STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335827	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nrsg at River Valley	140 Main Street Poughkeepsie, NY 12601

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 43478 Based on record review and interview during an abbreviated survey (NY00364683), the facility did not ensure the resident's representative was informed of a significant change in the resident's physical status or a need to alter treatment significantly for 1 of 3 residents (Resident #2) reviewed for abuse. Specifically, Resident #2 was a victim of sexual abuse on 12/13/24 by Resident #3, and there was no documented evidence that Resident #2's representative was notified of the incident until 12/16/24. The findings are: The facility policy, Abuse Prevention Program reviewed 3/2024 documented the Administrator or Director of Nursing Services or designated person will keep the resident and his or her representative informed of the progress of the investigation. Resident #2 had diagnoses including unspecified dementia, anxiety, and muscle weakness. The 11/21/24 Quarterly Minimum Data Set (assessment tool) documented Resident #2 had severe cognitive impairment and required assistance with activities of daily living. The facility accident incident report dated 12/13/24 at 8:48 PM documented that Certified Nurse Aide #2 observed Resident #3 touching Resident #2's left breast. The facility conclusion documented that there was reasonable cause to believe that resident abuse neglect or mistreatment may have occurred. The accident incident report documented the Resident's family member was notified at 3:45 PM with no date documented. There was no documented evidence that the Resident's family member was notified when the incident occurred on 12/13/24. On 2/14/25 at 11:47 AM during an interview with Certified Nurse Aide #2 who witnessed the incident on 12/13/24, they stated they observed Resident #3 touching Resident # 2's left breast. Review of Certified Nurse Aide #2's written statement confirmed their interview. There was no documented evidence in the Nurse's Notes that Resident #2's son was notified of the incident from 12/13/24 until 12/16/24. The 12/16/24 Nurse's Note documented the Assistant Director of Nursing spoke with Resident #2's son regarding the incident. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/14/25 at 1:25 PM during an interview with the Assistant Director of Nursing, they stated they did not notify Resident #2's family until 12/16/24. On 2/19/25 at 9:40 AM during an interview and review of the accident/incident report with the Director of Nursing, the accident incident report documented the Resident's family member was notified at 3:45 PM with no date documented. There was no documented evidence that the Resident's family member was notified when the incident occurred on 12/13/24. The Director of Nursing stated the Resident's family member should have been notified when the incident occurred. On 2/19/25 at 11:31 AM during a follow-up interview, the Director of Nursing stated they confirmed that the Registered Nurse Supervisor who completed the accident incident report did not reach the Resident's family on 12/13/24 and did not document as such. The Director of Nursing additionally stated they do not know if or when a facility staff member called the Resident's family prior to 12/16/24 for the incident which occurred on 12/13/24. The Director of Nursing reiterated that the Resident's family member should have been notified when the incident occurred. 10 NYCRR 415.3(f)(2)(ii)(c)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43478 Based on interviews and review of facility documentation conducted during the abbreviated (NY00371494, NY00364683) surveys the facility did not ensure that residents were free from abuse. This was evident for 2 (Residents #1, #2) of 3 residents reviewed for abuse. Specifically, 1) Registered Nurse Supervisor observed Certified Nurse Aide #3 pushing Resident #1's arm, and 2) Resident #3 was observed by a Certified Nurse Aide touching Resident #2's breast. The findings are: The facility policy titled Abuse Prevention Program reviewed 3/2024 documented the residents have the right to be free from abuse and will be protected from abuse. It documented the Administrator or Director of Nursing Services, or designated person will keep the resident and his or her representative informed of the progress of the investigation. An alleged violation of abuse will be reported immediately, but not later than two hours if the alleged violation involves abuse or 24 hours if the alleged violation does not involve abuse. Resident #1 originally admitted on [DATE] and readmitted on [DATE] with diagnoses of Dementia in other diseases classified elsewhere, mild, with mood disturbance and Cognitive communication deficit. Quarterly Minimum data set (an assessment tool) dated 1/7/2025 indicate that the resident is severely impaired to make decisions regarding tasks of daily living. The 10/9/24 Care Plan, Resident is at risk for potential abuse related to cognitive impairment documented the goal that the resident will not experience any form of abuse or neglect. Interventions included to assess the resident for signs and symptoms of abuse and or neglect and report to appropriate resources, investigate all allegations of abuse and neglect promptly. Resident #2 had diagnoses including unspecified dementia, anxiety, and muscle weakness. The 11/21/24 Quarterly Minimum Data Set (resident assessment) documented Resident #2 had severe cognitive impairment and required assistance with activities of daily living. The 10/9/24 Care Plan, Resident is at risk for potential abuse related to cognitive impairment documented the goal that the resident will not experience any form of abuse or neglect. Interventions included to assess the resident for signs and symptoms of abuse and or neglect and report to appropriate resources, investigate all allegations of abuse and neglect promptly. Resident #3 had diagnoses including schizophrenia, dementia, and major depressive disorder. The 9/30/24 Quarterly Minimum Data Set (resident assessment) documented Resident #3 had moderately impaired cognition and required supervision with ambulation and other activities of daily living. The 10/9/24 Care Plan, Resident is at risk for potential abuse, neglect related to cognitive impairment documented the goal that the resident will not experience any forms of abuse or neglect through the review date. Interventions included investigate all allegations of abuse and neglect promptly. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the accident and incident report dated 2/7/2025 revealed that Certified Nurse Assistant #3 had an altercation with Resident #1 and in their attempt to push the resident in their wheelchair through doors to exit the dining room Resident #1 put their arms out to stop their wheelchair from exiting of the room, and the Certified Nurse Assistant #3 pushed their arm forcefully out of the way. This event was witnessed by Registered Nurse Supervisor #1, they stopped Certified Nurse Assistant #3 and evaluated the resident and reported the incident to the Director of Nursing. On 2/13/25 at 10:51am in an interview with Registered Nurse Supervisor who was the supervisor on the day of the incident, stated while they were walking in the hallway, they heard Resident #1 cursing and observed Certified Nurse Aide # 3 attempting to wheel Resident #1 through the doorway from the dining room into the hallway, they observed Resident #1 forcefully holding the door jam to prevent Certified Nurse Aide #3 to wheel Resident #1 out of the dining room, and observed Certified Nurse Aide #3 forcefully push Resident #1's left arm off of the door jam. Registered Nurse Supervisor #1 stated they observed scratches on the Certified Nurse Aide #3 arms but no bite marks. Stated they assisted Resident #1 into the hallway, completed a quick head to toe assessment and did not see any injuries to Resident #1. On 2/14/25 at 11:47 AM during an interview with Certified Nurse Aide #2 who witnessed the incident on 12/13/24, they stated they observed Resident #3 touching Resident #2's left breast. The facility accident incident report dated 12/13/24 at 8:48 PM documented that Certified Nurse Aide #2 observed Resident #3 touching Resident #2's left breast. The facility conclusion documented that there was reasonable cause to believe that resident abuse neglect or mistreatment may have occurred. On 2/14/25 at 1:20 PM during an interview, the Director of Nursing stated they could not rule out that abuse may have occurred. On 2/18/25 at 3:55 PM, during a follow-up interview, the Director of Nursing stated that after investigation of the incident, they could not rule out that abuse may have occurred. 10NYCRR 415.4(b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 43478 Based on interviews and review of facility documentation conducted during the abbreviated (NY00364683) survey, the facility did not ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made to either the State Survey Agency or local law enforcement in accordance with State law through established procedures. This was evident for 2 of 3 residents (Residents #2, #3) reviewed for abuse. Specifically, Certified Nurse Aide # 2 observed Resident #3 touching Resident #2's breast on 12/13/24 at 8:48PM and the facility did not report the incident to the State Survey Agency until 12/14/24 at 3:59 PM, the facility also never notified law enforcement, although the facility could not rule out abuse. The Finding is: The Facility Policy, Abuse Prevention Program reviewed 3/2024 documented residents have the right to be free from abuse and will be protected from abuse. It documented the Administrator or Director of Nursing Services, or designated person will keep the resident and his or her representative informed of the progress of the investigation. An alleged violation of abuse will be reported immediately, but not later than two hours if the alleged violation involves abuse or 24 hours if the alleged violation does not involve abuse. The facility policy, Reporting suspicion of a crime, reviewed January 2024 documented that each covered individual must report to the state survey agency and at least one local law-enforcement agency, any reasonable suspicion of a crime against the resident of the facility. Examples of crimes that would be reportable include but are not limited to sexual abuse. Resident #2 had diagnoses including unspecified dementia, anxiety, and muscle weakness. The 11/21/24 Quarterly Minimum Data Set (an assessment tool) documented Resident #2 had severe cognitive impairment and required assistance with activities of daily living. Resident #3 had diagnoses including schizophrenia, dementia, and major depressive disorder. The 9/30/24 Quarterly Minimum Data Set (an assessment tool) documented Resident #3 had moderately impaired cognition and required supervision with ambulation and other activities of daily living. The facility accident and incident report dated 12/13/24 at 8:48 PM documented that Certified Nurse Aide #2 observed Resident #3 touching Resident #2's left breast. The facility conclusion documented that there was reasonable cause to believe that resident abuse neglect or mistreatment may have occurred. During an interview on 2/14/25 at 11:47 AM Certified Nurse Aide #2 stated that on 12/13/24, they observed Resident #3 touching Resident # 2's left breast. Review of Certified Nurse Aide #2's written statement confirmed their interview. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/25 at 1:20 PM, the Director of Nursing stated the incident occurred on 12/13/24 at approximately 8:45 PM, but they did not report to the State Survey Agency until 12/14/24 around 3:00 PM, although the facility could not rule out that abuse may have occurred. The Director of Nursing stated nobody besides them and the Administrator have access to the Health Commerce System for reporting to the State Survey Agency. The Director of Nursing additionally stated they did not call law enforcement. During a follow-up interview on 2/18/25 at 3:55 PM, the Director of Nursing stated the facility should report to the State Survey Agency if abuse cannot be ruled out within 2 hours. The Director of Nursing stated when they investigated the incident, they could not rule out that abuse may have occurred. The Director of Nursing further stated that they only call law enforcement if at least one of the residents involved in an incident is alert and oriented. 10 NYCRR 415.4(b)(2)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 43478 Based on record review and interviews during an abbreviated survey (NY00364683), the facility did not ensure the comprehensive care plan was reviewed and revised in a timely manner for 1 of 3 residents (Resident #2) reviewed for abuse. Specifically, Resident #2 was a victim of witnessed sexual abuse on 12/13/24, and there was no documented evidence of the care plan having been revised to reflect the abuse incident or any new intervention. The Findings are: The facility policy, Care planning - Interdisciplinary team, reviewed January 2024 documented the facility care planning interdisciplinary team is responsible for the development of an individualized comprehensive care plan for each resident. The interdisciplinary team must review and update the care plan when there has been a significant change in the resident's condition, when the desired outcome is not met, when the resident has been readmitted and at least quarterly. Resident #2 had diagnoses including unspecified dementia, anxiety, and muscle weakness. The 11/21/24 Quarterly Minimum Data Set (an assessment tool) documented Resident #2 had severe cognitive impairment and required assistance with activities of daily living. The 10/9/24 Care Plan, Resident is at risk for potential abuse related to cognitive impairment documented the goal that the resident will not experience any form of abuse or neglect. Interventions included to assess the resident for signs and symptoms of abuse and or neglect and report to appropriate resources, investigate all allegations of abuse and neglect promptly. There was no documented evidence of Resident #2's care plan being revised to reflect the abuse incident or new intervention. The 12/16/24 Physician's note documented incident with Resident #2, Resident #2 showed no overt signs of distress or discomfort. Plan: Resident's son was informed; staff will increase monitoring and prevent further contacts with Resident #2. On 2/14/25 at 4:02 PM during an interview, Registered Nurse Supervisor #7 stated Resident #2's Care Plan should have documented the incident and the intervention to be separated from the perpetrator. On 2/14/25 at 4:55 PM during an interview, the Director of Nursing stated no Care Plan Notes or new interventions were documented related to the abuse incident on 12/13/24. They stated the Care Plan should have been updated. 10 NYCRR 415.11 (c)(2)(i-iii)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 43478 Based on staff interviews and review of facility documentation conducted during the abbreviated (NY00371494, NY00364683) surveys, it was determined that the facility did not ensure that a performance review of every certified nurse aide was completed at least once every 12 months, and that each certified nurse aide received no less than twelve hours of in-service education per year. This was evident for 2 of 3 Certified Nurse Aides (#3, #5) reviewed for completion of performance evaluations and in-service education. Specifically, the facility did not ensure that Certified Nurse Aide #3 and #5 had a performance evaluation completed at least once every 12 months and received no less than twelve hours of in-service education per year. The findings are: The facility policy, In-service training program, Nurse Aide, reviewed January 2024 documented that the facility will complete a performance review of Nurse Aides at least every 12 months, in-service training will be based on the outcome of the annual performance reviews addressing weaknesses identified in the reviews, and annual in- services must be no less than 12 hours per employment year. On 2/14/25 at 10:05 during an interview with Director of Human Recourses, the surveyors requested performance reviews for Certified Nurse Aides #2, #3, and #5. The Director of Human Recourses stated they do not have performance reviews for any clinical staff. They stated in their 2 years at the facility, they have never received a performance review for clinical staff. On 2/14/25 at 10:29 AM during an interview, the Director of Nursing stated they do not complete performance evaluations. On 2/14/25 at 11:04 AM during an interview, the Administrator stated they do not complete performance evaluations for the Certified Nurse Aides. On 2/14/25 at 11:28 AM during an interview, the former Staff Educator stated they had never completed or received a performance evaluation for any Certified Nurse Aide. Mandatory Annual Education Packets reviewed for Certified Nurse Aides #2, #3, and #5 did not ensure they had completed the required number of in-service education per year. On 2/14/25 at 1:40 PM during an interview with the Former Staff Educator and a review of Certified Nurse Aide #5's education packet, they stated Certified Nurse Aide #5 completed 7.5 hours of training and might have completed more but the tally of education minutes was not up to date. They stated every Certified Nurse Aide should complete 12 hours of training each year. On 2/14/25 at 1:40 PM during an interview with the Former Staff Educator and a review of Certified Nurse Aide #3's education packet, they stated Certified Nurse Aide #3 completed 9 hours of training and might have completed more but the tally of education minutes was not up to date. They stated every Certified Nurse Aide should complete 12 hours of training each year. 10NYCRR 415.26