in talking to the residents, Resident #2 had forgotten about the whole thing and Resident #2 thought they were having a marital incident. They stated they did not know the residents were seen by Certified Nurse Aide #1, sitting on Resident #1's bed together prior to the incident. They stated that if they had seen the residents together, they would have gotten Resident #2 out of the room. They stated they would have separated and redirected both residents. During an interview on 4/3/2024 at 1:43 PM, Registered Nurse Supervisor #1 stated the incident between Resident #s 1 and 2 was reported to them by the Certified Nurse Aides on the unit. They stated the Certified Nurse Aides described a sexual interaction, and the residents were separated. Registered Nurse Supervisor #1 stated when Resident #2 was asked about the incident, the resident was not understanding what was happening or what had occurred. When they questioned Resident #1, the resident told them it was something that they and their husband liked to do. They stated Resident #1 was upset because they were separated. They stated they asked Certified Nurse Aide #1 why they did not remove Resident #2 from Resident #1's room. Registered Nurse Supervisor #1 were told there was a mess in the room, the aide left to get cleaning supplies, and got distracted by helping another Certified Nurse Aide. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 4/8/2024 at 12:55 PM, Physician #1 stated the on-call provider was notified about the incident with Resident #s 1 and 2 on the day of the incident. They stated they were notified the day after the incident. They stated both residents had dementia and resided on a locked unit. They stated Resident #2 was only oriented to themselves, was confused all the time, and had an alcohol abuse disorder. They stated Resident #2 wandered into other resident rooms and was redirected out by staff. They stated Resident #1 was confused all the time and did not recognize other people. They stated they did not know that Resident #2 was seen in Resident #1's room prior to the incident. They stated Certified Nurse Aide #1 just thought they were talking and did not think it to be a problem. They stated the residents should have been separated when seen in the room together and stated that residents usually socialized in the dining room. They stated Resident #1 felt that they were doing this sexual act with their husband. 10 New York Codes, Rules, and Regulations 415.4(b)(1)(i)

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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 34630

Based on record review and interviews during an abbreviated survey (Case# NY00333575), the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made, if the events that cause the allegation involve abuse, to the Administrator of the facility and to the State Agency for 1 (Resident #2) of 3 residents reviewed. Specifically, on 2/10/2024, the facility did not ensure an allegation of verbal abuse by Certified Nurse Aide #8 towards Resident #2 was reported to the Administrator and to the State Agency within 2 hours after the allegation was made. On 2/14/2024, Resident #12 reported to Licensed Practical Nurse Manager #3 that during the 11:00 PM - 7:00 AM shift on 2/9/2024 or 2/10/2024, Resident #12 heard Certified Nurse Aide #8 yelling and cursing at Resident #2 for about 10 to 15 minutes. The Administrator was first made aware on 2/14/2024 at 3:34 PM. The allegation was reported to the New York State Department of Health on 2/14/2024 at 3:58 PM.

This is evidenced by:

Refer to F550.

The Policy and Procedure titled Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, reviewed 1/2024, documented if resident abuse was suspected, the suspicion must be reported immediately to the administrator and to other officials, according to state law. It defined immediately as within two hours of an allegation involving abuse or result in serious bodily injury.

Resident #2:

Resident #2 was admitted to the facility with diagnoses of sequelae of cerebral infarction (complications after a stroke), anxiety disorder, and recurrent major depressive disorder. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment, could be understood, and usually understood others.

The General Statement (investigation) form, dated 2/14/2024 by Licensed Practical Nurse Manager #3 (unit 6), documented Resident #12 approached them and reported that during the 11:00 PM - 7:00 AM shift on 2/9/2024 or 2/10/2024, they heard Certified Nurse Aide #8 yelling and cursing at Resident #2, for about 10 to 15 minutes. Resident #12 reported it was loud enough for them to hear while they were in their room.

(continued on next page)

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	335565	A. Building B. Wing	04/08/2024

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility investigation report dated 2/16/2024 by Director of Nursing #1, documented an incident between Resident #2 and Certified Nurse Aide #8 on 2/10/2024 at approximately 7:00 AM. It documented staff were notified on 2/14/2024 at 2:30 PM. The incident documented that on 2/14/2024, Resident #12 reported to Licensed Practical Nurse Manager #3 on 2/14/2024, that over the weekend they overheard a Certified Nurse Aide #8 tell a resident, I don't like you. Get the fuck away from me. I can't deal with you. The report conclusion documented that upon interview, Resident #12 stated they were in their room with the door closed when they overheard a Certified Nurse Aide #8 yelling at Resident #2 and knew who was yelling because they were familiar with Certified Nurse Aide #8's voice. They stated that although they did not see the incident, they overheard Certified Nurse Aide #8 say Resident #2's name during the altercation. It further documented the facility's investigation revealed multiple witnesses overheard and saw Certified Nurse Aide #8 being verbally abusive to Resident #2. It documented the incident was reportable to the New York State Department of Health. The Nursing Home Facility Incident Report confirmation from the New York State Department of Health documented the report was successfully submitted on 2/14/2024 at 3:58 PM by Director of Nursing #1. The allegation type documented mental/verbal abuse and it was documented that reasonable cause to believe abuse had occurred was undetermined. Incident location documented Unit 6 hallway. The incident date/time was Saturday, 2/10/2024 at 7:00 AM. The date/time staff first made aware of the incident was Wednesday, 2/14/2024 at 2:30 PM, and the administrator was first made aware of the incident on 2/14/2024 at 3:34 PM. During an interview on 3/28/2024 at 10:53 AM, Licensed Practical Nurse Manager #3 (unit 6), stated Resident #2 was cognitively impaired. Resident #2 walked around the unit, and always asked where the bathroom was. They stated Resident #2 was easily redirected. They stated that on 2/14/2024, Resident #12 reported that there was an incident involving Certified Nurse Aide #8 and Resident #2 on 2/10/2024 between 7:00 AM and 8:00 AM. They stated Resident #12 overheard Certified #8 screaming at Resident #2. Resident #12 told Licensed Practical Nurse Manager #3 that Resident #2 was looking for the bathroom and Certified Nurse Aide #8 told Resident #2 to Put their dick away, I don't want to see it and stated I can't look at it right now. Licensed Practical Nurse Manager #3 stated Resident #2 probably got out of bed, looking for the bathroom and all Certified Nurse Aide #8 had to do was point Resident #2 in the right direction. Licensed Practical Nurse Manager #3 reported the incident to Assistant Director of Nursing #1, and then it was then reported to Director of Nursing #1. They would expect the incident to get reported immediately by staff to the nursing supervisor that the abuse occurred. During an interview on 3/29/2024 1:51 PM, Certified Nurse Aide #5 stated they witnessed an incident with Certified Nurse Aide #8 and Resident #2 on Saturday, 2/10/2024 between 7:00 AM and 7:15 AM. They stated Certified Nurse Aide #8 was sitting at the front desk charting when Resident #2 came out of their room with no clothes on. They stated Certified Nurse Aide #8 just got up out of their chair and went straight for Resident #2 and told them to get the fuck in your room and stated Certified Nurse Aide #8 told Resident #2 that more than once. They stated Certified Nurse Aide #8 had been thrown off every nursing unit and it was no surprise that they did that to Resident #2. They stated they did not report the incident because with Certified Nurse Aide #8, yelling and swearing at residents was a common occurrence, and it was nothing abnormal for them. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/29/2024 2:17 PM, Resident Assistant #9 stated they were familiar with Resident #2. There was an incident on Saturday morning, 2/10/2024, involving Resident #2 and Certified Nurse Aide #8. They stated Certified Nurse Aide #8 was at the desk doing their charting when Resident #2 wandered out of their room towards Certified Nurse Aide #8. They stated Certified Nurse Aide #8 told Resident #2 to get the F to their room. They stated Certified Nurse Aide #8 screamed at the resident and stated Certified Nurse Aide #8 was always loud. They stated they witnessed the incident as they were coming off the elevator to start their shift. They stated they did not report the incident because they did not want to get anyone in trouble and lose their job. They stated they recently had abuse training and received training on verbal redirection. They stated they knew they were supposed to tell the supervisor or the nurse on the unit whenever there was an allegation of abuse. During an interview on 3/29/2024 at 10:31 AM, Director of Nursing #1 stated they were not made aware of the allegation of abuse that occurred on 2/10/2024 until 2/14/2024. They stated they reported the incident to Administrator #1 and to the New York State Department of Health. They stated the facility's abuse training included immediately reporting any allegation of abuse. During an interview on 4/5/2024 at 1:55 PM, Registered Nurse Supervisor #2 stated they worked during the night shift on 2/9/2024. They stated they were not made aware of the incident with Certified Nurse Aide #8 and Resident #2 until several days after the incident. Resident #12 was not in the facility and was not interviewed. 10 New York Codes, Rules and Regulations 415.4(b)(2)