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	04/17/2026

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 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 2626225, 2712590, and 2740528), 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 seven (7) residents (Residents #1 and #2) reviewed. Specifically, Resident #2 was not toileted as planned; and Resident #1 was not provided with oral care as planned.Findings include: The facility policy Resident Care with Activities of Daily Living, last reviewed 01/2026, documented the facility would accurately assist with the residents need for basic activities of daily living functions; would provide adequate toileting maintaining maximum level of toileting and continence; would offer toileting assistance every two (2) to four (4) hours to those on a toileting program; would assist residents to cleanse and freshen the resident's mouth; and the supervisor would be notified of any refusals. 1)Resident #1 had diagnoses including dementia, anxiety, and Parkinson's disease (a progressive neurological disorder). The 01/11/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition, required substantial/maximum assistance with hygiene and toileting, partial/moderate assistance with oral care, did not have broken or loose teeth, and did not reject care. The Comprehensive Care Plan initiated 10/05/2023 and revised 03/17/2026 documented the resident required assistance with self-care and mobility. Interventions included substantial/maximum assistance for personal hygiene and oral care. The undated care instructions documented the resident required substantial/maximum assistance with oral hygiene. Resident #1 was observed with foul breath: -on 04/13/2026 at 10:19 AM -on 04/15/2026 at 8:01 AM On 04/15/2026 at 1:15 AM Certified Nurse Aide #32 documented oral care was completed for Resident #1. During an interview on 04/15/2026 at 9:04 AM the resident stated staff did not brush their teeth and they liked them brushed. During an interview on 04/15/2026 at 9:48 AM, Certified Nurse Aide #33 stated they were responsible for completion of resident care including washing, dressing, shaving, washing hair, nail care, and oral care for their assigned residents. When a resident's level of assistance was substantial/maximum, it required putting toothpaste on the toothbrush and brushing the resident's teeth. They were assigned (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 and did not brush their teeth because it was completed by the night shift when they got the resident up for the day. Resident #1 had never refused care in the past. It was important to perform oral care, so residents did not get mouth disease or cavities. During an interview on 04/16/2026 at 12:50 PM, Certified Nurse Aide #32 stated they worked the overnight shift. Every day when they arrived at their assigned unit, they completed rounds to ensure residents were clean and dry. After rounds, they completed their documentation for care they anticipated to complete when they got the resident up in the morning. They were never told to complete documentation only after the care was completed. They worked on the resident's floor on 04/15/2026 and they did not perform oral care for Resident #1 and did not recall signing for oral care. It was important to perform oral care to prevent cavities and infections in the mouth. During an interview on 04/17/2026 at 8:09 AM, Licensed Practical Nurse #28 stated routine dental care was important for dignity and to prevent infections. It was everyone's responsibility to perform oral care; however, the task primarily fell on the certified nurse aides. If the care plan documented a resident required substantial/maximum assistance for oral care that meant staff had to brush the resident's teeth. They stated Resident #1 was independent with brushing their teeth. During an interview on 04/17/2026 at 1:16 PM, Licensed Practical Nurse Unit Manager #5 stated both certified nursing aides and nurses performed oral care for residents. Care that was completed was documented only after the care was completed. Staff utilized the resident specific care card to determine the level of assistance required when completing care. Substantial/maximum assistance meant the resident required staff to put toothpaste on the toothbrush and brush their teeth. When a resident refused oral care or refused to see the dentist, the refusal should be documented in a progress note. 2)Resident #2 had diagnoses including dementia and assistance for personal care. The 02/27/2026 Minimum Data Set assessment documented the resident was rarely understood, was dependent on most activities of daily living, and was always incontinent of bowel and bladder. The comprehensive care plan initiated 11/05/2025, and revised 02/17/2026, documented assistance was required for self-care and mobility. Interventions included dependence on toileting hygiene and supervision or touching assistance for toilet transfers. The comprehensive care plan initiated 08/19/2023, and revised on 02/17/2026, documented the resident had occasional bladder incontinence. Interventions included check/change brief every three (3) to four (4) hours and as needed. During a continuous observation on 04/15/2026 from 9:13 AM-1:40 PM the resident was seated at a table in the dining area and was not repositioned, taken to the bathroom, or offered to be taken to the bathroom. At 1:40 PM staff walked the resident into the bathroom where their incontinence brief was removed and was observed to be saturated. During a continuous observation on 04/16/2026 from 8:27 AM-1:05 PM the resident was seated at a table in the dining area and was not repositioned, taken to the bathroom, or offered to be taken to the bathroom. At 1:05 PM Certified Nurse Aide #10 asked the resident if they wanted to be changed and Certified Nurse Aide #13 walked the resident to their room. The resident's right buttock and right inner thigh area of their pants had a wet area approximately 12 x 8 inches. The 04/15/2026 and 04/16/2026 toileting hygiene documentation report documented the resident was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toileted during the day shift on 04/15/2026 at 12:50 PM and 04/16/2026 at 2:53 PM. During an interview on 04/16/2026 at 1:05 PM, Certified Nurse Aide #10 stated most residents were toileted or repositioned every two (2) to three (3) hours; they were supposed to document each time a resident was taken to the bathroom; and any refusals of care should be reported to a nurse. They took care of Resident #1 on 04/15/2026 and 04/16/2026 during the day shift. The resident should be toileted every two (2) to three (3) hours. On both days, the night shift got the resident up and dressed prior to the start of the 7:00 AM day shift and both days they asked the resident if they needed to be changed, and the resident declined. They never reported the declinations or reapproached the resident because they got busy and forgot. During an interview on 04/17/2026 at 9:10 AM, Licensed Practical Nurse #11 stated residents should be repositioned and toileted every two (2) hours. The aide assigned to that resident was responsible for doing that and the nurse was responsible for making sure it happened. Resident #1 was incontinent and needed assistance to be toileted every two (2) to three (3) hours. They had not noticed the resident sat for a long time in the dining area on either 04/15/2026 or 04/16/2026 and no one reported any care declinations. The resident should not have been sitting for over four (4) hours. 10 New York Codes, Rules and regulations 415.12(a)(3)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record review, and interviews (iQIES Intake 2620687) the facility failed to ensure a system of records and accounts of all controlled drugs was maintained for one (1) of five (5) residents (Residents #28, #40, #57, #99, and #106) reviewed. Specifically, on Unit 1 a controlled substance reconciliation (a system of recordkeeping that ensures an accurate inventory of controlled medications) was not performed between the oncoming and outgoing nurse, narcotic keys were not transferred between nurses in a secured manner, a narcotic medication was signed out as administered, but was not, and a poured controlled substance was insecurely stored in the medication cart; Resident #28's, Resident #40's, Resident #57's, and Resident #99's controlled substance records did not accurately reflect the level of medications on hand; and Resident #106 did not receive an as needed dose of lorazepam that was signed out on the reconciliation sheet. Findings include:The facility policy Controlled Substance/Narcotic Management Protocol, last reviewed 01/2026, documented with each administration the nurse must document the date, time, prior count, and post administration count of the remainder of the medication and sign in the controlled substance log book; in the event a resident does not take a controlled substance that had already been removed from its package, the nurse must destroy the medication in the presence of another nurse; all narcotics would be counted and reconciled at the beginning of every shift with the outgoing and oncoming nurse and both must sign the controlled substance log attesting to the presence of the narcotic as stated from the previous shift; and any discrepancies in the count must be reported to the unit manager or supervisor immediately.The Unit 1 04/12/2026-04/14/2026 Narcotic Count record documented on 04/14/2026 at 7:00 AM Licensed Practical Nurses #11 and #15 signed as the oncoming and outgoing nurses.Resident #40The 04/06/2026 physician order documented Resident #40 was to receive Vimpat (lacosamide; a controlled substance anti-seizure medication) 10 milligrams/milliliter, 20 milliliters by mouth two (2) times a day.The following observations were made on 04/14/2026 at 10:28 AM of the Unit 1 medication cart and medication room:-An opened bottle of Resident #40's Vimpat was in the locked compartment of the Front medication cart. The bottle was marked at 50-millimeter increments starting at 50 and going to 400 and was filled to the 50-milliliter increment. An additional two (2) unopened bottles filled to the 400 milliliter mark were locked up in the medication room for a total of 850 milliliters.-The 04/12/2026- 04/14/2026 Narcotic Count record documented on 04/14/2026 at 7:00 AM 940 milliliters of lacosamide (Vimpat) were remaining.-Resident #40's Vimpat controlled substance administration record documented on 04/14/2026 at 8:00 AM Licensed Practical Nurse #15 signed out 20 milliliters leaving a balance of 940 milliliters. -Resident #40's April 2026 Medication Administration Record documented Licensed Practical Nurse #15 administered the resident 20 milliliters of Vimpat on 04/14/2026 between 7:00 AM and 10:00 AM.During an interview on 04/14/2026 at 10:28 AM, Licensed Practical Nurse #15 stated Resident #40 had a total of 850 milliliters of Vimpat. They did not know why they signed on the narcotic sheet there were 940 milliliters. They last counted the narcotics with Licensed Practical Nurse #11 at 6:00 AM on 04/14/2026 and used 20 milliliters of Resident #40's Vimpat since that count. Resident #99Resident #99's April 2026 Medication Administration Record documented they were scheduled to receive 10 milliliters of Vimpat twice a day. The start date was 03/12/2026. On 04/14/2026 Licensed Practical Nurse #15 documented a 9 (a code meaning other/see nurse notes) for the 7:00 AM - 10:00 AM administration time.The 04/14/2026 at 1:29 PM Licensed Practical Nurse #15's progress note documented the resident did not wake up, this medication was poured but not given.The following observations were made on 04/14/2026 at 10:28 AM during inspection of the Unit 1 medication cart and medication room:-Resident #99's Vimpat administration record documented Licensed Practical Nurse #15 signed out 10 milliliters on 04/14/2026 at 8:00 AM leaving a balance of 120 milliliters.-A 30-milliliter clear plastic cup with an unidentified clear liquid was partially spilt in the bottom of the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	locked narcotic compartment of the front medication cart.During an interview on 04/14/2026 at 10:28 AM, Licensed Practical Nurse #15 stated the clear liquid was Resident #99's Vimpat. The resident was not awake when they first brought the medication to them, so they held it. They had forgotten they put it in the narcotic compartment. They should have discarded it but did not because the resident did not have a lot of the medication left.Resident #106The following observations were made on 04/14/2026 at 10:28 AM during inspection of the Unit 1 medication cart and medication room:-Resident #106 had a medication card (blister pack) containing 26 lorazepam 0.5 milligram tablets. -Resident #106's lorazepam administration record documented Licensed Practical Nurse #15 signed out one (1) tablet on 04/14/2026 at 8:00 AM leaving a balance of 25 tablets.Resident #106's April 2026 Medication Administration Record documented lorazepam 0.5 milligrams (an anti-anxiety medication) every six (6) hours as needed for anxiety. The start date was 03/31/2026. There was no documented evidence the resident received lorazepam on 04/14/2026.During an interview on 04/14/2026 at 10:28 AM, Licensed Practical Nurse #15 stated they signed out Resident #106's lorazepam at 8:00 AM on 04/14/2026 intending to administer it but did not because the resident was not having any behaviors. They signed it out on the yellow (count sheet) sheet but should not have. Narcotics should be signed at the exact moment they were given.Resident #57Resident #57's April 2026 Medication Administration Record documented the resident was scheduled to receive gabapentin 300 milligrams (a controlled anti-seizure medication) twice a day. The start date was 11/21/2023.The following observations were made on 04/14/2026 at 10:28 AM during inspection of the Unti 1 medication cart and medication room:-Resident #57 had a full card of 30 gabapentin 300 milligram tablets in the medication room and one (1) card with 25 tablets in the medication cart for a total of 55 tablets.-The 04/12/2026- 04/14/2026 Narcotic Count record documented on 04/14/2026 at 7:00 AM Resident #106 had a balance of 56 gabapentin 300 milligram tablets.-Resident #57's gabapentin Control Substance Record documented Licensed Practical Nurse #15 signed out one (1) gabapentin tablet on 04/14/2026 at 8:00 AM leaving a balance of 56 tablets.During an interview on 04/14/2026 at 10:28 AM, Licensed Practical Nurse #15 stated when they signed out the gabapentin at 8:00 AM on 04/14/2026, they must have counted wrong and documented there were 56 tablets.Resident #28Resident #28's April 2026 Medication Administration Record documented they were scheduled to receive one tablet of hydrocodone-acetaminophen tablet 5- 325 milligrams (a narcotic pain killer) three (3) times a day. The start date was 03/26/2026.The following observations were made on 04/14/2026 at 10:28 AM during inspection of the Unti 1 medication cart and medication room:-Resident #28 had two (2) cards of hydrocodone-acetaminophen 5-325 milligrams tablets, each containing 30 tablets and a third card in the medication cart containing six (6) tablets for a total of 66 tablets.-Resident #28's hydrocodone-acetaminophen tablet 5-325 controlled substance administration record documented Licensed Practical Nurse #15 signed out one (1) tablet leaving a balance of 66 tablets.-The Narcotic Count record documented on 04/14/2026 at 7:00 AM Resident #28 had a balance of 68 hydrocodone-acetaminophen 5- 325 milligram tablets.During an interview on 04/14/2026 at 10:28 AM, Licensed Practical Nurse #15 stated narcotics were counted by two (2) nurses to make sure everything was accounted for and the number of pills documented on the count sheets should match the number of pills on hand. A two (2) person count was needed to confirm and agree on what the count was. They stated when they arrived that morning, Licensed Practical Nurse #11 had already filled out the narcotic count sheet with the number of medications and signed it. When they came on duty, they counted the narcotics by themself and co-signed the Narcotic Count record. They were supposed to look at the narcotic count sheet and the yellow controlled substance administration record to make sure both matched what was on hand.During an interview on 04/14/2026 at 1:02 PM, Licensed Practical Nurse #11 stated controlled substance counts were supposed to be done at the beginning and end of each shift by two (2) nurses to verify in writing the count was correct. The nurses should not sign the count sheets if they were not actually counting with someone but did because they were taking responsibility for counting themselves. They counted Resident #40's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vimpat last night when they came in at 11:00 PM and after referring to the bottles stated the count sheet should not say 940 milliliters as there were about 850 milliliters. When counting they roughly looked at the Vimpat bottles because there had not been issues with the count on that unit. They did not have their glasses on and could not see well. At the start of the day shift on 04/14/2026, they recounted the medications and brought out the medications they needed for the day medication pass. When Licensed Practical Nurse #15 arrived, they gave them the medication keys without first counting the narcotics with them. They should not have done that, but at the time they were busy with a tube feeding.During an interview on 04/17/2026 at 9:28 AM, Licensed Practical Nurse Unit Manager #12 stated the controlled substance count should be done with two (2) nurses; during the count both count sheets should be checked to verify the amount of medication matched; nurses should not be signing if they did not actually count with a second nurse; keys should not be exchanged until the count was verified; medications should be wasted if not immediately administered; and medications should be signed out at the time they were to be administered. Signing the Narcotic Count record attests the numbers were accurate. Nurses could prefill this form with the numbers and their signature but would have to make any necessary changes if there was a discrepancy found during the count.During an interview on 04/17/2026 at 11:22 AM the Director of Nursing stated controlled substance counts should be done by two (2) nurses while looking at the medication and both count sheets, and any discrepancies should be reported immediately. The Narcotic Count record should be filled out at the time of the count; the individual medication count sheets should reflect the time of the actual administration; and medications should not be poured and then put back in the cart. Liquid medications usually came in bottles that were marked with increments and levels were visually verified. They would expect that if the count sheet documented there was 940 milliliters of a medication but only 850 milliliters was visualized then that should be caught and reported. 10 New York Codes, Rules and Regulations 415.18

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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 (iQIES intake 2620687), the facility failed to ensure drugs and biologicals were labeled and stored in accordance with currently accepted professional principles for three (3) of four (4) medication carts (Wing Three front and back and Wing Four back medication carts) reviewed. Specifically, Wing Three front medication cart was unlocked and unattended with two (2) medicine cups containing pre-poured medications; Wing Three back medication cart had an undated, unlabeled, open vile of lidocaine (anesthetic), an opened and undated inhaler, one (1) expired insulin pen and one (1) expired insulin vial, and one (1) insulin pen and one (1) insulin vial that were opened and undated; and Wing Four had two (2) opened undated eyes drops, and five (5) opened undated inhalers. Findings included:The facility policy Storage of Medications, last reviewed 01/2026, documented nursing staff were responsible for maintaining medication storage. The facility did not use outdated drugs or biologicals and were returned to pharmacy. Compartments containing drugs and biologicals were locked when not in use, when unattended, or when potentially available to others.The facility policy Security of Medication Cart, last reviewed 01/2026 documented medications carts were securely locked at all times when out of the nurse's view.The facility policy Administering Medications, documented when multi-dose medications were opened the date opened was recorded on the container. Wing Three During an observation and interview on [DATE] at 11:05 AM the Wing Three front medication cart was unlocked and unattended. The first drawer of the medication cart contained two (2) unlabeled cups of pre-poured medications. The first cup contained one (1) round large white pill, two (2) round small white pills, one (1) oval white pill, one (1) round peach colored pill, one (1) round brown pill, and one (1) oval yellow pill. The second cup contained one (1) round yellow pill, one (1) round small red pill, one (1) beige capsule, and one (1) round white pill. Licensed Practical Nurse #6 stated they just walked away for a second to speak to a family member of a resident. They stated the medication cart should never be unlocked and unattended. One (1) resident was not available when they went to administer their medications, and they were waiting for the other resident's inhaler to come from pharmacy to administer their medications. The medicine cups were unlabeled, but they knew who each cup was for. They were unsure what they were supposed to do with the medications that were poured if the resident was not available.During an observation and interview on [DATE] at 9:35 AM the second drawer of the Wing Three back cart contained an opened, unlabeled, and undated vial of lidocaine. Licensed Practical Nurse #7 stated the lidocaine came with ertapenem (antibiotic) and was not labeled or dated when opened. They were unsure if the vial needed to be dated when opened. The third drawer of the cart contained an undated fluticasone/salmeterol inhaler. Licensed Practical Nurse #7 stated it probably should have been labeled when it was opened, but it was not. They were unsure why it was not dated. The small first drawer on the right of the cart contained a Rezvoglar (long acting) insulin with an opened date of [DATE], and a Humulin R (short acting) insulin vial with an opened date of [DATE]. Licensed Practical Nurse #7 stated insulins were good for 28 days after they were opened. They were both expired and needed to be discarded and reordered. They were unsure why expired insulins were in the cart. The drawer contained an opened and undated insulin lispro (short acting) vial and an opened and undated Lantus (long acting) insulin pen. Licensed Practical Nurse #7 stated insulins were required to be dated when opened. They were unsure when they were opened or if they were expired. The pen and vial needed to be discarded and reordered.During an interview on [DATE] at 2:10 PM Licensed Practical Nurse Unit Manager #8 stated when they administered medication, they checked the medication against the medication administration record and popped it into the medication cup prior to checking if the resident was available. Multiple medications cups should not be pre-poured. They were unsure what to do with (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pre-poured medications if the resident was unavailable. The medication carts should always be locked when unattended for safety. Any insulins, eye drops, open vials, and inhalers should be dated when opened. Insulin was good for 30 days and they were unsure how long nasal sprays or eye drops were good for. Anytime the nurse was given the med keys they looked over the cart. The overnight shift checked the cart for outdates and they audited the carts at the end of every month. Wing Four During an observation and interview on [DATE] at 10:14 AM the first drawer of the Wing Four back medication cart had artificial tears eye drops and latanoprost eye drops that were not dated when opened. Licensed Practical Nurse #9 stated eye drops were supposed to be labeled when opened, with an open date and an expiration date. Eye drops expired 30 days after they were opened. They were unsure why the eye drops did not have open dates. The third drawer of the medication cart contained opened, undated dinium/vilanterol) and albuterol inhalers that were unlabeled when open. Licensed Practical Nurse #9 stated they were never trained that inhalers had to be labeled when opened. They were unsure why the bag they came in had an open date sticker on them. They did not think that inhalers expired, they were good until the medication was finished.During an interview on [DATE] at 11:47 AM Licensed Practical Nurse Unit Manager #5 stated inhalers needed to be dated when they were opened, they were typically good for 30 days. They should have been thrown away if they did not have an open date. Eye drops should also be dated when they were opened, they were good for 30 days. If they were found to be undated, they should be discarded and reordered. 10 New York Codes, Rules and Regulations 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 observations and interviews (iQIES Intake 2620687), the facility failed to store food in accordance with professional standards for food service safety in one (1) of one (1) main kitchen and 1 (one) of 4 (four) unit pantries (Unit 2 pantry). Specifically, a black substance was observed on the main kitchen cold production reach in cooler door gasket; in the main kitchen walk-in milk cooler along the rim of the ceiling; and on the Unit 2 snack refrigerator door gasket; the cold production reach in cooler did not maintain a safe temperature, the food inside tested at unsafe temperatures; and Food Service Worker #19 attempted to serve Resident #108 a meal tray removed from a food cart with dirty trays. Findings include:The facility policy General Sanitation of Kitchen, revised 01/2026, documented cleaning and sanitation tasks for the kitchen would be recorded, and staff would be trained on the cleaning schedule and how to perform the cleaning tasks.The facility policy Foodborne Safety, revised 01/2026, documented cold food would be stored below 41 degrees Fahrenheit. Food Storage During an observation on 04/13/2026 at 7:36 AM, the cold production reach in cooler internal temperature was 50 degrees Fahrenheit. The refrigerator contained a bag of hard-boiled eggs, a large package of cheese slices, a large package of poultry cold cuts, a tray of liquid supplements and poured juices. The hard-boiled egg temperature was 43.2 degrees Fahrenheit. Equipment Safe/Clean During an observation and interview on 04/13/2026 at 7:36 AM, there was a black substance in the main kitchen cold production reach in cooler door gasket. Food Service Director #16 stated the maintenance department cleaned the refrigerator gaskets.During an observation and interview on 04/13/2026 at 8:10 AM in the main kitchen, there was a black substance along the ceiling crease in the milk walk-in cooler in the main kitchen. Food Service Director #16 stated the maintenance department was responsible for cleaning the ceiling creases.During an observation on 04/14/2026 at 9:20 AM, there was a black substance in the Unit 2 snack refrigerator door gasket.There was no documented evidence of a main kitchen cleaning schedule. The food service communication logbook for maintenance for September 2025 through April 2026 did not include documentation of gasket cleaning or walk in cooler ceiling crease cleaning. Meal ServiceDuring an observation and interview on 04/14/2026 at 1:10 PM Resident #108 changed their mind and wanted their lunch after initially declining. The food cart just left the wing with dirty and uneaten trays mixed throughout the cart. Food Service Worker #19 approached the dirty cart in the hall and pulled several trays out before finding one they stated, looked okay and removed it from the cart. They brought the tray to the unit and handed it to Certified Nurse Aide #17. There was no tray ticket present on the tray. Food Service Worker #19 stated they should not serve a tray removed from a dirty food cart. They removed the tray and stated they were getting a fresh tray.During an interview on 04/16/2026 at 11:44 AM, Certified Nurse Aide #17 stated nursing was responsible for cleaning the unit refrigerators and they tried to clean them often but there was no set schedule. They did not clean the gaskets and did not know who did.During an interview on 04/16/2026 at 11:00 AM, Licensed Practical Nurse #20 stated nursing was responsible for cleaning the unit refrigerators and whoever had time on the unit should clean them. They were not sure who cleaned the gaskets.During an interview on 04/16/202 at 11:17 AM, Licensed Practical Nurse Unit Manager #21 stated the unit refrigerators were clean, and they cleaned them every day. It was nursing's responsibility to clean them.During an interview on 4/17/26 at 9:52 AM, Food Service Director #16 stated there was a set schedule assigned to each kitchen position and the staff assigned to the I position was scheduled to clean the cold production reach in cooler daily, except for the door gaskets. Maintenance came and cleaned door gaskets when food serviced requested. There was a logbook kept in the kitchen that maintenance checked daily. Maintenance should have cleaned the gaskets monthly and as requested in the logbook. They would log any equipment with issues in the logbook or call maintenance directly. They stated if uneaten meal trays were mixed in with dirty trays, they should not be served for infection control reasons. Staff should (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	04/17/2026

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	get a new tray from the kitchen. During an interview on 04/17/2026 at 11:37 AM, Maintenance Director #18 stated kitchen staff were responsible for cleaning the refrigerators and gaskets. They had not received any requests to clean gaskets since being hired at the facility months ago. 10 New York Codes, Rules and Regulations 415.14(h)