

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/30/2026
NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nursing at Barnwell		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interviews and record review, the facility failed to ensure residents were free from abuse, neglect, misappropriation of resident property and exploitation for one out of three residents reviewed for abuse. Specifically, the Facility Incident Report documented on 05/26/2026, Resident #1 became combative during the provision of care and Resident #1 struck Certified Nurse Aide #1 in the face. Certified Nurse Aide #2 reported that Certified Nurse Aide #1 then struck Resident #1 in the face in response. Care continued to be provided to the resident, and it was documented the resident had a bloody nose. The resident was not reapproached or redirected after striking Certified Nurse Aide #1. This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. Findings include: Facility policy titled Abuse-Prohibition Protocol, Types of Abuse/Reporting last reviewed 01/2026 documented every resident had the right to be free from abuse, mistreatment, neglect, misappropriation of property and to be free from abuse facilitated or caused by the facility's staff. All personnel must attempt to immediately stop the abuse, then promptly report any incident or suspected incident of resident abuse. Regular in-service training and education would include working with difficult and abusive residents. Emotional and psychological abuse was defined as the infliction of anguish, pain, or distress through verbal or nonverbal acts. Signs and symptoms included being emotionally upset or agitated. Facility policy titled Behavioral Assessment, Intervention and Monitoring, last revised 01/2022, documented interventions will be individualized and part of an overall care environment that supports physical, functional, and psychosocial needs, and strives to understand, prevent, or relieve the resident's distress or loss of abilities. Resident #1 was admitted to the facility with diagnoses of Alzheimer's disease (a progressive, irreversible brain disorder and the most common cause of dementia), neurocognitive disorder with Lewy bodies (a progressive brain disorder caused by the abnormal buildup of proteins in the brain), and atrial fibrillation (common, irregular heart rhythm where the heart's upper chambers beat chaotically). The Minimum Data Set (a resident assessment tool) dated 03/27/2026 documented the resident was usually understood, sometimes understood others, and was severely cognitively impaired. Comprehensive Care Plan with focus refuses medications/treatments/blood tests/consultations, activities of daily living care, out of bed initiated 03/03/2026 documented as an intervention: reapproach, offer alternative choices. Comprehensive Care Plan with focus, Resident exhibits behavior symptoms such as socially inappropriate/verbally aggressive/abusive; physically aggressive/abusive, irritability and anger initiated 01/29/2026 documented as an intervention: redirect negative behavior as needed. Facility incident report documented on 05/26/2026 at approximately 9:05 AM, Certified Nurse Aide #2 reported to Assistant Director of Nursing #1 an allegation of staff abuse involving a resident. Certified Nurse Aide #2 reported they were providing care to Resident #1 with Certified Nurse Aide #1. During the provision of care, Resident #1 became combative and struck Certified Nurse Aide #1. They stated Certified Nurse Aide #1 then struck Resident #1 in the face in response. Per the facility investigative report, Certified Nurse Aide #1 acknowledged Resident #1 struck them during care and they denied striking the resident back. Certified Nurse Aide #1 stated they continued to provide care as usual to Resident #1 after the incident. Certified Nurse Aide #1 reported Resident #1 had a bloody nose, but (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 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	they did not know the cause of the bloody nose. Pending the outcome of the investigation, Certified Nurse Aide #1 was placed on indefinite suspension. Witness statement from Certified Nurse Aide #2 dated 05/26/2026 documented at 6:30 AM, they asked Certified Nurse Aide #1 to assist them with getting Resident #1 out of bed and warned Certified Nurse Aide #1 the resident was combative and would swing. The resident ended up swinging; they hit Certified Nurse Aide #1 in the face and Certified Nurse Aide #1 swung back at the resident in the face and Resident #1 had a bloody nose for about 30 seconds. Witness statement from Certified Nurse Aide #1 dated 05/26/2026 documented at 6:00 AM that day, Certified Nurse Aide #2 asked them for help with providing care for Resident #1. Both certified nurse aides were attempting to change the resident and Certified Nurse Aide #2 warned Certified Nurse Aide #1 the resident may swing so they should be careful. As they were rolling the resident towards Certified Nurse Aide #2, the resident threw their left hand up which hit Certified Nurse Aide #1 in the face, causing their glasses to fall off their face. They stated Certified Nurse Aide #2 handed their glasses back to them, and they continued to provide care to Resident #1. Certified Nurse Aide #2 asked Certified Nurse Aide #1 if they needed a break and they stated they did not need a break and should continue to provide care to Resident #1. They continued to clean the resident and get them dressed. When they transferred the resident into a wheelchair, they noticed Resident #1's right nostril was bleeding. Witness statement of events documented by Assistant Director of Nursing #1 on 05/26/2026 collected during a phone interview (time unknown) with Certified Nurse Aide #1 documented after Certified Nurse Aide #2 handed them their glasses, they continued to change the resident. They transferred the resident to a wheelchair and that was tough as Resident #1 was holding onto the certified nurse aides and they struggled to sit in the wheelchair. Resident #1's nose started to bleed after being transferred into the wheelchair. Nursing Progress Note dated 05/26/2026 at 1:56 PM by Assistant Director of Nursing #1 documented Resident #1 was reportedly involved in an altercation with a certified nurse aide during the 11:00 PM to 7:00 AM shift. Small amount of dried blood noted to Resident #1's right nostril. New orders were received to obtain facial x-rays. Resident #1's family and sheriff's office were notified. During a telephone interview on 06/29/2026 at 11:33 AM, Certified Nurse Aide #2 stated if a resident was being aggressive or combative during care, if the resident could be left in a safe setting, they would reapproach the situation. They stated on the day of this incident; they told Certified Nurse Aide #1 to be careful when providing care as the resident will punch somebody. They stated Resident #1 punched Certified Nurse Aide #1 and then Certified Nurse Aide #1 hit Resident #1. Certified Nurse Aide #2 stated to Certified Nurse Aide #1 they could come back and reapproach the resident, but Certified Nurse Aide #1 said No, let's get it done and over with. During a telephone interview on 06/29/2026 at 1:00 PM, Director of Nursing #1 stated when handling a resident that may be combative or aggressive, certified nurse aides were expected to use deescalating techniques which included speaking to the resident in a calm manner, explaining what they were doing and why they were doing it, and to use redirection and other things they knew would calm the resident down. If a resident was at harm to their self or others, certified nurse aides should call for help. In this instance there were two certified nurse aides providing care to Resident #1. They would expect one aide to step out and let a nurse know the resident was having behaviors. During a telephone interview on 06/30/2026 at 3:32 PM, Administrator #1 stated during orientation, staff received behavioral and mental health training in which appropriate interventions used with residents who were combative/aggressive were discussed. Interventions needed to be resident specific. Certified nurse aides should not be alone if they were providing care for a resident with a history of combative or aggressive behavior. If a resident was exhibiting combative or aggressive behavior during care, the certified nurse aide should step out of the situation and reapproach the resident. They should not continue providing care to the resident if the resident was being combative or aggressive. 10 New York Code, 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. Based on record reviews and interviews, the facility failed to ensure that all allegations of abuse or neglect were reported immediately to the facility administrator. Specifically, Certified Nurse Aide #2 stated they witnessed Certified Nurse Aide #1 strike Resident #1 in the face and did not report it until two and a half hours later. The findings include: Resident #1 Resident #1 was admitted to the facility with diagnoses of Alzheimer's disease (a progressive, irreversible brain disorder and the most common cause of dementia), neurocognitive disorder with Lewy bodies (a progressive brain disorder caused by the abnormal buildup of proteins in the brain), and atrial fibrillation (common, irregular heart rhythm where the heart's upper chambers beat chaotically). The Minimum Data Set (an assessment tool) dated 03/27/2026 documented the resident was usually understood, sometimes understood others, and was severely cognitively impaired. The policy and procedure titled Abuse - Prohibition, Protocol, Type of Abuse, Response/Reporting, last reviewed 01/2026, stated persons observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to their immediate supervisor or administrative staff. The Progress Note dated 05/26/2026 at 1:56 PM documented that Assistant Director of Nursing #1 was informed of an altercation between Resident #1 and Certified Nurse Aide #1 during the overnight (11:00 PM to 7:00 AM) shift at 09:10 AM. They then informed the family, medical provider, and started an investigation. In the Incident and Accident Statement Form Witness Statement dated 05/26/2026. Certified Nurse Aide #2 documented they had witnessed abuse at 06:30 AM and did not report it until 09:10 AM to Assistant Director of Nursing #1. During an interview on 06/03/2026 at 12:07 PM, Certified Nurse Aide #2 stated they did not want to report it to the shift supervisor because of an incident they knew of that happened at another facility, so they waited for Assistant Director of Nursing #1 to come in. During an interview on 06/03/2026 at 01:28 PM, Director of Nursing #1 stated the incident should have been reported immediately. They stated education on abuse and abuse reporting was given to all employees upon hire and annually. Past non-compliance has been identified for F609. Findings include facility education on abuse and abuse reporting that began on 05/26/2026 and completed on 06/01/2026. This education was provided to approximately 200 employees all employees of the facility. 10 New York Codes, Rules, and Regulations 415.4 (b) (4)		