STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335265	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Van Rensselaer Manor	85 Bloomingrove Drive Troy, NY 12180

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 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 observation and interview conducted during the survey, the facility failed to provide effective maintenance services on seven (7) of seven (7) resident units. Specifically, several walls were in various states of disrepair. Findings include:During facility tours on 3/24/2026 through 3/27/2026 between the hours of 9:00 AM and 3:00 PM, walls corners and baseboards were found to be in a state of disrepair at seven (7) of seven (7) of the active nursing stations and in seven (7) of seven (7) of the unit dining rooms. Walls in the following resident rooms walls were identified to be in a state of disrepair:A104A112A122B102A205A214A213 During interview, on 3/25/2026 at 1:45 PM, Director of Security #1 stated that the facility had focused on ensuring the safety of the residents when it came to prioritizing repairs and that the facility was currently undergoing renovations where almost all identified items would be replaced. 10 New York Codes, Rules, and Regulations 415.14(h)

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews conducted during the survey, the facility failed to ensure alleged violations were investigated, prevented, or corrected according to professional standards for two (2) (Resident #31 and #271) of 12 residents reviewed. Specifically, Resident #271 was found on the floor of their room with an injury of unknown origin; an investigation was started and closed without any documented statements from the resident or persons identifying how the injury occurred. Resident #31 reported a missing tote of clothing; an investigation was started and closed without a documented outcome. Findings include:The policy titled Abuse/Neglect revised 11/2024, documented investigations were to be completed for possible abuse or crime. Interviews were to be obtained from the resident and any person/s who may be able to provide information. The information is reviewed by nursing administration at the onset, during, and at the close of the investigation. The Director of Nursing or Assistant Director of Nursing will review and close the incident. The policy titled Resident Incident/Accident Reporting reviewed 8/2025, documented all resident are reported, investigated, and documented at the time of the incident/accident or at the time of discovery in effort to prevent or decrease reoccurrence. Attachment Checklist for Brises documented, determine if bruise is explained (witnessed fall) or unexplained (possible abuse until determined otherwise). Resident #271 Resident #271 was admitted to the facility with diagnoses of anxiety disorder (persistent and excessive worry that interferes with daily activities), macular degeneration (an eye condition that causes blurred vision or reduced central vision) and unspecified asthma (condition that causes you airways to swell, narrow, and fill with mucous). The Minimum Data Set (an assessment tool) dated 01/30/2026, documented they could usually be understood, usually understand others, and was mildly cognitively impaired.^ Accident report dated 03/01/2026 at 1:45 PM documented the resident was found lying on floor on 03/01/2026. They had a 3.5x3.5 (three and a half by three and a half) centimeter round purple colored bump on their left forehead. Description was unwitnessed fall on floor with injury and outcome was resident fell asleep and fell forward out of their wheelchair. Accident report included two (2) statements detailing the resident was found on the floor. There were no documented statements from the resident or person/s identifying how the determination was a fall causing the injury. During observation of the B2 unit on 03/23/2026 at 11:30 AM, Resident #271 was in their wheelchair outside of their room appearing well groomed without any signs of distress. There was a round dark purple raised area approximately one-half inch around on the left side of their forehead. During an interview on 03/23/2026 at 11:30 AM, Resident #271 was unable to report how they obtained the injury to their left forehead. During an interview on 3/30/2026 at 3:10 PM, Registered Nurse #3 stated they were not in the facility at the time of Resident #271's injury. They reviewed the Accident report dated 03/01/2026 and they were unable to determine how the outcome for the injury was determined in the accident report. They stated the resident would have been able to provide a statement providing how the injury occurred, but that was not documented. During an interview on 3/31/2026 at 11:44 AM, Director of Nursing #1stated for an unwitnessed fall with injury they would expect to see a resident statement or a statement to determine how the accident was determined to be a fall. They were familiar with Resident #271 and that the resident would have been able to vocalize if they were abused or if they fell. Resident #31 Resident #31 was admitted to the facility with diagnoses of anxiety disorder (persistent and excessive worry that interferes with daily activities), quadriplegia (paralysis below the neck that affects all of a person's limbs) and polyneuropathy (simultaneous malfunction of many nerves throughout the body). The Minimum Data Set, dated [DATE], documented that they were understood, understood others, and was cognitively intact. Accident Report dated 07/07/2025 documented that the resident phoned the social worker on 07/07/2025 and stated they were missing a storage bag containing sweaters and sweatshirts. It was in their room when they were sent to the hospital, and when they were readmitted to the facility, they discovered the bag was (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missing. The Accident report was closed and there was no documented outcome. During an interview on 03/23/2026 at 3:30 PM, Resident #31 stated some time ago they had a storage bag of clothes go missing. They spoke with Social Worker #1 to report their missing clothing. They did not think an investigation was started and eventually had asked Administrator #1 about their missing clothing they were told there was no justification to reimburse or replace the resident's missing clothing. During an interview on 03/31/2026 at 1:13 PM, Social Worker #1 stated the resident did report the missing clothing. They had started an investigation, but the resident was not able to list items and never logged items to be labeled or placed onto their belongings list in the facility. The resident had a habit of shopping online and having things shipped to facility without having them labeled or logging them as the resident's belongings. They had reviewed all the resident belonging lists with the resident and there were none describing sweaters or sweatshirts. During an interview on 03/31/2026 at 1:18 PM, Director of Social Worker #1 stated they thought they had documented the outcome of investigation. They recalled spending time on the investigation for Resident 31's missing clothing. They stated the investigation revealed the was resident had not been able to describe items, and the items were not logged or labeled through the facility so the facility could not replace or reimburse the resident for their missing items. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interviews during the survey, the facility failed to ensure that nurse staff posting data was posted on a daily basis at the beginning of each shift in a prominent place readily accessible to residents and visitors. Specifically, the facility entrance lobby was observed on 04/01/2026 at 11:30 AM without the Daily Staff Posting. Additionally, there were no Daily Staff Posting elsewhere throughout the building.Finding is:During an observation on 04/01/2026 at 11:30 AM, the lobby was without the Daily Staff Posting. Additionally, there were no Daily Staff Posting elsewhere throughout the building.During an interview on 04/01/2026 at 11:40 AM, Staffing Coordinator #1 stated they were not responsible for posting the Daily Staffing and referred to the Administrator.During an interview on 04/01/2026 at 11:45 AM, Administrator #1 stated The Daily Staff Posting was posted in the main lobby but was not posted due to an oversight and said the previous day's posting was taken down. They further stated they were aware that Daily Staffing and census should be posted daily. 10 New York Codes, Rules, and Regulations 415.13

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review and interviews during the survey, the facility failed to ensure that food was stored, prepared, distributed, or served following professional standards for food service safety in seven (7) of seven (7) resident unit nutrition rooms and the central kitchen. Specifically, several items were found without expiration dates and proper food cooling procedures were not followed.Findings include:During inspection in the central kitchen on 3/23/2026 between 11:00 AM and 2:00 PM, the following items were found to be out of compliance with New York State food safety regulations:Cold, facility-made sandwiches were identified without proper expiration dates in the following areas:Sandwich prep station refrigerator in main kitchen;3A Dietary refrigerator;1B Dietary refrigerator;3B nutrition refrigerator.The temperature logs for the dietary refrigerators on all units were not completed for every day.No unit was able to provide temperature logs for resident-owned refrigerators.During kitchen tour a full-size kitchen pan filled with beef stew was identified in the walk in refrigerator. Without a proper cooling log sheet to ensure proper cooling is taking place. During interview, on 03/23/2026 at 1:15 PM, Director of Food Services #1 stated the tray had been in the refrigerator for approximately two (2) hours. When the temperature was checked, the food was still at 105 F, which is greater than the temperature of 70 F required to by food safety requirements.Subsequent to the interview, food was noted to be reheated and broken down into smaller containers for enhanced cooling in keeping with food safety requirements. During record review on 03/24/2026 at 3:00 PM, a cooling log showed the proper handling of the beef stew after the original reheating.During interview, on 03/23/2026 at 2:00 PM, Director of Food Services #1 stated they would dispose of all of the premade sandwiches that could not be confirmed as to have been made during lunch preparation and properly date and time the ones that could be. They would also institute dating procedures in keeping with current food safety regulation on these sandwiches in the future.10 New York Codes, Rules, and Regulations 415.14(h)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews, observations, and interviews conducted during the survey, the facility failed to ensure medical records were kept in accordance with accepted professional standards and the facility did not ensure that resident identifiable information was not released to the public according to professional standards, complete and accurate for five (5) of five (5) units and one (1) (Resident #271) of one (1) resident. Specifically, a) narcotic count record books for five (5) of five (5) units were incomplete, b) for Resident #271, nebulizer tubing was labeled with date of 03/08/2026 and the treatment administration record was signed weekly for tubing changes through the remainder of 03/2026, and c) two (2) of two (2) laptop computers were left unattended on medication carts with resident identifiable information accessible. Findings include:A review of the narcotic count record book for unit A2 documented blank spaces forOncoming nurse did not sign for 03/23/2026 at 7:00 AM.A review of the narcotic count record book for unit A3 team 2 documented blank spaces forOncoming nurse did not sign for 03/30/2026 at 7:00 AM.A review of the narcotic count record book for unit C3 team 1 documented blank spaces forOff going nurse did not sign for 03/27/2026 at 3:00 PM.Oncoming nurse did not sign for 03/30/2026 at 7:00 AM.During an observation on 03/30/2026 at 11:46 AM on unit A3 Team 1, 7-3 Nurse signed off for 3-11 shift before 3:00 PM.During an observation on 03/30/2026 at 11:49 AM on unit A2, Day nurse Licensed Practical Nurse #3 was observed to sign as off going nurse at 3:00 PM before 3:00 PM.During an observation on Unit B3 on 03/31/2026 at 11:20 AM, surveyor asked to see the narcotic sign off book. Licensed Practical Nurse #2 did not provide the book to the surveyor until they had signed the book in front of the surveyor. They had no explanation on why it had not been signed beforehand or why they would not provide the book to the surveyor until after they had signed it.During an interview on 3/30/2026 at 11:15 AM Registered Nurse #2 stated they were going to sign it at the end of their shift, as they were busy that morning. They further stated that as long as the count was right, it should be okay so they would sign it.During an interview on 03/30/2026 at 11:29 AM, Licensed Practical Nurse #1 stated they knew they should have signed it but forgot to complete it that morning.During an interview on 03/30/2026 at 11:46 AM, Licensed Practical Nurse #5 stated they would usually sign the book like that. They further stated that they had not been told they could not complete that way.During an interview on 03/30/2026 at 11:49 AM, when observed signing off as off going nurse in the narcotic book prior to the end of the shift, Licensed Practical Nurse #3 stated they sign it so they do not forget and understood that they should not do it that way.During an interview on 03/30/2026 at 12:00 PM, Director of Nursing #1 stated they had just completed an education on signing the narcotic books. They stated staff should know they should sign as soon as they receive the keys and not sign until they release the keys to the next nurse.Resident # 271Resident #271 was admitted to the facility with diagnoses of anxiety disorder (persistent and excessive worry that interferes with daily activities), macular degeneration (an eye condition that causes blurred vision or reduced central vision) and unspecified asthma (condition that causes you airways to swell, narrow, and fill with mucous). The Minimum Data Set (an assessment tool) dated 01/30/2026, documented they could usually be understood, usually understand others, and was mildly cognitively impaired.ˆ A review of the Treatment administration record for Resident #271 documented signed nebulizer tubing changes for the dates of 03/14/2026, 03/21/2026 and 03/28/2026.During an observation on 03/30/2026 at 1:17 PM, nebulizer tubing for Resident #271 noted to have tag with date of 03/08/2026.Observation on 3/24/2026 at 11:01 AM on unit B2, Team two (2) medication cart noted to have open computer, logged in as Licensed Practical Nurse #6, with resident information accessible. Licensed Practical Nurse #6 was not near the computer, two (2) Licensed Practical Nurses noted to be in Unit Managers office.Observation on 03/30/2026 from 11:08 AM to 11:13 AM of laptop computer located on unit C3 Team two (2) medication cart, laptop computer was open with readable resident information. Nursing staff were not (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	near the computer.During an interview on 03/30/2026 at 11:13 AM, Licensed Practical Nurse #4 stated they would usually minimize their laptop screen or shut the laptop and they had forgotten to do so.10 New York Codes Rules and Regulations 415.22(a)(1-4)