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

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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observations, record review, and interviews, the facility failed to ensure correct installation, use, and maintenance of bed rails (side rails, safety rails, grab bars, assist bars, enabler bars) to ensure there was no gap between the bed rail and mattress wide enough to entrap a resident's head or body for four of four residents (Residents #3, #10, #12, #101, and #112) reviewed. Specifically, Resident #10's bed rail failed the entrapment zone test in Zone 3 (space between the mattress and the bed rail); Resident #101's bed rail failed the entrapment zone test in Zone 1 (space within the bed rail itself); and Residents #3, #10, #12, #101, and #112 did not have routine inspections of their mattress and/or bed rails for areas of possible entrapment. The facility did not evaluate alternatives to bed rails, failed to review the risks and benefits of bed rails with the residents or resident representatives, and failed to obtain informed consent prior to the installation of bed rails. This resulted in no actual harm with likelihood of serious harm, serious injury, serious impairment, or death that is Immediate Jeopardy and Substandard Quality of Care for all 77 residents with bed rails.Findings include: The facility policy and procedure Proper use of Side Rails, revised 01/2026 documented side rails were only used to treat a resident's medical symptoms or to assist with mobility and transfer of residents. An assessment was made to determine the residents' symptoms, risk of entrapment and reason for using side rails. When used for mobility of transfer, an assessment included a review of the resident's bed mobility, ability to change positions, transfer to and from bed or chair, and to stand and toilet; and risk of entrapment from the use of side rails and the bed's dimensions are appropriate for the resident's size and weight. Consent for the use of restrictive device was obtained from the resident or legal representative and less restrictive interventions were incorporated in care planning. Risk and benefits were considered for each resident and consent for side rail use was obtained from the resident or legal representative, after potential benefits and risks were presented. Manufacturer instructions for the operation of side rails were adhered to. Residents were checked periodically for safety related to side rail use and the facility assessed the space between the mattress and side rails to reduce risk for entrapment. The 2006 United States Food and Drug Administration Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment documented dimensional limits for entrapment in Zones 1-4 to reduce the risk for entrapment. Zone 1 was any open space within the perimeter of the rail. Openings in the rail should be small enough to prevent the head from entering. A loosened bar or rail can change the size of the space; the recommended space was less than 120 millimeters, representing head breadth. Zone 3 was the space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail, and the degree of play from loosened rails. The recommendations were for a dimension of less than 4 3/4 inches because the head was presumed to enter the space before the neck.During observations on 05/13/2026 between 9:42 AM and 10:30 AM, bed entrapment zones were measured as identified by the United States Food and Drug Administration Hospital Bed Safety Workgroup Clinical Guidance for the (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 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Assessment and Implementation of Bed Rails in Hospitals, Long Term Care Facilities, and Home Care Settings using the facility's bed system measurement tool. A total of five beds were sampled (Residents #3, #10, #12, #101, and #112). One bed was out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail should be no greater than 4 and 3/4 inches) and one bed was out of compliance with Zone 1 entrapment guidelines (the perimeter of the side rail with a space less than 120 millimeters). During observations and record review on 05/14/2026, 77 residents had bed rails on their beds.1) Resident #10 had diagnoses including fractured vertebrae and hemiplegia (paralysis on one side of the body). The 03/06/2026 Minimum Data Set (a resident assessment tool) documented the resident had moderate cognitive impairment, required supervision for rolling, partial to substantial assistance for all other transfers and mobility, had two or more falls since last admission, and did not use side rails.The comprehensive care plan, initiated 12/19/2025 and revised 03/25/2026, documented Resident #10 had an actual fall related to cognitive deficits and gait/balance problems. Interventions included the bed against the wall on the right side and side rails placed to the left side of the bed. There was no documented evidence of a physician order for the use of side rails; physical therapy assessments to determine how the resident used side rails; if alternatives to a bed rail were attempted; a side rail assessment was completed prior to installation; risks and benefits of the side rails were explained to the resident or their representative; consent was obtained prior to side rail installation; or of ongoing monitoring of entrapment zones.During an observation on 05/11/2026 at 4:11 PM, Resident #10 was not in their room. The resident's bed was not against the wall, there was one side rail on the right side of the bed, and a border mattress (elevated edges) in place. There was a large gap between the mattress and the side rail. During an observation and on 05/13/2026 at 9:42 AM, the resident's bed had a side rail on the right side and a border mattress in place. The Director of Maintenance and the Director of Rehabilitation measured entrapment zones with the facility side rail measuring tool as outlined in the Food and Drug Administration guidelines. The bed and side rail were out of compliance with Zone 3 entrapment guidelines (the space between the mattress and the side rail was greater than 4 3/4 inches). 2) Resident #101 had diagnoses including Alzheimer's disease and history of falls. The 02/26/2026 Minimum Data Set documented the resident had severe cognitive impairment, required partial to substantial assistance for most transfers and mobility, and did not use a bed rail.The Comprehensive Care Plan, initiated 01/06/2026 and revised 03/06/2026, documented Resident #101 had an actual fall related to limited mobility, gait/balance issues, poor safety awareness, history of falls and cognitive impairment. Interventions included the bed against the wall with side rails for bed mobility. There was no documented evidence that alternatives to a bed rail were attempted; a bed rail assessment was completed prior to bed rail installation; risks and benefits of the bed rails were explained to the resident or their representative; consent was obtained prior to bed rail installation; and of ongoing monitoring of entrapment zones. During an observation and interview on 05/11/2026 at 3:09 PM, Resident #101's bed had a side rail on the right side with a large gap between the top of the rail and the top of the mattress. The resident stated they used the rail to pull themselves up and to get out of bed. During an observation on 05/13/2026 at 10:30 AM, Resident #101's bed had a side rail on the right side of the bed. The Director of Maintenance and the Director of Rehabilitation measured entrapment zones with the facility side rail measuring tool as outlined in the Food and Drug Administration guidelines. The bed was out of compliance with Zone 1 entrapment guidelines (Zone 1 within the rail itself, was greater than 4 3/4 inches). 3) Resident #3 had diagnoses including paraplegia (inability to control/move lower parts of the body), lack of coordination, and muscle weakness. The 03/18/2026 Minimum Data Set documented the resident had intact cognition, was dependent or required substantial/maximal assistance for most transfers and mobility and did not have side rails. The 03/12/2026 Comprehensive Care Plan, revised 04/20/2026, documented the resident was at risk for functional decline in mobility and self-care related to polyneuropathy (nerve damage), chronic kidney disease, and wounds. Interventions included side rails to assist with turning (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and positioning in bed and engage, encourage, educate and regularly assess the resident's ability to use call bell and appropriate assistive/adaptive devices to improve, maintain, and reduce risk of decline in function, injury and falls. There was no documented evidence of a physician order for the use of side rails; physical therapy assessments to determine how the resident used side rails; if alternatives to a bed rail were attempted; a side rail assessment was completed prior to installation; risks and benefits of the side rails were explained to the resident or their representative; consent was obtained prior to side rail installation; or of ongoing monitoring of entrapment zones. During an observation on 05/11/2026 at 3:15 PM, Resident #3 was in their chair and bilateral side rails were on their bed. They stated the bars were too high up on the bed for them to use to help with bed mobility. During an interview on 05/13/2026 at 9:42 AM, the Director of Rehabilitation stated side rails could not be more than 4 3/4 inches away from the mattress. Resident #10's bed failed Zone 3 entrapment guidelines, using the side rail measuring tool. They were unsure when the resident had an assessment with therapy for side rails as the resident had not been taking part in physical therapy for a while. They were unsure how often resident assessments or side rail assessments needed to be done. They were unsure if they needed to get consent for side rails but believed that they had never gotten one. Side rail use was placed in the care plan, and the provider had to be okay with putting them on. They were not sure if side rails required an order. The therapy department identified where side rails were in the building quarterly, but did not perform risk assessments for them. To place them on beds, an email or maintenance ticket was placed and maintenance attached the bar to the bed. They were unsure if maintenance assessed the risk of entrapment. During an interview on 05/13/2026 at 9:45 AM, the Director of Maintenance stated they installed the side rails on the beds. They get an email or a maintenance request and then attach side rails to the bed. They never conducted an entrapment assessment on any of the beds that had side rails on them. They were not sure how to perform the assessment or how to use the side rail measuring tool. During an interview on 05/13/2026 at 4:06 PM, Registered Nurse Unit Manager #20 stated when a resident wanted a side rail, physical therapy assessed the resident. If therapy felt it was beneficial, they would let the provider know. They stated they did not know if maintenance or therapy placed the side rails on the bed. If they noticed a resident was no longer using the side rail or if they thought the resident would benefit from a side rail, they placed a referral for physical therapy. There were no routine assessments, just occasional changes. Side rails were used to help residents with independence and increase mobility. They were not sure what other interventions there were to help with bed mobility. They believed that side rails needed a provider order and were unsure if consents were needed. Risks of side rails included the resident sliding, getting hurt, getting pinched, the side rail unscrewing and the resident falling. They were not sure if maintenance performed any checks on the side rails. During a follow up interview on 05/13/2026 at 4:17 PM, the Director of Maintenance stated no side rail was placed on a bed without rehabilitation's approval. Therapy placed a work order with a specific side rail type, but would take any bar that was available and attach it to the bed the resident was in. The side rails were bolted on. The side rails they had available would not be able to fit every bed. Not all side rails were universal to fit all beds. Beds were checked once a year to ensure the bar was tight, but they did not do any assessments with the side rail measuring tool to identify entrapment zones. They never checked beds for risk for entrapment. During a follow up interview on 05/13/2026 at 4:44 PM, the Director of Rehabilitation stated they did not know where side rail assessments were documented. When they were asked by nursing to assess a resident for side rails, it should be in a physical therapy screen. When requested by rehabilitation, maintenance would put the side rail on the bed. They were unaware of other interventions for bed mobility other than a trapeze bar for paraplegic residents. They tried to educate residents to become confident to go without side rails on their bed. They stated they decided what side rail was needed by resident weight, if they needed a regular side rail or a bariatric side rail. If maintenance could not get the side rail to attach to the bed, they let therapy know, but that has not happened in a while. They did not know if risks and benefits of side rails were discussed with (continued on next page)

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F 0700 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	residents or resident representatives or where it would be documented. During an interview on 05/13/2026 at 5:58 PM, the Director of Nursing stated therapy saw all residents on admission and anyone who they deemed needed a side rail was discussed at their morning interdisciplinary team meeting. Physical therapy performed quarterly assessments or as needed with referrals or change in condition. Therapy determined the need for a side rail, but if they thought something else would help mobility, they tried that intervention first. Some residents asked for side rails for peace of mind. They needed approval from a provider for side rails. They would have a discussion with the resident or resident representative about side rails, but consents were never obtained. Side rails were added to resident care plans and were used as a fall intervention if they determined a fall happened because the resident was trying to move around in bed. Maintenance attached side rails to the bed. They stated they believed risk for entrapment assessments were done on admission. During an interview on 05/13/2026 at 10:11 AM, the Administrator stated they were not aware beds were not assessed for risk of entrapment. They stated they just found out beds were supposed to be checked regularly and residents required assessments regularly. They stated this was new territory for them. During a follow up interview on 05/13/2026 at 4:02 PM, Administrator stated side rail referrals were sent to rehabilitation for maneuvering issues. Rehabilitation evaluated for appropriateness and nursing was made aware to get a provider order and update the care plan. They were unsure how therapy determined other appropriate interventions prior to using side rails. The side rails and beds were not audited, and they were not aware of the measuring device or its use until 05/13/2026 when the beds were measured.During an interview on 05/14/2026 at 10:56 AM, Nurse Practitioner #22 stated they did not know that side rails required assessments, a provider order, and consents. They were never asked to place a side rail order. They stated they did not know the risks associated with side rails. Side rails should be used by cognitively intact residents working with physical therapy/occupational therapy for bed mobility. They believed a resident with cognitive impairment had poor safety awareness and could get a body part stuck in the rail. There was a possibility for significant risk or death. Repeated efforts were made to contact the Medical Director on 05/14/2026, but a response was not received. 10 New York Code Rules and Regulations 415.12(h)(1)(2)**********The facility was notified of the Immediate Jeopardy on 05/14/2026 at 12:00 PM. The Immediate Jeopardy was removed on 05/15/2026 prior to the completion of the survey.The facility implemented the following to remove the immediacy:- The facility removed all bed rails from resident beds, except for two residents who refused to have them removed. They provided proof of risk of entrapment assessment, an assessment from physical therapy and a consent that included a discussion of the risk versus benefit. - The facility provided in-service education to 100% of staff as of 05/14/2026 at 9:01 AM, with plans for ongoing education of staff prior to the start of their next shift for those not currently on the schedule.- The survey team interviewed 19 staff members from various disciplines. All staff demonstrated knowledge of the education provided regarding bed rails.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and interviews, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety and to prevent an outbreak of food borne illness in one (1) of one (1) main kitchen. Specifically, the 3-bay sink chemical sanitizer concentration was not within manufacturer range and subsequently the Food Service Director did not monitor chemical sanitizing; Dietary Aide #32 was reusing trays and plate covers without sanitizing them; Cooks #55 and #56 improperly cooled potentially hazardous food on the kitchen counter; Dietary Aide #57 stacked pans that were not air dried; and there were unlabeled items and staff food in the kitchen reach in refrigerator. Findings include:The facility policy Temperatures Cooking and Cooling, revised 04/2024, documented food would be cooled from 140 degrees Fahrenheit to 70 degrees Fahrenheit within 2 hours. Acceptable and safe cooling methods were ice bath, ice paddle, dividing food into small and shallow pans placed in the refrigerator, or in a blast chiller. The undated facility policy Dishwashing Down, documented when the dish machine was down, no tray, pan, or food contact surface would be reused until it was properly sanitized and air dried. The facility policy Foodborne Illnesses, revised 01/2025, documented potentially hazardous foods included meat and eggs, and leading cause of foodborne illness was improperly cooled foods. The facility policy HACCP (Hazard Analysis Critical Control Points) Guidelines for Food Safety, updated 01/2025, documented food must be cooled rapidly to 41 degrees Fahrenheit by dividing into small, shallow pans in an ice bath or refrigerate on the top shelf and stir every 15 minutes to 60 minutes. Food Storage During an observation and interview on 05/11/2026 at 11:49 AM, the reach-in refrigerator on the cookline was 47 degrees Fahrenheit and contained a pan of unlabeled and undated rice for resident consumption. There were several staff food items. The Food Service Director stated it was not an issue to combine staff and resident food in the refrigerator if staff food was limited to a certain shelf. During an observation on 05/13/2026 at 9:50 AM, the reach-in refrigerator on the cook line contained several resident food items and a staff member's partially consumed soda on the same shelf. During an interview on 5/18/26 at 12:50 PM, the Food Service Director stated they did not use the reach in refrigerator on the cook line for resident food because they did not trust the temperature of it, and it was used for staff food only. They did not realize it was used for residents' food, but it was not an issue to mix the two if staff food was only in one corner. Sanitation The April 2026 and May 2026 Dish Machine Ware Washing Log documented the dish machine was working through dinner on 04/30/2026 and was out of order on 05/01/2026 at breakfast. During an observation and interview in the main kitchen on 05/12/2026 at 10:50 AM, Dietary Aide #32 sprayed down the dirty breakfast trays and plate covers with the hose in the dish machine area. They wiped them off with a cloth that was sitting in a metal bowl containing brown water. No suds were visible in the water. They stated the bowl contained soapy water. No sanitizer was present in the area. They stacked the trays and plate lids upright on a cart after wiping them off and brought them to the tray line for use at lunch. During an observation and interview on 05/12/26 at 11:56 AM, Dietary Aide #57 was washing pots and pans at the 3-bay sink. They stated they did not wash any trays, or insulated plate covers that day, only pots. Those were usually cleaned in the dish washer, which was broken. They stated staff were cleaning them in the dishwasher area still. During an interview on 05/12/2026 at 12:03 PM, the Food Service Director stated the dish machine had been down for about 2 weeks because it was not heating correctly, and parts would arrive that day. They were washing the trays and plate covers by spraying them with cold water, washing with detergent, then soaking in a bucket of sanitizer. The correct method for washing them when the dish machine was down was in the 3-bay sink by washing, sanitizing, then drying them on a rack. They were not using any adaptive equipment currently because they could not properly sanitize them without hot water. The unit staff were washing the adaptive mugs and lids up on the units but did not know how or what they were using to do that. They could (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not be sure the mugs and lids had been properly washed or sanitized. The dishwasher was reported to maintenance and the Administrator at the time it broke. During an interview on 05/12/2026 at 12:16 PM, Maintenance Secretary #59 stated they were notified by electronic mail that the dishwasher went out of service on 04/22/2026 and shared the information with the Administrator. During an interview on 05/12/2026 at 12:23 PM, the Administrator stated the vendor received their check and would be in by tomorrow with the parts to complete the dishwasher repair. They came in a couple weeks ago, but the parts were not available yet. They did not notify the Department of Health of the dishwasher being down because they thought it would be a quick repair. The facility was using disposable dishware and followed the normal sanitizing process in the kitchen for trays, plate covers, and pans. They had residents with illnesses that could be transmitted on unclean dishes. There were residents who still received their adaptive feeding equipment as needed. They stated therapy should take all adaptive feeding equipment down to the main kitchen to be adequately cleaned and sanitized. They were not aware the kitchen staff were not properly washing and sanitizing the reused trays and insulated lids. During an interview on 05/12/2026 at 12:29 PM, the Director of Rehabilitation stated they were using a modified built-up grip with residents and wiped them off with a sanitizer wipe. Adaptive mugs with lids were brought back to the therapy department and washed with soap and water in the sink in the bathroom. The process was to let hot water run for 20 seconds then wash with soap and water. During an observation in the main kitchen on 05/12/26 at 2:33 PM, Dietary Aide #32 had three separate bins to clean, rinse, and sanitize the dirty trays and plate covers from lunch. All bins were visibly cloudy and soiled. Dietary Aide #32 placed some visibly soiled lids into the rinse bin, then placed them onto the rack for the next meal without washing or sanitizing them. Stacks of four trays were rinsed at one time, not submerged individually, then stacked together on a rack without air drying. During an observation of the main kitchen 3-bay sink on 05/12/26 at 2:46 PM, the sanitizer concentration measured over 500 parts per million (high). The water was dark red color, and the test strip turned a dark blue. The Food Service Director tested the sanitizer concentration, and it again measured over 500 parts per million. They started to add water to dilute the sanitizer but were unsure how much to add or what the water temperature should be. During an observation and interview on 05/12/26 at 3:58 PM, the 3-bay sink sanitizer measured over 500 parts per million. The Food Service Director stated the acceptable sanitizer level for their product was 200-400 parts per million and 500 parts per million was not acceptable. They used a vendor-maintained dispenser but had to adjust the sanitizer concentration manually. They did not know why, it was just how it was, and they adjusted the strength of sanitizer each time they set up the sanitizer sink. During an interview on 05/13/2026 at 11:00 AM, the Food Service Director stated dishware was sanitized to kill harmful germs, and they were still waiting on a dishwasher part to come in. When the dish machine was down, therapy cleaned the special adaptive mugs and lids in the rehabilitation department. They did not know how or what they were using to do that. They were aware that the facility had Clostridium Difficile (highly contagious spore resistant to many sanitizers) positive residents in the facility but stated the quaternary sanitizer they used in the main kitchen killed that organism. During an observation and interview on 05/13/2026 at 11:08 AM, the following residents required specific adaptive feeding equipment. The equipment was observed on the tray line near the dishware for lunch meal service. -Resident #50: 2-handled mug with lid, plate guard, regular metal silverware (no plastic);-Resident #52: regular silverware (no plastic);-Resident #123: 2-handled mug with lid;-Resident #183: 2-handled mug with lid, built up grip with metal silverware;-Resident #197: 2-handled mug with lid, scoop dish;-Resident #215: 2-handled mugs, built up grip with metal silverware. The Chemical Sanitation Record log had entries 3 times a day for 05/13/2026, 05/14/2026, and 05/15/2026 and then stopped. The log did not record any actual sanitizer concentration results and only recorded the recommended manufacturer range of 200-400 parts per million repeatedly. During an observation and interview on 5/18/26 at 12:50 PM, the Food Service Director stated the 3-bay sanitizer dispenser was serviced 05/13/2026 by the vendor and was sometimes working correctly. The water in the sanitizer bay was (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	bright red and tested over 500 parts per million. They stated sometimes the water was pink in color and tested at 400 parts per million. The chemical level in the sink was too high because the dispenser was still broken, had still to adjust the concentration manually, and the sink was just filled. The sinks were changed at least every 2 hours. During an interview on 05/19/2026 at 9:15 AM Vendor Representative #60 stated they were in the facility on 05/13/2026 and adjusted the sanitizer level in the 3-bay sink to dispense at 400 parts per million. They found it was running at 500 parts per million when they arrived. The facility used Knoxville, which was a quaternary sanitizer and the manufacturers recommendation was 200-400 parts per million concentration. They were coming back to the facility, but it did not make sense the dispensed sanitizer mix was red in color and tested over 500 parts per million one time, then a pink color and tested 400 parts per million another time. Cooling The Cooks Time Temperature Cooling Log documented the date, the food item to be cooled, the time and temperature the cooling process started at, the time and temperature after 2 hours of cooling, and the time and temperature after 4 hours of cooling. None of the entries on the log recorded start times with temperatures and the last entry was 05/12/2026. During an observation and interview on 05/13/2026 at 10:08 AM, four pans of food were sitting on a rack at room temperature and were identified by the Food Service Director as sausage, scrambled eggs, hard boiled eggs, and pureed scrambled eggs left over from the breakfast tray line. They stated their cooling procedure was to pull the food from the tray line and leave it on the rack or counter at room temperature for 2 hours, then check the temperature. If it was 70 degrees Fahrenheit or less, they left it out for 2 more hours and rechecked the temperature. If it was 41 degrees Fahrenheit or less, they put the pan in the refrigerator. They never cooled food in the refrigerator. None of the items were listed on the cooks cooling log and they could not determine exactly when the items were taken off the tray line to start cooling. At 10:50 AM the following temperatures were recorded; -scrambled eggs 84 degrees Fahrenheit;-sausage 129 degrees Fahrenheit;-hard boiled eggs 97.5 degrees Fahrenheit;-pureed scrambled eggs 90.2 degrees Fahrenheit. During an interview on 05/13/2026 at 11:00 AM, the Food Service Director stated the cooks should utilize the cooks cooling log every time they cooled cooked food, including leftovers from the tray line. They did not know why the cooks were not following this, they had been in-serviced on the form, and it could be hazardous to residents and cause foodborne illness if the food did not reach a safe temperature quickly. During an interview on 05/13/2026 at 11:10 AM, [NAME] #55 stated they were only instructed to use the cook cooling log for items they cooked then immediately chilled as part of a recipe, such as the pasta they made for a cold pasta salad. They were never instructed on how the log was supposed to be used, it was just posted on the wall one day without explanation. During an interview on 5/18/26 at 12:50 PM, the Food Service Director stated the current cooling process was the same as last week, they still put leftover food from the steamtable on the rolling cart or the prep table to cool for 2 hours then checked the temperature. If the results were 70 degrees Fahrenheit or less, it was put in the cooler. Their cooling practices were based on facility cooling policies. They used cooling at room temperature despite that method not listed in their cooling policy as an acceptable method because they did not have time for ice baths. During an interview on 05/18/2026 at 3:45 PM, [NAME] #56 stated when cooling food left over from the steam table, they followed the posted policy on the wall by the cook area. They put it on the counter for 2 hours, then checked the temperature. If it was 70 degrees Fahrenheit or higher, they threw it out. 10 New York Codes, Rules and Regulations 415.14(h)

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

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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)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for three (3) of six (6) residents (Residents #2, #5 and #62) reviewed. Specifically, Resident #5's urinary catheter drainage bag was placed directly on the floor; Resident #2 was on enhanced barrier precautions and Licensed Practical Nurse #38 provided medications via a feeding tube without wearing required personal protective equipment; and Resident #62 was on contact precautions for clostridium difficile (a highly infectious bacteria) and Certified Nurse Aide #39 entered and exited their room, removed a food tray wearing only gloves and without performing hand hygiene. Findings include: The facility policy Enhanced Barrier Precautions, last reviewed 01/2026, documented nursing home residents with wounds and indwelling medical devices were at high risk of both acquisition of and colonization of multi-drug-resistant organisms. The use of gowns and gloves were used only for high contact resident care activities; a sign was placed outside the residents' room and was intended to be in place for the duration of the wound or discontinuation of the indwelling device that placed them at a higher risk. High contact resident care activities included device care or use. The facility policy Contact Precautions, last reviewed 01/2026, documented all personnel, including visitors, that had direct contact with a resident on contact precautions were required to follow all procedures outlined in the policy. When precautions were implemented, a sign was placed on the resident's door and remained in place until precaution procedures had been discontinued. The Contact Precaution sign documented that everyone must clean their hands, including before entering, and when leaving the room. Staff must put gloves on before room entry and discard gloves before room exit; put on gown before room entry and discard gown before room exit; and use dedicated or disposable equipment, clean and disinfect reusable equipment before use on another person. 1) Resident #62 had diagnoses including clostridium difficile. The 04/30/2026 Minimum Data Set assessment documented the resident had intact cognition and was not on isolation precautions. The 04/28/2026 Comprehensive Care Plan documented the resident was at risk for infection related to immunocompromise related to multiple myeloma, and history of methicillin resistant staphylococcus aureus and vancomycin-resistant enterococcus. Interventions included educating the resident or significant other regarding proper hand washing and handing of secretions, monitor labs, and monitor vital signs as ordered. The 04/28/2026 physician order documented strict contact precaution/isolation every shift for clostridium difficile, norovirus, vancomycin-resistant enterococcus, and methicillin resistant staphylococcus aureus. The 05/14/2026 Licensed Practical Nurse #38 progress note documented to monitor labs and vital signs, ensure resident safety, medication and treatments as ordered and enforce and follow contact precautions. During an observation and interview on 05/14/2026 at 9:24 AM Certified Nurse Aide #39 exited (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #62's room with a meal tray and did not wear personal protective equipment or perform hand hygiene. Certified Nurse Aide #39 handed the food tray to another certified nurse aide and did not perform hand hygiene with soap and water prior to collecting a food tray from a different resident room. Certified Nurse Aide #39 stated they received infection control training in orientation. The white stop sign on the resident's door meant they had to look at the yellow sign to see what precautions the resident was on. When they performed care, they sometimes had to wear a gown and gloves. They were unsure why Resident #62 was on precautions. They stated they did not have to wear a gown in Resident #62's room because they were just collecting the meal tray and not performing care. During an interview on 05/14/2026 at 10:27 Licensed Practical Nurse #38 stated Resident #62 was on contact precautions for clostridium difficile and norovirus. Staff should wear a gown in the room, even when picking up a meal tray. Any time staff entered a contact or droplet precaution room they had to wear a gown and gloves. The infection control signage should be followed to protect residents and staff from spreading the virus. 2) Resident #2 had diagnoses including a gastrostomy (a feeding tube). The 05/07/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition and had a gastrostomy tube. The 04/10/2026 Comprehensive Care Plan documented the resident had impaired skin integrity related to tube feeding and incontinence of bowel. Interventions included enhanced barrier precautions. The 04/10/2026 physician order documented to maintain enhanced barrier precautions every shift for indwelling medical device. During an observation on 05/13/2026 at 8:15 AM there was a sign outside the room documenting enhanced barrier precautions and to wear gown and gloves when performing resident care. Licensed Practical Nurse #38 checked the resident's gastrostomy tube site, checked for placement and proceeded to administer crushed medications through the gastrostomy tube and did not wear a gown. During an interview on 05/13/2026 at 1:49 PM Licensed Practical Nurse #38 stated Resident #2 was on enhanced barrier precautions and when doing high contact care activities, they had to wear a gown and gloves. Resident #2 had a gastrostomy tube, which meant when administering medication through the tube a gown and gloves needed to be worn. They did not wear a gown earlier when they administered medication to Resident #2. They did not wear a gown because they forgot. 3) Resident #5 had diagnoses that included stroke and urinary bladder dysfunction. The 12/29/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment and had an indwelling urinary catheter. The 05/13/2021 Comprehensive Care Plan, revised 08/07/2025 documented the resident was at risk for infection related to environmental exposure, indwelling catheter, incontinence, open skin areas, and history of methicillin resistant staphylococcus aureus and extended-spectrum beta-lactamases (drug resistant organisms). Interventions included maintaining transmission-based precautions and performing hand hygiene before and after contact with the resident. The resident had an indwelling catheter related to bladder disorder/disease. Interventions included to change indwelling catheter as needed and change the urine collection bag per orders. The goal was for the resident to show no signs or symptoms of urinary infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 05/11/2026 at 4:17 PM Resident #5 was lying on their back in bed. The urine collection bag was sitting directly on the floor without a barrier. During an observation on 05/12/2026 at 9:33 AM the resident's urine collection bag was sitting directly on the floor without a barrier. During an observation on 05/12/2026 at 2:00 PM the resident's urine collection bag was sitting directly on the floor without a barrier. During an observation and interview on 05/12/2026 at 2:55 PM Certified Nurse Aide #19 stated they were Resident #5's aide that day. They made sure urinary collection bags were in a privacy bag, below the level of the bladder and off the floor. The resident's bag was hooked to the frame of the bed, but the resident had a low bed. They did not know how they were supposed to keep the bag from touching the floor when the resident had a low bed. If the resident had a normal bed the catheter bag would not touch the floor. During an interview on 05/12/2026 at 3:01 PM Licensed Practical Nurse #17 stated residents with low beds should have a barrier between the floor and the collection bag. They used clean disposable bed pads as a barrier. Resident #5 had a catheter and had a low bed. They should have a barrier between the collection bag and the floor. They did not know why they did not notice that the collection bag was on the ground. During an interview on 05/13/2026 at 9:12 AM Licensed Practical Nurse Unit Manager #19 stated special considerations for catheters placing the collection bag in a privacy bag when the resident was out of their room, keeping the bag below the level of the bladder and keeping the collection bag off the ground. They had to keep the bag from touching the ground to decrease the risk of infection. There needed to be a barrier between the bag and the ground if a resident had a low bed. Resident #5 had a catheter and a low bed. There should be a barrier between their collection bag and the ground. The facility used to have privacy bags that covered the whole entirety of the collection bag, so it worked as a barrier. The current privacy covers had an open bottom, so now they had to remember to put down a barrier. During an interview on 05/15/2026 at 11:03 AM Infection Control Registered Nurse #50 stated a catheter bag on the floor could introduce bacteria into the system and cause a urinary tract infection. Residents in low beds should have a barrier between the catheter bag and the floor. They could use a clean disposable bed pad as a barrier and change regularly to reduce infection risk. When orders were placed for a resident to be on transmission-based precautions they went to the floor and put up signage and reviewed with staff present. They reviewed donning and doffing personal protective equipment, depending on type of precaution. They should follow what was on the signage, it told them everything they needed to know. Contact precautions required personal protective equipment every time they went into the room and hands washed at a sink after doffing gloves. Enhanced barrier precautions were different; if answering a call bell or dropping off a meal tray, gown and gloves were not required. If staff needed to empty a catheter bag, reposition the resident or medication administration with tube feeding, they should wear personal protective equipment. During a follow up interview on 05/19/2026 at 9:14 AM Infection Control Registered Nurse #50 stated administering medications through tube feed required personal protective equipment. Staff did not need to wear gowns when medications were administered orally, only if they were through the feeding tube as this was high contact. Any time staff entered a room with clostridium difficile or any contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room they should wear personal protective equipment, even if they were just picking up a pen. Staff were required to wear gowns and gloves when delivering or removing a meal tray from a resident room with clostridium difficile or contact precautions. 10 New York Code Rules and Regulations 415.19(a)(b)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observations, record review, and interviews, the facility failed to promote and facilitate resident self-determination including the resident's right to make choices about aspects of daily life that are significant to the resident for one (1) of five (5) residents (Resident #198) reviewed. Specifically, Resident #198 requested to be transferred back into bed and was not assisted timely after their request. Findings include:The facility policy Resident Rights, last reviewed 01/2026, documented all residents had the right to be treated with kindness, respect, and dignity as well as the right to self-determination. Resident #198 had diagnoses including muscle weakness and difficulty walking or moving around. The 04/14/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident had moderate cognitive impairment and required substantial/ maximum assistance with chair/ bed-to-chair transfers. The comprehensive care plan initiated 11/27/2024, documented the resident was at risk for being a victim due to dependence on others for activities of daily living. Interventions included signs and symptoms of abuse and/ or neglect were assessed and reported. Resident #198 was observed at the following times:-On 05/11/2026 at 12:17 PM sitting in their wheelchair outside their room. Licensed Practical Nurse #10 was in the hallway with the medication cart. The resident told Licensed Practical Nurse #10 they wanted to get back in bed because their back hurt. The nurse wheeled their medication cart away and told the resident someone would come to help them. At 12:28 PM, the resident was still sitting in their wheelchair outside of their room and stated to the surveyor the staff was ignoring them and that was why they did not like to go to therapy because staff did not assist them back to bed when they returned. They stated their back and legs were hurting. At 1:03 PM Certified Nurse Aides #11 and #12 wheeled the resident and the mechanical lift into the room to put them back into bed (46 minutes after their initial request).- On 05/14/2026 at 11:22 AM, sitting in their wheelchair in the dining room eating pizza. At 11:30 AM they told Certified Nurse Aide #13 they wanted to get back in bed and the resident was told they had to until after lunch. At 1:31 PM they were assisted back to bed with the mechanical lift (121 minutes after their initial request). During an interview on 05/14/2026 at 1:34 PM, Resident #198 stated they were just put back in bed. They stated staff kept them up for so long and it was not right. That was the reason they did not like to attend physical therapy. It took two certified nurse aides to put them back to bed with the mechanical lift. Staff always told them they would put them back in bed after lunch but look at the time, they just left me in the hallway, and it was not right. During a telephone interview on 05/15/2026 at 1:03 PM, Certified Nurse Aide #11 stated if residents wanted to get back in bed during lunch, it was dependent on the number of staff available. If there were only one or two certified nurse aides, they could not do it because they had four residents who required feeding assistance and had to pass out meal trays. If the resident needed a mechanical lift for transfers, they would have to wait. Resident wishes should be honored because this was their home, and they were there for help with care. Resident #198 usually asked to go back to bed immediately after they returned from physical therapy and that was always around lunch time. The lunch trays arrived on the unit around 11:30 AM. They stated the certified nurse aides typically took their breaks before lunch which also decreased the number of staff to assist the resident back to bed. During an observation on 05/15/2026 at 1:34 PM, the resident was sitting in their wheelchair in the hallway outside of their room. They stated to the surveyor, see they are doing it again. During an interview on 05/15/2026 at 1:35 PM, Licensed Practical Nurse #10 stated when Resident #198 returned from therapy, they immediately requested to get back in bed. It was usually lunchtime, so they asked them to wait until after lunch. They should honor the resident's wishes to the best of their ability because this was their home, and they should get what they wanted and what they needed. During an observation on 05/15/2026 at 1:44 PM, Resident #198 asked the surveyor if they knew when the staff would assist them back to bed. At 1:45 PM, Licensed Practical Nurse #10 stated to the (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident they had just told them that they wanted to get back to bed. Registered Nurse Unit Manager #9 and Certified Nurse Aide #14 wheeled the resident into their room with the mechanical lift. During an interview on 05/18/2026 at 1:38 PM, Registered Nurse Unit Manager #9 stated the residents had rights to have certain choices and preferences. If it was lunchtime, the resident still had the right to get back in bed. It was challenging to meet all requests based on staffing. The resident was participating in physical therapy and wanted to get back in bed as soon as they returned to the unit. If the resident was not assisted back to bed timely, they may not want to get up out of bed anymore. 10 New York Codes, Rules, and Regulations 415.5(b)(1-3)

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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 [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, (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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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 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observations, record review, and interviews, the facility failed to implement a comprehensive person-centered care plan to meet a resident's needs one (1) of two (2) residents (Resident #11) reviewed. Specifically, Resident #11 was not provided with 1:1 assistance with meals as planned. Findings include: The facility policy Resident Care with Activities of Daily Living, last reviewed 1/2025, documented the facility was to assist residents with the need and support for activities of daily living.Resident #11 had diagnoses including stroke, malnutrition, and gastro-esophageal reflux disease. The 03/18/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition and required moderate assistance with eating.The 3/6/2026 at 3:06 PM Registered Dietitian #5 progress note documented the resident weighed 179 pounds and the reweight was 182 pounds. The resident had an unplanned significant weight loss due to hospitalization, variable intakes, selective eating habits and distraction during meals. The 03/13/2026 at12:47 PM Registered Nurse Unit Manager #25 progress note documented the care team discussed the resident's lack of interest in meals with diminished appetite. The team decided to make the resident 1:1 at meals to see if it would result in better engagement at meals. The 03/14/2026 comprehensive care plan documented the resident was at risk for functional decline in self-care related to syncope (fainting) and collapse. Interventions included partial/moderate assistance with eating. The 5/13/2026 care instructions documented the resident was 1:1 feeding for all meals due to lack of interest.During an observation and interview on 05/13/2026 from 8:58 AM until 9:04 AM, the resident was in the unit dining room feeding themself. There were no staff feeding or assisting the resident. The resident ate most of the meal. At 8:58 AM, Certified Nurse Aide #7 stated the night shift was to get the resident up in the morning so they could eat breakfast in the unit dining room. During an observation on 05/13/2026 at 1:09 PM, the resident only ate their ice cream and pineapple tidbits at lunch. No staff was engaged with the resident during the meal. During an interview on 05/13/2026 at 1:14 PM, Certified Nurse Aide #15 stated they knew which resident required feeding assistance by looking at the care instructions. A resident who was 1:1 feeding meant a staff member only fed that 1 resident until they were done eating. They stated they did not believe Resident #11 was 1:1 because they ate independently.During an observation on 05/14/2026 at 8:49 AM, the resident was feeding themselves in the unit dining room with no staff assistance or engagement as planned. During an observation and interview on 05/15/2026 at 12:43 PM, the resident was sitting in a wheelchair in the unit dining room. At 12:47 PM, the resident began wheeling themself out of the dining room while staff were passing meal trays. Staff redirected the resident to the dining room and the resident wheeled out a different exit. The resident did not eat anything on their meal tray. During an interview on 05/15/2026 at 1:45 PM, Licensed Practical Nurse #21 stated 1:1 for feeding meant staff had to sit and feed the resident. Resident #11 was not on a 1:1 feeding program. During an interview on 05/15/2026 at 2:05 PM, Certified Occupational Therapy Assistant #24 stated nursing staff were expected to look at the care plan or care instructions to see if a resident was 1:1. Resident #11 was 1:1 with feeding and would eat well when fed. The resident needed reminders to eat, was hungry, and ate when they were provided with 1:1 assistance. During an interview on 05/19/2026 at 10:34 AM, Registered Dietitian #5 stated Resident #11 was made 1:1 feeding on 3/14/2026 due to significant weight loss. The resident tended to wander during the meal and did not actively eat. During an interview on 05/19/2026 at 2:03 PM, Registered Nurse Manager #35 stated Resident #11 was 1:1 feeding for meals as they had difficulties remaining engaged while eating and also had significant weight loss. A resident who was 1:1 for feeding meant that a staff member was to feed only that specific resident, and it should be documented in the resident's care instructions. 10NYCRR 415.11(c)(1)

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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 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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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and interview the facility failed to ensure that a resident who needed respiratory care was provided such care, consistent with professional standards of practice for one (1) of one (1) resident (Resident #3) reviewed. Specifically, Resident #3 was observed with a BiPAP (bilevel positive airway pressure) machine in their room and did not have a physician order or care plan for the device, and the mask was unclean. Findings include: The facility policy CPAP/BiPAP, revised 01/2026, documented the facility provided continuous positive airway pressure with or without supplemental oxygen to the spontaneous breathing resident to improve arterial oxygenation in residents with respiratory insufficiency, obstructive sleep apnea, or restrictive/obstructive lung disease. The physician ordered the oxygen concentration and flow and the positive end expiratory pressure for the machine. The humidifier chamber was filled with distilled water only and cleaned weekly, disinfecting with vinegar-water solution (1:3) in clean humidifier, soaking for 30 minutes and rinsing thoroughly. The filter was cleaned with running water weekly and replaced annually. The masks, nasal pillows, and tubing were cleaned daily using soap and water. The time of application and machine settings were documented in the electronic medical record. Resident #3 was admitted to the facility with diagnoses including stroke with paraplegia (paralysis of lower half of body) and muscle weakness. The 03/18/2026 Minimum Data Set assessment documented the resident had intact cognition, did not use oxygen therapy, and did not utilize bilevel positive airway pressure therapy. The 03/10/2026 hospital discharge summary documented the resident had diagnoses including acute respiratory failure and aspiration pneumonia (lung infection where food or liquids enter the lungs). The 04/10/2026 Respiratory Therapist #61 progress note documented the resident was ordered BiPAP (bilevel positive airway pressure) at night and the resident stated it was worn most nights. Bronchial breath sounds were clear, and respiratory distress was not observed. There was no documented evidence of a physician order or comprehensive care plan addressing the use of bilevel positive airway pressure therapy. During an observation and interview on 05/11/2026 at 1:36 PM, Resident #3 stated they used the BiPAP (bilevel positive airway pressure) every night. Staff never cleaned the tubing or mask, and the mask was dirty. They wanted the tubing and mask cleaned so they did not get sick. The BiPAP (bilevel positive airway pressure) mask was observed with a significant amount of white debris inside the mask: -on 05/11/2026 at 1:36 PM-on 05/11/2026 at 3:15 PM-on 05/12/2026 at 9:57 AM-on 05/12/2026 at 4:36 PM-on 05/15/2026 at 11:02 AM During an interview on 05/15/2026 at 11:02 AM, Licensed Practical Nurse #38 stated when a resident was transferred from the hospital and had a BiPAP (bilevel positive airway pressure) machine they contacted the pulmonologist to secure the resident specific settings for the machine and to ensure the settings were accurate for the resident. The physician wrote an order for the BiPAP (bilevel positive airway pressure) therapy, and the admission nurse documented use of the therapy on the care plan. The order generated the machine settings, the time of placement (usually at bedtime or when napping), and the cleaning schedule for the tubing and mask. The mask and tubing were cleaned daily, usually on the day shift. Resident #3 utilized a BiPAP at night and was on their assignment for the day. They did not clean the tubing or facemask as it was not on the treatment administration record. They stated the mask was dirty and required cleaning. During an interview on 05/18/2026 at 11:42 AM, Registered Nurse Unit Manager #35 stated Resident #3 was admitted with acute hypoxic respiratory failure and obstructive sleep apnea and used a bilevel positive airway pressure machine. They were not sure why the resident did not have a respiratory care plan or why there was no order and instructions for use of the bilevel positive airway pressure machine. The resident had been in the facility for a few months using the bilevel positive airway pressure machine and all nurses that cared for the resident, including themselves, should have noticed there were no orders, care plan, interventions, or a cleaning schedule for the machine. 10 New York Codes, Rules, and Regulations 415.25(a)(4)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews, the facility failed to ensure that residents who required dialysis services (a process that filters blood when the kidneys do not work efficiently) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #122) reviewed. Specifically, Resident #122 received dialysis, had a dialysis access and there was no documented evidence pre and post dialysis evaluations were consistently completed. Findings Include:The facility policy Dialysis Communication, last reviewed 01/2026, documented on the days of dialysis the nurse will take vital signs and document relevant labs and pre-dialysis weight in the dialysis communication book. An evaluation of the resident's access site will be completed and all findings documented in the communication book as well as the resident's medical chart. Resident #122 had diagnoses including end stage kidney disease and dependence on dialysis. The 04/16/2026 Minimum Data Set assessment documented the resident had intact cognition and required dialysis treatment.The comprehensive care plan initiated 04/12/2024 and revised on 04/29/2026, documented the resident had fluid overload or potential for fluid volume overload related to end stage dialysis and required dialysis. The interventions and goals listed did not include the resident's type of dialysis, monitoring vital signs, weights, nutritional and fluid needs or restrictions, lab results, and type of access site and the care required for the access site.The 08/25/2025 physician orders documented:-Hemodialysis three times a week, and as needed per the dialysis center plan, every Tuesday, Thursday and Saturday for end stage renal disease.-Hold the once-a-day blood pressure medications on dialysis day and give upon return from dialysis.-Complete pre and post dialysis assessment on dialysis days.- Right femoral perma-catheter site (dialysis access site), keep dry, monitor for infection; and monitor site for bleeding and report changes to the provider-Resident has a temporary dialysis catheter in place in right groin area near hip. Resident #122's dialysis intercommunication pre-dialysis form notes documented the following:-On 04/02/2026, 04/14/2026, 04/16/2026, the resident went to dialysis. -On 04/18/2026, the resident went to dialysis. The access dressing site was documented as n/a and a positive symbol (+) documented for access condition, bruit and thrill (used to determine blood flow with a fistula). The resident did not have a fistula.-On 04/21/2026, 04/23/206 and 04/28/2026 the resident went to dialysis. There was no documentation the access site was assessed. -On 04/30/2026 and 05/05/2026, the resident went to dialysis. The access site was documented with an X, and the bruit and thrill were documented with symbol (+) for positive.-On 05/07/2026, the resident went to dialysis.-On 05/09/2026, the resident went to dialysis. The staff documented the symbol (+) positive for bruit and thrill.-On 05/12/2026, the resident went to dialysis. The staff documented there was no dressing intact, and site condition was positive.There was no documentation that a pre-dialysis assessment/progress note was completed on the days the resident went to dialysis. Resident #122's post-dialysis dialysis intercommunication forms documented the following:-On 04/02/2026, the resident returned from dialysis. Their access site was not addressed.-On 04/14/2026 and 04/16/2026, the resident returned from dialysis and the vital signs were documented.-On 04/18/2026, the resident returned from dialysis and staff documented, the dressing was not intact with a line through the word no.-On 04/21/2026 and 04/23/2026, the resident returned from dialysis. The access site was not addressed. -On 04/28/2026 and 04/20/3036 the resident returned from dialysis and the access site was documented with dressing intact.-On 05/05/2026, 05/07/2026 and 05/0/2026 the resident returned from dialysis. The vital signs were completed.-On 05/12/2026, the resident returned from dialysis. The access site dressing was intact, and there were positive bruit and thrill.There was no documentation that post dialysis assessment/progress notes were completed on the days the resident returned from their dialysis treatment.The May 2026 treatment administration record did not include monitoring of the resident's right femoral artery perma-catheter access site.During an interview on 05/13/2026 at 9:09 AM, Resident #122 stated they received dialysis treatments for four (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	years and had a catheter for their dialysis access. The catheter dressing was intact and located on the upper right hip. They stated the nursing staff at the facility never looked at their dialysis access site. When they returned from dialysis in the evening, they did not usually see a nurse. They were tired, they ate the food left in their room and then slept.During an interview on 05/15/2026 at 11:05 AM, Dialysis Clinic Registered Nurse Manager #28 stated the resident had frequent catheter access site infections in the past. The infections were usually related to resident hygiene issues. The resident was non-compliant and would deny staff assistance with their care. The resident received dialysis three times a week and had a catheter in their groin tunneled into the femoral vein. The resident had been on dialysis for a long time and was very sick. The nursing home nursing staff should be assessing the dressing, to ensure it was clean, dry and intact, and without signs of infection.During a telephone interview on 05/18/2026 at 10:40 AM, Licensed Practical Nurse Unit Manager #29 stated the resident went to dialysis three times a week. The resident had a catheter in their right groin for treatment access. The nursing staff did not touch the dressing, as dialysis nurses did the dressing. Nurses should let the Registered Nurse Supervisor know if the dressing was leaking or saturated. Prior to dialysis and upon return from dialysis treatments, the licensed practical nurse should take vital signs, weigh the resident, and observe the access site. The registered nurse would not assess the resident unless there was an issue reported pre or post dialysis treatment.During a telephone interview on 05/18/2026 at 11:46 AM, Assistant Director of Nursing #30 stated they thought the nurses on the unit observed the dialysis access site, but any dressing changes or issues with the perma-catheter were addressed by the dialysis nurses. The licensed practical nurse on the unit should collect the resident's vital signs and weight, and if there were any abnormalities they would reach out to the registered nurse to assess. The registered nurse did not routinely assess the resident pre and post dialysis. They would only assess the resident if they were called to the unit for something outside of the resident's routine observation. 10 New York State Codes Rules and Regulations 415.11(a)(5)

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure a resident who displayed or was diagnosed with a mental disorder received appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychological well-being for one (1) of five (5) residents (Resident #145) reviewed. Specifically, Resident #145 had a history of anxiety and depression, expressed worsening depression symptoms and there was not consistent or timely support provided by the facility addressing the resident's psychosocial well-being. Findings include: The facility policy Behavioral Assessment, Intervention and Monitoring, last reviewed 01/2026, documented the facility provided and residents received behavioral health services as needed to attain or maintain the highest practicable physical, mental and psychosocial well-being in accordance with the comprehensive assessment and plan of care. Behavioral health services were provided by qualified staff who had the competencies and skills necessary to provide appropriate services for the residents. Resident #145 had diagnoses including insomnia (difficulty sleeping), depression, and anxiety. The 03/13/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact; had little interest or pleasure in doing things several days; felt down, depressed, or hopeless nearly every day; had trouble falling or staying asleep, or sleeping too much several days; felt tired or had little energy half of more of the days; poor appetite or overeating nearly every day; felt bad about self-or that they were a failure or had let themselves or their family down half or more of the days; and received antianxiety and antidepressant medications. The comprehensive care plan initiated 10/16/2025 documented the resident had a mood state of depression and anxiety. Interventions included the resident was assessed for suicidal ideation and family involvement was encouraged. Physician orders documented: -On 12/12/2025 psychiatry and psychology consultation, treatment, and follow-up per recommendation, and mirtazapine 30 milligrams at bedtime for depression.-On 01/24/2026 Lamictal 200 milligrams daily for anxiety.-On 05/07/2026 lorazepam 0.5 milligrams every 24 hours as needed for anxiety.-On 05/08/2026 trazodone 100 milligrams at bedtime for depression. The 01/28/2026 Psychiatric Nurse Practitioner #48 initial evaluation progress note documented the resident had a history of depression and anxiety and reported increased depression over the past month and ongoing anxiety. The resident suffered quite a bit of depression in the past month and endorsed current anxiety symptoms. Their motivation was low, and they did not feel like doing anything and had to make themselves do things. The plan was to follow up in 6 weeks. The 02/16/2026 Social Worker #46 progress note documented the resident discussed depressive symptoms with them and they would contact the psychiatric nurse for follow up. On 02/16/2026 at 2:00 PM an electronic mail communication was sent from Social Worker #46 to psychiatric Registered Nurse #47. Registered Nurse Unit Manager #9 and the Director of Social Work were copied on the communication. The communication documented the resident scored a 12 (moderate depression) on the PHQ-9 test (a screening tool used to measure the severity of depressive symptoms) and asked if they could meet with the resident to assess depression. There was no documented evidence the resident was seen by psychiatric Registered Nurse #47. The 03/10/2026 Interdisciplinary Team note completed by Registered Nurse Unit Manager #9 documented the resident was requesting a psych follow up. There was no documented evidence the resident had a psych follow up. The 04/14/2026 Registered Nurse Unit Manager #9 progress note documented the resident would like to be added to the psych list. The 04/21/2026 Psychiatric Nurse Practitioner #48 progress note documented the resident was seen for follow up psychiatric evaluation (12 weeks after initial evaluation). The resident reported increased anxiety and increased grogginess in the morning. There were medication changes. Continued psychiatric care for medication management and symptom (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment as well as supportive therapy as needed. Follow up in one month. During an observation and interview on 05/11/2026 at 1:06 PM, Resident #145 was lying in bed dressed. The room was quiet, and they were looking off into the distance with an unfocused, blank expression. They stated they were depressed and nothing was being done. Prior to being in the facility, they spoke with a therapist once a week. They stated the psychologist came to see them once and they would see them weekly, but it took over 10 weeks. The last time they were seen was 3-4 weeks ago and the practitioner told them they must have fallen through the cracks. Today they felt extremely depressed and did not even want to get out of bed. They needed to see a therapist but did not think it was offered at the facility. Sometimes they wanted to go the psych ward just to talk to someone. They told the facility at the beginning of the year and again a month later they were going through a great depression, and the staff had not done anything about it. At 3:48 PM, they were still lying in bed, dressed, room quiet, without expression on their face. During an interview on 05/14/2026 at 11:53 AM, Certified Nurse Aide #11 stated Resident #145 did seem down sometimes and seemed tired lately. During an interview on 05/14/2026 at 12:20 PM, Licensed Practical Nurse #10 stated there were psychiatric nurses and nurse practitioner, but they did not know their names or how often they came to the facility. If a resident was feeling down, they should check on them. Resident #145 seemed more anxious and had verbally expressed depression. During an interview on 05/18/2026 at 1:38 PM, Registered Nurse Unit Manager #9 stated the facility used the services of Psychiatric Nurse Practitioner #48 and psychiatric Registered Nurse #49. If the resident displayed depression or anxiety, they let Registered Nurse #49 and social work know by sending an email. They had not noticed any changes with Resident #145; they got out of bed, ambulated, talked, and were not withdrawn. During an interview on 05/18/2026 at 2:43 PM, the Director of Social Work stated nursing submitted a psychiatric referral in an email that went to psychiatric Registered Nurse #49, and they were copied on it. Registered Nurse #49 was in the facility Monday-Friday, and they met with residents all throughout the day. They had not noticed any big mood changes with Resident #145. Depression symptoms should be taken very seriously and should not be brushed off because they can [NAME]. During an interview on 05/19/2026 at 10:00 AM, psychiatric Registered Nurse #49 stated they covered the whole facility. They mainly managed the list of residents to be seen by the Psychiatric Nurse Practitioner #48 when they came once a week. They saw the residents if there were medication changes. If the resident requested to speak with Psychiatric Nurse Practitioner #48, they would see them first. Psychiatric Nurse Practitioner #48 told them when they wanted to see a resident again and they kept a list for them of who needed to be seen. They were in the facility to provide emotional supportive therapy to anyone if they just wanted to talk. They only had one resident that they saw weekly. They were not familiar with Resident #145, but Psychiatric Nurse Practitioner #48 had seen them. During a telephone interview on 05/19/2026 at 10:54 AM, Psychiatric Nurse Practitioner #48 stated residents were evaluated at facility request. Registered Nurse #49 was available for emotional support and had residents they saw weekly. Resident #145 was depressed and anxious last week and had been every time they had seen them. They completed the resident's initial evaluation when they were just starting at the facility. They were trying to manage their case load 3 months went by before they had a follow up. The facility had not asked for the resident to be seen again, or they would have seen them sooner. They were now seeing the resident monthly as the resident would benefit from regular emotional support. The resident was highly anxious and very depressed with issues getting motivated. They had a history of deep depression, but they did not have the details off hand and did not have access to the electronic medical record at the time. 10 New York Codes, Rules, and Regulations 483.40(b)(1)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional standards and principles for one (1) of six medication carts (Unit 5 B Medication cart) reviewed. Specifically, the Unit 5 B Medication Cart had one (1) undated Humalog insulin vial and one (1) expired Trelogy Inhaler cartridge.Findings include:The facility policy Storage of Medications, last reviewed 01/2026, documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Drug containers that had missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing; the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.During an observation on 05/12/2026 at 1:37 PM with Licensed Practical Nurse #23, the Unit 5 B Medication Cart top drawer contained one undated vial of Humalog insulin and one expired Trelogy inhaler cartridge dated 03/25/2026. During an interview 05/19/2026 at 12:21 PM, Registered Nurse Unit Manager #20 stated if a vial of medication was not dated when opened there was no way of knowing when the medication expired and it should be discarded. There should be no expired medications in the cart.During an interview on 05/19/2026 at 1:31 PM, Licensed Practical Nurse #23 (assigned to Unit 5 B Medication Cart) stated open vials of insulin should have a date it was opened with the nurse's initials. Expiration dates of medications should be checked before administration and any medication without a label was discarded. Licensed Practical Nurse #23 stated that the nurse who opened the medication should have written the date when it was opened. 10 New York Codes, Rules and Regulations 415.18(d)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and interviews, the facility failed to ensure the daily current resident census, the total number, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift was posted in a prominent location readily accessible to residents and visitors for three 3 of 4 days reviewed. Specifically, daily nurse staffing was not posted daily at the beginning of each shift and in a prominent location on 5/9/2026, 5/10/2026, and 5/11/2026 as required. Findings include: There was no documented evidence of a facility policy for Posted Nursing Staffing Information. The daily nurse staffing and resident census information was not posted in the main lobby, on the main entrance doors, or on the reception desk during the following observations:- on 5/11/2026 at 11:19 AM.- on 5/11/2026 at 1:49 PM. During an interview on 05/13/2026 at 2:42 PM, Human Resources Director #25 stated staffing, and the resident census should be posted in an accessible area for visitors to view so they can know how many staff are in the building caring for residents. They were not responsible for posting the staffing daily, Staffing Coordinator #26 was responsible for posting staffing. During an interview on 05/15/2025 at 1:32 PM, Staffing Coordinator #26 stated they were aware staffing should be posted daily. The resident census and daily staffing for licensed and unlicensed staff was posted in the main lobby at the front desk and in the back hallway outside their office. They posted the staffing everyday Monday through Friday, and the Registered Nurse supervisor posted the staffing on the weekend. When they arrived at work on Monday 5/11/2026, they noticed the posted staffing was dated Friday 5/8/2026 and was not updated over the weekend, or for Monday. They were not sure why it was not posted on the weekend or what time it was posted on Monday 5/11/2026. They stated it should have been done first thing in the morning, and it was not. 10 New York Codes, Rules, and Regulations 415.13