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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for one (1) of two (2) medication rooms (Units A and B medication rooms) and one (1) of one (1) medication carts (Unit A South) reviewed. Specifically, the Unit A medication room had medications stored on the floor, discontinued medications were placed on a shelf with a resident's unlabeled personal medications stored in an emesis bag (used to collect vomit), and the medication refrigerator temperatures were out of range and contained frozen insulin pens; the Unit A South medication cart had an unlabeled insulin pen in the top drawer, and a licensed practical nurse handed their medication cart and medication room keys to another licensed practical nurse without completing a narcotic medication reconciliation count.Findings include: The facility policy Storage of Medications, last reviewed 1/2023, documented drugs and biologicals should be stored in the packaging, containers or other dispensing systems in which they are received. The nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. Drug containers with missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. The facility policy Controlled Substance/Narcotic Management Protocol, last reviewed 1/2023, documented all narcotics would be counted and reconciled at the beginning of every shift with the outgoing and oncoming nurse. Both must sign the controlled substance log attesting to the presence of the narcotic as stated from the previous shift. The facility policy Maintenance Policy and Patient Care-Related Electrical Equipment, revised on [DATE], documented medication refrigerators were inspected annually and maintained according to manufacturer's' specification as stated in the user manual for the item by the maintenance department at the facility.The [DATE] A Wing Refrigerator /Freezer Temperature log documented temperatures above 41 degrees and below 32 degrees Fahrenheit should be reported to the Director of Maintenance or designee. The A wing refrigerator temperatures were documented as follows:-On [DATE] at 12:30 AM, 28 degrees Fahrenheit, the temperature was not in compliance, and a text was sent to the Administrator on call.-On [DATE] at 8 PM, 30 degrees Fahrenheit and was documented as a Y for in compliance.-On [DATE] at 11:30 PM, 28 degrees Fahrenheit and the temperature was adjusted as a corrective action.-On [DATE] at 7:00 AM, 28 degrees Fahrenheit, and the temperature was adjusted. N/A (not applicable) was documented each day the refrigerator was out of temperature for corrective action taken.During an observation and interview with Licensed Practical Nurse Unit Manager #1 on [DATE] at 1:07 PM, the Unit A medication room had three 2-gram vials of ceftriaxone (an antibiotic) in a clear bag and a box of 100 count 25-gauge syringes on the floor. Licensed Practical Nurse Unit Manager #1 stated the resident was no longer taking the antibiotic and it should be hung in the bag on the wall and returned to pharmacy. Licensed Practical Nurse Unit Manager #1 stated there should not be anything on the floor in the medication room. There was a green emesis bag with an unlabeled bottle of Tylenol Extra Strength inside. Licensed Practical Nurse Unit Manager #1 stated (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Tylenol belonged to a new resident and was supposed to be sent home with the family but should be labeled and stored in a clear bag and not wrapped in an emesis bag. The bottom refrigerator temperature read 28 degrees Fahrenheit and there were two vials of lispro insulin, and three Humalog insulin pens that appeared frozen and frosty in color. The Licensed Practical Nurse Unit Manager #1 stated the refrigerator was for storing surplus insulins and the insulin would need to be thrown out. They were not sure what they needed to do and would call their pharmacy representative and notify maintenance. They stated the refrigerator temperature was out of range that morning and they turned the temperature up. The refrigerator was supposed to be above 32 degrees Fahrenheit and was still out of temperature range. During an observation on [DATE] at 1:16 PM, Licensed Practical Nurse #3 gave their medication cart and narcotic keys to Licensed Practical Nurse Unit Manager #1 so the locked narcotic cabinet in the medication room could be opened. Licensed Practical Nurse Unit Manager #1 stated they realized they should not have taken Licensed Practical Nurse #3's keys and returned them to the nurse. At 1:22 PM, the top refrigerator in the medication room had a buildup of ice in the freezer. There were vaccines, insulin vials and rectal suppositories. Licensed Practical Nurse Unit Manager #1 stated the freezer would need to be defrosted and the cleanliness and organization of the medication room was the responsibility of all nurses.During an interview on [DATE] at 1:23 PM, Licensed Practical Nurse #3 stated they gave their narcotic cupboard, and medication room keys to the manager because they were passing medication and the manager asked for them. They realized they should not have given the keys to the manager; the keys were their responsibility. During an interview on [DATE] at 1:27 PM, Licensed Practical Nurse #2 stated a nurse should never hand over the keys without a narcotic count.During an observation and interview on [DATE] at 2:26 PM, Licensed Practical Nurse #2 had a Lantus insulin pen that was in the top right drawer of the medication cart, and it did not have a resident name or label. They were not sure who the pen belonged to and stated it should be thrown out. They discarded the insulin pen into the sharp container.During an interview on [DATE] at 12:41 PM, the Director of Nursing stated the medication rooms and cart should be kept clean and medications should be stored properly and with labels. Medications that were not in use or expired should be sent back with the pharmacy the same day and personal medications from home should be sent home with family or stored in a plastic bag with a proper label. The refrigerator temperatures should be checked nightly, and they were made aware of the out-of-range temperatures and Licensed Practical Nurse Unit Manager #1 was directed to reset and recalibrate the temperature. The frozen insulin was thrown out and reordered. The maintenance staff had to reset the refrigerator temperature. They stated a licensed nurse should not hand their medication room/cart keys over to another nurse without a proper narcotic medication reconciliation count. That was the facility policy. Also, insulin pens should always have a pharmacy sticker with a resident name and the date they were opened. 10NYCRR 415.18(d)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure food was stored, prepared, distributed, and served in accordance with professional standards in one (1) out of one (1) main kitchen and for two staff (Dietary Aide #5 and Dietary Aide #6). Specifically, in the main kitchen staff did not wash their hands before preparing food; food was not labelled and dated; and food contact surfaces were not sanitized appropriately. Additionally, Dietary Aide #11 and [NAME] #9 did not wear beard restraints during food preparation.Findings include:The undated facility policy Sanitization documented all equipment, food contact surfaces and utensils would be sanitized using chemical sanitizing solutions per manufacturer's instructions.The facility policy Hair Net Use, revised 1/2025, documented all foodservice staff would wear hair restraints when handling food or working in food related areas, and the hair net would fully cover all hair. In addition, all staff with facial hair would wear a beard net in the kitchen. The undated facility policy Hand Washing documented foodservice staff would wash their hands when entering the kitchen at the start of their shift.The product label for the three-bay sink sanitizer documented dishes were immersed completely in a 150-400 parts per million active quaternary solution for at least 60 seconds. The chlorine test strips for the dish machine stated the test strip would be immersed in the sample and immediately removed. The test would be read after 5-10 seconds. Handwashing:During an observation on 9/22/2025 at 6:25 AM, there were no paper towels at both main kitchen handwashing sinks, and both sinks were dry. Dietary Aide #5 and Dietary Aide #6 had just arrived and started work on food preparation for the day. Staff were not observed washing their hands before starting food preparation. When asked about the paper towels they looked at each other wide eyed and stated the director would arrive soon then left the area.During an observation on 9/23/2025 at 11:45 AM, [NAME] #9 changed their gloves and touched the garbage can, then went back to meal preparation without washing their hands. When questioned about this, they went and washed their hands. Food Service Director #10 stated they should have washed their hands after touching garbage and staff sometimes forgot the garbage lid was dirty.Undated and unlabeled items:During an observation of the 2-door reach-in cooler on 9/22/2025 at 6:25 AM, there were three unlabeled and undated sandwiches in a metal pan. Dietary Aide #5 stated they must have been from the previous evening dinner. During an observation of the walk-in cooler on 9/22/2025 at 6:40 AM, there were two unlabeled pans of sliced meat in a metal pan. During an observation of the walk-in cooler on 9/23/2025 11:10 AM, there was one unlabeled pan of sliced meat in a metal pan.Hair Restraints:During an observation on 9/23/2025 at 11:40 AM, Dietary Aide #11 and [NAME] #9 were observed with uncovered beards, working with food. Sanitization:During an observation on 9/23/2025 at 10:30 AM, the following sanitization issues were observed:-the 3-bay sinks were all empty. [NAME] #8 brought a metal pan over and ran some detergent mix from the far right sink into the pan and scrubbed it clean. They rinsed it under the sanitizer mix in the first sink for fifteen seconds. They stated the pan needed a quick dip in the sanitizer and utensils and pans needed to be submerged for 30 seconds to sanitize. They demonstrated testing the sanitizer strength by dipping the strip in the sanitizer quickly and pulling it out. They were not sure how to read it and stated they didn't usually do this task. -Dietary Aide #7 stated they tested the sanitizer of the low temperature dish machine most days. They demonstrated how they did this every day and placed the test strip in the water at the end of the machine cycle and read the result immediately. No sanitizer registered on the test strip. They tried to test it again with the same results. The label of the test strips stated the reading would take place after waiting 10 seconds. After 10 seconds, the sanitizer read 300 parts per million.- A red bucket of liquid with a cloth in it was observed under the cooks' table. [NAME] #8 stated it was sanitizer used to sanitize the tray line, and they had filled the bucket about an hour prior. They tested the sanitizer strength, and no sanitizer registered. They stated they accidentally filled the bucket with (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleanser instead and had used it to sanitize tray line.During an interview on 9/25/2025 at 10:37 AM, Dietary Aide #7 stated they tested the dish machine temperature and sanitizer strength every morning they worked and recorded the information of the dish machine log sheet. They stated they dipped the test strip in the water at the end of the wash and immediately read it. They stated it was always around 50 parts per million. They stated they sanitized dishware to kill germs. They stated they were required to wash their hands anytime they entered the kitchen, when they were dirty, after using the bathroom, and after breaks. They stated all hair needed to be in a hair net, including beards. During an interview on 9/25/2025 at 10:45 AM, [NAME] #8 stated hand washing occurred when staff arrived at work, after touching food, when gloves were changed, and when dirty and they were trained years ago on the 3 bay sink procedure, and all three sinks would be filled when in use. The pans would be washed in the far-right sink, rinsed in the middle sink, then submerged in the left sink for 30 seconds. The sinks were always full when used at the scheduled washing times, four times a day. [NAME] # 8 stated the sinks were empty when they used it because it was not time to fill the sinks yet. They stated dishes were sanitized to kill germs. They stated the sanitizer strength was tested to make sure it worked properly, and staff assigned to the 3-bay sink did the testing. They stated they did not usually test the sanitizer. [NAME] #8 stated all leftover food was put in a new pan, wrapped up, then labelled and dated to be used first. They stated all staff with facial hair needed it covered so facial hair did not fall in the food.During an interview on 9/25/2025 at 10:52 AM, Food Service Director #10 stated all foodservice staff washed their hands before starting work, after breaks, before touching food, after using the bathroom, and as needed. They stated any leftover sandwiches in the cooler would be dated and labelled or thrown away. All staff were trained to fill all three sinks three to four times a day and if the sinks were not filled dishes would not be washed and the 3-bay sink procedure was to fill the far-right sink using the detergent mix from the dispenser, the middle sink with warm water, and the left sink with the sanitizer mix from the dispenser. The sanitizer strength would be tested after the sinks were filled, to make sure the sanitizer was at the correct strength. Staff would scrub the pans in the far-right sink, rinse in the middle sink, then submerge in the left sink for at least 30 seconds to sanitize. They stated this was being done every day and [NAME] #8 was in a hurry and did not follow procedure. They stated facial hair would be covered to prevent hair from falling in the food. 10NYCRR 483.60(i)(1)-(2)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record review, and interview during the recertification survey conducted 9/22/2025-9/25/2025, the facility did not ensure residents had a means of directly contacting staff for assistance for one (1) of one (1) residents (Resident #9) reviewed. Specifically, Resident #9's call bell was out of reach and not accessible. Additionally, Residents #10, 24, 62's call bells were observed to be out of reach one day of survey and Resident #63's call bell was observed to be out of reach two days of survey. Findings include:The facility policy Call Bell System, revised1/2025, documented that each resident would have a call bell within reach and the cord would be clipped to the bed or another appropriate area within the reach of the resident.Resident #9 had a diagnosis of dementia. The 8/24/2025 Minimum Data Set assessment documented impaired cognition, was usually understood, and was dependent for most activities of daily living.The 12/1/2023 Comprehensive Care Plan, revised 8/18/2025, documented the resident required assistance with self-care. Interventions included encourage resident to use call bell for assistance. During an observation on 9/22/2025 at 7:39 AM, Resident #9 was in bed, and their touch pad call bell was on the floor out of their reach.Additionally, the following observations of call bells were made:-on 9/22/2025 at 6:42 AM, Resident #6 was in bed, and their call bell was resting on the lower frame of the bed out of their reach.-on 9/22/2025 at 7:22 AM Resident #62 was in bed, and their call bell was on the floor out of their reach. The resident was calling out help me repeatedly.-on 9/22/2025 at 7:27 AM Resident #10 was in bed, and their call bell was on the floor under their bed out of their reach.-on 9/22/2025 at 8:44 AM Resident #63 was in bed, and their touch pad call bell was on the floor out of their reach.-on 9/23/2025 at 9:27 AM 15B Resident #63 was in bed, and their touch pad call bell was on the floor out of their reach.During an interview on 9/25/2025 at 10:06 AM, Certified Nurse Aide #26 stated every resident should have a call bell within reach regardless of their physical or cognitive status. Resident #9 was able to use their call bell, make some of their needs known, and should have a call bell in reach at all times.During an interview on 9/25/2025 at 10:18 AM, Licensed Practical Nurse #27 stated every resident should have either a touch pad or push button call bell within reach. They have had to get after the aides many times about making sure that happened. Resident #9 was able to make their needs known and should have a call bell within reach.10NYCRR 415.5(e)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, record review, and interviews 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)

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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. 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 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 unintended weight loss during the last four weeks and recommended a dietitian consult. There was no documentation that a dietitian consultation was completed. The 9/18/2025 Registered Dietitian #14's progress note documented the resident hospitalized (from 8/27/2025 through 9/17/2025) and was readmitted on a regular, pureed diet with honey thick liquids. They noted no change was made to current nutrition plan, no weights would be obtained due to new comfort care orders, and that a full nutrition assessment to follow. The 9/22/2025 Registered Dietitian #14 progress note documented Resident #2 triggered for significant weight loss in one month and intake of food and fluid was minimal. Comfort measures were in place. Their nutritional needs were estimated but no new nutritional interventions were implemented. During an interview on 9/25/2025 at 9:40 AM, Certified Nurse Aide #24 stated they notified their unit manager if they noticed a resident was not eating well, because it meant something might be wrong. They worked with Resident #2 and they were eating very well until a couple months ago. They needed more help with meals but would only allow a few staff to help. They stopped feeding themselves and the unit manager was notified. When they came back from the hospital last week, they ate very little if anything. During an interview on 9/25/2025 at 9:50 AM, Licensed Practical Nurse/Unit Manager #1 stated if a resident was not eating well, they increased supervision at meals, offered increased encouragement, and provided increased assistance. Weights were obtained monthly in the first week of each month. If there was a five-pound weight change a reweight was obtained. If weight loss was confirmed they would have investigated the cause. They monitored weights themselves because they had no dietitians for a couple months, however the dietitian usually monitored for weight changes and entered them into the medical record. They worked closely with Resident #2 and when they had a change in intake of food and fluid, they started feeding them if the resident allowed. The physicians followed Resident #2 closely. Physicians entered their own orders in the medical record, and if an order for a liquid supplement had been entered the nurses would have seen it and initiated the plan. Nurses did not go through the medical record daily to read all the notes that were written. During an interview on 9/24/2025, Dietitian #14 stated they started at the facility a few weeks prior. If a resident was not eating well, they met with them, obtained food preferences and added a supplement if needed. Nursing obtained the weights and typically the dietitian monitored the weights, but the unit manager had been doing it. If a resident was losing weight, they were weighed weekly and they were discussed in morning meeting with nursing and the physician. The dietitian made a list of who needed weekly weights and sent this to the unit manager, as well as any reweights needed. Once everything was finalized the dietitian entered the weights in the medical record. On 9/22/2025 Resident #2 triggered for significant weight loss in one month when the nutrition assessment was completed, and comfort measures were in place with very little intake. They followed up to see if Resident #2 wanted any changes in meal plan, but they declined. They stated any intervention initiated would have been on the care plan. The Comprehensive Care Plan had no new documented interventions. During a telephone interview on 9/25/2025 at 11:49 AM, Dietitian #13 stated they left the facility in the beginning of July 2025. They did not recall Resident #2 but stated nursing obtained the weights and obtained a reweight if a weight changed five pounds or more from the last weight. Nursing then handed the list of weights and reweights to them, and they entered them into the computer. This process often did not happen, and they often had to seek out weights and reweights themselves from nursing. If a resident lost weight, they asked for a reweight, then investigated the cause. Nursing (continued on next page)

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	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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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff was responsible for audit and monitor of weights, which did not always happen. During a telephone interview on 9/25/2025 at 11:56 AM, Nurse Practitioner #16 stated if a resident was losing weight they were discussed in the morning meeting, attended by medical staff, unit nursing managers, Director of Nursing, Administrator, and the dietitian. If there was no facility dietitian, the electronic medical record would have notified providers of a clinical issue for weight loss, however they had not received a weight loss notification since starting at the facility last month. During an interview on 9/25/2025 at 12:20 PM, Director of Nursing #4 stated nursing obtained weights monthly and recorded them in the medical record. The unit manager reviewed weights for any needed reweights then the dietitian reviewed the weights and reweights. Any significant changes were initiated by the dietitian or unit manager the next day and discussed with the physician. If a dietitian was not on staff, the physician filled in. The nursing staff alerted the physician if a weight loss triggered in the absence of a dietitian, and triggers occurred with a three percent weight change. Resident #2 lost significant weight on 8/1/2025 and it was not reported to the physician timely while a dietitian was not on staff at the facility. Timely interventions were important for good outcomes. The nursing team should have followed up on the poor intake and read provider notes that recommended starting a liquid supplement. They did not know if nursing followed up with the physician regarding the weight lost, however there was no documented evidence in the chart that they had. The weight loss was not on the 24-hour reports and should have been. They were not sure if Resident #2 was harmed by the lack of follow up regarding the weight loss. During a telephone interview on 9/25/2025 at 12:58 PM, Nurse Practitioner #18 stated they were notified of weight loss by the nursing team or dietitian and would have met with the dietitian to investigate why the weight loss occurred. When they assessed weight loss, they ordered a supplement, but they were not often in the facility to cover clinical issues. They evaluated Resident #2, who was acutely sick, and requested staff tried a liquid supplement with them. If they liked the supplement, then an order would have been written. They were not sure if the staff followed up on the recommended supplement, and they had not been back in the facility since. During a telephone interview on 9/25/2025 at 1:39 PM, Physician #19 stated they were usually notified of weight losses by electronic mail. They checked medications and diagnoses for causes. It is important to find the cause of unplanned weight loss. They were usually the one who notified the facility they had found weight loss when they reviewed weights for a resident assessment. They found Resident #2's weight loss when they reviewed the medical record and immediately wrote a note about it. They evaluated a change in condition with the resident and ordered some testing and consulted a specialist. When the results came back, the resident was sent out to the hospital for gallbladder concerns. If a dietitian was not on staff at the facility, there was nobody that covered the position. They did not know if an intervention was implemented when the weight loss occurred. They stated a lack of intervention when the weight loss occurred could have been harmful. The weight loss evaluation was delayed and should have been caught earlier. 2) Resident #8 had a diagnosis of intracerebral hemorrhage (a type of stroke), hemiplegia (limited use of one side of body), dysphagia (difficulty swallowing), and gastrostomy status (a tube placed in the stomach for the purpose of feeding). The 7/28/2025 Minimum Data Set assessment documented intact cognition; set up for eating; had a gastrostomy tube; and received 51% or more of total calories and 501 milliliters or more of fluids via their feeding tube.The 6/4/2024 Comprehensive Care Plan documented the resident required a tube feeding. Interventions included administer tube feeding and water flushes per the registered dietitian's recommendation and physician orders. It did not document the resident was able to self-administer flushes or feedings.The 6/2/2024 Licensed Practical Unit Manager #1's Care Plan Meeting note documented the resident's medications, tube feeding and trach were managed by nursing, however the resident had been taught and was able to administer their own medications and tube feeding with nursing supervision.The nursing progress notes did not document the dates of the teaching or that the resident was able to perform return demonstration.The physician orders documented the following:-2/3/2023 the resident was to receive 75 milliliters of water after each (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tube feeding and 100 milliliters before, with, and after each medication administration.-11/30/2023 the resident was to receive Jevity 1.5 (a tube feeding formula) 320 milliliters four times a day.-12/4/2023 the resident was to receive 100 milliliters of water four times a day prior to tube feeding.The physician orders did not document the resident could self-administer medications or feedings.The 6/27/2025 Dietitian #13's dietary note documented the tube feeding of Jevity 1.5 320 milliliters four times a day and the water flushes of 100 milliliters before each tube feeding, 75 milliliters after each tube feeding and 100 milliliters before, with and after medications provided 94-100% of the estimated kilocalorie needs, and greater than 100% of the estimated protein and fluid needs. During an interview on 9/23/2025 at 10:45 AM Licensed Practical Nurse #12 stated the resident did their tube feeding independently.During an observation and interview on 9/23/2025 at 11:00 AM the surveyor and Licensed Practical Nurse #12 entered the resident's room. The resident poured 200 milliliters of Jevity 1.5 into their feeding bag then added two 60 milliliter syringes of tap water. The resident stated after the feeding was done the amount of water they flushed with would depend on what they felt like. The resident connected the tube feed bag to their tube, unclamped the tubing and the feeding began to flow in. During an observation on 9/23/2025 at 11:49 AM Licensed Practical Nurse #12 brought the resident their crushed medications in a plastic drinking cup. The resident mixed the medications with 60 milliliters of water, poured it in the feeding bag and connected their tube to the bag. Licensed Practical Nurse #12 had to squeeze the bag to get the fluid to infuse and stated they might need to add more flush and asked the resident if they flushed their tube after their last feeding. The resident stated they flushed with 200 milliliters. The resident declined more flush and instead squeezed the tube to prompt the flow. After the bag was empty, they disconnected the tubing. No flush was given.During an interview on 9/23/2025 at 11:14 AM Licensed Practical Nurse #12 stated the nurses were supposed to observe the resident as they may have issues with the bag. After reviewing the order with the surveyor, they stated the resident's order was for 320 milliliters, and that should not include water; it should be 320 milliliters of Jevity 1.5 and then the additional water flushes.The September 2025 Medication Administration Record documented on 9/23/2025 Licensed Practical Nurse #12 signed for the 11:00AM administration of 100 milliliters of water flush prior to tube feed; 75 milliliters of water after tube feeding; and 320 milliliters of Jevity 1.5. Additionally, they signed for 12:00 PM administration of 100 milliliters of water flush before, with, and after medication administration.On 9/25/2025 at 10:30 AM a call was placed to Licensed Practical Nurse #12 and a voice mail left asking they return the surveyor's call. Surveyor did not receive a call back.During an observation and interview on 9/24/2025 at 10:54 AM the resident shook one partially filled carton and one full carton of Jevity 1.5. They emptied the partially filled carton into their feeding bag and then added more from the full carton to fill to the 200-milliliter line on the feeding bag. The resident stated their intent was to fill to the 200-milliliter mark. They then filled a 60-milliliter syringe full of water twice and added that to the bag. They hooked the feeding bag tuning to their gastrostomy tube and released the clamp. They stated they would flush with two more syringes of water once the feeding was done. During an observation on 9/24/2025 at 12:17 PM Licensed Practical Nurse #15 brought a plastic drinking cup of water with crushed medications in it to the resident and left the room. The resident stirred it, poured it into the feeding bag, hooked it up to their tube, and released the clamp allowing the solution to rapidly drip. Once completed the resident used a syringe to put in 60 milliliters of water in the bag. After that flowed in, they disconnected the tube.The September 2025 Medication Administration Record documented that on 9/24/2025 Licensed Practical Nurse #15 signed for the 11:00AM administration of 100 milliliters of water flush prior to tube feed; 75 milliliters of water after tube feeding; and 320 milliliters of Jevity 1.5. Additionally, they signed for 12:00PM administration of 100 milliliters of water flush before, with, and after medication administration.During an interview on 9/24/2025 at 12:57 PM Licensed Practical Nurse #15 stated if a resident was able to self-administer their medications and feedings it required a physician order and would be noted on the medication administration record. Self-administrations still had to be (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervised. When they signed the medication administration record it indicated that the right formula and the right amounts were given. They did not believe Resident #8 had to be directly supervised because being supervised upset them. They thought the resident was supposed to get a total of 300 milliliters of water with their medications and 75 milliliters before and after their feeding. That day they crushed the medications and put them in a cup with approximately 100 milliliters of water and brought it to the resident. They did not watch them self-administer. In the past they had observed the resident pour the correct amount of feeding which was four of the eight-ounce cartons. If the order was for 320 milliliters of Jevity 1.5 four times a day, that is what they should be getting. The resident should also receive water flushes as ordered.During an interview on 9/24/2025 at 3:53 PM Dietitian #14 stated they expected their recommendations were followed. They expected a tube feeding dependent resident's weight would be stable if they were getting what they were supposed to; stable meaning no changes of plus or minus 3%. Resident #8's weight had been stable for the past 6 months. They were made aware yesterday the resident self-administered their feeding. If the resident was giving themself 200 milliliters instead of 320 milliliters and not doing the full 300 with medication flushes, they would be falling below their recommendations and falling short of what they needed. During an interview on 9/25/2025 at 11:38 AM, the Director of Nurses stated for a resident to self-administer medications it would have to be determined they were cognitively able to do so. Nursing and therapy had to assess, and the physician needed to be involved as well. The education would be documented in a note. The resident would also be required to demonstrate correct administration. If a resident was deemed appropriate to do so, there should be a physician order, it should be in the care plan, and it should be reassessed quarterly and as needed. Resident #8 had been self-administering since mid-2024. The dietitian's recommendations should be followed and if the order was for 320 milliliters of Jevity 1.5 that is what the resident should be getting. The resident should also be receiving the amount of water flushes reflected in the physician order. They expected if the nurses were signing the medication administration record, that they were directly supervising to ensure it was being administered correctly.During an interview on 9/25/2025 at 11:52 AM, Nurse Practitioner #16 stated they depended on the hospital discharge and the recommendations of the dietitian for determining tube feeding and flush orders. They expected their orders were followed. Resident #8 was dependent on their tube feeding for nutrition. They did not know until just recently that the resident self-administered their feeding but should have known. If the resident was supposed to be getting 320 milliliters of Jevity 1.5 four times a day, the resident should not be administering 200 milliliters.