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	11/18/2025

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. Based on observations, record review, and interviews during the recertification and abbreviated (NY00495399) surveys conducted 9/22/2025-9/25/2025, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good grooming, and personal and oral hygiene for one (1) of one (1) resident (Resident #22) reviewed. Specifically, Resident #22 had unclean hands, face, fingernails and clothing; disheveled hair; and an unclean wheelchair. Findings include:The facility policy Showers/Tub Bath, last reviewed 1/2025, documented residents were provided regular showers or tub baths, thoroughly washed, dried, and groomed with attention to hair care. Documentation of the type of bath, assistance, tolerance, was completed and refusals reported to the supervisor.Resident #22 had diagnoses including Huntington's disease (a progressive neurological disease) and dementia. The 8/14/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment and required extensive assistance with showering and tub bathing and moderate assistance with personal hygiene. The Comprehensive Care Plan initiated 9/4/2025 documented the resident was at risk for functional decline. Interventions included substantial/maximal assistance for bathing, lower body dressing, and bed mobility; partial/moderate assistance for upper body dressing; and was dependent with a two-person mechanical lift for tub/shower transfers.The September 2025 Certified Nurse Aide Documentation Report documented the resident frequently refused or did not receive scheduled showers. The resident received bed baths or partial hygiene in place of full shower/tub bathing.The following observations were made of Resident #22:-on 09/22/2025 at 8:23 AM, sitting in their specialized wheelchair. The wheelchair was heavily soiled with dried matter on all sides including the seat cushion. The resident's hair appeared greasy, and their fingernails had brown matter on and underneath the nails. -on 9/23/2025 at 1:44 PM their sweatshirt was covered with food debris; their hair appeared greasy; and their fingernails were jagged and contained a dark matter underneath. -on 9/24/2025 at 9:58 AM and 11:53 AM their hair appeared greasy; their fingernails were jagged and unclean; their shirt was covered with food debris; and their wheelchair had dried matter on the sides and the seat cushion was heavily soiled.During an interview on 9/25/2025 at 9:31 AM Certified Nurse Aide #28 stated Resident #22s hair appeared greasy. The resident was washed up that morning. They stated they were unsure of when the resident's actual shower day was but assumed it was at night. Certified Nurse Aide #28 stated the resident had jagged nails and food matter on their face and hands and their chair was splattered with food.During an interview on 9/25/2025 at 9:35 AM, Licensed Practical Nurse Manager #17 stated the resident was scheduled for a shower every Friday. They stated the resident occasionally resisted care. Licensed Practical Nurse Manager #17 stated the resident had food on their face and the resident's wheelchair was soiled with dried food and matter. They attributed the increased soil to the resident's diagnosis of Huntington's disease, which caused frequent spilling and increased debris on the chair. Wheelchair cleaning was scheduled for Monday evening, but spot cleaning should be done. The resident should receive thorough care after meals and, if needed, more frequent hair and nail care on non-shower days.10NYCRR 415.12(a)(3)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335588	A. Building B. Wing	11/18/2025

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

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (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	11/18/2025

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, record review, and interviews during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure residents maintained acceptable parameters of nutritional status for two (2) of three (3) residents (Residents #2 and #8) reviewed. Specifically, Resident #2 had weight loss not addressed by the registered dietitian and there was no documented intervention implemented to prevent further weight loss, and Resident #8 was not supervised during self-administration of their tube feeding and was observed to be administering the incorrect amount. Additionally, Resident #8 did not have a physician order or a care plan to self-administer.Findings include: The 10/1997 facility policy Administering Medications, revised 1/2023, documented medications must be administered in accordance with the orders; residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, had determined that they had the decision-making capacity to do so safely; and the individual administering the medication would record the dosage in the resident's medical record.The 10/1997 facility policy Maintaining Patency of a Feeding Tube (Flushing), revised 1/2023, documented feeding tubes would be flushed after each feeding and medication administration. Additionally, the total amount used to flush the tube and how the resident tolerated the procedure would be documented. The 10/1997 facility policy Nutritional Assessment, revised 1/2023, documented the nutritional care plan would indicate the route of administration, the resident's requirements for nutrient intake, and would be consistent with the resident's wishes and goals. In addition, the dietitian would conduct a nutritional assessment which included estimated nutritional needs and interventions for residents with a change in condition that placed them at risk for impaired nutrition. The nutritional assessment included the resident interview, observations, and if the resident's current intake was adequate to meet their nutritional needs.The 10/ 1997 facility policy Weight Assessment and Intervention, revised 1/2025, documented nursing would have notified the dietitian of any significant weight losses, and the dietitian would have responded within seven days. The dietitian would have estimated nutritional needs and the interdisciplinary team (dietitian, nursing, medical, pharmacist) would have planned the appropriate interventions. 1) Resident #2 had diagnoses of urinary tract infection, pneumonia and depression. The 6/7/2025 Minimum Data Set assessment documented the resident had a Brief Interview for Mental Status score of eight, had daily symptoms of depression, weighed 149 pounds, and did not have weight loss. Their daily intake was 25% or less, and their fluid intake was 501 milliliters or less. The Comprehensive Care Plan initiated 4/4/25 and updated 9/23/25 documented the resident had depression, pneumonia, urinary tract infection, and a risk for malnutrition. Interventions included encourage and monitor meal intake, identify and honor preferences, double portions with meals, monitor weights, and monitor meal consumption. The resident's record documented the following weights:-on 5/1/2025 142 pounds;-on 6/3/25 149 pounds;-on 7/3/2025 147.2 pounds;-on 7/9/2025 142.6 pounds;-on 7/16/2025 142.3 pounds-on 7/24/2025 138.8 pounds-on 8/1/2025: 127.6 pounds with reweight 128.6 pounds (12.6 percent weight loss in one month and 9.5% loss in five months). There was no documented evidence the family, physician, or dietitian were notified timely of the significant change in weight. The 5/8/2025 Registered Dietitian #13 progress note documented the weight of 144.4 pounds and noted weights were stable with intake greater than 75 percent of meals. The 5/19/2025 Registered Dietitian #13 progress note documented Resident #2 requested double portions at meals, which was implemented. Meal Consumption Records for May of 2025 documented their intake ranged from fifty to one hundred percent of meals at that time. The 7/16/2025 Nurse Practitioner #18 progress note stated Resident #2 developed pneumonia, antibiotics were initiated, and recommended staff encouraged sips of liquid supplements and fluids at that time. There was no documentation that staff encouraged sips of liquid supplements or fluids. The 7/20/2025 Physician #19 progress note documented abnormal labs with altered mental status. They initiated one liter of hydration given by given subcutaneously for hydration. The treatment was on the Treatment Administration Record on 7/18/2025, however was not signed by staff as provided. The 7/29/2025 Nurse Practitioner #20 readmission note documented Resident #2 was treated for influenza and dehydration and was at risk for malnutrition and stated nutritional intervention was mandatory at that point. The 7/31/2025 Physician's Assistant #22, 8/8/2025 Nurse Practitioner #21, and 8/10/2025 Physician's Assistant #23 progress notes all documented Resident #2 was not having regular bowel movements and recommended increased movement and increased fluid intake. There was no evidence of increased fluid intake documentation. The 8/25/25 Physician #19 note documented the resident had