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	05/19/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews (iQIES intake 2961519), the facility failed to ensure a safe, clean, comfortable, and homelike environment for one (1) of six (six) resident units (Unit 3) and one (1) of six (6) unit dining rooms (Unit 3 dining room). Specifically, room [ROOM NUMBER] on Unit 3 had an unpainted patched wall, a wall with several long areas of scratched sheetrock, and missing and chipped paint on the bathroom door; the Unit 3 main dining room ice dispenser was not working and the basin that caught water was unclean. Findings include:The facility policy Quality of Life, Home Like Environment, last reviewed 1/26, documented residents were provided with a safe, clean, comfortable, and homelike environment. Characteristics of a homelike environment included, clean, sanitary, homelike setting, inviting colors and decor, comfortable noise levels, and comfortable lighting.The facility policy Work Orders, revised 7/22/2026, documented when there was a need for repairs or general maintenance, enter the request into the maintenance logs located at the nurse's station. Any repairs that took more than one day to complete were evaluated by the Director of Plan Operations and/or the Administrator to determine if the repairs needed to be outsourced for completion that it is scheduled in a timely manner. Unit 3The 11/26/2025 room [ROOM NUMBER] audit completed by Maintenance Technician #65 documented the doors and doors jams were unsatisfactory and needed painting, the window glass, sill, and tracks were unsatisfactory and needed cleaning, and the walls were unsatisfactory and needed painting.The 02/13/2026 room [ROOM NUMBER] unsigned audit documented the doors, door jams, and walls were unsatisfactory. There were no comments on pending repairs. The maintenance log dated 12/11/2025 to 05/18/2026 did not document any repairs to walls or doors in room [ROOM NUMBER].During observations on 05/12/2026 at 9:47 AM, 05/12/2026 at 2:40 PM, 05/14/2026 at 10:25 AM, and 05/15/2026 at 10:58 AM room [ROOM NUMBER]'s bathroom door had chipped and missing paint, a wall to the left was patched and not painted, and a wall to the left above the baseboard had multiple areas of scratched and missing sheetrock. During an interview on 05/14/2026 at 10:27 AM, Licensed Practical Nurse # 38 stated the resident in room [ROOM NUMBER] was on contact precautions and isolated to their room. If they noticed scratches in the sheetrock, unpainted patching of walls, or paint missing or chipped on a bathroom door, they notified maintenance by completing a work order in the computer. They stated they were in room [ROOM NUMBER] earlier in the day and did not notice the walls or bathroom door. They observed room [ROOM NUMBER] with the surveyor and stated the area was not homelike for the resident. During an interview on 05/15/2026 at 11:18 AM, Maintenance Technician # 64 stated their department was responsible for building maintenance including plumbing, electrical work, drywall, and painting. Nursing staff notified them of maintenance issues electronically by completing a work order. Work orders were prioritized and distributed amongst the department for completion. When a wall was damaged, they patched it the same day and painted it a few hours after the patch dried. If a patch was not painted, it was not homelike. Environmental rounds were completed daily by Maintenance Technician #65 and when repairs were necessary, the department was notified, and the repairs were completed. There were no outstanding work orders for room (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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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[ROOM NUMBER]. After observing the walls and bathroom doors in room [ROOM NUMBER], they stated the room was not homelike and the door and walls needed repairs. Ice Machine During observations on 05/11/2026 at 1:33 PM, 05/12/2026 at 10:25 AM, 05/13/2026 at 7:56 AM, and 05/18/2026 at 11:38 AM the Unit 3 main dining room ice machine did not dispense ice, and the drain rack was covered with white and brown debris. All maintenance requests and emails regarding the third-floor ice machine were requested. On 05/19/2026 at 3:30 PM the Administrator stated all information regarding the ice machine was forward electronically. The only information received was an invoice for the ice machine dated 04/29/2026. During an interview on 05/13/2026 at 8:01 AM, Certified Nurse Aide #7 stated the Unit 3 ice machine was broken for at least 6 months. They stated the debris in the catch basin looked like mold. Most days Unit Secretary #66 filled up a bucket with ice for residents because they were always asking for ice. When the ice in the bucket was used, they went to another floor to get ice for residents. During an interview on 05/18/2026 at 11:42 AM, Registered Nurse Unit Manager #35 stated when things needed repair, they completed a work order for maintenance to address. The ice machine was broken for at least 6 months. They put in a work order at that time and when they did not get a replacement or hear about a replacement, they sent a follow-up email to the Maintenance Director. They looked in the computer and the date of the email to the Maintenance Director was 04/01/2026. Since the ice machine was broken, they had a round thermal container filled with ice that residents accessed because it was a rehab floor and residents often asked for ice. The container had a metal scoop residents used to scoop the ice into their water pitchers. During an interview on 05/18/2026 at 12:06 PM, the Maintenance Director stated they requested a replacement for the Unit 3 broken ice machine one year ago and still did not have administrative approval. During an interview on 05/19/2026 at 8:22 AM, Unit Secretary #66 stated they worked Monday through Friday, and they started every workday by taking the thermal container to the kitchen and filling it with ice. They stated several months ago the Maintenance Director took the machine apart, ordered parts, and 2 days later put it back together and it still did not work. The Maintenance Director tried to order a new machine and corporate would not approve a new machine at the time. Many residents asked for ice every day and there were not enough certified nurse aides to leave the unit to get ice, so they filled the thermal bucket every day. Many residents on the unit filled their ice pitchers with ice daily. During an interview on 05/19/2026 at 8:31 AM, Resident #211 stated they asked for ice several times throughout the day. They liked a pitcher of ice first thing so as it melted, they had cold water. They wore oxygen and their mouth was always dry. They stated the ice machine was broken and had been for a while. There were many times the ice bucket was empty, and staff said they were out of ice, and they were directed to the fourth floor for ice. During an interview on 05/19/2026 at 8:35 AM, Resident #83 stated they went to the nurses every morning and filled their pitcher with ice using the metal scoop. Usually, they ran out of ice by the change of shift and there was not always staff available to refill the bucket. 10 New York Codes Regulations and Rules 415.29(j)(1)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on observations, record review, and interviews (IQIES intake 3011442), the facility failed to ensure all alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for one (1) of two (2) residents (Resident #46) reviewed. Specifically, Resident #46 was observed with a large bruise covering the left side of their face and there was no documented evidence the injury was thoroughly investigated to rule out abuse. Findings include:The facility policy Abuse-Prohibition Protocol, Type, of Abuse, Response/Reporting, last reviewed 01/2026, documented all reports of alleged mistreatment, neglect, abuse, or misappropriation of resident property or exploitation will be responded to immediately and intervention shall be initiated. Events to be investigated include but not limited to suspicious bruising. If the investigation involves an employee, the employee is suspended pending outcome of the investigation. The facility must report, to the New York State Department of Health, any suspected resident abuse immediately and no later than two hours after the allegation if the incident resulted in physical injury. Resident #46 had diagnoses including dementia, aphasia (difficulty speaking), and seizure disorder. The 03/18/2026 Minimum Data Set assessment documented the resident had severely impaired cognition and was dependent on staff for all activities of daily living. The comprehensive care plan dated 04/02/2026 documented the resident was at risk of being a victim of abuse due to the inability to understand their surroundings related to cognitive impairment. Interventions included assess for signs and symptoms of abuse, provide assistance with activities of daily living, ensure the resident was free from abuse, and offer food or activities of interest to keep the resident occupied. The undated care instructions documented the resident required the use of a mechanical lift with assistance of two for transfers in and out of bed, was dependent on staff for all care, and was on 30-minute safety checks. The video on call Consultant report dated 05/10/2026 at 12:39 AM documented Resident #46 was evaluated by Physician Assistant #37 for extensive ecchymosis (bruising) to the left side of the face. The exact mechanism of injury was unclear, and nursing was uncertain whether the resident experienced an unwitnessed fall. The resident was unable to provide a history. The diagnosis was facial ecchymosis of unclear etiology and possible unwitnessed fall. The plan was to continue monitoring for pain and discomfort, increased swelling or bruising, changes in responsiveness, notify provider of acute clinical changes or controlled discomfort, and notify family per protocol. The undated Accident and Incident Report completed by the Director of Nursing documented Resident #46 was observed with a dark purple discoloration mark located to the left side of their face. The resident was unable to give a description of events. The provider was notified, and they would update the significant other at a more appropriate time. There were no injuries observed at time of the incident. The remainder of the report was blank including level of consciousness, mobility, and injury type. There were three witness statements attached: -05/10/2026 witness statement completed by Certified Nurse Aide #40 documented they completed care on Resident #46 between 7:00 PM and 7:30 PM on 05/09/2026.They washed and changed the resident and made sure safety measures were in place including floor mats and booster pillows. They completed rounds before leaving at 9:00 PM and the resident was safe in their bed. Licensed Practical Nurse #42 administered medication around the time they were leaving at 9:00 PM. -05/10/2026 witness statement completed by Certified Nurse Aide #41 documented they did not assist with Resident #46's care on 05/09/2026. The last time they observed the resident was at approximately 8:00 PM when the resident was in the common area. They did not observe the resident or give care to the resident after that time. -05/11/2026 witness statement completed by Licensed Practical Nurse #42 documented they were assigned to the unit where Resident #46 was located on 05/09/2026 and arrived on the unit around 8:00 PM. At approximately 9:00 PM they entered Resident #46's room and administered medications. They left the room and did not notice a bruise because the left side of the resident's face was turned away from them. The 05/09/2026 3:00 PM-11:00 PM schedule for Unit 3 was documented the following staff were assigned:-Licensed Practical Nurse #42 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 8:00 PM-Certified Nurse Aide #40-Certified Nurse Aide #41-Certified Nurse Aide #43 There was no documented evidence of a witness statement from Certified Nurse Aide #43 included in the Accident and Incident Report. During an observation on 05/12/2026 at 1:30 PM, Resident #46 was in bed on their back with a large bruise covering the entire left side of their face. During an interview on 05/14/2026 at 5:53 PM Licensed Practical Nurse #42 stated they worked on 05/09/2026 and was assigned to the Unit 3 medication cart from 8:00 PM until 11:00 PM, then floated to Unit 5 from 11:00 PM until 8:00 AM shift. At approximately 9:00 PM they prepared medications for Resident #46 who was in their room in bed. The light in the room was off, and the resident was sleeping. They did not notice a bruise because the left side of the resident's face was away from them. Staff did not report a bruise or an incident. When they left on 05/10/2026 at approximately 8:00 AM, Registered Nurse Supervisor #36 stated Resident #46 had a bruise on their face, they completed the incident report and notified the Director of Nursing. During an interview on 05/14/2026 at 6:51 PM, Certified Nurse Aide #40 on 05/09/2026 they worked the 3:00 PM shift and was scheduled to leave at 9:00 PM. They floated to Unit 3 and was assigned to Resident #46. They were not sure of the names of the other two certified nurse aides or the licensed practical nurse, because it was not their normal unit. Around 7:00 PM to 7:30 PM they wheeled Resident #46 from the day room area to their room to get them ready for bed. They asked another staff to assist with transferring the resident back to bed because the resident required use of a mechanical lift. They were not sure of the name of the certified nurse aide that assisted them with the transfer. They left the unit at 9:00 PM and did not see a bruise on the resident prior to leaving. At approximately 4:00 AM they were awoken to several calls from the facility and when they answered they were told they were suspended until the investigation was completed. During an interview on 05/19/2026 at 1:31 PM, Certified Nurse Aide #41 stated they worked on 05/09/2026 from 3:00 PM until 11:00 PM with Certified Nurse Aides #40 and #43. They observed Resident #46 in the common area around the television around 8:00 PM. Resident #46 required the use of a mechanical lift to transfer back to bed. Certified Nurse Aide #40 was assigned to the resident and transferred the resident back to bed before they left at 9:00 PM. They did not assist with transferring the resident back to bed as they had their own assignment and was busy. They did not see anyone assisting Certified Nurse Aide #40 transfer the resident to bed. They worked on 05/10/2026 at 7:00 AM and between 9:00 AM and 10:00 AM the registered nurse supervisor sent them home and said they were suspended until the investigation regarding Resident #46 was completed. During an interview on 05/19/2026 at 1:44 PM, Certified Nurse Aide #43 stated they worked on Unit 3 on 05/09/2026 from 3:00 PM until 11:00 PM. They observed Resident #46 in the dining room for dinner and in the day room after dinner. The resident was assigned to Certified Nurse Aide #40 who put the resident to bed before leaving for the evening at 9:00 PM. They did not assist with the transfer and did not observe anyone assisting with the transfer. They worked 05/10/2026 and received a call from the Director of Nursing who stated they were suspended because of the incident. After speaking to the Director of Nursing and explaining they did not assist with the transfer, they were allowed to work. The Director of Nursing then reached out again on 05/12/2026 and explained they were suspended until the investigation regarding the incident with Resident #46 was completed. During an interview on 05/19/2026 at 11:45 AM, the Director of Nursing stated Resident #46 had an incident on 05/09/2026 that they investigated. Registered Nurse Supervisor #36 reported Certified Nurse Aide #44 found the resident around 11:30 PM with a large bruise to their face and notified Licensed Practical Nurse #34. The only staff that remained in the building from the 3:00 PM to 11:00 PM shift was Licensed Practical Nurse #42, and their witness statement was obtained. Registered Nurse Supervisor #36 obtained witness statements from Licensed Practical Nurse #42 who did not observe the bruise, and Certified Nurse Aide #43 who reported Certified Nurse Aide #40 and Certified Nurse Aide #41 put the resident to bed that evening. That witness statement was not attached to the accident and incident report with the other witness statements and they were not sure where that statement was located. The Director of Nursing obtained the witness statement from Certified Nurse Aide #41 who (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented they did not participate in the care for Resident #46, and the resident was assigned to Certified Nurse Aide #40. When they asked Certified Nurse Aide #40 to describe the person that assisted them with transferring the resident to bed, they stated the staff was not working on the unit and came to Unit 3 looking for an adult brief when they asked for help transferring the resident. After the incident was discovered, the physician was notified, there were no new orders, and they told the supervisor to call the significant other in the morning. Certified Nurse Aide #40 and Certified Nurse Aide #41 were both suspended. When assisting with staffing on 05/10/2026 around 8:00 AM they were notified Certified Nurse Aide #41 was working and they directed the Registered Nurse Supervisor to notify Certified Nurse Aide #41 they were suspended pending investigation and had to leave until the investigation was completed. They observed the injury for the first time on 05/11/2026 in the early morning and observed patterns of bruising and a hole in the resident's bottom right lip. After reviewing the witness statements they concluded Resident #46 hit their head on the bar of the mechanical lift when being put to bed by Certified Nurse Aide #40 and Certified Nurse Aide #41 even though Certified Nurse Aide #40 stated the staff that assisted them was from another unit and Certified Nurse Aide #41 stated they did not participate in the residents care that evening. Since there was not a care plan violation and neglect was ruled out within two hours, it did not meet the requirements of reporting to the Department of Health. 10 New York Codes Rules Regulations 415.4(b)(3)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on record review, and interviews (iQIES 2579030), the facility failed to ensure that it provided sufficient preparation to residents to ensure a safe and orderly transfer or discharge from the facility for one (1) of three (3) residents (Resident #240) reviewed. Specifically, Resident #240 was discharged from the facility without notification to the receiving social services department, without safe/secure housing, and without ensuring the resident had access to outside services.Findings include:The facility policy Discharge Planning, last reviewed 01/2026, documented the facility was to maintain a coordinated program to ensure each resident had a plan of continuing care that met the resident's post discharge needs.The facility policy Discharge Summary and Plan, last reviewed 01/2026, documented the post-discharge plan would include where the resident planned to reside and arrangements for follow-up care and services.Resident #240 had diagnoses including schizophrenia (a serious mental illness), bilateral below knee amputations, and a history of psychoactive substance abuse. The 01/28/25 admission Minimum Data Set assessment documented the resident had was cognitively intact, had disorganized thinking, depression symptoms, required set-up assistance with eating, supervision with oral hygiene/upper body dressing/personal hygiene/bed positioning/wheelchair use, moderate assistance with toilet hygiene/shower/bath/lower body dressing/transfers/picking up objects, was on a therapeutic diet, was receiving occupational and physical therapy, and received an antipsychotic/antibiotic/opioids.The 01/28/2025 comprehensive care plan documented the resident's placement was short-term with a plan to reside with Unity House upon discharge to the community. The resident's discharge status was uncertain at the time of admission, and the resident and/or designated representative would be involved in discharge planning. Interventions included facilitating discharge planning with all disciplines via comprehensive care plan meeting and making appropriate referrals such as home care as needed. The 04/16/2025 at 10:46 AM Social Worker #33 progress note documented they reached out to a supportive living facility (half-way house) previously used by the resident. The supportive living facility refused to take the resident back unless specific conditions were met as the resident had caused damage and the local police were contacted. The 04/25/2025 quarterly Minimum Data Set assessment documented the resident had intact cognition, was independent for eating/oral hygiene/upper and lower body dressing/personal hygiene/bed positioning/wheelchair use/toilet hygiene/transfers/picking up objects, required moderate assistance with a shower/bath, and was receiving an antipsychotic.The 04/28/2025 at 09:16 AM Social Worker #33 progress note documented an assisted living facility referral was declined as the resident was not age appropriate.The 05/02/2025 at 12:23 PM, 05/29/2025 at 4:28 PM, and 06/26/2025 at 9:34 AM Social Worker #33 progress notes documented more assisted living referrals were sent to various facilities.The 05/30/2025 at 10:23 PM Social Worker #33 progress note documented the resident was cleared as independent and medically stable. The facility issued a 30-day discharge notice with a tentative discharge date of 07/01/2025 to a local Department of Social Services listed to assist with appropriate housing. The Ombudsman was notified via facsimile. The social worker continued to assist with possible assisted living arrangements.The 05/30/2025 Transfer/Discharge Notice documented the resident would be discharged on 7/1/2025 to a local Department of Social Services and it was appropriate because the resident's health had improved sufficiently so that the resident no longer needed facility services.The 06/30/2025 at 2:01 PM Social Worker #33 progress note documented discharge planning was finalized. The resident was set to be discharged on 07/01/2025 to the County Department of Social Services via medical transport. A primary care provider follow-up appointment was scheduled, and the resident was made aware of the situation. There were no additional social services progress notes addressing the resident's discharge. The 07/01/2025 at 12:21 PM Licensed Practical Nurse #38 nursing note documented the resident was discharged . There was no documentation where the resident was (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharged to, how the resident was transported, and if discharge instructions or medication reconciliation information was provided to the resident. There was no documentation of a physician order to discharge the resident.The 07/01/2025 discharge Minimum Data Set assessment documented the resident was discharged to home/community (e.g., private home/apartment, board/care/ assisted living, group home, transitional living, other residential care arrangements). The section Provision of Current Reconciled Medication List to Subsequent Provider at Discharge was not completed. Functional abilities at the time of discharge was independent for all activities of daily living. There was no documented evidence of a post-discharge summary indicating where the resident planned to reside, any arrangements for follow-up care, and any post-discharge medical and non-medical services. There was no documented evidence of a medical provider discharge summary with a recapitulation of the resident's stay that included, but not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. During an interview on 05/18/2026 at 1:26 PM, Licensed Practical Nurse #34 stated the facility's social services department and the unit manager were involved in discharge planning. The facility had some residents that were homeless prior to admission and were sent to a shelter or the appropriate county's Department of Social Services when discharged . They stated they were aware Resident #240 was homeless prior to their discharge. The resident was transferred to another unit prior to being discharged from the facility.During an interview on 05/19/2026 at 10:37 AM, the Director of Social Services #33 stated discharge planning started when the resident was admitted to the facility. That planning was entered into a progress admission note. Residents with pending discharges were discussed at weekly interdisciplinary team meetings. The facility moved ahead with those plans of meeting home needs to ensure a safe discharge. Those residents that were homeless were educated about community services and subsidized housing. Assisted living referrals were also sent. The facility would also assist with group home living. If there were no other options for the resident, a 30-day notice of discharge was given to the resident and they were taken to the Department of Social Services office in the county they were last known to come from, unless the resident gave the facility another county to go to. The facility contacted the Ombudsman regarding Resident #240's discharge. The facility did not notify the county Department of Social Services prior to sending the resident there. Each resident should be discharged with a discharge packet outlining the situation and care received from the facility. If the resident was going to another facility, the receiving facility was contacted prior to the discharge. They stated the facility tried to find a suitable housing arrangement for Resident #240 but was unable to do so prior to the planned discharge date as no one would accept the resident. The resident was sent to the county Department of Social Services with a discharge packet that included medical follow ups and a list of medications.During an interview on 05/19/2026 at 10:56 AM, the Director of Nursing stated medication prescriptions were sent to the pharmacy prior to the resident leaving the facility. The social work department discussed any assistance the resident needed and accompanied the resident out of the building. They should also call the receiving facility and notify the county Department of Social Services if appropriate.During an interview on 05/19/2026 at 11:01 AM, the Administrator stated discharge communication should occur with the receiving facility when discharge planning started. A potential receiving facility needed to confirm they would accept the resident. Every attempt should be made to ensure a safe discharge and ensure the receiving facility was able to meet the resident's needs. There was a concern with the facility's previous Director of Social Services, but that had been rectified regarding the receiving facility's notification. A progress note should be written when the facility notified the receiving facility of the pending discharge. 10 New York Codes, Rules, and Regulations 415.2(v) and 415.3(i)(vi)(vii)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews (iQIES intakes 2697750, 2747995, 279049, 2961519, and 2970887), the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, personal and oral hygiene for two (2) of nine (9) residents (Residents #4 and #46) reviewed. Specifically, Resident #4 was not provided with a shower as planned and was not assisted with shaving per the resident's preference; and Resident #46 was not assisted with feeding as planned.Findings include: The facility policy Resident Care with Activities of Daily Living, last reviewed 01/2025, documented the purpose was to accurately assist with the residents' need for support for basic activities of daily living function. When residents were assisted with personal skin care and cleanliness staff reviewed the resident's care plan and assessed any special needs of the resident. Shaving the residents was included with personal skin care and cleanliness. Staff notified the supervisor if residents refused the procedure. The purpose of the procedure was to promote cleanliness, provide comfort to the residents and to observe the condition of the resident's skin 1) Resident #4 had diagnoses including dementia and schizophrenia (a serious mental health disorder). The 02/28/2026 Minimum Data Set assessment documented the resident had severely impaired cognition, did not refuse care, and required partial/moderate assistance for personal hygiene and substantial/maximum assistance for bathing. The 09/14/2022 comprehensive care plan, revised 01/24/2026, documented Resident #4 required assistance with activities of daily living related to dementia and limited mobility. Interventions included encourage the resident to fully participate possible; encourage the use of the call bell for assistance; monitor for changes in status; notify interdisciplinary team as needed; inspect the skin to monitor for redness open areas, scratches, cuts, bruises and report changes to the nurse. There was no documented evidence of the resident's preference for facial hair. The undated care instructions (Kardex) documented the resident required substantial/maximum assistance for showering and bathing. Their shower was scheduled on Tuesday during the day shift. There was no documented evidence of the resident's preference for shaving and facial hair. During an observation on 05/11/2026 at 4:04 PM Resident #4 was sitting in the lounge area. Their hair appeared greasy and brushed back. They had long, white hairs on their chin and upper lip. The resident stated they did not like the hair on their face and wanted it off. The May 2026 Certified Nurse Aide tasks documented the resident did not receive a shower on Tuesday 05/12/2026. During an observation on 05/13/2026 at 9:16 AM the resident was sitting in the dining area waiting for breakfast. Their hair appeared greasy, and they had long white hairs on their chin and upper lip. During an observation and interview on 05/14/2026 at 9:20 AM Certified Nurse Aide #16 stated they were responsible for giving residents their showers. If needed they shaved both men and women on their shower days. They stated Resident #4 had long white hair on their face. They were supposed to give the resident a shower on Tuesday, but there were two certified nurse aides on, and they did not have enough time to get to it. They did not tell the next shift the shower was not done and should have. They intended to do it the next day but did not get to it again because they were busy. They (continued on next page)

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	335565	A. Building B. Wing	05/19/2026

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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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have told the nurse Resident #4 did not get their shower. During an interview on 05/14/2026 at 9:24 AM Licensed Practical Nurse #17 stated certified nurse aides gave the residents showers. They were not told that Resident #4 did not get their shower, or that the certified nurse aides were too busy to give them one. They did not know the resident wanted to be shaved but Resident #4 could tell them they wanted to be shaved if they asked. During an interview on 05/14/2026 at 9:27 AM Licensed Practical Nurse Unit Manager #18 stated certified nurse aides were primarily responsible for providing showers to the residents. They expected the certified nurse aide to fully wash the resident from head to toe, which included shaving. If the day was busy, they expected the next shift to perform the shower. They were not aware Resident #4 did not receive their shower on their care planned shower day. The next shift should have given the resident their shower and shaved them. Razors were kept in the medication room; a nurse would have to retrieve the razor for the certified nurse aide. They did not know the resident wanted to be shaved. 2) Resident #46 had diagnoses including dementia, protein calorie malnutrition, and seizure disorder. The 03/18/2026 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent on eating, weighed 188 pounds, and was on a mechanically altered diet. The Comprehensive Care Plan initiated 03/11/2026 documented the resident was at risk for functional decline in self-care related to dementia with aphasia (difficulty speaking). Interventions included the resident was dependent on feeding. The undated care instructions documented the resident required 1:1 feeding, was dependent on feeding, and was on a regular ground texture diet. During an observation and interview on 05/11/2026 at 12:18 PM, Resident #46 was in bed being fed by their significant other. They stated they visited the resident every day at lunch because the resident was unable to feed themselves. During an observation on 05/12/2026 at 1:30 PM, Resident #46 was observed in bed being fed by their significant other. During a constant observation on 5/13/2026 starting at 7:26 AM Resident #46 was in bed. At 8:40 AM Certified Nurse Aide #7 entered the resident's room with their breakfast tray, prepared the tray by opening lids and putting straws in liquids. They greeted the resident, said they had breakfast, and would return to feed them. After leaving the tray on a table at the foot of the bed they passed trays from a green cart they were pushing from room to room. Certified Nurse Aide #7 did not return to the resident's room to feed the resident. At 9:09 AM Certified Nurse Aide #8 pushed a green cart from room to room placing finished breakfast trays in the cart. Outside of Resident #46's room they asked Certified Nurse Aide #15 if anyone fed the resident. Certified Nurse #15 stated Certified Nurse Aide #7 fed the resident. Certified Nurse Aide #8 entered the room, took the resident's uneaten tray and placed it on the green cart with other trays. During an observation and interview on 05/14/2026 at 9:07 AM, Certified Nurse Aide #6 entered Resident #46 room. At 9:14 AM they were observed leaving the room with the residents' breakfast tray. The items on the resident's tray were untouched. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Certified Nurse Aide #6 stated the resident refused to open their mouth when they attempted to feed the resident. The resident did not eat anything on their breakfast tray There was no documented evidence on the Certified Nurse Aide survey report for May 2026 the resident was fed: -05/12/2026 7-3 shift -05/13/2026 7-3 or 3-11 shift -05/14/2026 3-11 shift During an interview on 05/15/2026 at 1:45 PM, Licensed Practical Nurse #21 stated Resident #46 was 1:1 for meals because they were unable to feed themselves. When the certified nurse aide was done feeding the resident, they documented the percentage of food the resident consumed in the electronic medical record. If there was no documentation in the electronic medical record for meal intake, they would not know what percentage of the meal was consumed. If a resident did not eat, they should be offered something from the refrigerator stocked with sandwiches and juice. The certified nurse aide should notify the nurse, who should document a progress note. They were not notified Resident #46 refused any meals. During an interview on 05/18/2026 at 12:15 PM, Certified Nurse Aide #7 stated if a resident refused to eat, they notified the licensed practical nurse and the nurse document in the progress note. Resident #46 required 1:1 assistance when being fed and they were not fed on 05/13/2026 because they dropped the tray off and prepared the tray for the resident. They had to pass trays for the remaining residents, so food was not cold. They got busy, thought another staff member fed the resident, and never returned to Resident #46 to feed them. During an interview on 05/19/2026 at 9:33 AM, Certified Nurse Aide #6 stated they were responsible for feeding residents. When a resent refused a meal, they reapproached the resident later in the day. If they continued to refuse, they notified the nurse on the medication cart. Resident #46 refused their breakfast on 05/14/2026 and they reapproached the resident later in the morning when the yogurt arrived in the unit. They did not notify the nurse because the resident had refused meals in the past, so they were aware the resident refused meals. They should notify the nurse every time the resident refused meals to ensure the resident was getting the nutrients and calories they needed and were not losing weight. During an interview on 05/19/2026 at 10:34 AM, Dietitian #5 stated occupational therapy determined the level of assistance each resident required, and nursing documented the recommendation in the care plan. When a resident was 1:1 for feeding they expected staff to sit with the resident and feed them. When a resident refused a meal, they should be reapproached and the nurse on duty should be notified. When the meal intake percentage was not documented in the electronic medical record, they relied on the certified nurse aides to recall the meal intake percentage. During an interview on 05/19/2026 at 2:03 PM, Unit Manager #35 stated when a resident required 1:1 assistance with meals they expected staff to be with the resident and feed the resident. Resident #46 could not feed themselves and was dependent on for eating. When a resident refused a meal, they should be offered an alternative, and the refusal should be reported to the nurse. The certified nurse aides documented the percentage of food and fluids consumed in the electronic medical record. They (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	looked in the electronic medical record for Resident #46 and stated they could not say how much the resident ate on 05/08/20206, 05/09/2025, or 05/13/2026 as there was no intake documented on those days and on many other days there was only one or two meals documented. They expected the resident to be fed as soon as the tray entered the room. Staff should not leave the tray in the room to pass trays to other residents. 10 New York Code Rules and Regulations 415.12(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews (iQIES Intakes 2747995, 2961519, 2976530), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for one of 12 residents (Resident #56) reviewed. Specifically, Resident #56 had a fall that was not immediately reported, and diagnostic imaging was not completed as ordered to rule out fracture. Findings include:The facility policy Change in a Resident's Condition or Status, last reviewed 01/2026, documented the facility notified the resident, attending physician, and resident representative of changes in the resident's medical condition and/or status including an accident or incident that involved the resident.The facility policy Lab and Diagnostic Test Results-Clinical Protocol, reviewed 01/2026, documented the physician identified and ordered diagnostic testing based on diagnostic and monitoring needs. Staff processed test requisitions and arranged tests. The nurse reviewed and communicated to the physician all results. The facility policy Communication Policy-Nursing to Provider, revised 01/2026 documented the facility maintained a process for communication between nursing staff and providers regarding resident's changes, treatment needs, orders, and follow up care. Communication was timely, documented and supported continuity of care. Resident #56 had diagnoses including dementia, difficulty walking or moving around, and muscle weakness. The 10/13/2025 Minimum Data Set assessment (a health status assessment tool) documented the resident had moderately impaired cognition, required supervision with bed mobility and transfers, and did not have any falls. The comprehensive care plan initiated 08/12/2025 and revised 01/19/2026 documented the resident was at risk for falls related to abnormalities of gait and mobility. Interventions included anticipate needs; call light within reach and use was encouraged; and bed was in lowest position. On 12/19/2025 the resident had an actual unwitnessed fall, and additional interventions included enabler bars were placed, and a bariatric (large size) bed was requested. The 12/19/2025 at 2:48 PM Fall Incident Report initiated by Registered Nurse Unit Manager #9 documented the resident's spouse received a telephone call from the resident they fell at approximately 10:45 PM the prior evening. Immediate actions included nurse and medical doctor assessments, placement of enabler bars, and staff were educated. The resident had three bruised areas to the left rib cage/ abdomen area. The conclusion of the investigation by Assistant Director of Nursing #30 was that the resident had an unwitnessed fall the night before. There was an undated or signed handwritten statement by Certified Nurse Aide #43 documenting they witnessed the resident slip out of bed. There was education on fall reporting with Certified Nurse Aide's #43 name at the top of the posttest. There was no documented evidence Certified Nurse Aide #43 reported the resident's fall on 12/18/2025 or the resident was assessed by a qualified individual immediately after the fall. The 12/19/2025 at 3:01 PM, Registered Nurse Unit Manager #9 progress note documented the resident reported that day they fell out of bed on 12/18/2025 at 10:45 PM. Upon skin check the resident had bruising to the left rib area. The resident requested a larger bed with enabler bars. The medical provider and physical therapy were made aware. The 12/19/2025 at 2:47 PM Physician #53 progress note documented the resident was seen for follow up after a fall. The resident had an unwitnessed fall last night when rolling in bed to change position. The resident struck their chest and sustained three bruises to the left lower chest, the resident denied head strike and was not on anticoagulation. The plan was for a chest x-ray to exclude rib fracture and Tylenol 500 milligrams 3 times daily for 3 days. The 12/19/2025 Physician #53 order documented a diagnostic test for ribs-bilateral with chest x-ray one time only. The order was discontinued and removed on 12/19/2025. There was no documented evidence that an x-ray was completed to rule out rib fracture, or that the diagnostic testing was no longer needed. During a telephone interview on 05/14/2026 at 11:47 AM, Certified Nurse Aide #43 stated if a resident falls, they were supposed to notify a nurse or supervisor right away. They did not recall Resident #56's fall (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 12/18/2025. During a telephone interview on 05/15/2026 at 1:47 AM, Licensed Practical Nurse #54 stated if a certified nurse aide witnessed a fall or found a resident on the floor, they should report it to a nurse or supervisor. The supervisor then completed an incident report, the certified nurse aide completed a statement, and the provider and family were updated. They did not recall if they were notified of Resident #56's fall on 12/18/2025. If they were made aware, they would have documented in a nursing note. During a telephone interview on 05/18/2026 at 1:09 PM, Assistant Director of Nursing #52 stated in 12/2025 they were a supervisor for the evening shift. If they were notified of a resident fall, they completed an assessment. If there were any injuries, they called the physician and the family and documented in the electronic record. They did not recall if they were notified of Resident #56's fall on 12/18/2025. If there were no documented progress notes, it meant they were not notified. During an interview on 05/18/2026 at 1:38 PM, Registered Nurse Unit Manager #9 stated in the event of a fall the certified nurse aide notified a nurse. A registered nurse and a provider assessed the resident. A certified nurse aide needed to report the fall because it was not in their scope to determine if there were any injuries. Family was also notified. If a provider wanted an x-ray there was an order and the order went directly to the imaging company. They completed an incident/accident report for Resident #56 on 12/19/2025. The resident self-reported a fall to their spouse who then notified them. Physician #53's note indicated they wanted an x-ray. They did not see the order or the results of the x-ray. After the fall, they updated the resident's care plan to include enabler bars. If statements were obtained, the Assistant Director of Nursing #30 would have them. During a telephone interview on 05/19/2026 at 11:37 AM, Physician #53 stated they no longer worked at the facility. They did not recall Resident #56's fall, but if there was bruising to the left ribcage and pain, they would have ordered an x-ray to rule out fracture. If they ordered an x-ray they told the registered nurse manager. Results were followed up after they were listed as pending results in the electronic record. They were on the dashboard and nursing saw pending results as well. This was all discussed in morning meeting. They stated they were responsible for ensuring orders were completed and results were reviewed but they relied on the nurse manager and the Director of Nursing to check if they missed something. During an interview on 05/19/2026 at 1:17 PM, Assistant Director of Nursing #30 stated when Resident #56 fell on [DATE] it was reported to Registered Nurse Unit Manager #9 the next day by the resident's spouse. When nothing was documented in the chart, they initiated the fall protocol. They questioned staff from the night before and Certified Nurse Aide #43 had witnessed the fall and did not report it to a nurse. Certified Nurse Aide #43re-educated, and a statement was obtained. The statement should have had a date and signature so there was proof of who was spoken to and the date they did so. During a follow up telephone interview on 05/19/2026 at 1:47 PM, Certified Nurse Aide #43 stated they now remembered Resident #56's fall. They helped the resident back into bed. The resident's spouse called the unit about the fall and then nursing questioned them about what happened. They stated the night was busy, and they forgot to report the fall to anyone. They did not recall being re-educated. 10 New York Codes, Rules, and Regulations 415.12

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations and interviews, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for two (2) of two (2) test trays (05/13/2026 breakfast meal and 05/19/2026 lunch meal). Specifically, food was not served at palatable and appetizing temperatures during the breakfast meal on 05/13/2026 and lunch meal on 05/19/2026.Findings include: The facility policy Dining and Meal Service Policy and Procedure, dated 04/19/2026, documented individuals would be provided with nourishing, palatable, attractive meals that meet daily nutritional and special dietary needs. The facility policy Food Temperature and Test Tray Audits Policy and Procedure, dated 04/19/2026, documented hot food would be served at 135 degrees Fahrenheit or above, cold beverages and puddings would be served at 55 degrees Fahrenheit or below, and milk or milk products would be served at 45 degrees Fahrenheit or below. During an observation on 05/13/2026 at 8:45 AM, Resident #154's meal tray was tested, and a replacement was provided. Food temperatures were measured as follows: eggs (not listed on ticket) were 106.9 degrees Fahrenheit, breakfast sausage was114.6 degrees Fahrenheit, milk was 48.2 degrees Fahrenheit, and cinnamon oatmeal was 97 degrees Fahrenheit. All food was served on paper plates and coffee was missing from the tray. The eggs were cold, and the oatmeal was cold and pasty. During an interview on 05/13/2026 at 11:00 AM, Food Service Director #58 stated they used to get complaints of cold food but that resolved when they started using the new delivery carts last week. The dietitian did test trays a few times a week and checked tray temperatures on the floor but did not taste or evaluate the food. During an interview on 05/14/2026 at 10:27 AM, Licensed Practical Nurse #38 stated residents complained the food did not taste good, was tough, or was cold. During an interview on 05/18/2026 at 11:42 AM, Registered Nurse Unit Manager #35 stated some residents complained about the food; it did not taste good and was cold. During a lunch meal observation on 05/19/2026 at 11:49 AM, Resident #51's meal tray was tested in the presence of Certified Nurse Aide #7, and a replacement was provided. The super pudding was 66.7 degrees Fahrenheit, brown sugar glazed ham was 112.3 degrees Fahrenheit, candied yams was 132.4 degrees Fahrenheit, and green beans was 122.4 degrees Fahrenheit. All food was served on paper plates. During an interview on 05/19/2026 at 12:51 PM, Food Service Director #58 stated the temperature range of food items was not sufficient. The milk and pudding should not have been served above 40 degrees Fahrenheit, and the hot food should have been at least 135 degrees Fahrenheit. They felt the low temperatures for hot foods were due to using paper plates for dining. 10 New York Codes, Rules and Regulations 415.14(d)(1)(2)