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	01/28/2026

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

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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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review the facility did not ensure individual financial records were available to residents through quarterly statements. This was evident for (6) six residents (Residents #18, #103, #127, #140, #157, and #160) reviewed for personal funds. Specifically, there was no documented evidence Residents #18, #103, #127, #140, #157, and #160 were provided with quarterly statements for personal need accounts managed by the facility. The findings include:The policy titled Deposit of Resident Funds dated 01/2025 documented the resident was provided with a confidential quarterly statement of funds on deposit with the facility and activity since the previous statement.On 01/20/2026 at 12:26 PM, Resident #127 was interviewed and stated they did not know how much money was in their account and had not received an account statement in the past year.On 01/20/2026 at 2:12 PM, Resident #140 was interviewed and stated they had not received quarterly statements for their personal funds account managed by the facility.On 01/27/2026 at 11:58 AM, Resident #103 was interviewed and stated they did not know their personal fund account balance and had not received quarterly statements since approximately 06/2025.On 01/28/2026 at 9:02 AM, the Administrator was interviewed and stated they took over responsibility of resident banking within the facility and disbursed funds from resident personal needs accounts upon resident request. The facility's former Finance Coordinator was responsible for resident banking but resigned in 11/2025. Residents were provided with their account balances upon request. The Administrator stated the corporate finance office operated offsite and were responsible for providing residents or their representatives with quarterly statements for personal needs' accounts managed by the facility. They stated there were no onsite staff members or other disciplines that helped to deliver the statements to residents. The Administrator stated they did not know when the last quarterly statements were sent out and would have to contact the corporate finance office to find out more information. At 5:07 PM, the Administrator stated they were unable to provide documented evidence that quarterly personal funds statements were provided to residents. 10 NYCRR 415.26(h)(5)(ii)(a-c)

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews conducted during the recertification survey from 01/20/2026 to 01/28/2026 the facility did not ensure residents were provided food and drink that was palatable, and at a safe and appetizing temperature. Specifically, due to food temperature complaints from residents at the resident council meeting on 01/21/2026 at 11:11AM a test tray temperature was taken of egg salad that had a holding temperature of 70 degrees Fahrenheit, and during the observation of a lunch meal service in the kitchen, the egg salad and yogurt temperatures were held at 58 degrees Fahrenheit. The findings include:According to the United Stated Food and Drug Administration food code, cold holding of cooked eggs and egg containing foods should be at 41 degrees Fahrenheit or below.During Resident Council meeting conducted 01/21/2026 at 11:11 AM multiple residents at the meeting voiced concerns about foods being overcooked, and undercooked and at times food did not arrive hot.During an observation on 01/23/2026 at 1:04 PM, the last lunch tray was served on the second floor, and the cook used the facility thermometer to test the temperatures of the lunch main meal on one tray and alternate meal on a second tray. The alternate meal tray had a covered plate containing an egg salad sandwich, a cold item, with a holding temperature of 70 degrees Fahrenheit, and a bowl of stewed tomatoes, a hot item, with a holding temperature of 126.7 degrees Fahrenheit. During the observation, the cook was interviewed and stated the second floor was the last unit to get lunch service. Cold food items should be kept well below 70 degrees Fahrenheit. Usually, the egg salad sandwich would be kept separate from the stewed tomatoes and not stored under the same cover. The [NAME] stated the kitchen decided to change the presentation of the food and this might have affected the holding temperatures.During an observation on 01/27/2026 at 11:27 AM of the lunch meal service, yogurts, and pre-portioned cups of egg salad were held on a rack to be used on meal trays during the assembly of the meal. The temperature taken of yogurt by the acting Food Service Director documented it was at 51 degrees Fahrenheit, and the egg salad was 43 degrees Fahrenheit. At that time, the acting Food Service Director was interviewed and stated the procedure was to keep the rack of cold foods in the walk-in refrigerator until just before meal tray assembly started. They stated the current rack had been out of the walk-in refrigerator for less than ten (10) minutes. The documented temperature logs of the walk-in refrigerator were within normal limits, and the acting Food Service Director was not sure why the temperatures were elevated and attempted to use another thermometer to measure the temperatures. The temperatures continued to remain above the standard 41 degrees Fahrenheit. They stated they typically did not obtain and track cold food temperatures on the temperature log.10 NYCRR 415.14 (d)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility did not ensure food was stored and prepared in accordance with professional standards for food service safety. Specifically, 1) unlabeled foods were stored in the kitchen walk in refrigerator, freezer, and cooks prep counter 2) expired foods were stored in the walk-in refrigerator, emergency food supply, and Resident #5's personal refrigerator and 3) staff were observed not wearing beard nets while in the kitchen.The findings include: The policy last reviewed 01/2024 titled Food Receiving and Storage documented all foods stored in the refrigerator or freezer will be covered, labeled and dated (use by date).The policy last reviewed 01/06/2026 titled Resident Personal Refrigerators documented staff will monitor and discard any expired or improperly stored items.The policy last revised 11/2020 titled Dress code/Professional Appearance Policy documented beards and mustaches must be neat and closely trimmed to a 1/4 of an inch, if longer a beard net is required.During the initial tour of the kitchen on 01/20/2026 at 9:16 AM with the acting Food Service Director, the following was observed:The main walk-in refrigerator contained a plate of unlabeled food, the freezer contained a bag of unlabeled tortellini, and a pan of unlabeled white smooth consistency type food was on the cook's counter. The walk-in refrigerator contained pans of grape jelly, chopped lettuce, and chopped tomato with a discard date of 01/17/2026; a pan of hard-boiled eggs with a discard date of 01/16/2026; and four (4) gallons of whole milk with an expiration date of 01/05/2026. In the emergency food supply storage, there was a case of honey thick apple juice with an expiration date of 11/07/2025 and a case of rice cereal with an expiration date of 11/21/2025.During an observation and interview with the acting Food Service Director on 01/22/2026 at 9:15 AM a cook was in the kitchen preparing chicken with the beard net not covering their moustache and a recreation staff was filling containers for a beverage cart with no beard net. They stated staff had been educated on wearing hair and beard nets and produced an in-service sign in completed 05/15/2025.During an observation on 01/22/2026 at 10:33 AM Resident #5 had a personal refrigerator in their room that contained two (2) individual servings of Lactaid milk dated 12/09/2025, a carton of whole milk dated 10/15/2025, two (2) cartons of whole milk dated 11/29/2025, and one (1) carton of 2% milk dated 10/22/2025.During an interview with the acting Food Service Director on 01/20/2026 at 9:16 AM they stated the plate of unlabeled food was probably dietary staff saving food to eat later, it should not have been there, and the evening cook should have removed it. They stated the pan of unlabeled white smooth consistency type food on the cook's counter was pancake batter, but the cook stated it was alfredo sauce. The acting Food Service Director stated it was the evening cook's responsibility to discard any expired items. They stated the expired whole milk had just been delivered by the company that morning but must have been delivered by mistake. They stated deliveries were usually left at the door and no one from the kitchen had time to check it in when it was delivered. They stated the expired honey thick apple juice and rice cereal had been overlooked in the emergency food supply.During an interview on 01/22/2026 at 1:05 PM Certified Nurse Aide #6 stated Resident #5's personal refrigerator had a thermometer at one time, but not sure where it is now or who was keeping a record of the temperatures. They stated they thought the Certified Nurse Aide assigned to the resident each shift cleaned out Resident #5's personal refrigerator.During an interview on 01/22/2026 at 1:29 PM Licensed Practical Nurse Unit Manager #5 stated Resident #5's personal refrigerator was grandfathered in to allow them to have it since the previous administration did not want personal refrigerators in their rooms. They stated they were not sure who monitored/cleaned the personal refrigerator.10 NY CRR 415.14(h)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, record review and interview the facility did not ensure proper disposal of garbage and refuse. Specifically, three (3) garbage/recycle dumpsters were left open and there were cardboard boxes spilling over the top of the dumpsters and litter on the ground around the dumpsters.The findings are:The policy titled Food-Related Garbage and Refuse Disposal reviewed 1/2024 documented outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter. During an observation of the garbage area on 01/20/2026 at 10:14 AM with the acting Food Service Director, one (1) of three (3) dumpsters had the lid closed. The remaining two (2) dumpsters were open. There was observed litter on the ground including a plastic unused garbage bag, plastic straws, used blue and white plastic gloves, carboard, and spilled food. There was also a plastic bag full of garbage on the ground between the two (2) open dumpsters.During an observation of the garbage area on 01/22/2026 at 4:17 PM three (3) dumpster lids were open. The dumpster to the right was spilling over with cardboard boxes and one box on the ground. The middle dumpster was full of garbage and boxes, including a bag hanging over the side of the dumpster. Various litter was observed scattered in front of the dumpster including an empty bottle of tube feeding formula, straws, gloves, plastic, napkins, and a plastic bag of garbage partly under the dumpster. The third dumpster was partially full. There were cardboard boxes trapped under it and scattered around was a milk carton, used gloves, and other debris.During an interview with the acting Food Service Director on 01/20/2026 at 10:14 AM, they stated the garbage, and recycling was picked up several times a week. They stated the dumpsters were usually left open during the day. They stated staff typically filled one (1) dumpster and closed the lid before they used the next dumpster.During an interview on 01/28/2026 at 4:00 PM the Housekeeping Director stated the garbage is picked up four (4) times a week for both recycling and garbage. They stated the dumpster lids were left open all day starting around 7AM and it was the responsibility of the last housekeeper to close the lids at 11PM. They stated staff tried to fill one dumpster and close it before moving to fill the next dumpster. 10 NYCRR 415.14(h)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review the facility did not ensure residents were informed of items and services the resident may be charged for and the amount charged for those items and services for (2) two of (3) three residents (Residents #13 and #157) reviewed for Beneficiary Notification. Specifically, there was no documented evidence the facility provided Resident #13 and Resident #157's representative with a Skilled Nursing Facility Advanced Beneficiary Notification informing them of the cost to continue receiving skilled services once their Medicare Part A coverage ended.The findings include:The facility list of residents discharged from Medicare Part A services (with benefit days remaining) from 07/20/2025 to 01/20/2026 documented Resident #13 was discharged from services on 09/30/2025, Resident #157 was discharged from services on 12/04/2025, and both Resident #13 and Resident # 157 remained in the facility after their Medicare Part A coverage ended.The Notice of Medicare Non-Coverage dated 09/25/2025 documented Resident #13's signature affirming notification the resident's Medicare Part A services would end 09/30/2025.The Notice of Medicare Non-Coverage dated 12/04/2025 documented Resident #157 was cognitively impaired and a telephone call to the resident's representative on 12/01/2025 went unanswered.There was no documented evidence Resident #13 and Resident #157's representative were provided with a Skilled Nursing Facility Advanced Beneficiary Notification informing them of the cost to continue skilled services after their Medicare Part A coverage ended.On 01/28/2026 at 1:58 PM, Resident # was interviewed and stated they did not receive any notices from the facility with the cost of their skilled services once their Medicare Part A coverage ended.On 01/28/2026 at 2:31 PM, the Assistant Administrator was interviewed and stated the Minimum Data Set Coordinator was responsible for providing the Advanced Beneficiary Notification forms to qualifying residents. The Assistant Administrator stated the coordinator position was vacant when Resident #13's and Resident #157's Medicare coverage ended, and the Advanced Beneficiary Notification forms had not been issued to them or their representative.10 NYCRR 415.3(h) (2)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review and interview the facility did not ensure the accuracy of the preadmission screening for 1 (one) of thirty-eight residents reviewed for preadmission screening. Specifically, on the preadmission screen for Resident #81, number 23 was marked yes indicating that Resident #81 had a serious mental illness. However, the categorical determinations, numbers 27 to 30, were not completed as instructed to determine if a level two screen was indicated. The findings included:The policy titled Preadmission Screening and Resident Review Requirements last reviewed 01/2025, documented all individuals applying for a new admission to the facility must be screened to identify serious mental illness or mental retardation/developmental disability per regulations. The admissions department will review the screen form completed by the referring entity to determine if the Level I review reflects the need for a Level II referral. If, after the resident is admitted , the social worker determines that a Level II determination was required and not done, the social worker will make Level II referral to the appropriate agency.Resident #81 was admitted with diagnoses that included schizophrenia (a serious mental illness that affects a person's thought process and behavior), depression, and anxiety disorder. The preadmission screen dated 03/21/2025 documented in number 23 that Resident #81 had a serious mental illness but categorical determinations numbers 27 to 30, were not completed.During an interview on 01/22/2026 at 4:10 PM, the Assistant Director of Social Work stated screens should be reviewed for accuracy by the Admissions Department prior to admission. Once a resident was admitted , social work checked screens for accuracy. They stated preadmission screen numbers 27 to 30 should have been completed for Resident #81 once it was determined that Resident #81 had a serious mental illness as indicated by number 23 being marked yes. During an interview on 01/28/2026 at 2:38 PM, the Director of Admissions stated the admissions department reviewed preadmission screens for accuracy prior to the resident being admitted . They stated after a resident is admitted the social worker should check the screen again for accuracy. If an error is found, they should have the screen corrected. NYCRR 415.11 (e)

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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. Based on record review and interview the facility did not ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments for (2) two (5) five residents (Resident #18, Resident # 157) reviewed for care planning. Specifically, 1) there was no documented evidence that Resident #18's comprehensive care plan was reviewed and/or revised with the quarterly Minimum Data Set completed on 8/25/2025 and 11/18/2025 and 2) there was no documented evidence that a care plan meeting was conducted between 09/2025 and 01/2026 for Resident #157. The findings are: The policy titled Care Plans, Comprehensive Person-Centered, last reviewed January 2025 documented the Interdisciplinary Team must review and update the care plan at least quarterly, in conjunction with the required quarterly Minimum Data Set Assessment. Resident #18 had diagnoses that included paroxysmal atrial fibrillation, type 2 diabetes mellitus and anemia. The 11/18/2025 Quarterly Minimum Data Set (assessment tool) documented Resident #18 was cognitively intact. There was no documented evidence that the care plan was reviewed and revised after the completion of the 08/25/2025 and 11/18/2025 Minimum Data Sets. During an interview on 1/28/2026 at 10:57 AM, the Director of Nursing stated resident care plans should be reviewed every quarter. They stated care plans needed to be reviewed to determine if the resident had changes and to determine if care plan interventions needed to be updated. 2)Resident #157 had diagnoses that included abscess of the head/scalp, chronic osteomyelitis of the skull, and hemiplegia. There was no documented evidence that a care plan meeting was held between 09/2025 and 01/2026. The 01/02/2026 Quarterly Minimum Data Set (assessment tool) documented Resident #157 had moderately impaired cognition. During an interview on 1/27/2026 at 12:50 PM the Director of Social Work stated care plan meetings were held every quarter, and the Minimum Data Set Coordinator would send a list of residents that were due for care plans meetings. They stated they did not have a quarterly team care plan meeting for Resident #157 between 09/2025 or 01/2026 due to the facility not having a Minimum Data Set Coordinator. 10 NYCRR 415.11(c)(2)(i-iii)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, observation and record review the facility did not ensure the resident environment remains as free of accident hazards as is possible for one (1) of seven (7) residents (Resident # 54) reviewed for Accidents. Specifically, there was no documented evidence that hazards and risks were evaluated and analyzed and that care plan interventions were monitored for effectiveness and/or modified when necessary for Resident #54 who was observed in their room on 01/28/2026 with a lighter in their possession. Additionally, the 06/15/2025 Annual Minimum Data Set Assessment documented Resident #54 did not use tobacco.The findings include:The undated details of smoking policy documented residents would be evaluated on admission, quarterly, to determine if they are a smoker, non-smoker, and/or desire to smoke. Evaluation will also include smoking safety and understanding of policy. If a smoker the evaluation will include ability to smoke safely with or without supervision (per a completed smoking evaluation) and residents identified as smokers may not have or keep any smoking articles including cigarettes, tobacco etc. in resident rooms or on their person.Resident #54 had diagnoses including but not limited to Paraplegia and Multiple Sclerosis.The 05/18/2022 care plan titled Resident is a Smoker and Aware the Facility is a Non-Smoking Facility. The resident refuses to give staff their lighter. Risks explained, return demonstration of the understanding. Assess the residents' physical and mental ability as needed for ability to understand and follow policy. Remove lighter and keep it in a secure location. Instruct resident. The resident chooses to be non-adherent.The 03/20/2023 unnamed contract signed by Resident #54 documented that by signing they agreed to comply with policies and procedures of the facility. The contract documented the resident agreed to not keep smoking materials such as lighters and/or matches in their room.The 06/15/2025 Annual Minimum Data Set Assessment documented Resident #54 was cognitively intact, had no behaviors, had functional limitation in range of motion to both upper extremities and did not use tobacco. The 12/02/2025 Quarterly Minimum Data Set Assessment documented Resident #54 was cognitively intact, had no behaviors, and had functional limitation in range of motion of to both upper extremities.During observation on 01/22/2026 at 8:30 AM Resident #54 was sitting in a wheelchair outside the gate surrounding the facility. Resident #54 was to the left of the entrance midway between the entrance and the corner block. Resident #54 was smoking.During interview on 01/27/2026 at 5:33 PM the Director of Nursing stated resident cigarettes and lighters were to be kept at the front desk.During interview on 01/28/2026 at 10:25 AM the Nurse Practitioner stated Resident #54 was physically safe to go out and cognitively safe to go out on leave of absence for smoking. Preventing Resident #54 from smoking would aggravate them. They stated Resident #54 was advised not to smoke but once they go beyond the gate, they can do whatever. They stated Resident #54 in the past may have smoked in their room.During interview on 01/28/2026 at 10:54 AM Certified Nurse Aide #7 stated Resident #54 is a smoker and keeps their cigarettes and lighter in their room because they are responsible. During interview on 01/28/2026 at 11:45 AM the Receptionist stated staff at the front desk did not keep any resident cigarettes and lighters. They stated they did not have a list with the names of residents in the facility that smoked and did not know which residents were smokers.During interview on 01/28/2026 at 1:09 PM the Social Work Director stated the front desk staff were responsible for keeping cigarettes and lighters in a locked drawer at the front desk.During interview on 01/28/2026 at 3:30 PM Resident #54 stated they were a smoker and reported that they smoked outside the facility behind the gated area. Resident #54 stated they kept cigarettes and a lighter in a bedside drawer. Resident #54 stated when they wish to smoke, they retrieve their cigarettes and lighter and inform staff they would be going downstairs. They stated they went outside past the gate when they smoked. Resident #54 stated they had been doing this without any issues or concerns.During interview and observation on 1/28/2026 at 5:34 PM Resident #54 stated they kept smoking items in their room. Resident #54 stated they did not have cigarettes with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them at that time because they ran out of cigarettes. Resident #54 had a blue lighter in their fanny pack.During interview on 01/28/2026 at 5:45 PM the Administrator stated smoking materials should be kept at the front desk and should not be held by the residents.10 NYCRR 415.12 (h)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews and interviews conducted during the recertification survey from 1/20/2026 to 1/28/2026, the facility did not ensure specialized care needs for the provision of respiratory care in accordance with professional standards of practice for one (1) of one (1) residents (Resident #34) reviewed for respiratory care. Specifically, Resident #34 was administered oxygen without a medical order from 01/06/2026 to 01/22/2026.The findings include:The facility policy, Administering Medications last reviewed 1/2025 documents that medications must be administered in accordance with the orders, including any required time frame. The individual administering the medication must verify the right resident, right medication, right dosage, right time and right route of administration before giving the medication. The individual administering the medication must sign the resident's medication administrative record after giving each medication and before administering the next one. The facility policy, Oxygen Administration, last reviewed 1/2025 documents to verify that there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration.Resident #34 was admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease, respiratory failure, and heart failure.The admission Minimum Data Set (assessment tool) dated 1/13/2026 documented the resident had intact cognition, required supervision/touching assistance or partial/moderate assistance for activities of daily living. The resident experienced shortness of breath or trouble breathing when lying flat or on exertion.The care plan titled, Alteration in Cardiovascular Function, dated 1/10/2026 documented an intervention to provide oxygen per medical doctor orders.The care plan titled Resident at Risk or has an Alteration in Respiratory Function, dated 1/10/2026, documented an intervention to assess oxygen needs and provide as ordered by a medical doctor. During an observation on 1/20/2026 at 10:37 AM, Resident #34 was in their room receiving oxygen at four (4) liters per minute via nasal canula from an oxygen concentrator. During an observation on 1/21/2026 at 9:15 AM Resident #34 was sitting in their room receiving oxygen at four (4) liters per minute via nasal canula from a tank on their wheelchair. During an observation and interview on 1/22/2026 at 10:42 AM, Resident #34 was receiving oxygen at four (4) liters per minute via nasal canula from a tank on their wheelchair. The room oxygen concentrator was on at four (4) liters per minute. The resident stated they just returned to the room and had not switched back to the oxygen concentrator. Resident #34 stated they had been on oxygen at four (4) to five (5) liters per minute before coming to the facility.During a record review on 1/22/2026 at 12:41 PM, no oxygen orders were documented in the resident's medication administration record or in the physician orders from their admission on [DATE] to 1/22/2026. During an interview on 1/22/2026 at 2:38 PM, Licensed Practical Charge Nurse #14 reviewed Resident #34's electronic medical record and stated there was not a documented order for oxygen. They stated the resident arrived at the facility receiving oxygen at four (4) liters via nasal canula continuously and the oxygen administration was continued. The medical administration record takes its input from the physician orders, therefore there was no record of the oxygen being administered.During an interview on 1/22/2026 at 2:59 PM, Medical Doctor #1 stated orders were generally put in by medical providers or written down and put into the system by a nurse. A resident's medications and orders were reviewed on admission and entered into the facilities system by the medical doctor or nurse. Resident #34's oxygen administration was correct and not entered into the electronic health record. During an interview on 1/27/2026 at 5:52 PM, Registered Nurse #15 stated the resident was on oxygen continuously. The resident arrived at the facility receiving oxygen at four (4) liters per minute via nasal canula and the oxygen administration was continued. During an interview on 1/28/2026 at 10:57 AM, the Director of Nursing stated they expected the nurses to follow orders. There should have been an order for oxygen, and it was an oversight that the order was not entered.10 NYCRR 415.12(k)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026
NAME OF PROVIDER OR SUPPLIER The Grand Rehabilitation and Nrsg at River Valley		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review during Recertification and Abbreviated Surveys (#723126) the facility did not ensure that the Minimum Data Set accurately reflected the resident status for two (2) of six (6) residents (Resident #162, and Resident #157) reviewed for general skin issues. Specifically, 1) the 09/29/2024 Minimum Data Set Assessment did not reflect documented refusal of care/s for Resident #162 and 2) Resident #157 had a chronic ulcer to the scalp, that was not reflected in the 11/28/2025 and 01/02/2026 Minimum Sata Set Assessments. The findings included: The policy titled Minimum Data Set Assessment Coordinator last reviewed 01/2024 documented a registered nurse shall be responsible for conducting and coordinating the development and completion of the resident assessment. Everyone who completes a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. 1) Resident #162 had diagnoses that included diabetes mellitus, heart failure, and morbid obesity. The Quarterly Minimum Data Set, dated [DATE] documented Resident #162 had intact cognition and no behaviors including refusal of care, medications, or activities of daily living. The Nursing Note dated 09/23/2024 documented Resident #162 refused an intravenous catheter for intravenous infuvite. The Nursing Note dated 09/27/2024 documented resident refused milk of magnesia. The resident stated they have not eaten in days. The quarterly Note dated 09/27/2024 documented the resident presents aggressive/combative and is resisting/refusing care. The September Medication Administration Record documented refusals of Eliquis on 09/22/2024, 09/24/2024, and 09/25/2024. The Certified Nurse Aide Activities of daily living documentation for September 2024 documented behavior symptoms on 09/23/2024, 09/24/2024, 09/26/2024 and 09/27/2024. During an interview on 01/28/2026 at 2:46 PM, the Regional Minimum Data Set Coordinator stated that the behaviors should have been on the Minimum Data Set. They stated they did have someone new at the time, and the information may have been entered incorrectly. 2)Resident #157 had diagnoses that included urinary abscess of head/scalp, unspecified open wound of the head, and chronic osteomyelitis of the skull. The Physician's Note dated 11/26/2025 documented Resident #157 had a chronic right scalp infection with greenish-brown exudate noted. The Physician's Order dated 11/26/2025 documented cleanse right temporal area with normal saline solution pat dry, apply clean dry dressing daily Monday through Friday. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2026

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

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	The Physicians Order dated 11/27/2025 documented Gentamicin Sulfate external ointment apply to right scalp topically in the AM for osteomyelitis of the scalp. The Five-Day Minimum Data Set, dated [DATE] documented Resident #157 did not have other ulcers, wounds and skin problems. The Treatment Administration Record documented cleanse right temporal area with normal saline and apply a clean dry dressing was administered on 12/30/2025 and 12/31/2025. The Quarterly Minimum Data Set, dated [DATE] documented Resident #157 did not have other ulcers, wounds and skin problems. During an interview on 01/28/2026 at 2:59 PM the Regional Minimum Data Set Coordinator stated staff that entered information in the Minimum Data Sets made mistakes. They stated the Minimum Data Set Coordinator position had been vacant, and corporate staff were trying to complete the assessments. The Regional Coordinator stated they were overseeing the staff, but it was hard for them to keep up. NYCRR 415,11 (b)