STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335589	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Rome	801 North James Street Rome, NY 13440

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 33421 Based on observation, record review, and interview during the abbreviated (NY00339441) survey the facility did not ensure residents at risk for pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to prevent new ulcers from developing and promote wound healing for 1 of 5 residents (Resident #293) reviewed. Specifically, Resident #293 developed a Stage 2 (partial-thickness skin loss) facility-acquired pressure ulcer when incontinence care was not provided routinely or as planned and treatments to the area were not consistently administered. Subsequently, the pressure injury progressed to an unstageable pressure ulcer (full thickness tissue loss in which the base of the wound is covered with dead tissue). Findings include: The facility policy, Prevention of Pressure Ulcers/Injuries, revised 1/2024, documented residents' skin was to be inspected daily when staff were performing or assisting with personal care or activities of daily living. Any signs of developing pressure injuries would be identified. Inspect pressure points (heels buttocks, elbows, sacrum), wash skin after any episode of incontinence using pH balanced cleanser, keep skin clean and free of exposure to urine or fecal matter, moisturize dry skin daily, and reposition the resident as indicated on their care plan. Residents who were chair/bed bound or dependent on staff for positioning would be repositioned at least every 2 - 3 hours or more frequently, as needed. All staff was responsible for reporting any changes to a resident's skin. All alterations in skin integrity would be reported immediately to the nurse, Unit Manager and/or Nursing Supervisor as well as the medical professional. Treatment orders would be obtained and initiated as ordered. Resident #293 had diagnosis including non-traumatic subarachnoid hemorrhage (bleeding in the brain) from a ruptured aneurysm. The 3/30/2024 Minimum Data Set assessment documented the resident had moderately independent decision making skills, had unclear speech, rarely/never understood others or made self-understood, did not reject care, was dependent on staff for all activities of daily living, was frequently incontinent of bladder and bowel, was at risk for pressure ulcers, did not have current unhealed pressure ulcers, had moisture associated skin damage (damage from prolonged moisture on the skin), applications of ointments/medications other than to feet, and had a pressure reducing device for the chair. The comprehensive care plan documented: (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
	335589	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Rome	801 North James Street Rome, NY 13440

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- initiated 3/26/2024 and revised on 4/8/2024 the resident had impaired skin integrity related to moisture associated skin damage of the coccyx (tailbone) and buttocks and a Stage 2 pressure ulcer to the right buttocks. Interventions included monitor/document/report signs and symptoms of infection, document wound measurements weekly, apply zinc ointment (protects from moisture) to the buttocks with each incontinent episode and cover with abdominal pad (a thick, absorbent dressing), no tape, encourage to turn and position every 2-3 hours, air mattress, and no incontinence pads over the air mattress. - initiated 3/26/2024 the resident had bowel incontinence related cerebral vascular accident (brain injury). Interventions included check resident every 2-4 hours and as needed and assist with toileting as needed. Provide peri-care after each incontinent episode. The resident's Kardex (care instruction) active as of 6/27/2024 documented keep skin dry, clean, and well lubricated; provide peri-care after each incontinent episode; incontinence brief check/change every 3-4 hours and as needed; check resident every 2-4 hours and as needed, assist with toileting as needed; and apply zinc oxide to buttocks and coccyx every shift and with each incontinence episode. The 4/1/2024 through 4/7/2024 certified nurse aide Documentation Survey Report did not document the resident was provided toileting hygiene on 4 of 7 dates (7 of 18 shifts). The 4/7/2024 at 9:07 AM Licensed Practical Nurse #20 progress note documented a certified nurse aide (unidentified) informed them at 8:00 AM that Resident #293 had dried feces on their buttocks, their bed was soaked with urine from the night before. The resident was cleaned, and they now had a skin tear to their right buttock. The 4/7/2024 at 12:00 PM Registered Nurse Unit Manager #47 wound assessment documented the resident had moisture associated skin damage to the right buttock measuring 7 centimeters x 5 centimeters. There was scant amount of serosanguinous (blood tinged serum) exudate (drainage) present. The wound had no odor, and the surrounding tissue was bright red and macerated (moisture damage). The resident tolerated the assessment and dressing change well (there was no documentation of what the dressing was). The 4//7/2024 at 9:35 PM Physician Assistant #22 progress note documented they were notified by staff that Resident #293 had skin irritation on the buttocks due to urinary incontinence that had developed into a Stage 2 pressure ulcer. Zinc ointment was to be applied to the area with each incontinence episode and wound care was to follow up with the resident. The 4/8/2024 Initial Wound Evaluation and Management Summary completed by Wound Physician #23 documented the referring provider requested a wound care assessment. The resident had a Stage 2 pressure ulcer on the right buttock that measured 8 centimeters x 4 centimeters x 0.1 centimeter with light serous (clear fluid) drainage. The development of the wound and the context surrounding the development were considered. Relevant conditions including dementia, urinary incontinence, and fecal incontinence were addressed. The treatment pan included: off-load wound; reposition per facility protocol; turn side to side in bed every 1-2 hours if able; apply zinc ointment every shift and as needed; and evaluation by wound care specialist within 7 days with further intervention as indicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335589	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Rome	801 North James Street Rome, NY 13440

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 4/8/2024 physician order documented cleanse right buttock with wound wash and pat dry. Apply zinc every shift and as needed for wound care. The 4/2024 Treatment Administration Record documented cleanse right buttock with wound wash and pat dry. Apply zinc every shift and as needed for wound care with a start date of 4/8/2024 and a discontinue date of 4/15/2024. There was no documented evidence the treatment was administered 4/9/24 on the 11:00 PM-7:00 AM shift; on 4/10/2024 on the 3:00 PM-11:00 PM and 11:00 PM-7:00 AM shifts; on 4/11/2024 on the 3:00 PM-11:00 PM shift; on 4/12/2024 on the 7:00 AM-3:00 PM shift; and on 4/14//2024 on the 11:00 PM-7:00 AM shift. The 4/8/2024 through 4/15/2024 certified nurse aide documentation of care did not document the resident was provided with toileting hygiene on 6 of 8 days (9 of 24 shifts). The 4/15/2024 Wound Evaluation and Management Summary completed by Wound Physician #23 documented a Stage 2 pressure ulcer of the right buttocks that measured 7 centimeters x 3.5 centimeters x 0. 1 centimeter. Treatment included: off-load wound, reposition per facility protocol, turn side to side in bed every 1-2 hours if able, and application of zinc ointment every shift and as needed. The wound had improved as evidenced by decreased surface area. The 4/15/2024 physician order documented cleanse bilateral buttocks with wound cleanser, pat dry. Apply barrier cream every shift and as needed for wound care. The 4/2024 Treatment Administration Record documented cleanse bilateral buttocks with wound cleanser, pat dry. Apply barrier cream every shift and as needed for wound care with a start date of 4/15/2024 and a discontinue date of 4/17/2024. The treatment was not documented as completed on 4/16/2024 on the 11:00 PM-7:00 AM shift. Physician orders documented: -On 4/17/2024 cleanse bilateral buttocks with wound cleanser, pat dry. Apply Vitamin A&D every shift and as needed for wound care. -On 4/19/2024 cleanse bilateral buttocks with wound cleanser, pat dry. Apply barrier cream every shift and as needed for wound care. The 4/16/2024 through 4/22/2024 certified nurse aide documentation of care did not document the resident was provided with toileting hygiene on 6 of 7 dates (10 of 21 shifts). The Comprehensive Care Plan initiated on 4/8/2024 and revised on 4/19/2024 documented the resident had an actual pressure ulcer related to impaired mobility and incontinence. On 4/15/2024 the resident had a Stage 2 pressure ulcer on the right buttocks and moisture associated skin damage on both buttocks; on 4/19/2024 the moisture associated skin damage was improved. The skin was pink, and there was a small scab on the right buttock. Interventions included pressure relieving devices for bed; assess wound weekly; document wound measurements, wound bed appearance, odor, drainage, and surrounding tissue; monitor wound daily for signs and symptoms of infection; monitor/document/report to physician as needed, changes in skin status. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335589	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Rome	801 North James Street Rome, NY 13440

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/22/2024 Wound Evaluation and Management Summary completed by Wound Physician #23 documented a Stage 2 pressure ulcer of the right buttocks that measured 6.5 centimeters x 6.0 centimeters x 0.1 centimeters. Treatment included: off-load wound, reposition per facility protocol, turn side to side in bed every 1 - 2 hours if able, and application of house barrier every shift and as needed. The wound was improved as evidenced by decreased surface area. The 4/23/2024 through 4/29/2024 certified nurse aide documentation of care did not document the resident was provided with toileting hygiene on 4 of 7 dates (5 of 21 shifts). The 4/29/2024 Wound Evaluation and Management Summary completed by Physician #23 documented an unstageable (full thickness tissue loss in which the base of the wound is covered with dead tissue) pressure ulcer of the right buttocks that measured 1.0 centimeter x 2.0 centimeter x unknown due to necrotic tissue (dead tissue that appeared black in color). Treatment included: off-load wound, reposition per facility protocol, turn side to side in bed every 1-2 hours if able, application of honey (medical grade honey used for wound healing) once a day and as needed, and application of barrier cream to peri wound every shift. The progress of the wound and the context of the wound were considered. Relevant conditions including fecal incontinence were addressed through treatment changes or investigations. The wound was chronic and stable with an insignificant amount of necrotic tissue and no signs of infection. The 4/29/2024 physician order documented cleanse right buttocks with wound cleanser and pat dry. Apply barrier cream to peri-wound (surrounding area of wound). Apply honey to wound bed and cover with border gauze daily and as needed every shift for wound care. The 4/2024 treatment administration record documented apply barrier cream to peri-wound. Apply honey (medical grade honey used for wound treatment) to wound bed and cover with border gauze daily and as needed every shift for wound care with a start date of 4/29/2024 and a discontinue date of 5/3/2024. There was no documentation the treatment was administered on 4/29/2024. A 5/2/2024 at 7:30 PM Registered Nurse #48's progress note documented they were notified by the front desk receptionist the resident's family called Emergency Medical Services and had the resident sent to the hospital. The registered nurse attempted to speak with the family, but the family dismissed them. The resident was sent to the hospital per the family wishes. The on-call provider and the Director of Nursing were notified. During an interview on 6/28/2024 at 11:02 AM, Licensed Practical Nurse #20 stated Resident #293 was on hourly checks and toileted every 2-3 hours. The resident was incontinent, and staff would check on them frequently and their incontinence brief would already be soaked with urine. They remembered on 4/7/2024 the certified nurse aides notified them during AM care that the resident had dried stool on them and had a small skin tear. They notified a supervisor, and a treatment was started. They did not recall who the supervisor was. During an interview on 6/28/2024 at 11:36 AM, Nurse Practitioner #25 stated they knew Resident #293 and a Stage 2 pressure ulcer was not usually from a single incident. A Stage 2 was not significant and was like the surface of the skin that came off. They stated it was not likely that Resident #293 sustained any harm from the incident, but the family was upset, and it was corrected immediately. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335589	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Rome	801 North James Street Rome, NY 13440

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 11:58 AM, Licensed Practical Nurse Unit Manager #6 stated they expected dependent residents to be checked and changed every 2 - 3 hours and as needed. They were not aware of staff not providing appropriate care, and they did not remember much about Resident #293. They expected staff to follow the resident's care plan and Kardex (resident care instructions). Staff should check the Kardex at the beginning of each shift in case changes were made to care. During an interview on 6/28/2024 at 12:13 PM, the Director of Nursing stated Resident #293 was dependent on staff for all their care, and they did not remember any family complaints about incontinence. They stated Resident #293 never had an order to be up, out of bed, or for a specific amount of time and it was not in their care plan or Kardex. Resident #293's pressure ulcer could have developed from not being toileted or repositioned as planned, but usually a one-time occurrence would not have caused it. During an interview on 7/9/2024 at 8:48 AM, Licensed Practical Nurse #47 stated all treatments were highlighted in the computer to let the unit nurse know what was due. They usually did the treatments after the morning medication pass or after lunch. The nurse doing the treatment should sign for it after completion. They always signed for the treatment if they did it and would document any refusals in a progress note. Resident #293's treatment frequently to their buttocks frequently changed. They did not know why the treatment was not signed for on 4/3/2024, 4/5/2024, and 4/10/2024. During an interview on 7/9/2024 at 9:01 AM, Licensed Practical Nurse #48 stated Resident #293 was admitted with a wound to their bottom, and it had improved by the time the resident was sent to the hospital. They were unsure why there were times the treatment was not signed for. Sometimes the nurse reported to work at 6:00 AM and that was why they signed for it on the night shift as being done. If a treatment was not done regularly, the wound could get worse. If something was not signed for, technically it was not done. During an interview on 7/9/2024 at 9:25 AM, Certified Nurse Aide #49 stated Resident #293 was dependent for all care, was able to help with turning, and only needed assistance of 1 at times. If there was only 1 nurse aide on duty, the unit nurse assisted with care. Sometimes there was not time to sign for provided care by the end of the shift. They did not remember if Resident #293 had an open area on their buttocks. During an interview on 7/9/2024 at 10:13 AM, Certified Nurse Aide #50 stated they documented care that was provided twice a shift unless they were the only one assigned to the unit. The unit nurse assisted with care during the night. During 4/2024, the 2nd aide on the unit frequently got pulled to another unit during the shift and that may have been why the care did not always get signed for by the end of the shift. Resident care came before documentation. The aides were allowed to put stock barrier cream on a resident, but the nurse would have to do it if there was a physician order. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335589	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Rome	801 North James Street Rome, NY 13440

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/2024 at 4:56 PM Wound Physician #23 stated the definition of an unstageable pressure ulcer was one covered with necrotic (dead) tissue and could not be accurately staged. It had to be a Stage 3 or 4 under the necrosis. They expected all physician orders to be followed or staff were to notify them if a treatment could not be done and the reason why, so they could provide further guidance to the nurses. Resident #293's buttock wound was small and had dead tissue over it. They were not sure why they did not debride it (remove dead tissue) prior to hospitalization . Without debridement they could not determine what the actual stage of the wound was or if it worsened. The resident did not return to the facility from the hospital. They were unable to determine if the missing treatments made the wound worse as the residents many comorbidities could come into play in that aspect. 10NYCRR 415.12(c)(1)