

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Glendale Home-Schdy Cnty Dept Social Services		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Hetcheltown Road 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)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and interviews conducted during the survey, the facility failed to maintain and account for all controlled substances in accordance with professional standards of practice. Specifically, the narcotic count record signature sheet for three (3) of five (5) units were incomplete. Findings include: A review of narcotic count record book for unit Mohawk Trail side A cart documented blank spaces for Off going nurse did not sign for 04/20/2026 at 03:00 PM A review of narcotic count record book for unit Mohawk Trail side B cart documented blank spaces for On coming nurse did not have documented evidence of signature for 04/15/2026 at 03:00 PM Off going nurse did not have documented evidence of signature for 04/15/2026 at 11:00 PM A review of narcotic count record book for unit Union Station side B cart documented blank spaces for Off going nurse did not have documented evidence of signature for 04/07/2026 at 03:00 PM On coming nurse did not have documented evidence of signature for 04/15/2026 at 07:00 AM Off going nurse did not have documented evidence of signature for 04/15/2026 at 03:00 PM Off going nurse did not have documented evidence of signature for 04/16/2026 at 03:00 PM On coming nurse did not have documented evidence of signature for 04/17/2026 at 03:00 PM Off going nurse did not have documented evidence of signature for 04/17/2026 at 11:00 PM On coming nurse did not have documented evidence of signature for 04/20/2026 at 03:00 PM Off going nurse did not have documented evidence of signature for 04/20/2026 at 11:00 PM Off going nurse did not have documented evidence of signature for 04/21/2026 at 03:00 PM On coming nurse did not have documented evidence of signature for 04/22/2026 at 03:00 PM Off going nurse did not have documented evidence of signature for 04/22/2026 at 11:00 PM A review of narcotic count record book for unit Union Station side A documented blank spaces for On coming nurse did not have documented evidence of signature for 04/23/2026 at 07:00 AM A review of narcotic count record book for unit Dutch Hollow side B documented blank spaces for Oncoming nurse did not have documented evidence of signature for 04/20/2026 at 03:00 PM Off going nurse did not have documented evidence of signature for 04/20/2026 at 11:00 PM A review of the policy titled Controlled Substances dated 04/2025 stated Controlled medications are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together. Both individuals sign the designated controlled substance record. During an interview on 4/24/2026 at 9:47 AM, Licensed Practical Nurse #2 stated the narcotic book should be signed when nurses complete the narcotic count and hand-off of keys at the beginning and end of every shift. 10 New York Codes Rules and Regulations 415.22(a)(1-4)		

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview during the survey, the facility failed to ensure that food was stored, prepared, distributed, or served following professional standards for food service safety in the main kitchen and in 2 (two) of 5 (five) kitchenettes/nourishment stations. Specifically, proper dating of open items was not followed, and expired food items were found stored ready for use in the refrigerators and freezers. Findings include: Policy titled, Food Safety Policies and Standards revised 05/31/2025 documented refrigerated, ready to eat TCS (Time/Temperature Control for Safety) food prepared and held in a food establishment for more than 24 hours must be clearly marked with a use by/discard date. Food that is required to be date marked must be discarded if it is in a container or package that does not bear a date or date mark. Commercially packaged, ready-to-eat TCS foods must be clearly marked at the time the original container is opened and used within 7 days but cannot exceed the manufacturer's use by date. During inspection of the main kitchen and kitchenettes on 4/20/2026 at 10:12 AM the following items were found to be out of compliance with New York State food safety regulations: The following items were found to be opened without dates the items were opened on the packaging in the main kitchen: Refrigerator 1 (one) A bottle of chocolate syrup A bag of donuts Freezer off of (behind) Refrigerator 1 (one) A bag of hashbrown patties A bag of breakfast frittatas A bag of chicken and vegetable dumplings A bag of breakfast sausage patties The following item was found past its use by date in Refrigerator 2 (two) in the main kitchen: A bag of cut up potatoes with a use by date of 4/07/2026 marked on the packaging. Observations on unit kitchenettes/ nourishment stations noted the following: Dutch Hollow: In the nourishment station, food from home for a resident was dated 4/14/2026, two items of soup for a resident were dated 4/13/2026 and on item of soup for the same resident was dated 4/15/2026, food for a resident was in an undated paper bag, hot dogs for a resident with a sell by date of 2/25/2026, one slice of cheese for a resident was dated 3/30/2026. Also, in a cabinet there was a plate of tortilla chips that was not dated or labeled, covered with another paper plate. [NAME] Crossing: Kitchenette refrigerator contained bagels in an opened plastic bag that was undated. During a follow up visit to the Main Kitchen on 4/21/2026 at 12:48 PM, the back wall freezer contained an open bag of gluten free chicken nuggets that was not labeled with the date the bag was opened. During an interview on 4/20/26 at 11:01 AM and 4/23/2026 at 10:45 AM, Food Service Director #1 stated when an employee opened a food item, it was the employee's responsibility to date the packaging with the date the item was opened. All open items should have the date they were opened written on them. The undated items found during this tour were being discarded as the date the items were opened was unknown. When food items were brought from outside the facility for residents, they were kept in the kitchenettes on the unit or in the refrigerators in the main kitchen. The items were labeled with the resident's name, room number and date it was brought in. Items could be kept for up to three days. It was the kitchen staff's responsibility to check every shift for food that was past its use by date. If items past their use by date were found, they were discarded. 10 New York Codes, Rules, and Regulations 415.14(h)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the survey, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for two (2) (Resident #'s 28 and 137) of four (4) residents reviewed for infection control practices. Specifically, 1.) Certified Nurse Aide #1 failed to utilize Enhanced Barrier Precautions during resident care, increasing the risk of cross-contamination. 2.) Licensed Practical Nurse #3, while administering medications via gastrostomy tube (a tube placed into the stomach to provide nutrition) failed to maintain aseptic technique by placing the medication cup and supplies for the gastrostomy tube directly on the Resident's bedside table. In addition, the nurse dropped the cup full of crushed medication and proceeded to administer the medications without discarding and repreparing the dose. These deficient practices placed the residents at risk for potential infection and compromised care delivery. Findings include: The Facility's Policy and Procedure titled Infection Prevention and Control Program dated 12/2024, documented the purpose of surveillance of infections was to guide appropriate interventions, and prevent future infections. The Facility's Policy and Procedure titled Administering Medications revised date of 03/2023; documented staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Resident #28 Resident #28 was admitted to the facility with diagnoses of Alzheimer's Disease (a brain disorder that primarily affects memory, thinking, and behavior) Angina (chest pain) and nonthrombocytopenic purpura (purple or red skin discoloration due to bleeding under the skin that occurs without a decrease in platelets). Minimum Data Set (an assessment tool) dated 02/06/2026 documented the resident had severe cognitive impairment, frequent urinary incontinence, required partial/moderate assistance with toilet transfer and substantial/maximal assistance with toileting hygiene. The Active Physician's Orders documented an order for Enhanced Barrier Precautions. The Interdisciplinary Team Progress Notes dated 04/1/2026 - 04/21/2026 were reviewed and documented on 04/09/2026 the resident was seen by the medical provider for a urinary tract infection. The medical record documented a resident history of Extended-spectrum beta-lactamases (ESBL) (a type of antibiotic-resistant bacteria causing infection that is harder to treat and more easily spread in healthcare settings). During an observation on 4/20/2026 at 10:40 AM, Resident # 28 and Certified Nurse Aide #1 were exiting the bathroom located in the resident's room. The bathroom trash or bagged items had no isolation gowns in it. Certified Nurse Aide #1 stated they had just assisted Resident #28 with toileting. Certified Nurse Aide #1 stated they did not know that the resident was on Enhanced Barrier Precautions or why, but they would ask the nurse. An Enhanced Barrier Precaution sign was present outside the room. During an interview on 04/24/2026 at 9:57 AM, Infection Preventionist #1, they stated Resident #28 remained on Enhanced Barrier Precautions for colonized Extended-spectrum beta-lactamases. They stated the Certified Nurse Aide toileting a resident should be wearing a gown and gloves. Certified Nurse Aides knew which residents were on Enhanced Barrier Precautions by a sign outside the resident's room, the sign alerted them the resident is on Enhanced Barrier Precautions. Resident #137 Resident #137 was admitted to the facility with a diagnoses of congestive heart failure (heart muscle is unable to pump enough blood to meet the body's needs), hypertension and Gastrostomy status (artificial opening into the stomach to allow for direct delivery of nutrition, fluids or medications). The Minimum data set dated [DATE] documented, the resident was understood and was able to understand others with intact cognitive function. During an observation on 04/23/2026 at 11:35 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AM, "Licensed" Practical Nurse #3 was observed to place Resident #137's medication cup and equipment to flush the gastronomy tube on their bedside table without a barrier. "Licensed" Practical Nurse #3 was observed to pick up the medication cup from the bedside table with medication inside and drop it on the floor. They then picked the cup up from the floor and administered the medication to Resident #137. 10 New York Codes, Rules, and Regulations 415.19		

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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 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 (continued on next page)		

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews conducted during survey the facility did not ensure residents' personal property were free from loss or theft for one (1) of one (1) residents reviewed. Specifically, Resident #43 reported they did not receive their laundry back in a timely manner and also five (5) nightgowns were not returned. Findings include: CMS regulations (specifically 42 CFR S483.10(e)(2)) guarantee nursing home residents the right to retain and use personal possessions, including clothing and furnishings, as space permits. Facilities must respect personal property, ensure a homelike environment, and protect belongings from theft, provided they do not infringe on the health, safety, or rights of others. 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. 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: Retain and use personal possessions to the maximum extent that space and safety permit. 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. During an interview on 04/27/2026 at 11:41 AM, Resident #43 stated the facility does her laundry and they had not gotten back some blue and pink nightgowns. At first it was 3 and now it is up to 5 nightgowns that have not been returned to them. Resident stated they now have no nightgowns. Resident stated they have told several staff about the missing nightgowns. During an interview on 04/27/2026 at 11:53 AM, Registered Nurse #6 stated resident #43 had never reported any missing laundry to them. Registered Nurse #6 later stated the resident did have two (2) new nightgowns delivered over the weekend that were in process of labeling. They were unaware of where the other three (3) nightgowns were. They stated that when they are notified of missing items the item is searched for and if not found they will complete a missing item communication email and ultimately the items will be replaced if not found. During an interview on 04/27/2026 at 12:13 PM, Resident Representative #1 stated they had sent three (3) new nightgowns to the facility via amazon last week because their mother had no nightgowns. They stated resident often has laundry items missing and to ensure that their mother is not upset they send in replacement nightgowns. They had not reported the missing laundry to anyone as this is an ongoing issue. During an interview on 04/27/2026 at 12:21 PM, Director of Social Work #1 stated if the resident reports missing personal items the items are tracked by the social work department. If the item is not found the item will be replaced. During an interview on 4/2/2026 at 12:35PM, Administrator #1 stated an email communication is sent out for any resident missing laundry or personal items. The item is looked for in laundry, kitchen, etc. and if unable to locate the item, the item will be replaced. 10 NYCRR: 415.29, 415.29(d), 415.29(j)(1)		

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NAME OF PROVIDER OR SUPPLIER Glendale Home-Schdy Cnty Dept Social Services		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record reviews and interviews during a survey, the facility failed to ensure residents were free from unnecessary medications for,(4) four (Residents #55, 97, 13, and #155) of six (6) residents reviewed,^ Specifically, a) Residents #55 and #97 had as needed psychotropic medications with end dates outside the regulatory limit of 14 days. b) resident #13, did not have documented attempts of gradual dose reduction or documentation that a gradual dose reduction is clinically contraindicated c) Resident #155 did not have an appropriate diagnosis for an antipsychotic medication.^ Findings include: The policy and procedure titled Psychotropic Medication, reviewed 2/2025, stated as needed orders for psychotropic drugs were limited to 14 days and a gradual dose reduction must be attempted annually, unless clinically contraindicated. Resident #55 Resident #55 was admitted to the facility with the diagnoses of vascular dementia (a progressive decline in thinking skills caused by conditions that block or reduce blood flow to the brain), atrial fibrillation (an arrhythmia where the heart's upper chambers beat chaotically and out of sync with the low chambers, causing a rapid, irregular heartbeat), and major depressive disorder (a serious mental health condition characterized by persistent, severe low mood, loss of interest in activities, and fatigue lasting at least two weeks). The Minimum Data Set (an assessment tool) dated 2/12/2026 documented the resident was usually understood, sometimes understood others, and was severely cognitively impaired. The Physician's order dated 12/29/2025 stated lorazepam (a medication used to treat severe anxiety, anxiety-associated depression, and other conditions) 0.5 milligram tablet by oral route two (2) times for 30 days as needed. The Physician's Order dated 4/13/2026 stated lorazepam 0.5 milligram tablet by oral route every six (6) hours for 30 days as needed. Resident #97 Resident #97 was admitted to the facility with the diagnoses of Alzheimer's disease,(a brain disorder that primarily affects memory, thinking, and behavior), anemia, (a deficiency of healthy red blood cells leading to insufficient oxygen delivery to body tissues), and depression (a mood disorder that causes persistent feeling of sadness and loss of interest in activities once enjoyed). The Minimum Data Set (an assessment tool) dated 11/22/2025 documented the resident was usually understood, could usually understand others, and was severely cognitively impaired. The Physician's Order dated 3/17/2026 stated lorazepam 0.5 milligram tablet by oral route two (2) times per day for 30 days as needed. During an interview on 04/27/2026 at 12:13 PM, Registered Nurse #1 stated the provider ordered the psychotropic medications that way and were entered as ordered. During an interview on 04/27/2026 at 1:40 PM, Medical Director #1 stated psychotropic as needed medications should have a 14-day end date. They stated that in some cases, depending on the diagnoses, the duration may be extended but the reason should be documented. During an interview on 04/27/2026 at 1:47 PM, Physician's Assistant #1 stated the duration for as needed psychotropics should be 14 days. They stated the nurses would enter the order into the system for pharmacy and choose the duration. Resident #13 Resident #13 was admitted to the facility with the diagnoses of hemiplegia(a severe or complete paralysis on one side of the body caused by brain damage) following cerebral infarction (sudden disruption of blood flow to the brain, leading to cell death), generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry), and bipolar disorder (a chronic mental health condition characterized by extreme mood swings alternating between intense highs and severe lows). The Minimum Data Set (an assessment tool), dated 2/11/2026 documented the resident was able to be understood, was able to understand others, and was cognitively intact. The Physician's Order dated 03/03/2025 stated aripiprazole (an anti-psychotic medication) 10 milligram by oral route once daily for bipolar disorder. The Physician's Order dated 08/01/2024 stated trazodone 100 milligram by oral route once daily at bedtime for generalized anxiety disorder. The Physician's Order dated 8/13/2025 stated venlafaxine extended release 150 milligram give two (2) capsules (300 milligram) by oral route once daily with food for bipolar disorder. The Follow up Psychiatric Consult dated (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/13/2025 documented a failed gradual dose reduction in March 2025. Medical notes dated 09/01/2025, 12/04/2025, 01/12/2026, 02/08/2026, and 04/05/2026 documented a gradual dose reduction was not attempted and to defer to psychiatric services. During an interview on 04/27/2026 at 12:20 PM, Registered Nurse #3 stated they could not find any documentation of a gradual dose reduction of psychotropic medications for the past year. During an interview on 04/27/2026 at 1:40 PM, Medical Director #1 stated the resident should have psychiatric services involved and a gradual dose reduction should have been attempted per protocol within the past year. They did not know why it was not done. During an interview on 04/28/2026 at 11:22 AM, Nurse Practitioner #1 stated they assumed the resident was being seen by psychiatric services and that a psychiatrist would handle any gradual dose reductions. They were not aware that the resident had not seen psychiatric services since 8/13/2026. 10 New York Codes, Rules, and Regulations 415.4(a)(1)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record reviews and interviews conducted during a survey, the facility failed to timely report an injury of unknown origin to the State Survey Agency immediately, but not later than two (2) hours after the findings of serious bodily injury in accordance with State law through establish procedure for one (1) (Resident #8) of one (1) resident reviewed. Specifically, for Resident #8 a fracture of unknown origin was not reported Findings include: Facility policy titled, Abuse, Neglect, Mistreatment and Misappropriation of Resident Property, reviewed 04/2025, documented the facility prohibits abuse, neglect, misappropriation of resident property, and exploitation by anyone including but not limited to staff, family, friends and residents of the facility. The Administrator or Director of Nursing will notify the appropriate State Agency(s) immediately (no later than 2 hours after allegation / identification of allegation) by Agency's designated process after identification of alleged/suspected incident. Resident #8 Resident # 8 was admitted to the facility with a diagnoses of Quadriplegia (paralysis of all four limbs and the torso, typically caused by injury to the cervical spinal cord or brain,) paroxysmal atrial fibrillation (a type of irregular, rapid heart rhythm that begins abruptly and stops on its own,) and Gastro-esophageal reflux disease (a chronic digestive disorder where stomach contents (acid/food) frequently flow back into the esophagus.) The Minimum Data Set (an assessment tool) dated 02/24/2026 documented that they could be understood and understand others and was cognitively intact. Record review of portable diagnostic imaging Results from Mobile Imaging dated 02/12/2026, 12:02 PM documented findings of oblique/spiral fractures of the distal tibial and fibular diaphysis (a serious lower leg injury caused high energy twisting forces resulting in an angled break). Impression: Acute distal tibial and fibular fractures. Record review of progress note dated 02/12/2026 at 12:59 PM written by Registered Nurse #1 documented mobile imaging faxed result of right lower extremity x-ray. Documentation of notification of Nurse Practitioner #2 and Medical Director #1 of results of portable diagnostic imaging. Documentation of notification of administrator, Director of Nursing and Social Work of result of portable diagnostic imaging. Documentation of notification of Resident #8 of results of portable diagnostic imaging. Recommendation was to send Resident #8 to hospital for treatment. Review of Nursing Home Incident/Accident Investigation Report (Fracture) dated 02/12/2026 at 12:00 PM documented Resident # 8 was being treated for cellulitis of right leg, had been on antibiotic for 7 days. Redness did not resolve. Provider ordered X-ray, which showed a fracture of tibia/fibula (a break of the shinbone). Review of Nursing Home Incident/Accident Investigation Report (Fracture) dated 02/12/2026 at 12:00 PM documented Root Cause Analysis, Primary cause of fracture: Resident alert and oriented, denies being injured or falling. Stated I go all over; it could have happened anywhere. Resident denies injuring himself. Review of statement from Social Worker #1 dated 02/12/2026 at 01:00 PM documented Mobile Imaging results from an x-ray today showed oblique/spiral fractures of the distal tibial a fibular diaphysis.medial displacement of the distal tibial fracture component. Resident #8 is unable to identify any specific incident that may have resulted in the fractures. During an interview on 04/27/2026 at 11:45 AM, Resident #8 stated they were not sure how they got the injury. They stated they thought they caught the edge of their shoe on the side of the elevator, and it got twisted. They stated they had no concerns for abuse and had no fear of any staff members. During an interview on 04/28/2026 at 08:50 AM, Director of Nursing #1 stated that on the morning of 02/12/2026, a nurse noted redness and warmth to the right lower extremity of Resident #8. They were seen by the primary and wound doctor and started on an antibiotic for cellulitis. They were seen by the wound doctor again and they thought it could be osteomyelitis, so an x-ray was ordered. They stated a reportable incident would be one where they suspected abuse or I had no idea how the injury happened. They stated they did not feel like this was reportable after the Interdisciplinary Team met and they met with the resident. They stated (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they talked to the resident and felt there was no abuse. During an interview on 04/28/2026 at 11:05 AM, Director of Nursing #1 was asked if they were aware of the two-hour reporting window included injuries of unknown origin. They stated they knew but got most of the investigation done on the first day. The doctor reviewed it and determined it was a fracture that the staff could not cause. They stated they did not watch the injury happen. They stated they did not consider it an injury of unknown origin, they felt it was self-inflicted. They stated they all concluded with the Interdisciplinary Team and they felt that the resident did it to themselves and so it was not reportable. 10 New York Codes, Rules, and Regulations 415.4(a)(1)		

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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 reviews and interviews during the survey, the facility failed to provide care to dependent residents in accordance with professional standards of practice for 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, staff failed to provide assistance to the bathroom and toilet resident as scheduled. Findings include: Resident #201 Resident #201 was admitted to the facility with diagnoses of displaced intertrochanteric fracture of right femur (a type of broken hip), heart failure (when the heart muscle doesn't pump blood as well as it should), paroxysmal atrial fibrillation (episodes of an irregular heart rhythm). The Minimum Data Set (an assessment tool) dated 07/15/2024, documented that the resident could be understood, understand others, and was cognitively intact. Record Review Care Plan dated 12/20/2023 titled Activities of Daily Living, documented Resident #201 required extensive one assist for transfer, ambulation, and toileting. Care Plan dated 12/20/2023 titled Bowel Evacuation and Maintenance, interventions documented certified nurse assistant was to document bowel elimination every shift. Resident Certified Nurse Aide Documentation titled Toileting dated 07/2024 had no documented evidence 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, 07/26/2024 day shift, 07/27/2024 day shift, 07/28/2024 evening shift or night shift and 07/30/2024 night shift. Resident #2 Resident #2 was admitted to the facility with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting the non-dominant side (late-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. Record review 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 resident required extensive assist of two (2) for transfers due to safety concerns. 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. Interviews: During an interview on 4/28/2026 at 8:35 AM, Certified Nurse Aide #2 stated there were no instances where they had not been able to give a shower. They stated if they were not able to give a shower, it would be reported to the nurse, and the shower would be rescheduled for the next day. Interview with Licensed Practical Nurse #4 on Union Station Unit at 08:40 AM on 04/28/2026. They 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. 10 New York Codes, Rules, and Regulations 415.12(f)(1)		

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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. 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)		

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. Based on record reviews and interviews during the survey process, the facility failed to obtain necessary treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Specifically, for Resident #13, there was no psychiatric service follow-up as ordered by the psychiatrist. Findings include: Resident #13 was admitted to the facility with the diagnoses of hemiplegia (a severe or complete paralysis on one side of the body caused by brain damage) following cerebral infarction (sudden disruption of blood flow to the brain, leading to cell death), generalized anxiety disorder (a mental health condition characterized by persistent, excessive, and uncontrollable worry), and bipolar disorder (a chronic mental health condition characterized by extreme mood swings alternating between intense highs and severe lows). The Minimum Data Set (an assessment tool) dated 2/11/2026 documented the resident was able to be understood, was able to understand others, and was cognitively intact. The Follow Up Psychiatric Consultation, dated 8/13/2025, documented follow-up in two (2) to three (3) weeks. There was no follow-up scheduled or completed. Medical notes, dated 09/01/2025, 12/04/2025, 01/12/2026, 02/08/2026, 03/09/2026, and 04/05/2026, documented the resident was receiving psychotropic medication and management to be deferred to psychiatric services. During an interview on 4/27/2026 at 1:40 PM, Medical Director #1 stated Resident #13 should have had psychiatric services involved. During an interview on 4/28/2026 at 11:22 AM, Nurse Practitioner #1 stated they assumed the resident was being seen by psychiatric services but did not read any consultations. They stated the nurses would let them know if there were any changes or recommendations made. During an interview on 4/28/2026 at 11:40 AM, Registered Nurse #3 stated the nurses would arrange for follow-up appointments and that they had not made the follow-up appointment; they did not know why the lapse had occurred. 10 New York Codes, Rules, and Regulations 415.12(f)(1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Glendale Home-Schdy Cnty Dept Social Services		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Hetcheltown Road 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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a survey, the facility failed to ensure that its medication error rate did not exceed five (5) percent for two (2) (Resident #'s 32 and #57) of eight (8) residents observed during a medication pass for a total of 35 observations. This resulted in a medication error rate of 31.43 percent. Findings Include: The facility's policy and procedure titled Administering Medications revised 03/2023, documented the expiration/beyond use date was to be checked prior to administering a medication. Resident #32 Resident #32 was admitted to the facility with diagnoses of essential primary hypertension (most common type of high blood pressure), herpes viral ocular disease unspecified (group of eye disorders caused by infection with the herpes simplex virus), hyperlipidemia unspecified (excess amount of fats in your blood). The Minimum Data Set (an assessment tool) dated [DATE], documented that the resident could be understood, understand others, and was cognitively intact. Review of the Medication Administration Record dated April 2026 documented Resident #32 had a physician order and received: Propranolol 60 milligram tablet, give two (2) tablets (120 milligrams) by oral route once daily at 9:00 AM. Aspirin 81 milligram tablet delayed release, give one (1) tablet by oral route once daily at 9:00 AM. Losartan 25 milligram tablet, give one (1) tablet by oral route two (2) times per day at 9:00 AM and 8:00 PM. Valacyclovir 1 gram tablet, give one (1) tablet by oral route two (2) times per day at 9:00 AM and 8:00 PM. Myrbetriq 25 milligram tablet extended release, give one (1) tablet by oral route once daily at 9:00 AM. During an observation on [DATE] at 8:33 AM, Licensed Practical Nurse #1 reviewed Resident #32's Medication Administration Record and stated Resident #32 was to receive propranolol 60 milligram tablet two (2) tablets, aspirin 81 milligram tablet delayed release, Losartan 25 milligram tablet, Valacyclovir 1 gram tablet, and Myrbetriq 25 milligram tablet extended release. Licensed Practical Nurse #1 began to prepare the propranolol 60 milligrams, when they were asked to show the surveyor the expiration date of the medication, they had difficulty locating the information on the medication blister card. They then proceeded to prepare the four (4) additional medications without checking the expiration dates of the medications. Medications were administered to Resident #32. Resident #57 Resident #57 was admitted to the facility with diagnoses of multiple sclerosis (autoimmune disorder that affects the brain and spinal cord), ulcer of esophagus with bleeding (hole in the esophagus that causes bleeding), and essential primary hypertension (most common type of high blood pressure). The Minimum Data Set (an assessment tool) dated [DATE], documented that the resident could be understood, understand others, and was cognitively intact. Review of the Medication Administration Record dated [DATE] documented Resident #57 had a physician order and received: Tamsulosin 0.4 milligram capsule, give one (1) capsule once daily one-half hour following the same meal each day at 8:00 AM. Pantoprazole 20 milligram tablet delayed release, give one (1) tablet at 8:00 AM. Baclofen 20 milligram tablet, give one (1) tablet four (4) times per day at 8:00 AM, 12:00 PM, 4:00 PM, and 8:00 PM. Gabapentin 300 milligram capsule, give three (3) capsules (900 milligrams) three (3) times per day at 8:00 AM, 12:00 PM, and 7:00 PM. Metoprolol succinate ER 25 milligram tablet extended release 24 hour, give one (1) tablet once daily at 8:00 AM. During an observation on [DATE] at 8:50 AM, Licensed Practical Nurse #1 reviewed Resident #57's Medication Administration Record, and stated Resident #57 was to receive Tamsulosin 0.4 milligram capsule, Pantoprazole 20 milligram tablet delayed release, Baclofen 20 milligram tablet, Gabapentin 300 milligram capsule three (3) capsules, Metoprolol Succinate ER 25 milligram tablet extended release 24 hour. Licensed Practical Nurse #1 prepared medication for (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335252	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Glendale Home-Schdy Cnty Dept Social Services		STREET ADDRESS, CITY, STATE, ZIP CODE 59 Hetcheltown Road 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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration without checking expiration dates for any of the five (5) medications administered to Resident #57. During an interview on [DATE] at 8:33 AM, Licensed Practical Nurse #1 stated they did not routinely check expiration dates prior to administering medication. The night nurses did a good job at going through the carts ensuring medications were not expired. In general, the expirations dates of individual residents medications were checked prior to being placed in the medication cart, stock medications were checked prior to being placed in medication room. Occasionally the carts were cleaned out, and expiration dates were checked as well. During an interview on [DATE] at 9:39 AM, Director of Nursing #1 stated they would expect the five (5) rights (right resident, right medication, right dose, right time, and right route) to be completed as well as checking the expiration date prior to administering every medication. After being altered to medication pass being completed without expiration dates being checked, they stated they would follow up with the nurse. 10 New York Codes, Rules, and Regulations 483.45(f)(1)		