| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335252 | A. Building<br>B. Wing | 05/04/2026 |

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

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) |
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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice for three (3) (Resident #s 3, 2, and 7) of 4 residents reviewed. Specifically, (a.) (1.) Resident #3's pressure ulcer on the left heel had inconsistent wound staging (performed to indicate the characteristics and extent of tissue injury) from 8/03/2023 to 9/22/2023, (2.) a pressure ulcer on the right heel had treatment orders and did not have any weekly wound assessments, and (3.) a pressure ulcer on the back of the lower left leg had a treatment order and did not have weekly wound assessments, (b.) (1.) Resident #2's pressure ulcer on the coccyx identified on 10/11/2023, did not have weekly wound assessments when the wound was being treated from 10/11/2023 to 12/31/2023; (2.) did not ensure placement of an air mattress from 10/17/2023 to 12/31/2023, to prevent worsening of the coccyx wound, and (c.) For Resident #7, alternate arrangements were not made for daily wound treatment and weekly wound assessment of a pressure ulcer on the sacrum and left heel on 4/09/2026, when the resident was scheduled to be out of the facility for an appointment on the day the designated in-house wound care provider completed wound rounds. Findings include: The Policy and Procedure titled, Wound/Pressure Ulcer Policy, revised 4/18/2023 and 1/2025, documented the nurse would describe and document/report a full assessment of the pressure sore including location, stage, length, width and depth, presence of exudates (drainage that seeps out of a wound) or necrotic tissue (dead or devitalized non-viable tissue which impedes would healing), pain assessment, current treatments, support surfaces and all active diagnoses. The physician would assist staff to identify the type (for example, arterial or stasis (caused by vein problems) and characteristics of an ulcer and would order pertinent wound treatments, including pressure reduction surfaces. The physician would evaluate and or be notified of changes and or progress of wound healing especially for those with complicated, extensive, or poor-healing wounds. Resident #3: Resident #3 was readmitted to the facility with diagnoses of multiple sclerosis (body's immune system attacks the protective covering of the nerve cells of the brain), diabetes (body does make enough insulin or it well as it should to remove sugar from the bloodstream), and pressure ulcer of unspecified site and stage. The Minimum Data Set (an assessment tool) dated 8/4/2023, documented the resident had severe cognitive impairment, sometimes made themselves understood, and sometimes understood others. The resident was assessed as having two (2) unstageable (full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by dead tissue) pressure injuries that presented as deep tissue injury (intact skin with localized area of persistent deep red, maroon, purple discoloration due to damage of underlying soft tissue). The Comprehensive Care Plan for Skin Integrity: Presence of Skin Breakdown, effective 7/5/2023, documented the resident had a deep tissue injury (results from intense and/or prolonged pressure and may evolve rapidly to reveal the actual extent of tissue injury or may resolve without tissue loss) on the right heel. On 8/03/2023, the care plan was updated and documented the resident now had a deep tissue injury to the right heel. There was no documentation of the pressure ulcer on the left heel. On 9/07/2023, the care plan was updated and<br>(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 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | documented a new treatment for the left heel. Interventions included assessing the characteristics of ulcer daily during treatment care and document findings weekly, refer for follow up with the Wound Care Team, perform wound care rounds weekly, and maintain turning and positioning schedule every 2 (two) hours as recommended. Findings for the pressure ulcer on the left heel: The Nursing - Pressure Ulcer/Injury Monitoring record documented an unstageable, deep tissue injury on the left heel was identified on 8/03/2023 at 5:16 PM and measured four (4) centimeters long by four (4) centimeters wide by zero (0) centimeters depth. The wound was closed and there was no drainage or odor. Color was purple. The anatomical drawing was inconsistent with the assessment data and indicated the wound was on the right heel. The Nursing Progress Note dated 8/06/2023 at 10:46 AM by Licensed Practical Nurse #3, documented the left heel was noted to have a broken, blister like area. Reported to the supervisor and was to be addressed by the physician when available. The resident denied pain or discomfort to the area. There was no evidence of assessment of the wound dated 8/06/2023 by a Registered Nurse or qualified person when the wound had changed on 8/06/2023. The Medical Progress Note dated 8/07/2023 at 1:02 PM by Nurse Practitioner #1, documented they were notified of a blister on the left heel. The left heel had two (2) blisters noted, one that was approximately two (2) centimeters and intact, and the other approximately one (1) centimeter and appeared ruptured. Continue to apply skin prep (sterile liquid that provides a skin-protectant film). Review of the Nursing - Pressure Ulcer/Injury Monitoring record for the left heel wound dated August 2023, documented inconsistent wound staging: On 8/10/2023 at 12:47 PM, the left heel wound continued to be staged as a deep tissue injury, when it was documented on 8/06/2023 and 8/07/2023, that the wound had opened. Additionally, the assessment did not indicate there were two (2) wounds as was noted on 8/07/2023. On 8/18/2023 at 11:40 AM, 8/24/2023 at 11:41 AM, and 8/31/2023 at 3:33 PM, the left heel wound continued to be staged as a deep tissue injury and the assessment did not indicate there were two (2) wounds. The Nursing Progress Note dated 9/07/2023 at 11:07 AM, documented the left heel was assessed by Registered Nurse #3, secondary to bloody drainage. Nursing Progress Note dated 9/07/2023 at 11:09 AM by Registered Nurse #3, documented a new treatment for the left heel. The Nursing - Pressure Ulcer/Injury Monitoring record for the left heel wound dated 9/07/2023 at 11:59 AM, documented one (1) wound was assessed and documented the stage of the wound as unable to determine. The Medical Progress Note dated 9/11/2023 at 1:54 PM by Nurse Practitioner #1, documented a chief complaint of left heel wound. The wound had increased in size. The resident had no complaints of pain and no signs of distress. Assessment documented pressure ulcer of left heel, unstageable. Pressure ulcer of skin with full thickness skin loss. Plan documented decline in ruptured blister to left heel, area had enlarged, had purulent (foul, unpleasant) odor, and necrotic tissue (dead tissue). The Nursing - Pressure Ulcer/Injury Monitoring record for the left heel wound dated September 2023, documented inconsistent wound staging:On 9/15/2023 at 2:24 PM, the left heel wound was staged as a deep tissue injury and was improved which was inconsistent with findings noted on 9/11/2023, when it was assessed as an unstageable pressure ulcer and the wound had declined. On 9/22/2023 at 12:42 PM, the left heel wound documented the stage of the wound as unable to determine. Findings for the pressure ulcer on the right heel: Review of the Nursing - Pressure Ulcer/Injury Monitoring report for August 2023, did not document an assessment of the deep tissue injury on the right heel, identified on 8/03/2023 per the comprehensive care plan. There was no documented evidence of Nursing Progress Notes dated 8/03/2023. Review of Physician's Orders report documented: A treatment order for the right heel dated 8/10/2023 to apply skin prep two (2) times a day at 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM. The order was entered by Director of Nursing #1. A treatment order for the right heel dated 8/14/2023 for the right heel to apply zinc and cover with bordered gauze. Change daily and as needed. The order was entered by Registered Nurse #3. The Medical Progress Note dated 8/19/2023 at 7:00 PM by Nurse Practitioner #1, documented the resident had an open area to the right heel. No complaints of pain in the area. Heel boots to promote elevation. There was no description of the extent of the injury to the right heel and no measurements<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of the wound. Review of the Nursing - Pressure Ulcer/Injury Monitoring report for August and September 2023, did not document any weekly assessments of the pressure ulcer on the right heel. Findings for the pressure ulcer on the back of the lower left leg: The Nursing Progress Note dated 9/10/2023 at 12:30 PM by Registered Nurse #5, documented a new unstageable pressure ulcer was found on the back of the lower left leg that measured three (3) centimeters long by three (3) centimeters wide. Review of the Nursing - Pressure Ulcer/Injury Monitoring report for September 2023, did not document an assessment dated [DATE] of the pressure ulcer on the back of the lower left leg. Review of Physician's Orders report documented:A medication/treatment order dated 9/11/2023 for a pressure ulcer of unspecified site and unspecified stage for Collagenase Clostridium Histolyticum 250 unit/gram topical ointment (used to remove damaged tissue from chronic skin ulcers), apply to area on left dorsal (back) shin twice a day at 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM. The order was entered by Registered Nurse #3 and was renewed on 9/19/2023. Review of the Nursing - Pressure Ulcer/Injury Monitoring report for September 2023, did not document any weekly assessment of the pressure ulcer on the back of the lower left leg. Resident #2: Resident #2 was admitted to the facility with diagnoses of multiple fractures of left ribs, pressure ulcer of left buttock stage 2 (partial-thickness loss of skin that presents as a shallow ulcer or may present as an intact or open/ruptured blister), and diabetes without complications ( a chronic condition that happens when a person has persistently high blood sugar levels). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, was able to make themselves understood and understood others. The Comprehensive Care Plan for Skin Integrity: Presence of Skin Breakdown effective 11/22/2023, documented the resident had skin breakdown. The location was not documented. Interventions documented perform wound care rounds weekly. The Comprehensive Care Plan for Skin Integrity: Presence of Skin Breakdown effective 12/30/2023, documented the resident had skin breakdown located on the coccyx/buttocks related to moisture and shearing (when two layers of tissue slide past each other in opposite directions). Interventions included assess characteristics of ulcer daily during treatment care and document findings weekly. The Nursing - Pressure Ulcer/Injury Monitoring record dated 10/11/2023 by Registered Nurse #8, documented a stage two (2) pressure ulcer on the coccyx (tailbone) identified on 10/11/2023 at 9:51 PM. The wound measured one (1) centimeter long by four tenths (0.4) centimeter wide by one tenth (0.1) centimeter deep. Treatment was betadine (topical antiseptic). There were no additional assessments documented on the Nursing - Pressure Ulcer/Injury Monitoring record when the coccyx wound continued to be treated: The Medical Progress Note dated 10/17/2023 at 9:02 AM by Nurse Practitioner #2, documented the resident was seen on 10/17/2023 at the request of nursing for an open area on the coccyx that measured approximately one (1) centimeter long by approximately one (1 )centimeter wide by one tenth ( 0.1) centimeter deep. Present treatment with betadine. Diagnosis, Assessment, and Plan documented pressure injury of sacral region, stage two (2), coccyx. Cleanse with normal saline, apply scant amount of hydrogel (wound gel), cover with Optifoam (dressing). Air mattress to bed. There was no documented evidence of an order for the air mattress. The Physician's Orders report documented the following treatment orders for the coccyx: 10/11/2023 Betadine BID (twice daily) to coccyx pressure injury, every day at 7:00 AM - 3:00 PM and 3:00 PM - 11:00 PM. 10/14/2023 Coccyx treatment, cleanse with sterile normal saline (isotonic solution of salt and water), pat dry and apply thin layer of hydrogel (wound gel) and cover with Optifoam Gentle (dressing). 11/8/2023 Coccyx treatment, cleanse with sterile normal saline, pat dry and apply thin layer of hydrogel (wound gel) and cover with Optifoam Gentle (dressing), every 3 days and PRN (as needed). 12/27/2023 Dressing change to coccyx once daily and as needed, cleanse with normal saline solution, pat dry and apply wound gel to wound base and cover with border foam (dressing). Every day at 7:00 AM - 3:00 PM. Review of the Treatment Administration Record documented the coccyx wound was treated per physician order from 10/11/2023 to 12/31/2023. Resident #7: Resident #7 was admitted to the facility with diagnoses of osteomyelitis (infection in a bone) of vertebra (spine), sacral and sacrococcygeal region (lower spine), multiple sclerosis, and (continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | diabetes. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, was able to make themselves understood, and understood others. The resident was assessed with one (1) stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage or bone in the ulcer) that was present upon admission. The Comprehensive Care Plan for Skin Integrity: Presence of Skin Breakdown - Left Heel, Coccyx, Surgical Site RLE (right lower extremity), effective 4/06/2026 documented interventions which included: assess characteristics of ulcer daily during treatment care and document findings weekly, refer for follow up with the Wound Care team, perform wound care rounds weekly, apply local treatments as ordered by the physician. Notes documented the resident was seen on wound rounds on 4/16/2026. The Physician's Orders report documented:3/26/2026 Coccyx pressure injury stage four (4) cleanse with Dakins (strong topical antiseptic widely used to clean infected wounds, and ulcers), then cleanse with normal saline. Apply collagen particle (wound dressing), pack with silver alginate (antimicrobial wound dressing) gently once daily and as needed, then cover. Every day at 7:00 AM - 3:00 PM. 3/26/2026 Left heel: apply betadine WTM (wet to moist) once daily and as needed. Every day at 7:00 AM - 3:00 PM. The Nursing Progress Note dated 4/9/2026 at 3:19 PM by Licensed Practical Nurse #4 documented the resident had been leave of absence all shift. The Nursing Progress Note dated 4/9/2026 at 5:37 PM by Registered Nurse #6, documented the resident returned from the hospital status post aortogram (test that allows the physician to map out a patient's arteries) and angiogram (diagnostic procedure that uses imaging and injected contrast (dye) to show how the blood flows through the blood vessels) left leg. The Treatment Administration Record dated April 2026, did not document wound treatment for the pressure ulcer on the coccyx and left heel on 4/09/2026. The Wound Care assessment dated [DATE] and 4/16/2026 by inhouse Wound Care Provider #1, documented a wound assessment for a stage four (4) pressure ulcer on the sacrum and an unstageable pressure ulcer on the left heel that were present on admission. There was no documented evidence of a weekly wound assessment dated [DATE]. During an interview on 11/14/2025 at 3:27 PM, Licensed Practical Nurse #5 stated they had different people doing wound care, including the former Assistant Director of Nursing #2, when Resident #2 was in the facility. They recalled that Resident #2 did have wounds and reviewed the notes in the electronic medical record during interview. They further stated Assistant Director of Nursing #2 would come to the unit once a week for wound rounds. They stated Assistant Director of Nursing #2 did not have good notes about the wounds and there were no details about the wound bed or drainage. They further stated Registered Nurse #8 did the initial assessment of Resident #2's wound on 10/11/2023; Registered Nurse #7 was responsible for the unit and did not always have good follow through with the weekly wound assessments. They further stated the facility now had a wound care specialist who came into the facility once (1) a week. They stated that if they identified a wound, they would have a Registered Nurse immediately assess the wound. They stated Registered Nurse #4 would now do the initial wound assessments on the unit and sets up the wound care. They stated that in December 2023, Director of Nursing #1 was doing the wound rounds and there were no detailed notes from them about the wounds. They stated that ultimately, Director of Nursing #1 made the final decision for ordering an air mattress for a resident; If there was an order for an air mattress, there would be a treatment order for the nurse to check the functioning of the mattress. During an interview on 11/14/2025 at 4:28 PM, Registered Nurse #4 stated the following: There was an initial assessment of Resident #2's coccyx wound on 10/11/2023. There should be weekly assessments of the wound thereafter. The resident did have a hospitalization in October 2023 and returned on 11/8/2023. They stated they wrote a note about the wound on 11/8/2023 but did not do an assessment of it. There was no contract for wound care in 2023, and they would leave the skin assessments for the unit manager to do. A specialty mattress was typically ordered for a resident with a stage 3 wound or higher and would be approved by Director of Nursing #1. They reviewed Resident #2's wound assessment records and stated there were no other assessments of the coccyx wound after Registered Nurse #8 did the initial assessment on 10/11/2023. During an interview on 4/15/2026 at<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1:16 PM, Registered Nurse #7 stated Resident #7 had a pressure ulcer on the sacrum and left heel. Wound Care Provider #1 came into the facility every Thursday to assess wounds. On 4/9/2026, Resident #7 was out of the facility for an angiogram and there was no wound care note because Wound Care Provider #1 would come around 8:30 AM and Resident #7 had already left for the appointment. Resident #7 returned to the facility at 5:37 PM. They stated Registered Nurse #6 was the supervisor and would have been responsible for assessing the resident's wounds on 4/09/2026. Wound care was usually done during the assessment. During an interview on 4/15/2026 at 11:36 AM, Registered Nurse #3 stated pressure ulcers were to be assessed weekly, and any changes made to wound treatments were done at that time. They could not recall if there was a wound care team when Resident #3 was in the facility and stated they now had an in-house wound care provider that was doing the weekly assessments. During an interview on 4/15/2026 at 3:48 PM Director of Nursing #1 stated there was no wound care team when Resident #s 2 and 3 were in the facility. Director of Nursing #1 was doing the weekly wound assessment in the interim until the in-house Wound Care Provider #1 started coming to the facility. They recalled Resident #3 having a wound on their left heel and did not recall a wound on the right heel or back of left leg. A deep tissue injury was not open, and an unstageable pressure ulcer was open and usually covered with eschar (dead or devitalized tissue). If a pressure ulcer was documented as UTD (unable to determine) on assessment, it should have been documented as unstageable. They recalled Resident #3's left heel wound was dark, black. The anatomical drawing dated 8/03/2023, that indicated a pressure ulcer on the right heel, was documented incorrectly and should have been the left heel. They were not aware of Resident #2's pressure ulcer on the coccyx or the need for an air mattress and stated they were not always made aware of every pressure ulcer. Resident #7 was out of the facility on 4/9/2026, when the in-house wound care provider was doing wound rounds. Resident #7 came back to the facility late on 4/09/2026. Registered Nurse #7 was responsible for the unit and should have completed the wound assessment on 4/10/2026. During an interview on 4/21/2026 at 12:16 PM, Medical Director #1 stated Registered Nurse #3 and Director of Nursing #1 would have been responsible for ensuring weekly wound assessments for Resident #3. Ultimately, Nursing Administration was responsible for ensuring daily wound treatments and weekly wound assessments were completed for all residents. During an interview on 4/30/2026 at 1:34 PM, Administrator #1 stated the facility currently had an in-house wound care provider who came to the facility once a week. When Administrator #1 was made aware of Resident #7 not having a wound assessment on 4/9/2026, they had a discussion with nursing staff about the importance of the weekly wound assessments. 10 New York Code of Rules and Regulations 415.12(c)(2) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during survey, the facility failed to ensure each resident received adequate supervision to prevent accidents for one (Resident # 3) of three residents reviewed. Specifically, Resident #3 who was at high risk for falls and at risk for bleeding, fell out of bed with no injury on 05/25/2023, while care was provided by one Certified Nurse Aide per care planned interventions. The facility failed to (a.) reassess the resident's risk for falls, (b.) assess the resident for safe bed mobility with one staff, and (c.) implement new interventions to mitigate the risk of an accident. A fall risk assessment was completed on 06/06/2023 with the resident scoring a higher risk for falls than previously assessed, without documented evidence the facility assessed the resident for safe bed mobility and/or new interventions to mitigate the risk of an accident. Subsequently, on 06/19/2023, Resident #3 fell out of bed while care was being provided by one Certified Nurse Aide and was assessed with minor injuries. On 06/21/2023, the resident had a change in condition and was sent to the hospital where they were diagnosed with pelvis fractures (broken bones in the area of the body located between the hips) multiple pseudoaneurysms (contained rupture of an artery) that required embolization (procedure that stops blood flow to a specific blood vessel) of the right pudendal artery (passes through the pelvis). This resulted in actual harm to Resident #3 that was not Immediate Jeopardy.Findings include: The Policy and Procedure titled Falls Protocol, dated 07/22/2016, documented steps to be taken with all falls. The Registered Nurse/Licensed Practical Nurse would complete the Incident and Accident report and would document in the medical record identifying incident, assessment, and treatment rendered. The Policy and Procedure titled, Incident and Accident Reporting, dated 06/2022, documented Incident and Accident reports would be reviewed by the Interdisciplinary Team during the Interdisciplinary Team meeting. The facility administrator was responsible for ensuring implementation of individualized interventions to prevent reoccurrence. A nursing assessment would be completed for all incidents by the Registered Nurse Supervisor/Charge Nurse/Registered Nurse On-Call. A Registered Nurse Assessment was required for all observed and unobserved falls prior to the resident being moved. Major injury included bone fractures. When indicated, immediate intervention/action would be taken at the time of the incident to keep the resident in the safest environment and would be noted on the Incident/Accident Form under the Nursing Review section, in the Progress Notes, and on the Certified Nurse Aide Nursing Instructions. Immediate action(s) would be reviewed by the Interdisciplinary Team and evaluated and/or altered if indicated. The resident's Care Plan and the Certified Nurse Aide Nursing Instructions would be updated by the Team at that time. Resident #3: Resident #3 was admitted to the facility with the diagnoses of congestive heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing fluid to build up in the lungs and body), multiple sclerosis (body's immune system attacks the protective covering of the nerve cells of the brain), and history of falling. The Minimum Data Set (a resident assessment tool) dated 04/28/2023, documented the resident had severe cognitive impairment, usually made themselves understood, and usually understands others. The resident was assessed as totally dependent on staff for bed mobility (how the resident moved to and from lying position, turned side to side, and positioned body while in bed or alternate sleep furniture). The Comprehensive Care Plan for At Risk for Falls due to impaired mobility with an effective date of 12/20/2016, use of narcotics for pain control, and diagnosis of multiple sclerosis, the resident would be free from injury from falls. Interventions included resident belongings within reach, call light in reach, monitor resident to ensure positioned in middle of the bed, and position resident in center of bed. The Comprehensive Care Plan for Anticoagulation Therapy: Medication Use, effective 12/20/2016, documented the resident received Eliquis (blood thinner, anticoagulant). Interventions included avoid bumping and handle resident gently when providing hands<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | on care. Care Plan for ADLs (Activities of Daily Living): All Tasks, effective 05/10/2018, documented the resident required assistance with Activities of Daily Living and bed mobility. Interventions included staff to provide Activities of Daily Living assistance according to Nurse Instructions/Certified Nurse Aide care card. Resident Nursing Instructions (resident care instructions used by the Certified Nurse Aide) dated 05/01/2023 to 10/31/2023, documented one person physical assist for bed mobility effective 08/07/2014. A Fall Risk assessment dated [DATE] documented the resident had no falls in the past three months. The fall risk score was 12, high risk. The Incident/Accident Form for Resident #3 dated 05/25/2023 at 11:30 AM, documented an observed fall. There were no injuries. Resident Statement documented they objected to giving a statement. Identification of Root Cause/Contributing Factors documented the resident was last observed in bed during care and rolled on side. There was no documented evidence of a review by the Registered Nurse section per the facility's policy for Incident and Accident Reporting, with immediate care and actions taken to keep the resident safe and prevent reoccurrence. Some of the handwritten documentation on the incident/Accident Form was illegible and the facility was asked to provide clarification: An attestation dated 11/17/2025 by Assistant Director of Nursing #1, documented the Incident/Accident Form dated 05/25/2023 at 11:30 AM, was completed by Registered Nurse #3. Registered Nurse #3 was called into Resident #3's room at 11:30 AM. The resident was lying on the floor with a pillow under their head. Certified Nurse Aide #1 reported the resident rolled out of bed when they turned around to get more linen. Staff education was given to the certified nurse aide. Education provided to Certified Nurse Aide #1 was inconsistent with what was documented on the Incident/Accident Form dated 05/25/2023: Incident and accident Form dated 05/25/203 documented the resident rolled out of bed when Certified Nurse Aide #1 turned around to get more linen. On Site Education for Certified Nurse Aide #1 dated 05/25/2023 for an Incident/Accident occurrence on 05/25/2023, documented a verbal education for positioning resident - roll resident toward Certified Nurse Aide #1. Certified Nurse Aide #1 stated they would roll the resident toward them and not away from them. There was no documented evidence of education that addressed the aide turning around to get more linen. A Medical Progress Note dated 05/25/2023 at 8:18 PM by Nurse Practitioner #1, documented the resident was seen for follow up and a fall out of bed this morning, 05/25/2023.The resident reportedly rolled out of bed during care and denied hitting their head. The plan was to keep bed in the lowest position and anticipate needs. There was no evidence of any injury. There was no documented evidence of Interdisciplinary Team review of the fall or a fall risk assessment by nursing following the fall.Review of Physical/Occupational Therapy evaluations did not document any evaluation/treatment for safe bed mobility in May 2023.The Comprehensive Care Plan for At Risk for Falls was updated as follows:On 05/25/2023: at 11:30 AM Licensed Practical Nurse reported the resident rolled out of bed. The resident denied pain/discomfort and no redness or bruising was noted. Resident denied hitting their head. On 05/26/2023: a care plan intervention for staff education was added. There was no documented evidence regarding the details of education provided and there was no documented evidence of other new interventions to prevent falls.A Fall Risk assessment dated [DATE] documented one to two falls in the past three months. The fall risk score was 14, high risk.Review of the Care Plan for At Risk for Falls did not document any new interventions were implemented to mitigate the risk of an accident.The Incident/Accident Form for Resident #3 dated 06/19/2023 at 10:05 PM, documented an observed fall. Certified Nurse Aide #2 was providing care and rolled the resident away from them and the resident slid off the bed. The bed was about two feet off the ground. The resident was lying on the floor with their head against the closet. Injuries documented a one (1) centimeter abrasion on the left knee and a three (3) centimeter long by 0.3-centimeter-wide abrasion on the right upper back. Major injury documented pending x-ray results in the AM (morning). Nursing Review section, immediate care provided documented registered nurse assessment. Resident had two small abrasions to upper right back. Range of motion to arms/legs WNL (within normal limits). Denied pain. Resident was lifted to bed using a mechanical lift. X-rays of<br>(continued on next page) |

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| | 335252 | A. Building<br>B. Wing | 05/04/2026 |

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | the neck, right arm, and right shoulder were ordered. Identification of Root Cause/Contributing Factors documented Certified Nurse Aide #2 was doing care in bed in the resident's room at 10:05 PM. Other contributing factors: Certified Nurse Aide rolled the resident away from them and they slid off the bed onto the floor.The Facility Witness Interview Statement form dated 06/19/2023 by Certified Nurse Aide #2, documented they cleaned the front of the resident and when they turned the resident away from them to clean the back of them, the resident slid off the bed and fell next to their closet. Certified Nurse Aide #2 documented the pads were very slippery/thin which could have been one of the reasons the resident had fallen and to prevent this from happening they would get help from another aide and would turn the resident toward them. A Nursing Progress Note dated 06/19/2023 at 10:40 PM by Registered Nurse #4, documented that at 10:05 PM, the licensed practical nurse called to say the resident was on the floor. Registered Nurse #4 reported to the room and per the certified nurse aide, they were performing care in bed and when they rolled the resident away from them, they slid off the bed. The bed was above waist height, and the resident was lying on their back on the floor. The resident was assessed with two (2) small abrasions to upper right back that measured three (3) centimeters long by 0.3 centimeters wide. No other obvious injury was noted. The physician was notified and ordered x-rays to right arm, right shoulder and neck.The Comprehensive Care Plan for At Risk for Falls was updated as follows:On 06/19/2023: witnessed fall. Rolled out of bed during care with certified nurse aide. A new care plan intervention was added for two person assist with bed mobility and hygiene.The Interdisciplinary Team Review form dated 06/20/2023 for the fall on 06/19/2023, documented two person assist for bed mobility and care. The Interdisciplinary Team concluded the accident was unavoidable.A Medical Progress Note dated 06/20/2023 at 4:14 PM by Nurse Practitioner #1, documented they saw the resident on 06/20/2023 after rolling out of bed. The resident reportedly rolled onto the floor and their upper denture was cracked. The resident had no complaints, no signs of distress, or pain. No acute fractures were noted on x-rays. Would discuss possible intervention of upper side rails with Therapy/Nursing versus two person assist for care.A Nursing Progress Note dated 06/21/2023 at 6:39 AM by Licensed Practical Nurse #2, documented the aide reported the resident was not at baseline during first rounds. Writer went into the room and noticed the resident had some wheezing and was not responding. They were not answering basic questions and pupils were non-reactive. Registered Nurse supervisor was notified for an assessment. The physician was notified and ordered Lasix (water pill used to treat fluid retention), duo neb (an inhalation solution used to open airways and reduce inflammation), and Ceftriaxone (broad-spectrum antibiotic) that were given with little effect. The resident's spouse was notified and requested the resident be sent to the hospital. Resident was currently at the hospital.A Nursing Progress Note dated 06/21/2023 at 6:00 PM by Registered Nurse #3, documented the resident was admitted (to the hospital) with a pelvic fracture.A Medical Progress Note dated 06/21/2023 at 6:17 PM by Nurse Practitioner #1, documented they were notified on 06/20/2023 during the evening the resident had hypoxia (low level of oxygen in body tissues) and lethargy (a decrease in consciousness). Ordered extra dose of Torsemide (used help treat fluid retention) and cardiology follow up for the morning of 06/21/2023. The resident's condition deteriorated, and they were transferred to the Emergency Department. The resident was found to have a pelvic fracture per nursing report and would be kept for pain management and observation for bleeding.The Hospital History and Physical Reports, History of Present Illness dated 06/21/2023, documented the patient (Resident #3) came from the nursing home after they rolled out of bed while being changed. A computed tomography (CT scan, a non-invasive procedure that uses rotating X-rays and computer technology to create detailed, cross-sectional images of bones, organs, and tissues) of the abdomen and pelvis showed fractures of the right pubic bone with extension into the superior to inferior pubic rami (pelvis fracture) with active hemorrhage (ongoing, acute loss of blood from damaged vessels due to trauma, posing immediate risks of shock, organ failure, and death) and pseudoaneurysm formation(a collection of blood that forms outside an artery wall, typically caused by injury, and is contained by surrounding tissue). The Hospital<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Interventional Radiology Angiography (radiographic visualization of blood vessels after injection of a radiopaque substance) Consult dated 06/21/2023, documented a pre/post procedure diagnosis of pelvic trauma. Indication for the procedure was pelvic bleeding. Pelvic angiography demonstrated multiple pseudoaneurysms arising from the right internal pudendal artery. Embolization was performed until vessel occlusion was achieved.During an interview on 04/15/2026 at 11:36 AM, Registered Nurse #3 stated that falls were discussed during morning meeting by the Interdisciplinary Team and they would come up with new interventions to prevent falls. Resident #3 was dependent on staff for all care needs. They recalled Resident #3 fall on 05/25/2023 and they could not explain why there were no new interventions implemented. They did not recall any injury. A resident was usually assessed by Physical/Occupational Therapy following a fall. They stated they could not determine on 05/25/2023 if the aide rolled the resident or they turned away to get linen when the resident rolled off the bed. Immediate education was provided to the aide. They reviewed the electronic medical record and stated there was no fall assessment dated [DATE] and no evaluation by therapy following the fall on 05/25/2023. They stated there was an in-service for nursing staff related to turning and positioning safely following the fall. On 06/19/2023, when the resident fell out of bed while care was being provided by one staff per the care plan, they fractured their pelvis. The Interdisciplinary Team reviewed the fall, changed the resident to a two person assist for bed mobility and care, and updated the care plan. During an interview on 04/15/2026 at 3:48 PM, Director of Nursing #1 stated the Interdisciplinary Team attended the morning meeting and falls were discussed along with interventions to prevent further accidents. When Resident #3 rolled out of bed while the Certified Nurse Aide was providing care on 05/25/2023, the only intervention was immediate education for the aide for safe turning and positioning of a resident. They could not explain why there were no other interventions after the resident fell out of bed on 05/25/2023 and stated an evaluation by therapy would have been a good intervention. Additionally, nursing could have immediately made the resident a two person assist for bed mobility after the fall on 05/25/2023. They stated that after they educated the aide, education was provided to all nursing staff related to safe turning and positioning. During an interview on 04/21/2026 at 12:16 PM, Medical Director #1 stated they were not directly involved with the day-to-day operations of the facility that was managed by the Administrator and Director of Nursing. They attended quarterly Quality Assurance and Performance Improvement meetings and falls were discussed. They stated it would have been the responsibility of the nurse manager and nursing staff to implement interventions to prevent accidents.On 04/21/2026 at 4:07 PM, the surveyor attempted to interview Certified Nurse Aides #1 and #2, who no longer worked at the facility. The contact phone numbers were no longer in service.During an interview on 04/30/2026 at 12:19 PM, Director of Rehabilitation #1 stated the Interdisciplinary Team included staff from Physical and Occupational Therapy. They stated for the most part, a resident received an evaluation by therapy following a fall unless something precluded the evaluation.During an interview on 04/30/2026 at 1:34 PM, Administrator #1 stated they attended the morning meetings. Falls, and Incident and Accidents were discussed at the meeting. The Interdisciplinary Team attended the meeting, and they would talk about interventions to prevent recurrence during the meeting. They did not recall Resident #3 falls. 10 New York Code of Rules and Regulations 415.12(h)(2) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on record review and interviews conducted during a survey, the facility failed to provide pain management consistent with professional standards of practice and the comprehensive person-centered care plan for one (1) (Resident #3) of three (3) residents review. Specifically, for Resident #3, the facility did not have evidence of an assessment of the resident's pain, when there was a new physician order dated 9/23/2023 for Tramadol (narcotic pain medication) and the resident was already receiving Acetaminophen (helps treat mild to moderate pain) Extra Strength 1000 milligrams, every eight (8) hours. Findings include: Resident #3: Resident #3 was admitted to the facility with diagnoses of multiple sclerosis (body's immune system attacks the protective covering of the nerve cells of the brain), diabetes (body does make enough insulin or it well as it should to remove sugar from the bloodstream), and pressure ulcer(localized area of skin and tissue damage caused by prolonged, unrelieved pressure, friction, or shear forces) of unspecified site and stage. The Minimum Data Set (an assessment tool) dated 8/04/2023, documented the resident had severe cognitive impairment, sometimes made themselves understood, and sometimes understood others. The Policy and Procedure titled, Pain Management Protocol, revised 3/22/2023, documented the protocol would assist staff to recognize, evaluate, and treat relief of pain, according to the specific plan of care. Pain would be monitored and documented by the medication nurses in the electronic medical record using the pain scales before and after pain medication. Follow up in the electronic medical record should occur within one hour of administration supported by a progress note reflecting administration and effect for each dose administered. The Comprehensive Care Plan for Pain Management last revised 8/08/2023, documented the resident had pain related to diagnoses that included neuropathy (damage of the nerves outside the brain and spinal cord), Multiple Sclerosis, and spinal stenosis (space inside the backbone is too small and can put pressure on the spinal cord and nerves). It documented the care plan was reviewed and there were no issues with pain management this quarter. Interventions included on-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors and administer medications as ordered by the physician. The Physician's Orders report dated 5/01/2023 to 10/31/2023, documented an order renewal dated 9/19/2023 for Acetaminophen Extra Strength 500 milligram tablet, give two (2) tablets by oral route every eight (8) hours). Original order date was 6/28/2023. The Physician's Orders report dated 5/01/2023 to 10/31/2023, documented an order dated 9/23/2023 for Tramadol 50 milligram tablet, give 0.5 tablet (25 milligram) by oral route three (3) times per day as needed for unspecified pain. Mmaximum daily dose 75 milligrams. Start date 9/23/2023. There was no documented evidence of an assessment or that the physician was notified of the resident's pain and the need for additional pain medication. Review of the Medication Administration Record and Nursing Progress Notes dated September 2023, documented: The Medication Administration Record dated 9/23/2023 at 2:54 PM, documented Tramadol 25 milligram was administered by Registered Nurse #2, who was a Licensed Practical Nurse at the time. The Nursing Progress Note dated 9/23/2023 at 3:04 PM, documented Tramadol 25 milligram was given to the resident. There was no documentation of the description and location of the pain. The Medication Administration Record dated 9/24/2023 at 12:53 AM, documented Tramadol 25 milligram was administered. The Nursing Progress Note dated 9/24/2023 at 3:23 AM, documented Tramadol 25 milligram was given for pain with positive effect. There was no documentation of the description and location of the pain. The Medication Administration Report dated 9/25/2023 at 12:21 AM, documented Tramadol 25 milligram was administered. The Nursing Progress Note dated 9/25/2023 at 5:55 AM, documented Tramadol 25 milligram was given for pain with positive effect. There was no documentation of the description and location of the pain. During an interview on 4/15/2026 at 3:48 PM, Director of Nursing #1 stated Resident #3 should have had an assessment of their pain on 9/23/2023 prior to calling the on-call provider about the pain. The assessment and call to the provider<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | should have been documented in the electronic medical record. During an interview on 4/21/2026 at 12:16 PM, Medical Director #1 stated nursing staff probably called the on-call provider because the resident complained of pain. Nursing staff usually wrote a note in the electronic medical record when they had to call a provider and would document details about the reason for the call and any orders received. During an interview on 4/21/2026 at 3:46 PM, Registered Nurse #2 stated they were a Licensed Practical Nurse on 9/23/2023 and did not recall the order for the Tramadol or the need for the medication. They would not have given the Tramadol without talking to the supervisor first because it was a narcotic pain medication. The supervisor would have had to call the provider to get the order. They stated they probably did not write a note because they relied on the supervisor to document the call to the provider and the order received. 10 New York Code of Rules and Regulations 415.12 |