STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335252	A. Building B. Wing	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glendale Home-Schdy Cnty Dept Social Services	59 Hetcheltown Road Scotia, NY 12302

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review and interview during a survey, the facility failed to ensure a resident received a written notice, including the reason for the change, before a room change. In addition, the resident was not provided with the opportunity to disagree and or decline the decision to change rooms. This was evident for one (1) of one (1) residents (#43) reviewed. Specifically, Resident #43 was verbally informed of a room change because it was alleged that a roommate was assisting Resident #43 with activities of daily living. Findings include:The facility's Policy and Procedures titled Room Changes dated 10/29/2024, documented 2. Residents must receive at least 30 days' notice before any planned room change, except in emergency situations where immediate action is required. The interdisciplinary care team, in consultation with the resident and their representative, should determine the necessity and appropriateness of the room change. The notice should include the reason for the change and the new room assignment. 3. Resident Consultation: Residents and their representatives must be consulted about the proposed room change. Residents have the right to refuse the change if it is for the convenience of staff or if the new room is outside a distinct part of the nursing home. The facility's Policy and Procedure titled Resident Rights Revised: 1/2025, documented Glendale Home is committed to upholding the dignity, autonomy, and well-being of each resident. We recognize that residents have the right to be treated with respect and to participate in decisions regarding their care. This policy is designed to ensure that these rights are protected and that residents are informed of their entitlements. Policy Interpretation and Implementation 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a dignified existence; right to share a room with their roommate of choice when practicable, both residents live in the same facility and both residents agree. Resident #43 was admitted to the facility with diagnosis of Cerebral Ischemia (a condition that occurs when there isn't enough blood flow to the brain to meet metabolic demand), Anxiety (excessive, persistent, and uncontrollable fear or worry that disrupts daily life), and Depression (a serious medical illness characterized by persistent sadness, loss of interest in activities, and reduced energy). The Minimum Data Set (an assessment tool) dated 09/11/2024, documented they could be understood, understand others, and was cognitively intact.^ Resident # 129 was admitted to the facility with a diagnosis of Anemia (a blood condition where you lack enough healthy red blood cells to carry sufficient oxygen to your body's tissues), Anxiety (excessive, persistent, and uncontrollable fear or worry that disrupts daily life), and Depression (a serious medical illness characterized by persistent sadness, loss of interest in activities, and reduced energy). The Minimum Data Set (an assessment tool) dated 08/16/2024, documented they could be understood, understand others, and was cognitively intact.^ Social Worker Progress note dated 07/24/2025 at 02:45 PM, documented they met with Resident #43 today to discuss the importance of maintaining appropriate boundaries regarding personal care. Resident #43 was reminded that their roommate should not be providing or assisting with any aspects of care, including physical assistance or hygiene tasks. This was to ensure that both resident and roommate maintain safety. Resident #43 was receptive to the conversation and expressed understanding. They verbalized agreement and stated that they would refrain from asking or (continued on next page)

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

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accepting help from their roommate going forward. Social Worker progress note dated 08/07/2025 at 09:06 AM documented Room change today due to safety concerns related to Resident #43's non-compliance with seeking physical assistance with care from their roommate. Social Worker progress note dated 08/10/2025 at 10:54 PM, documented Resident #43 continued to stated they miss Resident #129. Resident was encouraged to enjoy their corner room view and reminded they were able to visit their old roommate and did visit for a short period then returned to their room much calmer. One on one (1:1) emotional support was documented as rendered as well with good effect. During an interview on 11/10/2025 at 9:45 AM, Resident #43 stated Resident #129 was my friend two (2) doors down, because Resident #129 helped so much they separated them. Resident was observed to be tearful about having to change rooms and separate from Resident #43. Resident #43 stated that when they needed a nursing aide, they would not come, and that Resident #129 helped them get their shoes on and get something from their closet. During an interview on 11/10/2025 at 9:30 AM, Resident #129 stated they moved their roommate, Resident #43, because they said their was helping them. They stated that they never asked them about the move and just separated them. Resident #129 stated they were somewhat helping but never lifted Resident #43. They further stated that if Resident #43 asked them to get something out of the closet, they would help. During an interview on 11/10/2025 at 11:00 AM, Resident Representative #1 stated they were never made aware that their parent moved from one room to another. They stated they found out about it from their parent who called them distraught after the move. The Social Worker or Nurse Manager never discussed the move with them at all to date. During an interview on 11/20/2025 at 10:20 AM, Registered Nurse #6 stated Residents #43 and #129 were separated because they had both been educated that Resident #129 was not to assist Resident #43 for safety purposes. Resident #129 helped Resident #43 get dressed by putting on their pants and shoes. Resident #129 was witnessed pushing Resident #43 in their wheelchair. The Social Worker notified families of the move, but not sure when that took place. When asked Registered Nurse #6 what interventions were placed prior to separating the two (2) residents, they replied they were warned previously that they would be separated if Resident #129 continued to assist Resident #43. During an interview on 11/10/2025 at 10:45 AM, Director of Social Work #1 stated they had no idea about the move and that another Social Worker covered Resident #43. They further stated that when a resident was moved, generally there would be a meeting with family. If a resident objected to the move, they would not move them. During an interview on 11/10/2025 at 10:59 AM, Director of Nursing #1 stated they were not aware of the move. They further stated all moves were discussed during the facility's daily morning meeting. If a resident does not want to change rooms, they will not move them. 10 New York Codes, Rules, and Regulations 415.5(e)(2)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey, the facility did not ensure it consulted with the resident's physician and notified the resident's representative when there was a significant change in the resident's physical status for two (2) (Resident #s 16 and 207) of four (4) residents reviewed. Specifically, (a.) Resident #16 family representative were not made aware of resident's change in condition and that resident received intravenous fluids. (b.) Resident #207 was assessed at pain level 10/10, the physician ordered medication adjustments and was not notified that the pain medication was ineffective. Findings include:The Facility's Policy and Procedure Title, Notification of Families, revised 2/28/2016, documented, Protocol: Notification process when acute or significant changes occur that affect the resident's mental, physical, or psychological status. Glendale nursing staff will inform residents/primary contact or legal representative via phone numbers provided before leaving a message when the following occurs: 1. Accident involving injury. 2. Significant change(s) in resident physical, mental, psychological status, such as life-threatening conditions, clinical complications, changes in mental status. 3. Significant alteration in treatment, labs, X-rays. 4. Decision to transfer/discharge resident to hospital, emergency room or other facility. 5. Notification of roommate change, or room/unit change. Key Points: Non-emergent changes where residents are not expected to be transferred out of the facility family notification can be made between 8 AM -9 PM. Supervisors are responsible for notification process. In lieu of the family member/legal representative being unavailable such as vacation, out of town and alternate representative with contact information should be provided.^ The Facility's Policy and Procedure titled Change of Condition, reviewed 2/2025, documented the facility monitors residents for changes in physical, mental, functional, and psychosocial status and responds in a timely manner consistent with the resident's clinical needs, provider orders, and recognized standards of nursing practice. The goal is to identify potential changes, provide appropriate evaluation. Guidelines: Observation & Awareness. Staff observe residents during routine care and interactions. Any potential change is communicated to the licensed nurse for further clinical assessment. Nursing Assessment: The licensed nurse evaluates the resident as indicated, using nursing judgment and available assessment tools. Assessment may include review of vital signs, pain, behavior, mobility, elimination, intake, skin, cognition, or other relevant clinical indicators. Provider Notification: The resident's practitioner is notified when, in the nurse's clinical judgment, the change warrants. Notification content includes: *Description of change *Assessment findings *Interventions attempted (if any) *Resident response. The practitioner provides direction for further evaluation or treatment, which is carried out as ordered. Resident #16 was admitted to the facility with diagnoses of fracture of shaft of left fibula (break in thin bone outer side of the leg), displaced bicondylar fracture of left tibia (injury where you break your bone and damage the cartilage on top of your tibia), and essential primary hypertension (most common type of high blood pressure). The Minimum Data Set (an assessment tool) dated 03/15/2026, documented that the resident could be understood, understand others, and was severely cognitively impaired. Provider order 03/18/2026 at 3:41 PM by Physician Assistant #1, documented an order for sodium chloride 0.9 percent intravenous solution instill 50 milliliters by intravenous route every hour times one (1) liter. Nursing Progress note by Registered Nurse #2, documented on 3/18/2026 at 3:42 PM Clysis (sodium chloride 0.9 percent) started at 50 milliliter an hour for hydration. There was no documented evidence of family notification. Nursing Progress note by Registered Nurse #2, documented on 3/18/2026 at 3:50 PM, resident had refused Clysis (sodium chloride 0.9 percent), provider was notified. There was no documented evidence of family notification. Late Entry Provider visit on 03/18/2026 documented Physician Assistant #1, documented an order for Clysis (sodium chloride 0.9 percent), intravenous 1 (one) liter. There was no documented evidence of family notification. During an interview on (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/20/2026 at 3:28 PM, Family Member #1 stated they were not notified of changes on a consistent basis. They stated they came into the facility in March 2026 and an intravenous bag of hydration fluids were hung at the resident's bedside. They were not made aware that the provider had ordered intravenous fluids. They did not feel the fluids were necessary and were not in agreement with the new orders. During an interview on 04/24/2026 at 1:40 PM, Staff Development Coordinator #1 stated they were interim unit manager for the unit starting about one (1) week ago. They notified family members of all changes with residents including change of conditions and medication changes.Resident #207 was admitted to the facility with diagnosis of Coronary Artery Disease (a common heart condition where plaque builds up in the arteries, restricting blood flow to the heart muscle); Peripheral Vascular Disease (a slow and progressive disorder of the blood vessels), and Chronic Obstructive Pulmonary Disease (COPD - a progressive, long-term lung disease that causes obstructed airflow, making it difficult to breathe). The Minimum Data Set, dated [DATE], documented they could be understood, understand others, and was cognitively intact.^ Nursing progress note dated 07/14/2024 at 04:47 PM, documented Registered Nurse #1 Spoke with Nurse Practitioner #1 regarding Resident #207's uncontrolled pain of 10 on 10. Nurse Practitioner #1 ordered Gabapentin (pain medication) 300 milligrams three times a day starting 7/15/2024, one (1) dose of Gabapentin to be given now at dinner time and one (1) dose be given at 9:00 PM. Nurse Practitioner #1 also ordered Hydrocodone as needed, dose to be given at 5:00 PM as the dose was due at 6:00 PM, then, give as needed Hydrocodone dose every 4 (four) hours on the hour for pain control.Nursing progress note dated 7/14/2024 at 9:46 PM documented Resident had a significant decline over the last two (2) days. Resident was not eating, drinking minimally, and was sleeping the entirety of 3:00 PM to 11:00 PM shift. Resident was able to be roused easily, to take medications, but then returned to sleeping. Resident had continued complaints of 10 out of 10 pain in their left foot despite medication adjustment, earlier in this shift. During an interview on 11/05/2025 at 2:25 PM, Nurse Practitioner #1 stated Resident #207 was not their patient and they were covering the shift. They further stated they adjusted medication to address complaint of pain 10 out of 10. Nurse Practitioner #1 stated if pain was not controlled it was the expectation that nurse/supervisor should call the provider back with a re-assessment for further direction. They should include vital signs, change in mental status, history each time to make decision on what to do next. 10 New York Code of Rules and Regulations 415.3(e)(2)(ii)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviewsˆand interviewsˆduring the survey, the facilityˆfailed toˆprovide care to dependent residentsˆin accordance withˆprofessional standards of practiceˆfor two (2) (Resident #s 2 and #201) of five (5) residents reviewed. Specifically, (a.) for Resident #2, staff failed to provide the resident with a shower/bath for the first two weeks after admission and (b.) for Resident #201, staffˆfailed toˆprovideˆassistanceˆtoˆthe bathroom and toilet resident as scheduled.ˆˆ Findings include:ˆ Resident #201ˆˆ Resident #201ˆwas admitted to the facility with diagnoses ofˆdisplaced intertrochanteric fracture of right femurˆ(a type of broken hip),ˆheart failureˆ(when the heart muscleˆdoesn'tˆpump blood as well as it should),ˆparoxysmal atrial fibrillation (episodes of an irregular heart rhythm).ˆThe Minimum Data Set (an assessment tool) dated 07/15/2024, documented that the resident could be understood, understand others, and was cognitively intact.ˆ Record Reviewˆˆˆ Care Plan dated 12/20/2023 titled Activities ofˆDailyˆLiving, documented Resident #201ˆrequiredˆextensive one assist for transfer, ambulation,ˆandˆtoileting.ˆˆˆ Care Plan dated 12/20/2023 titled Bowel Evacuation and Maintenance,ˆinterventionsˆdocumentedˆcertified nurse assistant was to document bowel elimination every shift.ˆˆˆ Resident Certified Nurse Aideˆ Documentation titled Toileting dated 07/2024 had no documentedˆevidence of toileting on 07/12/2024 on day shift or night shift, 07/13/2024 evening shift or night shift, 07/14/2024 day shift or night shift, 07/15/2024 night shift, 07/16/2024 day shift, 07/18/2024 night shift, 07/19/2024 day shift or night shift, 07/20/2024 night shift, 07/21/2024 day shift, 07/23/2024 day shift, 07/24/2024 day shift, 07/26/2024ˆday shift, 07/27/2024 day shift, 07/28/2024 evening shift or night shift and 07/30/2024 night shift. ˆˆ Resident #2ˆ Resident #2 was admitted to the facility with diagnoses ofˆhemiplegia and hemiparesis following cerebral infarction affecting the non-dominant sideˆ(ˆlate-effect weakness or paralysis on the side due to a previous stroke,) essential hypertension (a chronic condition characterized by persistently elevated force of blood against artery walls,) and hypo-osmolality and hyponatremia (a condition where the blood is too diluted). The Minimum Date Set dated 12/26/2023 documented that they could make themselves understood and understand others and was cognitively intact.ˆ Record reviewˆ Care plan dated 12/20/2023 titled Activities of Daily Living: All Tasks. Patient currently is extensive assist of 2 for bed mobility and transfers due to safety concerns. Resident requires assistance with activities of daily living and mobility. Minimum Data Set, dated [DATE] documents resident is substantial/maximal assist for the ability to bathe self, including washing, rinsing and drying self. Care plan dated 12/21/2023 titled Activities of Daily Living: All Tasks, notes documented residentˆrequiredˆextensive assist of two (2) for transfers due to safety concerns.ˆ Resident Certified Nurse Aide Accountability record titled Bathing dated 12/21/2023 had no documented evidence of bathing/shower on the evening shift, and 12/28/2023 had no documented evidence of bathing/shower completed on the evening shift.ˆ Interviews:ˆ During an interview on 4/28/2026 at 8:35 AM, Certified Nurse Aide #2ˆstated there were no instances where theyˆhad notˆbeen able to give a shower. They stated if theyˆwere not able toˆgive a shower, it would be reported to theˆnurse,ˆand the shower would be rescheduled for the next day.ˆ Interview with Licensed Practical Nurse #ˆ4ˆon Union Station Unit at 08:40 AM on 04/28/2026.ˆThey stated, there is no reason for a resident not to get their shower on the scheduled day. Stated if they are short staffed or the Aides need help, the nurses will step in and assist with giving care, including showers if necessary. Stated if they were not able to give a shower, it would be reported to the head nurse and we would ask the next shift to pick it up, If they could not, the shower would be scheduled for the next day. Stated we communicate this by leaving a note with the 24-hour report and we would pass it on in shift-to-shift report. ˆ 10 New York Codes, Rules, and Regulationsˆ415.12(f)(1)ˆˆ ˆ

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews during a survey, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for ONE (1) (resident #207) of thirty-five (35) residents reviewed. Specifically, on 7/14/2024 at 11:42 AM, Resident #207's daughter called expressing concern and stated resident complained of trouble breathing and pain 10/10. At 4:47 PM the provider was notified of pain 10/10 and adjusted the resident's pain medication. At 9:46 PM, resident #207 was lethargic with no appetite; the provider was not made aware of the change in condition and or persistent pain. On 7/15/2024 at 4:09 PM, Resident #207 was unresponsive, hypotensive and sent to the Emergency Room. Findings include:Resident #207 was admitted to the facility with diagnosis of Coronary Artery Disease (a common heart condition where plaque builds up in the arteries, restricting blood flow to the heart muscle); Peripheral Vascular Disease (a slow and progressive disorder of the blood vessels), and Chronic Obstructive Pulmonary Disease (COPD - a progressive, long-term lung disease that causes obstructed airflow, making it difficult to breathe). The Minimum Data Set (an assessment tool) dated 07/15/2024, documented they could be understood, understand others, and was cognitively intact.ˆ The Facility's Policy and Procedure titled Change of Condition reviewed 2/2025, documented The facility monitors residents for changes in physical, mental, functional, and psychosocial status and responds in a timely manner consistent with the resident's clinical needs, provider orders, and recognized standards of nursing practice. The goal is to identify potential changes, provide appropriate evaluation. Guidelines: Observation & Awareness. Staff observe residents during routine care and interactions. Any potential change is communicated to the licensed nurse for further clinical assessment. Nursing Assessment: The licensed nurse evaluates the resident as indicated, using nursing judgment and available assessment tools. Assessment may include review of vital signs, pain, behavior, mobility, elimination, intake, skin, cognition, or other relevant clinical indicators. Provider Notification: The resident's practitioner is notified when, in the nurse's clinical judgment, the change warrants. Notification content includes: *Description of change* Assessment findings* Interventions attempted (if any) *Resident response. The practitioner provides direction for further evaluation or treatment, which is carried out as ordered. The Facility's Policy and Procedure titled Quality of Care Policy reviewed 1/2023 documented, the facility provides care and services to ensure each resident attains or maintains the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and person-centered plan of care. Care is delivered by qualified staff in accordance with physician orders, evidence-based practices, and applicable federal and New York State Department of Health regulations. Changes in resident condition are promptly identified, evaluated, and addressed, with timely care plan updates and referrals as appropriate. Nursing progress note dated 7/4/2024 at 11:42 AM documented, Resident #207's daughter called stating that their father called them and said they were very, very sick. Registered Nurse #5 assessed resident #207. Vital Signs were temperature 98.9, blood pressure 112/64, heart rate 68, respirations 20. The Resident's upper lobe Lung sounds were clear, but they would not cooperate with lower lobe lung assessment. The resident complained of having trouble breathing; the resident was not observed using any accessory muscles to breathe. The resident's oxygen saturation level was 90%, which was within normal limits. The resident refused use of oxygen and refused to have their dressing changed. Registered Nurse #1 updated resident #207's daughter that resident was not in any acute distress, and that they were not dying as they had told both daughter and son earlier. Nursing progress note dated 07/14/2024 at 04:47 PM, documented Registered Nurse #5 Spoke with Nurse Practitioner #1 Nurse Practitioner #1 regarding residentsn#207's uncontrolled pain of 10 on 10. Nurse Practitioner #1 ordered Gabapentin 300 milligrams three times a day starting 7/15/2024, one dose of Gabapentin to be given now at dinner time and one dose be given at 9:00 PM. Nurse Practitioner #1 also ordered (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrocodone as needed dose be given at 5:00 PM as the dose was due at 6:00pm, then, give as needed Hydrocodone dose every 4 hours on the hour for pain control Nursing progress note dated 7/14/2024 at 9:46PM documented Resident has had a significant decline over the last 2 days. Resident is not eating, drinking minimally, and is sleeping the entirety of 15:00-23:00. Resident is able to be roused easily, to take medications, but then returns to sleeping. Resident had continued complaints of 10/10 pain in their left foot despite medication adjustment, earlier in this shift. Nursing progress note dated 07/15/2024 at 04:09AM documented Resident very lethargic and non-responsive; blood pressure 90/50 heart rate 53 temperature 95.9 blood glucose 194 unable to get an oxygen saturation reading. Nurse Practitioner #1 ordered resident be sent to hospital emergency room. Hospital Discharge summary dated [DATE] documented a diagnosis of Toxic metabolic encephalopathy. The resident had initially presented from nursing home for altered mental status along with lethargy. This is likely in the setting of severe sepsis due to gram-negative pneumonia. The resident's mental status has greatly improved throughout hospitalization after treatment with intravenous antibiotics and as per their daughter is at their baseline mental status. The patient was discharged back to extended care facility. During an interview on 11/5/2025 at 2:25PM, Nurse Practitioner #1 stated Resident #207 is not their patient. They were covering the shift. They adjusted medication to address complaint of pain 10/10. Nurse Practitioner #1 stated if pain was not controlled it is the expectation that nurse/supervisor should call the provider back with a re-assessment for further direction. They should include vital signs, change in mental status, history each time to made decision on what to do next. During an interview on 11/5/2025 at 12:00 PM, Director of Nursing #1 stated Resident #207 was seen by wound care. Once a resident goes to wound care they are no longer followed by the facility for wounds, the wound care center follows them. The Director of Nursing stated they do not recall anything about the wounds on resident #207's feet and was not aware of the change in condition on 7/14/2024-7/15/2024. During an interview on 11/5/2025 at 12:20PM, Registered Nurse #6 stated they do not remember the specifics regarding resident #207 but remember they had issues with their feet. However, when a resident has a change in condition, they would assess the resident for change in baseline, notify provider and document. They stated the documentation for resident #207 should have been better. 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i)