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	06/28/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 46276 Based on observations, record review, and interviews during the recertification and abbreviated (NY00330066) surveys conducted 6/24/2024-6/28/2024, the facility did not ensure residents had the right to a dignified existence for 2 of 18 residents (Resident #28 and #44) reviewed. Specifically, Residents #28 and #44 were referred to with undignified labels (feeders); and Resident #44 was assisted with eating while staff stood over them. Findings include: The facility policy, Quality of Life-Dignity, reviewed 1/2024, documented residents would be treated with dignity and respect at all times. Ttreated with dignity meant the resident would be assisted in maintaining and enhancing their self-esteem and self-worth and staff should speak respectfully to residents at all times, including addressing the resident by their name of choice and not labeling or referring to the resident by their room number, diagnosis, or care needs. 1) Resident #28 had diagnoses including dementia, cerebral infarction (stroke), and bipolar depression. The 4/26/2024 Minimum Data Set assessment documented the resident had severely impaired cognition and required extensive assistance of one for eating. The comprehensive care plan, revised 3/4/2024, documented Resident #28 required assistance with self-care related to dementia and limited mobility, and was dependent for eating. The 6/24/2024-6/28/2024 Unit 100 staff assignment sheet documented Residents #28 and #44 as Feeders. During an observation on 6/24/2024 at 12:00 PM, Resident #28 was on Unit 100, seated in a reclining chair in the dining area. Licensed Practical Nurse #3 was observed assisting the resident with eating. Certified Nurse Aide Instructor #13 asked if a nurse aide student could assist with the resident and the Licensed Practical Nurse Unit Manager #3 stated no, the resident was a difficult feeder. Certified Nurse Aide Instructor #13 asked if there were other feeders they could assist with eating. The conversation could be heard by others in the vicinity. 2) Resident #44 had diagnoses including dementia without behavioral disturbances, adult failure to thrive, and protein-calorie malnutrition. The 5/28/2024 Minimum Data Set assessment documented the resident had severe cognitive impairment and was dependent on staff for eating. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The comprehensive care plan revised 3/5/2024 documented Resident #44 required assistance with self-care and mobility related to confusion and dementia. Interventions included the resident was dependent on staff for eating. During an observation on 6/24/2024 at 12:11 PM, Resident #44 was seated in a recliner chair in the Unit 100 hallway. Certified Nurse Aide #12 placed the resident's lunch tray on a bedside table and stood over the resident while feeding them. During an interview on 6/27/2024 at 9:10 AM Certified Nurse Aide #12 stated Resident #44 was a feeder. They stated feeder meant the resident was dependent on staff for eating. They stated they should not have stood over the resident when assisting them with eating as it was undignified. 10NYCRR 415.5 (a)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46276 Based on observations, record review, and interviews during the recertification survey conducted 6/24/2024-6/28/2024, the facility did not ensure a safe, clean, comfortable, and home-like environment for 4 of 4 Units (Units 100, 200, 300, and 400) reviewed. Specifically, floors, walls, ceilings, and resident chairs were damaged or unclean on Units 100, 200, 300, and 400; drain flies were observed in the Unit 200 shower room; and there was no negative air pressure in Units 200, 300, and 400 soiled utility rooms (negative pressure rooms have a lower air pressure, created by ventilation, to reduce the flow of potentially contaminated air or odors from leaking into the surrounding areas). Findings include: The facility policy, Housekeeping Responsibilities, reviewed 1/2022, documented the facility would maintain a clean, safe, and sanitary environment for the residents. Routine cleaning included daily cleaning of all horizontal surfaces with an acceptable grade disinfectant/germicide. A schedule of cleaning tasks and the employees responsible was to be maintained by the Housekeeping Supervisor. The following observations were made on Unit 100: - on 6/24/2024 at 10:33 AM, the floors were sticky when walking on them. The left side of the hall outside of room [ROOM NUMBER] had paint scraped off on both sides of the doorframe. - on 6/24/2024 at 10:44 AM, resident room [ROOM NUMBER] had a call bell out of reach of the resident lying in bed. There was a very strong odor of urine in the room. - on 6/24/2024 at 11:26 AM, Resident #52's wheelchair was ripped on the inside back rest and both arm rests. - on 6/24/2024 at 12:07 PM, Resident #44's reclining wheelchair had a soiled footrest. - on 6/24/2024 at 3:00 PM, the Unit 100 shower room had a missing call bell cord. There were miscellaneous items in the room including two fall mats, a wheelchair, and pads on the floor by the toilet. The following observations were made on Unit 200: - on 6/24/2024 at 2:05 PM, the soiled utility room had no negative pressure. - on 6/24/2024 at 2:18 PM, the shower room had no call bell cord, and there were two drain flies in the room. The following observations were made on Unit 300: - on 6/24/2024 at 11:10 AM, the shower room toilet seat cover was in disrepair and was worn through. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- on 6/24/2024 at 11:17 AM, the soiled utility room had no negative pressure. The following observation was made on Unit 400: - on 6/24/2024 at 12:32 PM, the soiled utility room had no negative pressure. There was a 2 inch x 2 inch hole cut into the solid ceiling of the room. There was no documented evidence of work orders for any of the environmental issues identified during the tour of the facility. During an interview on 6/27/2024 at 9:21 AM, Housekeeper #4 stated they were assigned to work on Unit 100. They swept and mopped resident room floors, cleaned the resident room bathrooms, dusted the blinds, and replaced curtains if they were dirty. They also swept and mopped the hallways. It had been difficult to clean the unit floors due to residents with urinary incontinence issues. They stated they were responsible for cleaning and disinfecting the floors as needed if they appeared dirty. They used bleach for the floors. Nursing staff was responsible for cleaning wheelchairs, and certified nurse aides were responsible for cleaning body fluids. They stated the floors in the facility should not be sticky and could be caused by urine. During an interview on 6/28/2024 at 9:48 AM, Licensed Practical Nurse Unit Manager #3 stated the Maintenance Department was responsible for painting walls. The walls could use a paint touch-up. Work order tickets could be placed via the unit computers, or through a separate phone application, and the work orders went directly to the Maintenance Department. Work order requests would be submitted for things like leaky air mattresses, beds that were not working, plugged toilets, leaky sinks, unclean and damaged walls, and unclean and damaged wheelchairs. They stated the 11:00 PM to 7:00 AM nursing staff were responsible for cleaning wheelchairs, but this was not always completed. They should have been overseeing that wheelchairs were cleaned, and they had check sheets for the cleaning. The wheelchair for resident #52 was in disrepair and they should contact the Therapy Department to get a new chair. Licensed Practical Nurse #3 stated repairs should be completed within 24 hours unless it was urgent, and it should be completed immediately. During an interview on 6/28/2024 at 11:24 AM, the Maintenance Director stated they were responsible for overseeing maintenance for the entire building. They oversaw two maintenance technicians, a floor technician, and the housekeeping supervisor. All staff could use the hallway computers to place a work order, and the work orders would be sent immediately to the Maintenance Director. Work orders could also be created though an application on the phone, and orders completed this way went directly to the maintenance staff. Work order categories included floor care; electrical repair; heating, ventilation, air conditioning; call system; paint touch-ups; floors needing buffing, stripping, and waxing; and housekeeping mopping and sweeping. Priority work order tickets should be completed immediately or within 24 hours, painting work orders would usually take a couple of days, and resident equipment work orders would take a day and sometimes less. Maintenance staff were constantly on the resident units, and if they observed something they could create their own work orders. Nursing staff was educated on using the computers to submit work orders. The goal of the facility staff was to make and maintain a homelike environment for the residents. 10 NYCRR 415.29(j)(1)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 50561 Based on interview and record review during the recertification survey conducted 6/24/2024-6/28/2024, the facility did not ensure that residents with newly evident or possible serious mental disorders, intellectual disabilities, or a related conditions were referred for a Level II Pre-admission Screening and Resident Review (PASARR, a federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities were not inappropriately placed in nursing homes for long term care and a Level II PASARR identifies the specialized services required by the resident) for 1 of 2 residents (Resident #101) reviewed. Specifically, there was no documentation Resident #101 was referred for a Level II Preadmission Screening and Resident Review when the resident was newly diagnosed with a serious mental health disorder. Findings include: The New York State Department of Health Instruction Manual for DOH-695 (2/2009) documented if a Residential Health Care Facility resident is newly diagnosed with a mental illness, a new SCREEN and Level II referral must be completed within 14 calendar days. Resident #101 was admitted to facility 8/22/2022 with diagnoses of anxiety and depression. The 6/4/2024 Minimum Data Set assessment (a health assessment screening tool) documented resident had intact cognition, had no behaviors, was independent with most activities of daily living, had active diagnoses including schizophrenia, and was taking an antipsychotic and antidepressant medication daily. The Preadmission Screening and Resident Review dated 8/22/2022 documented the resident did not have a serious mental illness. The resident's face sheet documented the resident's schizoaffective disorder diagnosis had an onset date of 1/25/2024. A 1/25/2024 at 12:47 PM progress note by Nurse Practitioner #25 did not include documentation of newly diagnosed schizoaffective disorder. The Comprehensive Care Plan initiated 11/1/2023 and revised on 1/25/2024 documented the resident had diagnoses of anxiety, depression, and psychosis. Interventions included administer psychotropic medications as ordered, encourage resident to remain social with peers and staff, encourage participation in activities offered, monitor for changes in mood, provide support and reassurance, and psychological services as needed. A 3/3/2024 physician #46 progress note documented a current diagnosis of schizoaffective disorder and was receiving antipsychotic medications. There was no documented evidence a new Screen Level I had been completed when the resident was diagnosed with schizoaffective disorder and no documented evidence of a Level II referral. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 11:26 AM, Director of Social Work #9 stated they did not review The Preadmission Screening and Resident Reviews until after a resident had been admitted . Any new resident diagnosis was reported to the interdisciplinary team at the daily morning meeting. They would not initiate the process to get a new Preadmission Screening and Resident Review for a newly reported serious mental health diagnosis, but they would start the referral process for a psychiatric evaluation. The only time they would obtain a new screen was if a resident were transferring to another facility as a lateral transfer. They would contact the Regional Director of Social Work who was responsible to complete those screens. They believed Resident #101 had a serious mental illness diagnosis that was not new. After they referred to the medical record, they stated they did not see a schizophrenia diagnosis at the time of admission, that a serious mental illness was indicated on the initial screen, or that a new screen was performed. They did not believe a new screen was necessary, but they might need to be educated on the process. It was important residents were screened appropriately for the safety of all residents and to ensure appropriate placement as people should be placed in the least restrictive environment possible. During an interview on 6/28/24 at 12:35 PM the Director of Nursing stated new mental health diagnoses were brought forward during team meeting each morning or whenever needed. 10NYCRR 415.11(e)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 37516 Based on observation, record review and interviews during the recertification and abbreviated (NY00340701, NY00330066, NY00333069, and NY00328237) surveys conducted 6/24/2024 - 6/28/2024, the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for 4 of 11 residents (Residents #56, #80, #90, and #127) reviewed. Specifically, Resident #127 had untrimmed fingernails and was not wearing their glasses; and Residents #56, #80, and #90 had unclean and untrimmed fingernails. Findings include: The facility policy, Resident Care with Activities of Daily Living, reviewed 1/2022, documented the facility was to accurately assist with residents' needs to support basic activities of daily living function. The supervisor was to be notified if the resident refused care and to report other information in accordance with facility policy and professional standards of practice. The facility policy, Care of Fingernails/Toenails, reviewed 1/2024, documented nail care included daily cleaning and regular trimming. The supervisor was to be notified if the resident refused care. The facility policy, Care of the Visually Impaired Resident, reviewed 1/2024, documented assistive devices to maintain vision included glasses and any other device used by the resident to assist with visual impairment. Residents who had lost or damaged their devices would be assisted in obtaining services to replace the devices. The supervisor was to be notified if the resident refused care. 1) Resident #127 had diagnoses including cerebral infarction (stroke), dementia, and need for assistance with personal care. The 5/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent on staff for showering/bathing and personal hygiene and wore corrective lenses. The Comprehensive Care Plan documented: - on 11/24/2023 the resident required assistance with self-care and mobility related to limited mobility and deconditioning. Interventions included substantial/maximal assistance for showering/bathing, and supervision or touching assistance for personal hygiene. - on 11/24/2023 and revised 3/4/2024 the resident had impaired visual function. Interventions included glasses, ensure the resident wore their glasses which were to be clean, free from scratches, and in good repair, and report any damage to nurse/family. Remind the resident to wear glasses as needed. The care instructions as of 6/27/2024 documented the resident wore glasses, required substantial/maximal assistance for showering/bathing, and supervision or touching assistance for personal hygiene. There was no documentation the resident's glasses were kept in another location for safe keeping, or if the resident required nail care from licensed nurses. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #127 was observed: - on 6/24/2024 at 11:06 AM, in their room with long, unkept fingernails and was not wearing glasses. The resident stated staff did not trim their fingernails. - on 6/25/2024 at 11:14 AM, in their room with long, unkept fingernails and was not wearing glasses. - on 6/26/2024 at 10:14 AM, in their room with long, unkept fingernails and was not wearing glasses. At 11:17 AM staff brought the resident to the unit dining area and seated them in front of the nurse's station. They were not wearing glasses. - On 6/27/2024 at 9:52 AM, in their room not wearing glasses. The Activities of Daily Living documentation task for the resident wearing their glasses was signed off as yes: - On 6/24/2024 at 9:35 AM by Certified Nurse Aide #17. - On 6/25/2024 at 11:15 AM by Certified Nurse Aide #17. - On 6/26/2024 at 2:59 PM by Certified Nurse Aide #18. - On 6/27/2024 at 8:05 AM by Certified Nurse Aide #17. The Activities of Daily Living documentation task for showering/bathing and personal hygiene was signed off as being done on 6/25/24 by Certified Nurse Aide #17. During an interview on 6/26/2024 at 10:14 AM Certified Nurse Aide #18 stated they were not sure of the resident's shower day. There was a shower list at the nurse's station, and they would check. They stated the resident's shower day was Tuesdays during the 7:00 AM - 3:00 PM shift. Sometimes the resident refused care, would state no and then staff would reapproach them. During an interview on 6/27/2024 at 9:56 AM Licensed Practical Nurse #16 stated they were not sure if the resident wore glasses. They looked through the resident's dresser drawers and nightstand drawer and stated they thought the resident's daughter took the glasses home because they were broken. During an interview on 6/27/2024 at 10:23 AM Certified Nurse Aide #17 stated the resident's shower day was on Tuesdays. They usually did that task first thing in the morning because the resident was hard to get up once they went back to bed, as they spent most of their time in their room. The resident's fingernails were cleaned in the shower. They did not trim the resident's fingernails because they thought the resident was diabetic and they did not see why the nurses would not know that. They never saw the resident wear glasses. They stated they did not know why they signed the Activities of Daily Living tasks that the resident was wearing their glasses. The nurses would probably know if the resident wore glasses or not. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/2024 at 10:55 AM Licensed Practical Nurse Unit Manager #19 stated the licensed practical nurses did skin checks on residents and would also be looking at fingernails while doing so. The certified nurse aides were supposed to trim residents' fingernails and they should be notifying the nurse if they were unable to or if a resident refused. If a resident was supposed to be wearing glasses and they could not find the glasses or they were broken, they should notify the nurse. They were not sure if Resident #127 wore glasses, but they could be broken, or family could have taken them home. Certified nurse aides should not be signing for tasks they were not completing. During an interview on 6/28/2024 at 9:42 AM Licensed Practical Nurse Unit Manger/Supervisor #6 stated fingernails should be trimmed by the certified nurse aides during the residents' showers or with daily care. Certified nurse aides could trim diabetic residents' fingernails. They stated the resident was not diabetic and their nails should be getting trimmed. If a resident had adaptive equipment such as glasses, then it would be documented in the care instructions. If a resident had glasses and they were missing or broken the certified nurse aides should be notifying the nurse. They stated the unit secretary kept the glasses in a locked drawer for safe keeping at the nurse's station. Most routine staff would know the glasses were kept there but some staff would probably not know this. 2) Resident #80 had diagnoses including right hemiplegia (weakness of the right side of the body). The 6/21/2024 Minimum Data Set assessment documented the resident was cognitively intact, had functional limitations in both arms, and was dependent for personal hygiene. The 12/26/2023 updated Comprehensive Care Plan documented the resident required assistance with self-care and mobility due to right sided weakness. Interventions included dependence with personal hygiene. The 6/26/2024 Activities of Daily Living documentation report documented the resident was provided daily personal hygiene care and daily shower/bathing care most every day during the month of June 2024. The following observations of Resident #80 were made: - on 6/24/24 at 12:59 PM, their fingernails were long with brown debris underneath. - on 6/27/24 at 11:55 AM, their fingernails were long with brown debris underneath. - on 6/28/24 at 9:00AM, their fingernails were long with brown debris underneath. During an interview on 6/24/2024 at 12:59 PM, Resident #80 stated their nails were too long, they poked their palms, and they wanted them cut. During an interview on 06/28/24 at 9:23 AM, Certified Nurse Aide #7 stated fingernails should be cleaned and trimmed on shower days or whenever nails were long or soiled. If a resident refused nail care, they would report to a nurse. Nail care was important as long, soiled fingernails could cause scratches which could lead to infection. They noticed Resident #80's fingernails were long and soiled and planned to groom them that day. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/28/2024 at 9:37 AM, Licensed Practical Nurse #5 stated they were not sure what the nail care policy was but expected certified nurse aides to provide nail care daily, and if not done, it was reported to them for follow-up. Proper fingernail care was important for the prevention of infection that could occur through scratches or by a resident putting soiled fingernails in their mouth. They were not aware of the condition of Resident #80's fingernails, but the resident often refused, and those refusals should be documented by the certified nurse aide in the hygiene task. They had not received any recent report the resident refused fingernail care. During an interview on 6/28/2024 at 10:28 AM, Licensed Practical Unit Manager/Supervisor #6 stated fingernails should be trimmed and cleaned on shower day and whenever needed. They expected any refusals to be reported to the team leader so a second attempt could be made. If a resident continued to refuse it should be reported to them so it could be documented, and care planned. Proper nail care was important for dignity and to prevent skin injury and infection. They were aware that Resident #80's fingernails were long and that the resident had a history of giving them and other staff difficulty about personal care. They did not see any documented refusals for fingernail care or a behavioral care plan. 3). Resident #90 had diagnoses including dementia and need for assistance with personal care. The 1/4/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, was dependent on staff for personal hygiene, and did not reject care. The comprehensive care plan revised 6/26/2024 documented Resident #90 required assistance with self-care and mobility related to cognitive impairment. Interventions included dependence for personal hygiene. The June 2024 resident care instructions documented the resident was dependent for personal hygiene. Resident #90 was observed with long fingernails on both hands and brown debris underneath: - on 6/25/2024 at 9:18 AM, walking in the hallway. - on 6/26/2024 at 7:45 AM, eating breakfast. - on 6/27/2024 at 8:52 AM, walking in the hallway. The 6/27/2024 Unit 100 staff assignment sheet documented Resident #90's shower day was Thursday on the 7:00 AM - 3:00 PM shift and was marked as completed. During an interview on 6/27/2024 at 10:15 AM Certified Nurse Aide #14 stated the resident required total care and they cared for the resident that day. Certified nurse aides were responsible for nail care unless the residents were diabetic. Nail care should be done on day shift or any chance they get if they were soiled. They had showered the resident that day but did not do nail care. The resident's fingernails had a brown substance under them and should have been cleaned. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/27/2024 at 1:59 PM Licensed Practical Nurse Unit Manager #3 stated the certified nurse aides were responsible for cleaning Resident #90's fingernails and they were usually cleaned on shower days. The resident's fingernails had a brown substance under them, they should have been cleaned on their shower day, and it was undignified for them to be dirty. During an interview on 6/28/2024 at 11:47 AM the Director of Nursing stated personal hygiene should be completed every day per the residents' preferences. Fingernails should be cleaned and trimmed daily, and it was undignified if not completed. Certified nurse aides and nurses could clean and trim fingernails and it was not appropriate if Resident #90's fingernails were not clean. 10NYCRR 415.12(a)(3) 46276 50561

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46276 48675 49831 Based on observation, interview, and record review during the recertification and abbreviated (NY00340613, NY00328237, and NY0330066) surveys conducted 6/24/2024-6/28/2024, the facility did not ensure each resident received food and drink that was palatable, attractive, and at a safe and appetizing temperature for 2 of 2 meals (6/26/2024 breakfast meal and 6/26/2024 lunch meal) reviewed. Specifically, the breakfast and lunch meals were not served at safe and appetizing temperatures. Findings include: The facility policy, Policy and Procedure Food Temperatures, reviewed 01/2023, documented the temperatures of all food items would be taken and properly recorded prior to service of each meal. All hot food would be cooked to appropriate internal temperatures, held, and served at a temperature of at least 135 degrees Fahrenheit. Hot food items would not fall below 135 degrees Fahrenheit after cooking, unless it was an item which would be rapidly cooled to below 41 degrees Fahrenheit and reheated to at least 165 degrees Fahrenheit (for a minimum of 15 seconds) prior to serving. Temperatures would be taken periodically to assure hot foods stay above 135 degrees Fahrenheit and cold foods stay below 41 degrees Fahrenheit during the holding and plating process and until food left the service area. The facility policy, Food Preparation and Service, reviewed 01/2024, documented the danger zone for food temperatures was between 41 degrees Fahrenheit and 135 degrees Fahrenheit and promoted the rapid growth of pathogenic microorganisms that could cause foodborne illness. During an interview on 6/24/2024 at 10:49 AM, Resident #111 stated the food was not good. During Resident Council Meeting on 6/25/2024 at 10:30 AM, two anonymous residents stated the facility served food that was bland with no taste, and the hot foods were often served cold. During an observation on 6/26/2024 at 7:17 AM, Resident #111's breakfast meal tray was tested . A replacement tray was provided to Resident #111. Food temperatures on the tray were measured. The cheesy scrambled eggs were measured at 134 degrees Fahrenheit, the Super cereal was measured at 136 degrees Fahrenheit, the first can of diet cola was measured at 64.7 degrees Fahrenheit, and the second can of diet cola was measured at 64.9 degrees Fahrenheit. During an interview on 6/26/2024 at 12:35 PM Resident #63 stated the food was bland and had no taste, the hot foods were not hot, and the cold foods and drinks were not always cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/26/2024 at 12:39 PM, Resident #63's lunch meal was tested . A replacement tray was provided to Resident #63. Food temperatures on the tray were measured. The pureed barbecue chicken was measured at 129 degrees Fahrenheit, the pureed macaroni and cheese was measured at 123 degrees Fahrenheit, the pureed seasoned spinach was measured at 124 degrees Fahrenheit, the pureed fruit cocktail was measured at 69 degrees Fahrenheit, the honey thickened water was measured at 63 degrees Fahrenheit, the first 8 ounce container of 2% honey thick milk measured at 60 degrees Fahrenheit, and the second 8 ounce container of 2% honey thick milk measured at 62 degrees Fahrenheit. During an interview on 6/28/2024 at 10:13 AM Food Service Director #15 stated they tested food palatability for two test trays per week. Milk that measured at either 62 degrees Fahrenheit or 63 degrees Fahrenheit would not be acceptable and should not be served to residents. Hot foods that measured at 123 degrees Fahrenheit and 129 degrees Fahrenheit would not be acceptable and should not be served to residents. If residents were served food that measured outside the acceptable temperature range, they could become sick with a foodborne illness. 10NYCRR 415.14(d)(2)

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 46276 Based on observation, record review, and interviews during the recertification and abbreviated (NY00330066) surveys conducted 6242024-6/28/2024, the facility did not ensure each resident received and the facility provided food prepared in a form designed to meet individual needs for 1 of 7 residents (Resident #111) reviewed. Specifically, Resident #111 had a physician order for a chopped consistency diet and was served a whole sandwich. Findings include: The facility policy, Food Consistencies and Definitions, reviewed 1/2024, documented diets with a chopped consistency were nearly regular textures with exception of very hard, sticky, or crunchy foods. Foods should be tender and easy to break into pieces with a fork. Lunch/Dinner foods such as meatballs, thinly sliced deli meat, and grilled cheese sandwiches should be chopped. The policy did not include definitions for a mechanical soft diet. The facility policy, Accuracy and Quality of Tray Line, revised 1/2024 documented all meals would be checked for accuracy by the Food and Nutrition staff, and by the service staff prior to serving the meal to the individual. The meal would be checked against the therapeutic diet spread sheet to assure that foods were served as listed on the menu. All meals would be checked for accuracy of following the therapeutic diet extension. 1) Resident #111 had diagnoses of Alzheimer's disease, gastro-esophageal reflux disease (backflow of stomach contents to the esophagus), and dysphagia (difficulty swallowing). The 4/12/2024 Minimum Data Set assessment documented the resident had severely impaired cognition, required supervision/touch assistance with eating, did not have a swallowing disorder, and received a mechanically altered diet. The comprehensive care plan initiated 4/20/2023 and revised 5/5/2023 documented the resident had oral/dental health problems and was edentulous (lacking teeth). Interventions included diet per registered dietitian recommendation and physician order. The Comprehensive Care Plan initiated 4/20/2023 and revised 3/29/2024 documented the resident was at risk for malnutrition related to dysphagia and potential chewing difficulty due to being edentulous (no teeth). Interventions included provide diet and consistency per physician order, regular chopped texture; monitor for chewing and swallowing problems; and refer to the Speech Language Pathologist as needed. The 3/29/2024 physician order documented Resident #111 was to receive a regular diet, chopped consistency, and thin liquids for dementia with behaviors. The 4/24/2024 at 9:30 AM Speech Language Pathologist #26 discharge summary documented the resident had initially been evaluated for reports of food getting "stuck' when swallowing. Discharge recommendations included close supervision, small bites, slow rate of eating, remain upright for 30 minutes after meals, and mechanical soft/chopped texture consistency for solids and thin liquids. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/29/2024 at 11:21 AM Registered Dietitian # 11 Nutrition Assessment documented the resident continued a regular diet with regular textures and no new issues with chewing or swallowing. The care plan was reviewed and updated. The 6/2024 resident care instructions documented the resident required supervision/touch assistance with eating and was to receive diet and consistency per physician order regular, chopped textures and thin liquids. During the lunch meal observation on 6/24/2024 at 11:31 AM, the resident's meal ticket documented a regular-chopped diet with 3 ounces of chopped chicken, 1/2 chopped biscuit, 1/2 cup of chopped vegetables, and 1/2 cup of chopped mixed fruit. There were X's marked through all the items on the meal ticket. The resident's meal tray included a whole meatball hoagie, 1/2 cup of spinach, 1/2 cup of mixed fruit, and a whole grilled cheese sandwich. The resident ate a few bites of each sandwich before leaving the table. The food was not chopped or cut up. During an interview on 6/27/2024 at 9:35 AM, Certified Nurse Aide #27 stated a chopped consistency diet meant the food should be cut up, a whole meatball sub sandwich was not a chopped diet item and should be cut lengthwise and crosswise. A whole grilled cheese sandwich should be cut up. They were unsure if Resident #111 had a chopped diet. They stated if a resident received the wrong food consistency they could choke or aspirate (inhale food into the lungs) the food. During an interview on 6/27/2024 at 2:11 PM Resident Assistant #29 stated they knew how to care for a resident by looking up their profile in the computer. They thought Resident #111 had a regular diet. A chopped consistency diet should be cut up. They had received diet consistency training during orientation. During an interview on 6/28/2024 at 8:24 AM Licensed Practical Nurse Unit Manager #3 stated they were responsible for overseeing staff on the unit and staff knew how to care for a resident by looking up their profile in the computer. If a resident's diet changed, the speech pathologist would send an email and they would communicate it to staff. Licensed Practical Nurse #3 stated Resident #111 was on a chopped consistency diet, their food should be cut up, and it could be a choking risk if they consumed whole sandwiches. During an interview on 6/28/2024 at 8:48 AM Registered Dietitian #11 stated if they saw a resident with the wrong consistency diet, they would remove it and alert nursing and speech therapy. They were familiar with Resident #111 who had a regular diet with chopped consistency, and they should not receive whole sandwiches. A whole meatball sub needed to be cut and if whole, could cause a choking hazard to the resident. They referred to the speech pathologist for any changes in diet consistencies. During an interview on 6/28/2024 at 9:18 AM Speech Language Pathologist #26 defined a dysphagia diagnoses as one that made it difficult for a resident to swallow food. Their duties included evaluating residents for swallowing deficits. They were familiar with Resident's #111, they were on a regular diet with a chopped consistency, had no teeth, required their foods to be chopped or cut and not doing so could put them at a higher risk for choking. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 10:13 AM the Food Service Director stated they were responsible for checking meal tickets before the trays left the kitchen and were brought to the units on 6/24/2024. They stated they had just hired an employee for the M job position, which was a nutritional service aide position on the tray line. They had just started orientation and they were responsible for checking meal tickets before they were delivered. The Food Service Director stated nursing was also responsible for checking meal tickets once the trays were delivered to the unit. An X marked on a meal ticket meant the resident ordered the alternative meal and a whole sandwich was inappropriate for a chopped diet consistency. Employees were oriented upon hire regarding diet consistencies. During an interview on 6/28/2024 at 11:47 AM, the Director of Nursing stated nurses and aides should be checking meal tickets for the correct diet consistencies when they arrived on the units. Chopped diets were typically ordered if a resident had chewing problems. Resident #111 required a chopped diet and a whole grilled cheese sandwiches or meatball subs would not be appropriate as the resident could choke or aspirate (inhale food contents into the lungs). During an interview on 6/28/2024 at 12:17 PM Family Nurse Practitioner #25 stated that dysphagia diagnoses were for residents with neurologic disorders such as cerebral infarctions (strokes), Parkinson's Disease (a progressive disease involving the brain and spinal cord) and any other neuro-muscular disorder. They stated Resident #111 had no teeth, required a chopped diet, and should not be receiving whole meatballs or whole sandwiches. Staff should have cut them up. Having no teeth put the resident at a higher risk for choking or aspiration. 10NYCRR 415.14 (d-e)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 49831 Based on observation, interview, and record review during the recertification survey conducted 6/24/2024-6/28/2024, the facility did not ensure each resident received and the facility provided food that accommodated resident allergies, intolerances, and preferences for 1 of 1 resident (Resident #59) reviewed. Specifically, Resident #59 did not receive ordered fluids on their meal tray and was not offered a substitution when they requested a sandwich. Findings include: The facility's Always Available Menu documented lunch and dinner entree alternates included the following sandwiches; ham, egg salad, tuna salad, turkey, bologna, sliced cheese, peanut butter and jelly, and chicken salad. Resident #59 was had diagnoses including Alzheimer's Disease and chronic kidney disease. The 5/19/2024 Minimum Data Set assessment documented the resident was cognitively intact, had a poor appetite most days, required supervision or touching assistance for eating, did not have a swallowing disorder, had obvious or likely cavity or broken natural teeth, and did not require a mechanically altered diet (altered texture). The Comprehensive Care Plan initiated 10/7/2022 documented the resident had upper and lower dentures that they did not wear. Interventions did not include alterations in food consistency. A 5/26/2022 Comprehensive Care Plan focus documented the resident was at risk for malnutrition and fluid impairment related to disease process. Interventions included encourage meal intake and completion, identify and honor preferences, observe for chewing/swallowing problems, provide diet as ordered of regular, pureed textures, and thin liquids with exceptions of soft baked goods and soft sandwiches. Nourishments included diet pudding, cheese and crackers, and sandwich variety in the evening. The 5/20/2024 physician order documented the resident was to receive a regular diet, pureed texture, thin liquid consistency. A 6/3/2024 Speech Language Pathologist #26 progress note documented the resident was treated for oral phase dysphagia (difficulty using the mouth, lips, and tongue to control food or liquid). The resident presented with mild oral phase dysphagia however, during consumption of certain soft foods the resident displayed adequate oral phase. Certain soft solids were added to the pureed diet (soft baked goods, soft sandwiches, and pancakes). The 6/18/2024 Speech Language Pathologist #26 progress note documented the resident fluctuated in intake and tolerance of soft options indicating the need for pureed diet consistency as primary consistency for all meals. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 6/21/2024 Registered Dietitian #11 progress note documented the resident had variable intakes. The resident received pureed textures. Textures downgrade per speech language pathologist on 6/17/2024. This was a notable decline over one month. The resident's recommended daily fluid needs were 2400-2835 milliliters per day. The plan was to discontinue Magic Cup (supplement) and provide Ensure Clear per resident's preference. There was no documented evidence the resident's care plan was updated to exclude soft sandwiches and baked goods per the speech language pathologist's recommendations. The 6/21/2024 physician order documented the resident was to receive 240 milliliters of Ensure Clear (a nutritional supplement) three times a day. The following observations of Resident #59 were made: - on 6/24/2024 at 12:03 PM, the resident's lunch was placed in front of them, and staff assisted with opening containers. The meal ticket documented 8 ounces of Boost and 8 ounces of water, and neither were on the resident's tray. At 12:12 PM the resident began feeding themself and at 12:19 PM they asked for water. At 12:41 PM the resident asked for soda for a burning chest and ginger ale was provided. At 12:49 PM the resident asked Certified Nurse Aide #8 for a sandwich. Certified Nurse Aide #8 stated they would have to ask if the resident could have bread. Another unidentified certified nurse aide stated the resident could not have a sandwich because the resident was a pureed everything. No other substitution was offered including a pureed sandwich. Resident #59 ate only a few bites of the pureed meal. During an interview on 6/24/2024 at 1:18 PM, Resident #59 stated they were hungry a lot and they did not like the food they were served. The consistency of the food and their medicine left a bad taste in their mouth. During an interview on 6/28/2024 at 9:43 AM, Licensed Practical Nurse #5 stated if a resident was served food they did not like, staff should call the kitchen for an alternate. If the resident did not like the alternate, there were sandwiches the resident could have. They stated if the resident was on an altered consistency, they should be offered the same alternates. The resident's status had changed drastically and sometimes they were unable to feed themself, and they drank better than they ate. When the resident was eating normally, all they ate were sandwiches. The resident asked for a sandwich, and they asked the aide to call it in, but they were not sure if the sandwich was provided. They asked two different certified nurse aides to call in the request and they should have followed up with the certified nurse aide to confirm the resident received the sandwich as requested. Alternatives were important to ensure the resident gets the nourishments needed. If a resident was not nourished, their health could decline rapidly. They should have let the registered dietitian know the resident drank better than they ate so that fluids could be increased on the resident's tray. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview 6/28/2024 at 10:48 AM, Licensed Practical Nurse Unit Manager/Supervisor #6 stated they asked residents how the food served met their preferences, allergies and/or intolerances. If a resident did not eat, or disliked the food, dietary was alerted for alternatives. Alternatives included sandwiches, hamburgers, cold plates, and soups. If a resident was on an altered consistency diet, they would call down to the kitchen for alternatives and they believed everything could be pureed. If a resident's intake was consistently poor, they expected staff to notify them and they in turn would work with the dietitian on a solution. Resident # 59 was placed on comfort care some time ago due to renal failure and over the last four weeks they had more and more issues with intake. The resident would drink non-stop, and they would chew and chew. Staff should know there were alternatives for puree textured foods. If the resident asked for a sandwich, they expected staff to clarify what the resident wanted and call the kitchen to obtain it. Even if the resident did not eat it, they it should be offered to the resident. During an interview 6/28/2024 at 12:25 PM, Registered Dietitian #11 stated based on ordered consistencies and the diet they were on they made sure the resident's preferences aligned. If a resident did not like the consistency specified, the resident would be referred to the speech language pathologist for a determination of whether the consistency could be liberalized. For resident meals there was always a main alternative and sandwiches available, for every consistency. Sandwiches should be pureed. If a resident requested an alternative, it should be provided to the resident. Resident #59 rapidly declined, and the speech language pathologist re-evaluated the resident. There was no reason the resident could not have a pureed sandwich. 10NYCRR 415.14(c) 50561

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 46276 Based on observations, record review, and interviews during the recertification survey conducted 6/24/2024-6/28/2024, the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable mental and psychosocial well-being of each resident. Specifically, the facility received a letter from Centers for Medicare and Medicaid Services dated 2/09/2024, prohibiting the provision of a Nurse Aide Training and Competency Evaluation Program, conducting onsite nurse aide competency exams, or utilizing onsite clinical training by an off-site nurse aide training program, effective through 10/2025, and the facility was observed conducting an off-site nurse aide training program. Findings include: The facility contract with a local community college effective for the period of March 1, 2023, through December 31, 2024, documented the parties proposed to collaborate to provide for the certified nurse aide students at the college the In-Agency learning experiences necessary for them to become responsible practitioners and to qualify them for certification as nursing assistants. The college would provide the nurse aide curriculum, qualified instructors, and be responsible for the supervision of the students. The facility would provide the facilities, opportunities and favorable conditions, and staff time and cooperation necessary to provide the nurse aide students at the college with the agency experience required. During an observation on 6/24/2024 at 12:07 PM on Unit 100, there were 7 nurse aide students (students #36, #37, #38, #39, #40, #41, and #42) and Nurse Aide Instructor #13 assisting with meals. Nurse Aide Instructor #13 stated the nurse aide students were from a college and were in the facility for training Monday through Thursday from 9:00 AM-2:00 PM. During an observation on 6/25/2024 on Unit 100 at 9:52 AM, there were 7 nurse aide students (students #36, #37, #38, #39, #40, #41, and #42) and Nurse Aide Instructor #13 from an area college conducting clinical assignments on the unit. During an interview on 6/25/2024 at 1:26 PM Nurse Aide Instructor #13 stated the students were nurse aide students who had been coming to the facility for training since 1/10/2024. They had instructed two nurse aide training groups Group A and Group B. They stated Group A had tested out the week prior and Group B was finished Thursday 6/27/2024. Group B would return the following Monday through Thursday from 9:00 AM-2:00 PM. Nurse Aide Instructor #13 was unsure who approved the program to provide training at the facility. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2024 at 1:49 PM, the Administrator stated the off-site nurse aides had entered the building two weeks ago on 6/10/2024. They could not recall receiving a letter from the Centers for Medicare and Medicaid, they did recall a ban, but thought it only applied to in-house resident assistants training to become certified nurse aides. After re-reading and reviewing the Centers for Medicare and Medicaid enforcement letter dated 2/9/2024, the Administrator stated they must have received the letter and it meant they could not have any nurse aide training programs in the building. The Administrator stated that the nurse aide training program in the building would stop immediately. During an interview on 6/25/2024 at 2:29 PM Corporate Nurse #43 stated the facility had not applied for an exemption on the existing Nurse Aide Training and Competency Program. They were not aware they needed one to have an off-site nurse aide training through the community college. They thought the ban only applied to in-house staff being trained. Corporate Nurse #43 stated the current off-site facility would not be allowed to return as of 6/25/2024. 10NYCRR 415.26

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. 46276 Based on observation, interview, and record review during the recertification and abbreviated (NY00330066 and NY00331744) surveys conducted 6/24/2024-6/28/2024, the facility did not provide one or more rooms designated for resident dining and activities that were adequately furnished and had sufficient space to accommodate all activities for 2 of 4 dining rooms (Units 100 and 400). Specifically, Units 100's and 400's dining rooms had tables that did not accommodate residents' social and physical needs with inadequate space for dining or activities, and residents were lined up in the hallways during meals. Findings include: The facility policy, Preparing the Resident for a Meal, reviewed 1/2024, documented residents should be encouraged, not forced, to eat in the dining room to provide each resident the opportunity to socialize and make friends. Be sure the room was comfortable (i.e., not too warm, or cold) and had a relaxing environment (free of odors, loud noises, and bright lights). The following observations were made on Unit 100. The unit census was 36 residents. - During the lunch meal on 6/24/2024 between 11:31 PM and 12:16 PM the dining area had 6 square tables measuring approximately 3 feet x 3 feet. Two tables were placed together at the back of the room and 2 tables were placed together in the front of the room near the hallway. One square table was against the right side of the wall towards the back of the room and one square table was against the wall in the front of the room near the hallway. There were approximately 10 residents seated in the dining room. One resident was observed sitting in a reclining chair that was positioned sideways next to the back table near the wall. Two residents were seated at the back table with 2 square tables pushed together. One resident had a walker, the other a wheelchair. There were no other residents seated at the table. The meals were served on food trays that were approximately 12 inches long and were not removed during the meal. Residents seated at the tables were in wheelchairs, reclining chairs, or had assistive devices such as walkers and there was no room for ambulatory residents to sit. At 11:31 AM in the Unit 100 common area, there were approximately 10 residents seated at the tables in the common area and all other residents were lined up in the hallway, seated with bedside tables, across from the nursing station. The residents appeared cramped and were approximately 1/2 inch apart from one another. There was no music playing and no conversations between residents. Staff did not engage the residents in conversations. The following observations were made on Unit 400. The unit census was 39 residents. - on 6/24/2024 between 11:57 AM-12:18 PM there was no dining area on the unit. Several residents were lined up in the hallway eating on bedside tables. No conversations were observed between the residents. Other residents were eating in their rooms. - on 6/26/2024 at 8:08 AM, several residents were observed sitting lined up in the hallway eating breakfast served on bedside tables. (continued on next page)

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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 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/24 at 11:31 AM, Certified Nurse Aide #12 stated the main dining room was closed and had not been utilized in a couple of months due to staffing. They stated residents with wheelchairs were placed at the tables and the other residents that were feeders or needed supervision were lined up in the hallway. During an interview on 6/28/2024 at 10:00 AM, Licensed Practical Nurse Supervisor #6 stated the main dining room was not being utilized and they had not seen it used in the 2 years since they had been employed at the facility. They stated they thought the units would be less congested if the main dining room was opened to residents. During an interview on 6/28/2024 at 11:47 AM, the Director of Nursing stated the main dining room had been closed since the COVID-19 outbreak and there had been discussions amongst management to re-open it. They stated they thought residents were lined up in the hallways for lack of space and thought being lined up in the hallway was not a dignified dining experience for the residents. 415.29(e)(3)