STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335588	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Chittenango	331 Russell Street Chittenango, NY 13037

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35045 Based on observation, record review, and interview during the abbreviated survey (NY00303220) the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for 1 of 3 residents (Resident #1) reviewed. Specifically, Resident #1 was not assisted with toileting timely. Findings include: The facility policy, Resident Rights, last reviewed 1/2024 documented residents' basic rights included to be treated with respect, kindness, and dignity. The facility policy, Resident Care with Activities of Daily Living, last reviewed 1/2022, documented to provide residents with adequate toileting, maintaining maximum level of toileting and continence staff would first review the resident care instructions prior to assisting the resident to ensure appropriate numbers of person were available for assistance. Residents on toileting program would be offered toileting every 2- 4 hours and as needed. During napping or hour of sleep resident would be provided the bed pan and/or urinal if preferred every 2- 4 hours and as needed. Resident #1 had diagnoses including Alzheimer's Disease and cerebrovascular accident (stroke). The 9/29/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, did not refuse care, required substantial/maximal assistance for toileting hygiene, supervision and touching assistance with toilet transfers, was frequently incontinent of urine and always incontinent of stool, and was not on a toileting program. The undated care instructions documented the resident always required 2 staff during care, required substantial/maximal assistance for toileting hygiene, was on every 45-minute safety checks, the resident's call bell was to be within reach and encouraged to be used for assistance. The 8/22/2024 Comprehensive Care Plan documented the resident had bowel and bladder incontinence, was at risk for falls, and for impaired skin integrity. Interventions included offer toileting every 2 hours or check resident every 2 hours, encourage resident to use their call bell for assistance, check skin for impairment every shift, minimize extended exposure of skin to moisture by providing incontinence care and prompt removal of wet/damp clothing or sheets as needed, identify voiding patterns, and initiate a toilet schedule if indicated. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335588	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Chittenango	331 Russell Street Chittenango, NY 13037

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on the A unit on 10/17/2024 at 9:59 AM, there was a strong odor of urine and stool noted outside of Resident #1's room. Upon entering the room, Resident #1 was in their low bed with their head hanging off the left side. There was a pillow on the floor, and the resident's feet were off to the right side of the bed. The resident was dressed in blue pants and a green shirt, their bed sheet had a large brown circle and appeared wet. Their call bell was not in reach and was wedged behind the headboard of the bed and the wall. Licensed Practical Nurse #4 was notified by the surveyor the resident appeared to be falling out of bed and they stated, give me one minute and proceeded to walk away from the resident's room to the nurse's station. When Licensed Practical Nurse #4 entered the resident's room approximately 2 minutes later, they repositioned the resident in bed by pulling them over to the right and they covered the resident with a sheet. Licensed Practical Nurse #4 stated that not all residents were required to have their call bell. During an observation on the A unit on 10/17/2024 at 11:16 AM, Resident #1 was in their bed asleep with the sheet over them. The resident's call bell was tucked under their right side, and there was a strong odor of urine and stool. During an interview on 10/17/2024 at 11:18 AM, Licensed Practical Nurse Unit Manager #3 stated that Certified Nurse Aide #5 was assigned to care for Resident #1 but was on their break. During an observation at on 10/17/2024 at 11:20 AM, Licensed Practical Nurse #7 was applying antibiotic ointment to Resident #1's right eyebrow suture area and repositioned the resident straighter in the bed. They completed the treatment and exited the room. There was a strong odor of urine and stool in the room. During an observation and interview on 10/17/2024 at 11:30 AM, Licensed Practical Nurse #7 approached Certified Nurse Aide #6 to assist them with getting Resident #1 out of bed to change their clothing and wash them. They sat the resident on the edge of the bed and stood them up and the resident's green shirt was wet up their back and their blue pants were wet down to the back of their right leg. Certified Nurse [NAME] #6 stated the resident was wet with urine and they walked the resident to the bathroom and sat them on the toilet. The linen on the bed was wet with a brown ring on the sheet and the two soaker pads on the bed were wet. During an interview on 10/17/2024 at 11:41 AM, Certified Nurse Aide #5 stated they were assigned to Resident #1, but the nurse had told them in morning report to let the resident sleep until lunch and then wake them and provide care. They stated they went into the room at 10:40 AM and the resident had their call bell and was asleep. They did not notice an odor. They would typically wash residents in the morning but was told not to wake the resident up until lunch, so no care was provided to the resident. They stated it was important to not leave residents is urine soaked clothing or linen because this could lead to infection or skin irritation. The 10/17/2024 toileting and bathing tasks for Resident #1 documented the resident received bathing and bladder and bowel care by Certified Nurse Aide #5 at 2:59 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335588	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at Chittenango	331 Russell Street Chittenango, NY 13037

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 1:26 PM, Licensed Practical Nurse Unit Manager #3 stated all residents should have their call bells in reach. No one reported to them about not providing care to Resident #1 and leaving them in bed. The resident should have been checked on and changed even if they were sleeping. The resident required assistance of 2 for assistance with care and they were always available to assist with toileting and bathing. The resident's linen should have been changed as soon as it was noted to be wet. During an interview on 10/18/2024 at 11:22 AM, the Director of Nursing stated Resident #1 had dementia and required substantial/maximum assistance with toileting and required two staff present for care due to the resident's behaviors. All residents should have a call bell in reach even if they could not use it. All residents should be checked and changed every 2 hours per policy. Leaving a resident in bed without their call bell and wet linen was not safe, was a dignity issue, and could lead to infections and skin integrity issues. They stated Resident #1 was on every 45-minute checks and staff should have noticed the resident was incontinent and cleaned them. 10NYCRR 415.12(a)(3)