

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335014	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/19/2025
NAME OF PROVIDER OR SUPPLIER Schenectady Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 526 Altamont Ave Schenectady, NY 12303	

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 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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during recertification and abbreviated (Case #s: 2578580, 2576246, 596027, 2566657, 596028, 594500, 596019, 596018, 596016, 596012, 596015, 596007, 596011, 596005) surveys, the facility did not ensure residents were free from neglect for one (1) (Resident #253) of thirty-five (35) residents reviewed for neglect. Specifically, Resident #253 was admitted to the facility on [DATE] with NPO status (nothing by mouth) and received nutrition/hydration via a gastrostomy tube (G-tube, a feeding tube inserted through the abdomen into the stomach. It is used to deliver nutrition, fluids, and medications when a person is unable to eat or drink adequately on their own.) Tube feedings (a way to provide nutrition and hydration) were not initiated until the following day the resident was admitted to the facility (6/24/2025) at 10:00 AM. This is evidenced by: The facility policy titled, Abuse, created 9/2012, last revised 7/18/2025, documented that the facility prohibits the mistreatment, neglect, and abuse of residents/patients. The policy defined neglect as failure of the facility, its employees, or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish, or distress. The facility policy titled, Enteral Feedings, created/2015, last revised 2/2023, documented it was the policy of the facility to provide enteral nutrition therapy to residents unable to obtain nutrition orally, when such therapy is ordered by the physician and not clinically contraindicated. The first step in the procedure was to verify the physician's order. Resident #253 was admitted to the facility with diagnoses of pneumonia (infection that inflames air sacs in one or both lungs, which may fill with fluid), dysphagia (difficulty swallowing) following cerebral infarction (a condition where brain tissue dies due to lack of blood flow) and encephalopathy (any diffuse disease of the brain that alters brain function or structure). There was no completed Minimum Data Set (an assessment tool) for this resident as they were discharged to the hospital the day after they were admitted to the facility. The Comprehensive Care Plan with focus, Resident requires tube feeding related to tube feeding with dysphagia and, initiated 6/24/2025, documented as an intervention for Resident #253: Administer tube feeding and water flushes per Registered Dietician/Licensed Dietician and Doctor of Medicine orders. The discharge summary from the hospital documented that Resident #253 was discharged on 6/23/2025. Resident #253 had a PEG-tube (percutaneous endoscopic gastrostomy tube) (a feeding tube placed through the abdominal wall and into the stomach to provide food, water, and medicine) at baseline due to dysphagia. Patient Resident #253 was resumed with PEG-tube feedings, and was tolerating them well. Diet upon discharge from hospital was PEG tube feeding through Vital 1.5 [brand name] nutritional formula, currently at a rate of 65 milliliters an hour. The facility provided documentation that Resident #253 was admitted to the facility on [DATE] at 3:23 PM. Progress note from the provider the facility with Date of Service as 6/23/2025. The resident #253 was transferred from the hospital to the facility on 6/23/2025. They had a G-feeding tube. Were to continue tube feeds. Monitor for aspiration. Nursing Progress Note by Registered Nurse #4 (four)dated 6/23/2025, documented Resident #253 had swallowing problems. The Resident had an enteral tube,. Tthey were not to receive food, water, or medication by mouth, NPO. They had an Enteral Feed Order: (see physician orders),. Rand the resident tolerated the enteral feed well. Review of physician order dated 6/24/2025 documented enteral tube: Vital 1.5, may also use Peptamin 1.5, a different and comparable brand of nutritional feeding formula via enteral tube at a rate of 65 milliliters/hour to begin at 10:00 AM for a total volume of 1560 milliliters to be delivered. There were no physician orders for enteral tube feeding to be administered on 6/23/2025. Review of Medication Administration Record for June, 6/2025 documented Enteral tube (Vital 1.5, may also use Peptamen 1.5) via enteral tube nutritional feeding formula administration at a rate of 65 milliliters to begin at 10:00 AM for a total volume of 1560 milliliters to be delivered one time a day for neurogenic dysphagia, was administered on 6/24/2025 at 10:00 AM. There was no documentation on the Medication Administration Record that tube feedings were completed on 6/23/2025. In reviewing Resident #253's medical record, it was not documented that the provider was notified that Resident #253's tube feeding was not initiated on the date of admission, 6/23/2025. During an interview on 8/18/2025 at 10:38 AM, Nutritionist #1 (one) stated they reviewed the hospital paperwork to see what the hospital provided for a the resident that required tube feeding. They liked to review this information before the resident was admitted to the facility, so they knew what kind of tube feeding to provide and if there were other nutritional findings. They checked to see if they had the kind of tube feeding used for a resident in the facility. If they did not have it they asked the hospital to send extra tube feeding supplies and they would</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on observations, record review, and interviews conducted during the recertification and abbreviated surveys (NY00596011; NY00596018; NY00594500), the facility did not ensure residents who were unable to carry out activities of daily living received the necessary services to maintain grooming and personal hygiene for three (3) of nine (9) residents (Resident #100, #218 and #250) reviewed. Specifically, (a.) Resident #100 was not showered per the facility schedule and as requested. (b.) Resident #'s 218 and 250 were not provided toileting checks or care in accordance with their plan of care. This is evidenced by: The facility's Policy and Procedure titled Activities of Daily Living Care and Support, revised 2/28/2025, documented: 1. ADL Activities of Daily Living care and support will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the resident's assessed needs, personal preferences, and individualized plan of care, that includes but is not limited to supervision and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care); b. Mobility (transfer and ambulation, including walking); c. Elimination (toileting), transfers, and incontinent care. d. Dining (meals and snacks); and e. Communication (speech, language, and any functional communication systems). 2. The resident's bath or shower will be scheduled as per the resident's preference and assessed needs at a minimum of weekly, as needed, and may include a bed bath on non-shower days. Nail care should be provided as needed for the resident. Residents with certain medical conditions may require a licensed nurse to perform. 5. Oral care/denture care and teeth brushing will be provided with care and as needed. 6. Facial hair will be groomed as per the resident's preference and/or assessed needs. 7. Hair care should be provided to the resident as per the resident's preference and/or assessed needs or by appointment at hair dresser's or barber;. 8. Toileting/Perineal care/Incontinence care will be provided with care and as needed. Resident #100 Resident #100 was admitted to the facility with a diagnosis of unspecified dementia (a decline in cognitive function, impacting memory, thinking, language, and judgment); cerebral infarction (the death of brain tissue (necrosis) due to insufficient blood supply);, and depression unspecified (significant distress or impairment in daily life). The Minimum Data Set (an assessment tool) dated 7/21/2025 documented the resident's cognition could to be assessed, but they were usually able to be understood and understood by others. Resident #100's Comprehensive Care Plan titled Activities of Daily Living, dated 7/15/2025, documented resident requires assistance with Activities of Daily Living related to Dementia, Fracture, and Limited Mobility. Interventions: Encourage the resident to use the bell to call for assistance. Monitor for changes in status, notify interdisciplinary team as needed. Skin Inspection: monitor for redness, open areas, scratches, cuts, bruises, and report changes to the Nurse. Record Review of Certified Nurse Aide documentation, documented in June of 2025 resident received two (s) showers on 6/26/2025 and 6/29/2025, respectively. In July 2025, documented showers were given on 7/08/2025, 7/24/2025, and for August, on 8/08/2025. Not applicable were documented on 7/17/2025, 7/20/2025, 7/22/2025, 7/29/2025, 7/31/2025, 8/5/2025, and 8/07/2025. During an interview on 08/08/2025 at 10:30 AM, Resident Representative #1(one) stated Resident #100 had not had a shower in a very long time. They could not recall when the last shower was given, and they visit daily. During an interview on 08/08/2025 at 11:00 AM, Registered Nurse #5(five), stated resident #100's shower day is Tuesday. However, they were unable to generate the certified nurse aid documentation on showers for this resident. During an interview on 08/08/2025 at 11:00 AM, Certified Nurse Aide #5 (five) was asked to provide documentation for Resident #100's last shower. They were unable to retrieve or show any documentation for Resident #100's last shower. During an interview on 08/08/2025 at 11:05 AM, Director of Nursing #1(one) provided certified nurse aide documentation for August 2025, for resident #100's shower schedule, which indicated Non-Applicable. Director of Nursing #1(one) stated the entries were erroneous. Director of Nursing #1(one) was asked to provide documentation of the last shower for Resident #100. Director of Nursing #1(one) then retrieved the July dates showing blanks and Non-Applicable for July. Upon request via Health Commerce, Director of Nursing #1(one) submitted documentation as mentioned above for June, July, and August 2025. During an interview on 08/15/2025 at 11:32 AM, Certified Nurse Aide #3 (three) stated that every resident has one shower per week. They have a scheduled shower day. If a resident refuses a shower, they will go back later and offer a shower again. If the resident continues to refuse, the certified nurse aide will notify the nurse. The nurse will also offer a shower and document any refusals. During an interview on 08/15/2025 at 11:37 AM, Registered Nurse #5 (five) stated they cannot say that resident #100 received a shower in between the dates</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during recertification and abbreviated (Case #s: 2578580, 2576246, 596027, 2566657, 596028, 594500, 596019, 596018, 596016, 596012, 596015, 59600, 596011, 596005) surveys, the facility did not ensure residents received treatment and care in accordance with professional standards of practice for (seven) 7 of 35 residents reviewed. Specifically, (a) for Resident #14, medication was not administered per physician orders. Specifically, (b) for Resident #35, medication was not administered per physician orders. Specifically, (c) for Resident #103, medication was not administered per physician orders. Specifically, (d) for Resident #177, medication was not administered per physician orders. Specifically, (e) for Resident #146, weekly weights were not obtained per physician orders. Specifically, (f) for Residents #157 and #199, physician orders were not obtained to check for nor was documentation recorded for skin integrity for residents with hard ridged neck braces. This is evidenced by: Resident #14 Resident #14 was admitted to the facility on [DATE] with diagnoses including unspecified dementia with unspecified severity and with other behavioral disturbance (a degenerative memory loss condition that can cause behavioral disturbances), anxiety disorders (uncontrolled anxiety), and peripheral vascular disease (lack of blood flow to the hands and feet). The Minimum Data Set (an assessment tool) dated 5/02/2025 documented the resident sometimes understood others, sometimes could be understood, and was severely cognitively impaired. A Physician order created 8/22/2024 at 7:01 PM documented an order for Levothyroxine Sodium Oral Tablet 100 micrograms to be given 1 tablet by mouth one time a day for hypothyroidism. The Medication Administration Record for July 2025 documented the medication was scheduled for 9:00 AM and administered at that time. A facility provided document stating meal delivery times to each unit provided evidence that breakfast was scheduled to be delivered to all the units between 7:45 AM and 8:00 AM. The Levothyroxine (thyroid hormone replacement medication) manufacturer's recommendations document to only take the medication with water on an empty stomach and wait at least 30 minutes before consuming food. During an interview on 8/12/2025 at 9:26 AM, Licensed Practical Nurse #3 (three) stated that if they had seen an order for the thyroid hormone replacement medication to be given at 9 AM, they would speak with the medical provider to change the times so it could be given by the night shift as that medication needed to be given on an empty stomach. During an interview on 8/18/2025 at 12:20 PM, Director of Nursing #1(one) stated that when it came to the time of medications being administered, they deferred to the medical provider. During an interview on 8/18/2025 at 2:02 PM, Medical Director #1(one) stated medications like a thyroid hormone replacement medication don't need to be given at (six) 6 AM. There was a false impression as to when those medications need to be taken, and they just need to be given a few hours before a meal. The example given was to administer at (four) 4 PM because that would be a few hours before dinner or at bedtime. Additionally, Medical Director #1(one) stated that a thyroid hormone replacement medication would be taken anytime because the dose could be adjusted if the timing made the medication less effective. The example given was that the Medical Director #1(one) took all their medications at dinner because that was when their spouse gave it to them. Medical Director #1(one) stated that people should not be woken up for medications if it can be helped. It should be by preference, just before a meal. Medical Director #1(one) stated they tried to cater to resident timing not the ideal time and they educated the resident and families about the misconceptions regarding timing of medications to make it easiest for the resident. Resident #146 Policy titled, Physician Orders and created 10/2015 and last revised 02/2020, documented it was the policy of the facility to secure physician orders for care and services for residents as required by state and federal law. Physician orders will be dated and signed according to the state and federal guidelines. Physician orders would include the medication and/or treatment and a correlating medical diagnosis or reason. Policy titled, Food and Nutrition Services and created 11/2017 and last revised 2/19/2025, documented a nutritional assessment, including current nutritional status and risk factors for malnutrition, shall be conducted for each resident. Components of the nutritional assessment included weight status and anthropometric data and current height and weight. Resident #146 was admitted to the facility with diagnoses of type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), lymphedema (tissue swelling caused by an accumulation of protein-rich fluid that is usually drained through the body's lymphatic system), and urinary tract infection. The Minimum Data Set (an assessment tool) dated 7/20/2025 documented that the resident</p>		