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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review and interviews (iQIES Intake 2740528), the facility failed to ensure alleged violations involving abuse, neglect, or mistreatment were thoroughly investigated for three (3) of four (4) residents (Residents #11, #21, and #37) reviewed. Specifically, it was reported Certified Nurse Aide #31 was heard calling Resident #21 a liar and there was no documented evidence the facility investigated the allegation to rule out abuse; Resident #11 reported to several staff members that Licensed Practical Nurse #36 intentionally did not provide them with their pain medication and the allegation was not reported to administration to ensure an investigation was completed to rule out neglect or mistreatment; and Resident #37 used a broken plate to threaten another resident and there was no documented evidence the incident was investigated to determine root cause and prevent reoccurrence. Findings include: The facility policy Abuse, Neglect, Exploitation or Misappropriate-Reporting and Investigating, revised 01/2026, documented all reports of resident abuse, neglect, exploitation, or misappropriation are thoroughly investigated. Any employee accused of abuse was placed on leave with no resident contact until the investigation was complete. The administrator ensured that the resident or person who reported it was protected from retaliation. 1)Resident #11 had diagnoses including acute osteomyelitis (bone infection), brain bleed, and right leg fracture. The 02/22/2026 Minimum Data Set assessment documented the resident was cognitively intact and had no behavioral symptoms. The 10/18/2024 comprehensive care plan documented the resident was at risk for being a victim related to their dependence on others for activities of daily living and pain. Interventions included assessing the resident for signs and symptoms of abuse and neglect and report to the appropriate resources. The resident had musculoskeletal impairment related to a spinal infection, and fracture of the right leg. Interventions included administering pain medications per order, position for comfort, and refer to physical therapy/occupational therapy as needed. The 10/13/2024 physician order documented 15 milligrams of oxycodone (opiate pain reliever) every three (3) hours for post-surgical pain. The October 2024 Medication Administration Record documented oxycodone 15 milligrams tablet, give one (1) tablet every three (3) hours for post-surgical pain. The medication administration record included a box to record pain level. Licensed Practical Nurse #36 administered oxycodone on the following dates without documented evidence of a pain level: - 10/14/2024 at 3:00 PM - 10/14/2024 at 6:00 PM - 10/14/2024 at 9:00 PM (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 10/22/2024 at 9:00 PM The March 2025 Medication Administration Record documented oxycodone 15 milligram tablet four times a day for pain while awake. The medication administration record included a box to record pain level. Licensed Practical Nurse #36 administered oxycodone on: -03/03/2025 at 12:00 PM with a documented pain level of N/A -03/03/2025 at 6:00 PM with a documented pain level of N/A -03/14/2025 at 6:00 PM with a pain assessment of zero out of ten (no pain). During an interview on 04/17/2026 at 8:37 AM Resident #11 stated when they first were admitted to the facility in 10/2024, Licensed Practical Nurse #36 withheld three (3) doses of their oxycodone tablets. They again withheld their oxycodone sometime in March 2025, but they could not remember the exact date. They told Licensed Practical Nurse #15 and Certified Occupational Therapy Assistant #37 that Licensed Practical Nurse #36 had not given her multiple doses of oxycodone. They stated they also informed Director of Nursing #3 about the issue and was told I know. During an interview on 04/17/2026 at 9:29 AM Director of Physical Therapy #38 stated Resident #11 told them that one of the nurses did not give them their pain medication. They could not remember the name of the nurse, and they did not report what the resident told them to administration. During an interview on 04/17/2026 at 10:35 AM Licensed Practical Nurse #15 stated Resident #11 was alert and oriented and knew what their medications looked like. Resident #11 told them that they did not receive their pain medication, and they reported it to Licensed Practical Nurse Unit Manager #8. They could not remember the date the resident reported the omission. During an interview on 04/17/2026 at 10:46 AM Licensed Practical Nurse Unit Manager #8 stated they did not remember Licensed Practical Nurse #15 reporting Resident #11 did not get their pain medications. They recalled Licensed Practical Nurse #15 stating if Resident #11 said they did not receive the medication, then they did not receive it. They stated they did not report that to anyone but had a conversation with the resident about what their medication looked like, and maybe they must have forgotten that it was given to them. During an interview on 04/17/2026 at 11:05 AM Certified Occupational Therapy Assistant #37 stated Resident #11 told them they had not received their pain medication but could not remember anything specific. They stated Licensed Practical Nurse #36 was a part of medication issue and was terminated. During an interview on 4/17/2026 at 12:10 PM Director of Nursing #3 stated they investigated all allegations of abuse, neglect, and mistreatment. If a resident claimed they did not receive their pain medication it should be investigated. If the allegation was found to be true it would have been reported to the Department of Health. They stated they were not informed Licensed Practical Nurse #36 allegedly did not administer narcotics to Resident #11and if they were, the incident would have been investigated. 2) Resident #21 had diagnoses including anxiety, insomnia, and morbid obesity. The 01/20/2026 (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Minimum Data Set assessment documented the resident was cognitively intact, was independent for most activities of daily living after set-up and had no behavioral symptoms. During an interview on 04/13/2026 at 12:23 PM, Resident #21 stated they had an audio recording of Certified Nurse Aide #31 calling them a liar. In the recording they were also told about an inappropriate relationship between Certified Nurse Aide #31 and a resident (Resident #167). The resident was no longer in the facility. Resident #21 stated they played the audio recording for Social Worker #43, during a care plan meeting. On 04/14/2026 at 2:00 PM, a request was placed with the Administrator for all incidents and investigations related to Resident #167 and Resident #21. There was no documented evidence of an investigation. On 04/15/2026 at 1:00 PM the employee file for Certified Nurse Aide #31 was reviewed. Included in the employee file was an Employee Disciplinary Action Form dated 12/05/2024 documenting they violated the company policy on attitude and conduct by questioning a resident and calling them a liar. Certified Nurse Aide #31 was provided education on the customer service policy, gold service, resident rights, and service standards policy. Attached to the Disciplinary Action Form, was an undated statement from Certified Nurse Aide #31, stating they did not call the resident a liar and a statement dated 12/05/2024 from Social Worker #43, stating the resident reported Certified Nurse Aide #31 called them a liar and they requested the aide no longer provide care to them. During an interview on 04/14/2026 at 1:45 PM, Social Worker #43 stated in 2024 they did not remember hearing a resident concern about an inappropriate relationship between a certified nurse aid and a resident. Initially the Social Worker stated they did not recall hearing an audio tape at a care plan meeting because they would remember that. When asked about Resident #21, Social Worker #43 stated they recalled the audio tape and discussion about a certified nurse aide having an inappropriate relationship with a resident. They could not recall the name of the certified nurse aide involved. They stated Resident #21 had intact cognition, did not fabricate stories, and they believed the resident when they reported the allegation. They reported the audio tape to the Director of Nursing. During an interview on 04/15/2026 at 12:33 PM, the Director of Nursing stated all staff were trained on abuse and neglect. When they were notified of physical, financial, sexual, or emotional abuse and a staff member was involved, the staff member was contacted, removed from the care area, and brought to a conference room. When staff abuse concerned a resident, social work was involved, and an assessment of the resident was completed by a registered nurse and was documented in a progress note. Pending the investigation, if substantiated, the Department of Health was notified. They were never notified of staff having an inappropriate relationship with a resident, and they were not told about an audio recording. The Director of Nursing reviewed the 12/05/2024 counseling memo for Certified Nurse Aide #31's and stated Certified Nurse Aide #31 violated the facility policy on attitude and conduct in a resident care area including questioning a resident and referring to them as a liar. They completed an investigation of the incident which was the three pages (counseling memo, 12/05/2024 statement from Social Worker #43, and the undated statement from Certified Nurse Aide #31). The Director of Nursing stated Certified Nurse Aide #31 called the resident a liar because it had something to do with, breaking the heart of Resident #167. They could not recall asking what breaking the heart of Resident #167 meant. They did not get a statement from Resident #167 or Resident #21, and they should have. They did not complete a thorough investigation to rule out abuse, neglect, or misappropriation and Certified Nurse Aide #31 should have been taken out of work while the incident was investigated. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3) Resident #37 had diagnoses including paranoid schizophrenia (a serious mental illness), depression, and anxiety disorder. The 02/10/2026 Minimum Data Set assessment documented the resident had moderately impaired cognition, no behavioral symptoms, and required supervision with most activities of daily living. The Comprehensive Care Plan initiated 11/10/2025 and revised 04/13/2026 documented the resident exhibited behavioral symptoms such as verbal aggression/abuse, physical aggression/abuse, and hallucinations and delusions. Interventions included modifying the environment to reduce episodes of negative behavior and administer psychotropic medications as ordered. The 03/05/2026 at 6:20 PM Licensed Practical Nurse #15's progress note documented the resident picked up their glass plate, broke it, then proceeded to use a piece of it as a weapon. They said they were going to hurt another resident. The 03/05/2026 at 6:25 PM Licensed Practical Nurse #23's progress note documented they were called to the unit due to the resident breaking a plate and was using a piece of the plate to threaten staff and other residents; the broken plate was taken from the resident by staff; the resident was yelling out they were going to hurt a specific resident and staff; 911 was summoned to assist with the resident; and the resident told two (2) police officers they were going to cut another resident's throat. There was no documented evidence the incident was investigated, or a plan was put in place to protect other residents. During an interview on 04/17/2026 at 11:22 AM, the Director of Nursing stated there was not an investigation completed for the 03/05/2026 event involving Resident #37. They did not think Resident #37's behavior was directed toward a specific resident. After referring to the progress notes they stated the event involved another resident; they did not know who that resident was; that resident should have been identified; and there was nothing put in place to protect that resident. Because the event involved another resident there should have been an investigation. Resident #37 had schizophrenia and often saw things others did not and because it was an isolated incident. 10 New York Codes, Rules and regulations 415.4(b)(1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, record review, and interviews, the facility failed to ensure residents who required dialysis services (filtration of blood when the kidneys do not work) received such services consistent with professional standards of practice for two (2) of two (2) residents (Residents #3 and #16) reviewed. Specifically, Residents #3 and #16 received hemodialysis treatments at a community-based dialysis center and did not have consistent on-going assessments or oversight before and after dialysis treatments and there was no documented evidence the resident's Tesio catheter (access site for dialysis treatment) was routinely assessed. Findings include:The facility policy Dialysis, revised 01/2026, documented the facility had a written agreement with all dialysis center providers and the facility maintained a communication log with the respective centers for all residents that went to dialysis. The communication log was used to communicate the resident's needs and responses to dialysis treatment. 1)Resident #16 had diagnoses including chronic kidney disease with dialysis and diabetes. The 02/15/2026 Minimum Data Set assessment documented the resident had intact cognition and required dialysis. The comprehensive care plan initiated 09/23/2025 and revised 02/27/2026, documented the resident received dialysis on Tuesdays, Thursdays, and Saturdays. Interventions included checking and changing dressing daily to right upper chest Tesio catheter only if ordered by physician, obtain weights and vital signs per protocol, monitor and document peripheral edema (swelling), monitor intake and output, and document any signs of infection to the access site such as redness, swelling, warmth, or drainage and report to the physician. The 03/23/2026 physician orders documented: -hemodialysis double lumen catheter to right chest wall, monitor for bleeding and dressing placement every shift. Document abnormal findings in a progress note. -pre and post dialysis evaluation twice a day, three times a week on Tuesday, Thursday, and Saturday. -dialysis three times a week on Tuesday, Thursday, and Saturday. The 04/2026 Treatment Administration Record documented on 04/16/2026 Licensed Practical Nurse #28 monitored the hemodialysis double lumen catheter dialysis fistula site on the day shift. There was no documented evidence of pre-dialysis communication sheets for 01/03/2026, 01/06/2026, 01/17/2026, and 04/09/2026. The 03/07/2026 dialysis sheet was missing documentation and was not signed. There was no documented evidence of post-dialysis communication on 01/03/2026, 01/06/2026, 01/17/2026, 02/10/2026, 02/12/2026, 02/14/2026, 02/21/2026, 02/24/2026, 03/07/2026, 03/10/2026, 03/12/2026, 03/14/2026, 03/17/2026, 03/24/2026, 03/26/2026, 03/28/2026, 03/31/2026, 04/02/2026, 04/07/2026, 04/09/2026, and 04/11/2026. During an interview on 04/16/2026 at 7:24 AM, Licensed Practical Nurse # 28 stated they were responsible for oversite of residents including residents that went to dialysis. Resident #16 attended (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dialysis three times a week and had vital signs done before and after dialysis. The pre-dialysis vital signs, list of medications, and other required documentation were documented on a communication sheet and sent to the dialysis center with the resident. Dialysis completed their section and returned it with the resident after treatment. They were not responsible for anything related to the catheter. The catheter was flushed and cared for by the dialysis center. During an observation and interview on 04/16/2026 at 1:54 PM, Resident #16 was in their room in bed. They stated they returned early from dialysis because their dialysis catheter was clotted. When they returned no one looked at their catheter site or took their vital signs. The dressing was observed to the right chest wall and was dry and intact with no drainage noted. They were always sent to dialysis with a folder and most days their vital signs were taken before they left. They stated most days they did not have vital signs completed when they returned from dialysis, and it was rare for any nurse to look at their catheter site. During an interview on 04/17/2026 at 8:09 AM, Licensed Practical Nurse #28 stated Resident #16 attended dialysis Tuesday, Thursday, and Saturday. Prior to dialysis they completed a form to communicate with the dialysis center. The form included resident specific medications and change in condition to ensure the resident was able to tolerate the treatment. There were times when the dialysis center did not complete their portion of the communication sheet prior to sending the resident back to the facility. When that occurred, dietary called for a weight and Licensed Practical Nurse Unit Manager #5 called for a verbal report. They always completed the pre-dialysis form; however, they did not normally complete the post-dialysis form as the resident did not return on their shift. Resident #35 returned on their shift on 04/16/2026 and did not get vitals and they did not observe the dressing to ensure it was dry and intact because there were issues that occurred at dialysis that Licensed Practical Nurse Unit Manager #5 was addressing. During an interview on 04/17/2026 at 1:16 PM, Licensed Practical Nurse Unit Manager #5 stated when they had dialysis residents, vital signs were taken before and after dialysis to ensure the resident was able to receive treatment and did not have any change in condition after treatment. When the resident returned from dialysis, they reviewed communication from the dialysis center to see how the resident tolerated treatment. Resident #16 received dialysis and on 04/16/2026 they were notified by the dialysis center the catheter used for dialysis was clogged. The facility does not flush the catheter; the dialysis center administered that treatment. The facility only observed the catheter site every shift and if it was not clean and dry the supervisor was notified. That was documented on the medication administration record and should only be documented if completed. It was important to complete the pre and post-dialysis vital signs and monitor the dressing to ensure there was not a change in condition. They were not sure why this was not being done consistently. 2)Resident #3 had diagnoses including chronic kidney disease with dialysis and diabetes. The 01/11/2026 Minimum Data Set documented the resident had intact cognition and required dialysis. The comprehensive care plan, initiated 11/21/2025 and updated 4/7/2026, documented the resident received dialysis on Monday, Wednesday, and Friday. Interventions included checking and changing dressing daily at the access site for dialysis treatment only if ordered by physician, monitor and document peripheral edema (swelling), monitor intake and output, and document any signs of infection to access site such as redness, swelling, warmth, or drainage and report to the physician. The 12/29/2025 physician order documented pre and post-dialysis evaluations were required twice a day, three times a week on Monday, Wednesday, and Friday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 3/18/2026 Physician #45 progress note documented Resident #3 had end stage renal disease and was dependent on dialysis. They attended dialysis 3 times a week on Monday, Wednesday and Friday. There was no documented evidence of pre-dialysis communication forms for Resident #3 on 01/16/2026, 01/19/2026, 01/21/2026, 01/23/2026, 02/04/2026, 02/09/2026, 02/23/2026, 03/03/2026, 03/16/2026, 04/06/2026, 04/08/2026, 04/13/2026, and 04/15/2026. There was no documented evidence the resident's dialysis access site was routinely assessed as planned. During an interview on 04/16/2026 at 11:00 AM, Licensed Practical Nurse #20 stated they were responsible for completing a pre-dialysis assessment and documenting it in the electronic medical record before a resident assigned to them went to dialysis. When the resident returned to the facility, they completed a post-dialysis assessment to ensure the resident was stable and the fistula was patent. The pre and post dialysis assessments were documented in the electronic medical record under evaluations. They communicated with the dialysis center through a form that was sent with the resident to each treatment. Facility nursing staff filled out the pre-treatment information at the top of the form and dialysis sent back a report from the treatment. These were both scanned into the electronic medical record. During an interview on 04/16/2026 at 11:17 AM, Licensed Practical Nurse Unit Manager #21 stated the facility licensed practical nurses were responsible for completing a pre-dialysis assessment and documenting it in the electronic medical record before a resident assigned to them went to dialysis. When the resident returned to the facility, they completed a post-dialysis assessment to ensure the resident was stable, the fistula was patent, vitals, and post weights. The pre and post-dialysis assessments were documented in the electronic medical record under evaluations. That is the only place they would have been, and if they were not there the nurse -did not do them. They communicated with the dialysis center through a form that was sent with the resident in a red folder every time they went to dialysis. They filled out the top of the form and dialysis sent back a report from the treatment. These were both scanned into the electronic medical record in the scanned section. They did not know why some forms were not in the record. 10 New York Codes, Rules and Regulations 415.12(k)

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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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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 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)

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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)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews, the facility failed to ensure residents were provided with nutritional and hydration care services consistent with the resident's comprehensive assessment for one (1) of four (4) residents (Resident #3) reviewed. Specifically, Resident #3 was on a renal diet (specialized diet for kidney failure that limits specific minerals) and a fluid restriction. Resident #3's actual fluid intake was not monitored and the resident received extra fluids beyond the allotted restrictions at meals; and was provided with extra food which was limited on their prescribed renal diet. Findings include:The facility diet manual, approved on 9/25/2025, documented the renal diet assured sodium, potassium, and phosphorus were limited to prevent further burden on the kidneys. The diet description documented milk was limited to 4 (four) ounces daily and chocolate was excluded.Resident #3 had diagnoses including end stage kidney disease. The 01/11/2026 Minimum Data Set (assessment tool) documented the resident had intact cognition, was on a therapeutic diet, had kidney disease and received dialysis treatment (blood is filtered through a machine when the kidneys do not work).The comprehensive care plan, initiated 11/21/2025 and updated 4/7/2026, documented the resident had impaired cognitive function related to dementia, had fluid overload related to end stage renal disease, had renal disease requiring dialysis, and was prescribed a renal diet with a 1500 milliliter fluid restriction. The physician orders for Resident #3 documented: -Renal, No Concentrated Sweets Diet -1500 milliliter fluid restriction per day-fluid limited to 1080 milliliters for meals (Breakfast 480 milliliters/ Lunch 360 milliliters / Dinner 240 milliliters. -Serve 420 milliliters for nursing (7:00 AM -3:00 PM shift = 150 milliliters, 3:00 PM-11:00 PM shift = 150 milliliters, 11:00 PM-7:00 AM shift = 120 milliliters). -Every shift document total fluid consumed per shift.-hemodialysis three times a week on Monday, Wednesday, and Friday-Velphoro (medication that lowers blood phosphorus levels) 500 milligram tablet with each meal. The undated Kardex (care instructions) printed on 04/16/2026, documented the resident would be provided with a renal, no concentrated sweets, and 1500 milliliter fluid restriction diet as ordered by the physician.The activities of daily living meal consumption record for March 2026 and April 2026 documented Resident #3's solid and fluid intake varied from 26% to 100% of documented meals. The following meals were not documented:-03/02/2026: dinner-03/03/2026; breakfast, lunch, dinner-03/04/2026: breakfast and lunch-03/05/2026: dinner-03/13/2026: lunch-03/17/2026: dinner-03/23/2026: breakfast, lunch, dinner-03/24/2026: breakfast, lunch-03/25/2026: lunch-03/30/2026: dinner-04/01/2026: breakfast and lunch-04/07/2026: breakfast and lunch-04/10/2026: breakfast and lunch-04/14/2026: dinner The January 2026 through April 2026 medication administration record documented fluid restriction: 1500 milliliters/day, serve 1080 milliliters dietary/day breakfast 480 milliliters, lunch 360 milliliters, dinner 240 milliliters; for nursing/day amount per shift 7:00 AM -3:00 PM shift = 150 milliliters, 3:00 PM-11:00 PM shift = 150 milliliters, 11:00 PM-7:00 AM shift = 120 milliliters. Every shift document total fluid consumed per shift. The designated medication administration boxes for each shift did not include actual fluid consumed and were marked with a check. The 01/11/2026 Registered Dietitian #39 quarterly progress note documented the resident was on a renal, no concentrated sweets diet, and consumed 76% or more of solids and fluids at and between meals. There was no documentation of the resident's prescribed fluid restriction or monthly dialysis laboratory data. There was no documented evidence of the amount of fluids provided at meals or if fluid intake volume was assessed. The 02/03/2026 laboratory results collected 02/02/2026 documented the resident's phosphorus level was 6.2 milligrams per deciliter (normal range 2.5 -5 milligrams per deciliter) and calcium phosphorus product (assesses mineral balance) was elevated to 60.8 (normal value below 55). Registered Dietitian #39 progress notes documented: -on 02/27/2026 the resident was on a fluid restriction and consumed 76-100% of their solids at meals. There was no documented evidence of the amount of fluids provided at meals, fluid intake volume was assessed, or laboratory values were reviewed. -on 04/06/2026 the resident was on a renal, no concentrated sweets diet, and consumed 76% or more of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solids and fluids at and between meals. There was no documented evidence of the amount of fluids provided at meals, fluid intake volume was assessed, or laboratory values were reviewed -on 04/10/2026 the resident was on a fluid intake and consumed 76-100% of their solids at meals. There was no documented evidence of the amount of fluids provided at meals or fluid intake volume was assessed. During an observation and interview on 04/14/2026 at 12:41 PM, the resident's lunch meal ticket documented renal restriction diet and 1500 milliliter fluid. The following items were documented on the resident's meal ticket and were received for the lunch meal. -Four (4) ounces (120 milliliters) cranberry juice (consumed 100%)-Eight (8) ounces (240 milliliters) coffee (consumed 100%) The resident consumed the full 360 milliliter lunch fluid allotment at this time. At 1:00 PM, the resident was sitting with their empty tray in front of them and Certified Nurse Aide #41 brought them an eight (8) ounce (240 milliliters) chocolate milk. They consumed all 240 milliliters of the chocolate milk, which brought their lunch fluid consumption to 600 milliliters. Certified Nurse Aide #41 stated the tray ticket told them what diet a resident was on and they did not know what a renal diet was. They would have no idea if a resident was on a fluid restriction because this information was not in the section of the electronic medical record they accessed. During an interview on 04/16/2026 at 11:00 AM, Licensed Practical Nuse #20 stated a renal diet limited sodium, fluids, and potassium. A fluid restriction would limit the amount a resident could drink daily. They know if a resident was on a renal diet or fluid restriction by reviewing the care plan and the physician orders. Certified nurse aides should not give extra fluids without checking with the nurse and they should not have given Resident #3 chocolate milk or extra fluids not listed on their tray ticket. During an interview on 04/16/2026 at 11:17 AM, Licensed Practical Nurse Unit Manager #21 stated a renal diet was low potassium. They stated fluid restrictions were all different. Staff know if a resident was on a fluid restriction by looking at the meal ticket. A nurse aide should not give extra fluid or milk to a resident on a renal diet or fluid restriction, without checking with the nurse first and Resident #3 should not have been given chocolate milk. During an interview on 04/16/2026 at 11:44 AM, Certified Nurse Aide #17 stated they did not know what a renal diet was. A fluid restriction limited fluid to a certain amount. They would know about the renal diet and fluid restriction on the meal ticket, but it did not show up in the nurse aide section of the electronic medical record. They could not document the actual amount of fluid consumed in the electronic medical record, only a percentage range. They should not provide extra fluid to residents on a fluid restriction without checking with the nurse first. During an interview on 4/17/2026 at 7:30 AM, Certified Nurse Aide #17 stated both food and fluid were recorded in percentage only. If a resident drank everything they were given and received more, it was recorded as 76 to 100% for fluids and no specific fluid amount was recorded. Extra fluid intake would not be documented. During an interview on 4/17/2026 at 7:41 AM Licensed Practical Nurse #41 stated if a resident was on a fluid restriction, they recorded fluid intake in milliliters by clicking on the medication administration record and recorded the amount of fluid consumed.During an interview on 04/17/2026 at 7:42 AM, Licensed Practical Nurse Unit Manager #21 stated the nurse aides documented food and fluid intake in percentages. The licensed practical nurse documented fluid intake for those on fluid restrictions in the medication administration record. They opened Resident #3's medication administration record and saw only check marks were recorded and stated that was not how it should have been done. The documentation should have included actual fluid amounts. They did not know why fluid amounts were not recorded as they should have been. They did not complete intake and output records at the facility. During an interview 04/17/2026 at 8:30 AM, Registered Dietitian #39 stated a renal diet was low sodium, low potassium, and low phosphorus. Fluid restrictions were recommended by dialysis, and they broke down what fluids were allotted for meals and nursing in the electronic medical record. They obtained preferences as much as possible to provide the resident with fluids of choice. Staff knew if a resident was on a renal diet or fluid restriction from the electronic medical record. If a resident on a fluid restriction was given extra fluids, it was documented in the progress notes and in the medication administration record in fluid (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	amount. They stated the resident had a right to request extra fluids and milk, and staff should record this in the electronic medical record. They would document this information in their nutrition notes, document the non-compliance on the care plan, and provide the resident with education if a resident was non-compliant with their plan. They did not know if Resident #3 was care planned for non-compliance with their diet. They knew what the resident was drinking daily by looking at the general percentage under tasks in the electronic medical record. Nursing did not calculate actual fluid intake, and any extra fluids would not be captured in the fluid counts. The facility did not record intake and output records. They relied heavily on the task documentation and pieced together the data they had but had nothing concrete to tell them what Resident #3 was drinking daily. During a telephone interview on 04/17/2026 at 10:55 AM, Registered Nurse Charge Nurse #40 at the Dialysis Center stated Resident #3 was on a low potassium, low phosphorus, 1500 milliliter fluid restriction diet. Their phosphorus levels had increased, and they were supposed to be on 2 (two) different phosphate binders, Velphoro one (1) tablet at each meal and Renvela (lowers phosphate) 3 (three) tablets at each meal. Milk was high in phosphorus and facility staff should not have offered extra milk or extra fluids with meals. They should be tracking their fluid intake amounts in volume daily to monitor for compliance.10 New York Codes, Rules and Regulations 415.12 (i)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observations, record review, and interviews, the facility failed to ensure a resident who displayed or was diagnosed with dementia received the appropriate treatment and services to maintain their highest practicable physical, mental, and psychosocial well-being for one (1) of one (1) resident (Resident #47) reviewed. Specifically, there was no documented evidence Resident #47 had an individualized care plan with interventions in place that included person-centered approaches or steps to assist in guiding staff in managing the resident's care. Findings include: The facility policy Care Plans/Comprehensive Person Centered, last reviewed 01/2026, documented the comprehensive person-centered care plan is developed for each resident to include measurable objectives and timetables to meet a residents' medical, nursing, mental and psychosocial needs. The comprehensive care plan should reflect person- centered care with resident specific interventions and should be reviewed and revised as appropriate upon readmission to the facility, quarterly, annually and with any significant change. The facility policy Dementia-Clinical Protocol, revised 01/2026, documented the facility would assess, develop, and implement a person-centered care plan through an interdisciplinary team approach that included the resident, their family, and resident representative. The care plan goals would be agreed upon, and the facility would provide resources necessary for potential success in meeting their goals. The care plan interventions would be related to each residents' individual symptoms and rate of dementia progression. Individualized, non-pharmacologic approaches to care would be utilized to maximize remaining function and quality of life and enhancing the resident's well-being. Resident #47 had diagnoses including dementia and bipolar disorder (intense mood swings). The 07/20/2025 Minimum Data Set assessment documented the resident had severe cognitive impairment; required substantial to maximum assistance or was dependent with most of their daily living activities; required supervision/touch assistance with functional mobility; and was prescribed medications to treat psychiatric diagnoses. The comprehensive care plan initiated on 08/06/2024 and revised on 10/10/2025, documented impaired cognition related to dementia. Interventions included administer medications and ask yes or no questions. The comprehensive care plan initiated on 10/10/2025 documented the resident was at risk for changes in mood due to bipolar disorder and dementia. Interventions included administering psychotropic medications, monitoring changes in mood, and providing support and reassurance. There were no specific person-centered intervention for the diagnosis of dementia. The resident was observed at the following times: -on 04/14/2026 at 9:05 AM, walking up to surveyor, looking at the surveyor and continuing to walk past them and down the hallway into another resident room. Approximately two minutes later the resident exited the room and walked back down the hall toward the surveyor standing in the dining area of Wing 1 near the nursing station. There were no staff interactions with the resident -on 04/15/2026 at 7:41 AM and 11:40 AM, the resident was walking aimlessly up and down the hallway. There were no staff interactions with the resident. -on 04/16/2026 at 9:59 AM and 11:05 AM, the resident was sleeping seated in a chair in the hall with their head leaning back in the chair. There were no resident and staff interactions observed. -on 04/17/2026 at 9:27 AM and 9:59 AM, the resident was seated in chair in the hallway outside of another resident's room making loud vocalizations. They intermittently stood and sat lifting their bottom off the seat a couple of inches each time. They continued yelling and standing/sitting for approximately thirty minutes. There were no resident and staff interactions during this time. During an interview on 11/17/2026 at 10:16 AM, Certified Nurse Aide #34 stated they worked with the resident regularly. They stated residents with dementia required a great deal of one-to-one care and more attention, and they knew the resident enjoyed walking, juice, music, and visits from a male friend who brought in a small dog. During a follow up interview on 04/17/2026 at 12:48 PM, Certified Nurse Aide #34 stated when a resident had a behavior they would refer to the care plan for guidance when determining what to do for them. During an interview on 04/17/2026 at 11:05 (continued on next page)

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	AM, Licensed Practical Nurse Unit Manager #12 stated they were responsible for reviewing the care plans of the residents and made recommendations to give to the registered nurses, but they could not make changes to the plans. They stated the comprehensive care plan for the residents should document what they liked and disliked; appropriate ways to assist them; and ensure they had the best quality of life possible. They stated the resident liked music and liked wearing high heeled shoes. During an interview on 04/17/2026 at 12:18 PM, Registered Nurse #35 stated they created the basic care plan when a resident was admitted to the facility. They recently reviewed the resident nursing care plan and verbalized they were at risk because they had dementia. They stated a staff member unfamiliar with the resident would not be able to provide care using the current care plan, indicating that it required revision; as new staff may not know how to manage the resident's behaviors. The resident's likes and dislikes were documented in the activities care plan and all staff could reference that information. They stated the care instructions did not include that information. 10 New York Codes, Rules and Regulations 415.12

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observations, record review, and interviews the facility failed to ensure that residents were free of any significant medication errors for one (1) of one (1) resident (Resident #14) reviewed. Specifically, Resident #14 received Ativan (a medication for anxiety) twice a day and the medication was not administered within the prescribed time frame causing discomfort to the resident. Findings include: The facility policy Administering Medications, last revised 1/2026, documented medications were administered in a safe and timely manner as prescribed. Medications were administered within (1) one hour of the prescribed time unless otherwise specified. If a medication was not administered at the scheduled time, the individual administering the medication should document that in the electronic medication administration record and notify the attending/covering physician. The undated facility medication pass schedule documented the following times: 7:00AM-10:00 AM; 11:00 AM; 1:00 PM; 2:00 PM; 4:00 PM; 7:00 PM-10:00 PM; 10:00 PM; 12:00 AM; and 6:00 AM. Resident #14 had diagnoses including anxiety and depression. The 01/19/2026 Minimum Data Set assessment documented the resident had intact cognition and used an antianxiety medication. The Comprehensive Care Plan, initiated 10/10/2025, documented the resident used psychotropic medications related to anxiety and depression. Interventions included administer medications as ordered by the physician and monitor and document effectiveness and side effects.The updated 04/10/2026 physician order documented Ativan 0.5 milligrams, give two tablets one time a day for anxiety and one tablet at bedtime for anxiety.The February 2026 and April 2026 Medication Administration Record documented Ativan 0.5 milligrams two tablets in the morning from 7:00 AM until 10:00 AM and one tablet at bedtime from 7:00 PM to 10:00 PM. The Medication Administration Record documented Ativan 0.5 milligrams was administered:-on 02/04/2026 at 11:40 PM by Licensed Practical Nurse #29.-on 02/06/2026 at 11:11 PM by Licensed Practical Nurse #30.-on 04/13/2026 at 12:12 AM by Licensed Practical Nurse #24.-on 04/16/2026 at 11:12 AM by Licensed Practical Nurse #9.During an observation and interview on 04/13/2026 at 12:58 PM, Resident #14 stated they had anxiety and received medication for anxiety that should be taken twice a day. There were times when the medication was not administered at the appropriate time which caused an increase in their anxiety, and the anxiety caused them to be short of breath. They asked nursing staff to administer the medication at the prescribed times, and they were told by the nurses the medication could be administered up to eight hours late. During an observation and interview on 04/17/2026 at 8:42 AM, Resident #14 was observed utilizing their nebulizer (respiratory treatment). They stated they were anxious which caused shortness of breath. The Medication Administration Record documented Ativan 0.5 milligrams was administered on 04/17/2026 at 12:45 PM by Licensed Practical Nurse #22.During an interview on 04/17/2026 at 10:47 AM, Licensed Practical nurse #22 stated during medication administration they pulled up each resident one at a time and clicked medications as administered in the electronic medical record after the resident accepted the medication. They were still learning the software system, and most medications should be administered between 7:00 AM and 10:00 AM. There was a one-hour window that medications could be administered making the actual medication administration times 6:00 AM until 11:00 AM when medications were twice a day, and they could be administered between 6:00 PM until 11:00 PM. They administered all medications for Resident #14 including Ativan; however, they did not sign the medications as administered and they should have. They did not know why they did not click that all medications were administered at the time of administration. During an interview on 04/17/2026 at 4:05 PM, Licensed Practical Nurse #9 stated they worked the 3:00 PM shift on unit four and their primary responsibility was medication administration. They stated medications with an administration time from 7:00 PM until 10:00 PM could be administered any time between 6:00 PM and 11:00 PM. When a medication was administered outside that timeframe, they wrote a progress note and notified the medical provider. They worked the evening shift on 04/12/2026 and was not sure why the medication administration record (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the evening dose of Ativan for Resident #14 was administered at 12:12 AM on 04/13/2026. Administration of Ativan at that time would be late and they should have written a progress note and notified the medical provider. They were not sure why the medication was late. They stated they were slow when administering medications.During an interview on 04/17/2026 at 1:16 PM, Licensed Practical Nurse Unit Manager #5 stated the facility had a liberal medication administration policy. When medications were ordered from 7:00 AM until 10:00 PM this allowed the administration of medications one hour before or after that administration time. When a medication was administered outside the prescribed medication times, the supervisor should be notified, and the supervisor notified the physician or nurse practitioner. When a medication was ordered twice a day it was important to administer the medications within the prescribed timeframe to ensure medications were not administered too far apart or too close together. When they were notified that a medication was administered late, they documented that in a progress note. They were not notified of any medications that were administered late in the last week. They stated the Ativan dose administered by Licensed Practical Nurse #24 on 04/13/2026 at 12:12 AM was late; the Ativan dose administered by Licensed Practical Nurse #9 on 04/16/2026 at 11:12 AM was late; and the Ativan dose administered by Licensed Practical Nurse #22 on 04/17/2026 at 12:45 PM was late. They were not notified about any of the late administrations and should have been. A progress note should have been written and the medical provider notified to ensure there was appropriate time between administration of the medication. 10 New York Codes, Rules, and Regulations 415.12(m)(2)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations and interviews the facility failed to ensure garbage and refuse was disposed of properly for one (1) of one (1) dumpster area located near the loading dock. Specifically, there were several used gloves, empty food containers, and vegetable scraps on the ground around the dumpster.Findings include:The facility policy Dumpster and Waste Disposal, dated 01/2026, documented dumpsters would be maintained in a clean, secure, and sanitary condition. Dumpsters would be cleaned and sanitized on a routine basis and waste would not be placed outside dumpsters.During an observation and interview on 04/14/2026 at 8:20 AM, there were several used gloves, empty food containers, and vegetable scraps on the ground around the dumpsters near the loading dock. The ground near the dumpsters was mostly loose gravel in poor repair. Food Service Director #16 stated maintenance was responsible for keeping the area clean.During an interview on 04/17/2026 at 8:54 AM, Maintenance Director #18 stated the maintenance staff checked the dumpster area and was responsible for cleaning it to prevent animals in the area. 10 New York Codes, Rules and Regulations 415.14(h)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) of three (3) residents (Residents #61 and #146) reviewed. Specifically, staff did not wear the required personal protection equipment while caring for Residents #61 and #146 who were on contact precautions.Findings include: The 04/03/2024 Centers for Disease Control recommendations documented transmission-based precautions are the second tier of basic infection control and are used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Use personal protective equipment appropriately. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment The facility precaution sign Droplet/Contact Precautions documented everyone must wash or clean hands with hand sanitizer before entering and leaving the room; wear a mask and eye protection; put on gloves before entering the room and remove before exiting the room; and wash hands after removal of personal protective equipment. 1) Resident #61 had diagnoses including quadriplegia (paralysis), tracheostomy (a surgically created hole in the windpipe), and bladder dysfunction. The 01/14/2026 Minimum Data Set assessment documented the resident had intact cognition, was dependent for all activities of daily living, had an indwelling urinary catheter, a feeding tube, and received tracheostomy care. The revised 12/18/2025 comprehensive care plan documented the resident had colonized extended-spectrum beta-lactamases (enzymes produced by multi-drug resistant bacteria) and a suprapubic catheter (indwelling urinary tube). Interventions included maintaining transmission-based precautions as ordered and place on contact precautions. The 03/16/2026 hospital discharge summary documented the resident was diagnosed with urinary Morganella (bacteria that can cause infection) and enterococcus faecalis (bacteria that can cause severe infections). The resident had bilateral nephrostomy tubes (drains urine directly from kidney) and urinary sepsis (infection). The 03/17/2026 physician order documented maintain contact precautions every shift for infection control. During an observation on 04/13/2026 at 10:47 AM, there was a sign on Resident #61's doorway documenting Contact Precautions and included what type of personal protective equipment was required prior to entering the room. Certified Nurse Aide #25 was in Resident #61's room and was not wearing personal protective equipment. During an interview on 04/15/2026 at 10:20 AM, Licensed Practical Nurse #9 stated any staff entering a precaution room must follow infection control practices and wear the required personal protective equipment such as a gown and gloves. Resident #61 was on contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/17/2026 at 10:58 AM, Certified Nurse Aide #25 stated a sign outside a resident's doorway documented if the resident was on urinary or airborne precautions. If there was a doubt about what personal protective equipment should be worn, the staff member should look at the sign. They stated they were not sure why Resident #61 was on contact precautions. They did not know why they did not wear personal protective equipment while in Resident #61's room and they should have. They stated the purpose of wearing personal protective equipment was to prevent the spread of germs by cross contamination. 2) Resident #146 had diagnoses including chronic open wounds of both legs. The 01/21/2026 Minimum Data Set assessment documented the resident had intact cognition, required maximal assistance with most activities of daily living, had skin ulcers (open wounds), had nonsurgical dressings, and was receiving an antibiotic. The 09/19/2025 revised comprehensive care plan documented the resident was at risk for infection related to open skin areas. Interventions included maintain contact precautions per physician orders. The 10/27/2025 physician order documented to maintain contact precautions for weeping wounds and history of multidrug resistant organisms. The 04/2026 Treatment Administration Record documented contact precautions every shift for weeping wounds and history of multidrug resistant organisms. During an observation on 04/13/2026 at 7:52 AM, there was a Contact Precautions sign on the doorway of the resident's room. Certified Nurse Aide #26 left Resident #146's room and did not wear personal protective equipment while in the room. The aide then entered the room without donning a gown or gloves, came out into the hallway with an overbed tray table, and placed it in front of the resident without disinfecting the table. During an observation on 04/13/2026 at 9:54 AM, Certified Nurse Aide #26 entered and exited Resident #146's room without donning a gown or gloves prior to going into the room. During an interview on 04/16/2026 at 9:44 AM, Certified Nurse Aide #26 stated they had received infection control training and knew what type of personal protective equipment to wear by the sign on the doorway. If they had a question about it, they would look at the resident's care plan. Staff should wear a gown and gloves, as directed by the sign, every time they entered Resident #146's room. Resident #146 was on contact precautions due to drainage from their legs and had a Contact Precautions sign on their doorway. Overbed tray tables should not be taken from a precautions room unless necessary and should be sanitized prior to removing it from the room to prevent cross contamination of germs. They were in a rush that morning and did not think to put on a gown and gloves before entering the resident's room. During an interview on 04/17/2026 at 1:22 PM, Infection Preventionist #27 stated infection control education was provided to staff before they assumed the role. They provided on-the-spot reeducation to some staff when performing unit rounds the previous week and saw potential infection control issues. The facility recently had a COVID-19 case and an influenza outbreak that resolved prior to survey. Staff should wear a gown and gloves before entering a resident's room who was on contact precautions to prevent cross contamination of germs. They stated Residents #61 and #146 were on contact precautions. Both residents had a sign outside their rooms informing staff what types of personal protective equipment were required prior to entering the room. There should be a stocked (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personal protective equipment cart outside each resident's doorway and a designated bin in each room to dispose of the used equipment. 10 New York Codes, Rules and Regulations 415.19(a) (1-3)