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	07/31/2024

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 34630 Based on record review and interviews during an abbreviated survey (Case# NY00338151), the facility did not ensure pain management was provided to residents who required such services, consistent with professional standards of practice and the resident's goals and preferences for 1 (Resident #9) of 3 residents reviewed. Specifically, Licensed Practical Nurse #2 did not notify Registered Nurse Supervisor #1 in a timely manner on 3/31/2024, when Resident #9 was in pain and their scheduled Oxycodone (narcotic pain medication) was not available at 12:00 PM. The resident received the medication at 3:15 PM, over 3 hours past the scheduled time. This is evidenced by: Resident #9: Resident #9 was admitted to the facility with diagnoses of inflammatory spondylopathies, sacral and sacrococcygeal region (bone inflammation in the sacrum or coccyx); hidradenitis suppurativa (also known as acne inversa; a condition that causes small, painful lumps to form under the skin that usually develops in areas where the skin rubs together, such as the buttocks); and chronic pain syndrome. The Minimum Data Set (an assessment tool) dated 1/16/2024, documented the resident was cognitively intact. The Policy and Procedure titled, Pain - Clinical Protocol, reviewed 1/2024, documented that with input from the resident, the physician and staff would establish goals of pain management. The physician would order appropriate non-pharmacologic and medication interventions to address the individual's pain. Depending on the severity and location of pain, the physician might start with PRN (as needed) doses or supplement standing doses with PRN doses for breakthrough pain. Staff would reassess the individual's pain and related consequences at regular intervals, at least each shift for acute pain or significant changes in levels of chronic pain and at least weekly in stable chronic pain. The Comprehensive Care Plan for Alteration in Comfort related to sacral wounds, chronic pain syndrome, and chronic hidradenitis suppurativa, revised 6/27/2023, documented the resident was able to verbalize pain and request pain medications as needed and for staff to report to the nurse the resident's complaints of pain or requests for pain treatment. The Comprehensive Care Plan for Risk for Impaired Skin Integrity related to hidradenitis suppurativa, revised 5/04/2023, documented to give pain medications as ordered. (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

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 07/31/2024
NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nursing at Barnwell		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Summary Report for order date range 3/01/2024 to 4/30/2024, documented: - An order dated 3/29/2024 for Oxycodone oral tablet 20 milligrams, give 1 tablet every 6 hours for pain. - An order dated 3/31/2024 for Oxycodone oral tablet 10 milligrams, give 2 tablets one-time only pain, take from e-kit (emergency kit). Review of the Medication Administration Record 3/01/2024 to 3/31/2024, documented: - An order dated 3/29/2024 for Oxycodone oral tablet 20 milligrams, give 1 tablet every 6 hours for pain. The medication was scheduled to be given at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. - An order dated 3/31/2024 for Oxycodone oral tablet 10 milligrams, give 2 tablets one time only for pain, take from e-kit. It documented the medication was administered on 3/31/2024 at 3:15 PM. The DT Usage with Lockout (an automated medication dispensing system report) dated 3/31/2024, documented Oxycodone 10 milligrams was dispensed at 3:03 PM and 3:13 PM for Resident #9 by Registered Nurse Supervisor #1. During an interview on 4/02/2024 at 1:13 PM, Resident #9 stated that on Sunday, 3/31/2024, they had run out of their Oxycodone and the nurses were getting it of the e-kit, the electronic medication dispensing system. Resident #9 talked about their diagnoses of hidradenitis suppurativa and explained that their bottom was a wound, meaning there was a large open area, and they were in a lot of pain because of it. They stated their pain was managed when they received the pain medication as scheduled at 6:00 AM, 12:00 PM, 6:00 PM, and 12:00 AM. They stated Licensed Practical Nurse #2 who did not work on their unit that often, was their assigned nurse on 3/31/2024. They stated they told Licensed Practical Nurse #2 before 12:00 PM that they were out of the Oxycodone and told the nurse that the nurses had been getting it out of the e-kit. They stated they did not receive the 12:00 PM dose until after 3:00 PM, when Registered Nurse Supervisor #1 brought it to them. Resident #9 stated their pain level was 7 or 8, on a pain scale of 0-10 and stated if they had to wait any longer for the medication, they would have had to go to the hospital. During an interview on 4/03/2024 at 1:43 PM, Registered Nurse Supervisor #1 stated they did not know when Licensed Practical Nurse #2 told them on 3/31/2024, that Resident #9's Oxycodone was not available. They stated they physician renewed the order for the Oxycodone 20 milligrams on Friday, 3/29/2024 but the physician did not sign the order. Registered Nurse Supervisor #1 called the pharmacy on 3/31/2024, and they gave them authorization, but it was only for 10 milligrams. They called pharmacy again and told them the order was for 20 milligrams. They stated the pharmacy then gave authorization for an additional 10 milligrams. Registered Nurse Supervisor #1 stated the medication was dispensed from the electronic medication dispensing system and they brought it to the resident. During an interview on 4/03/2024 at 2:23 PM, Licensed Practical Nurse #2 stated they worked on Resident #9's unit on 3/31/2024 during the dayshift, and it was not where they usually worked. They stated they did not recall saying anything to Registered Nurse Supervisor #1 about Resident #9's pain medication because they were working with Registered Nurse Supervisor #1 about Resident #10, whose medications were not available in their medication cart. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/05/2024 at 3:20 PM, Registered Nurse Supervisor #2 stated Resident was always in a significant of pain because of an abscess on their buttock that was enormous. They stated Resident #9 was supposed to get Oxycodone every 6 hours to help manage their pain. They stated orders for narcotic pain medications were ordered by the provider for 14 days. The nurse or nurse supervisor would enter the order in the electronic ordering system and then would send a text message to the provider for the order to be signed. Registered Nurse Supervisor #2 stated when/if the provider did not respond to the text, Registered Nurse Supervisor #2 would call the pharmacy to get an authorization code to dispense the medication from the electronic medication dispensing system. They stated that in the meantime, the residents would be in a significant amount of pain because they must wait. They stated the charge nurse on the night shift was responsible for ensuring that narcotic medications were ordered and available, and was not consistently being done. 10 New York Codes Rules and Regulations 415.12