

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Van Rensselaer Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure residents were treated with dignity and respect for one (1) of one (1) resident reviewed (Resident #143) and B1 unit. Specifically, staff failed to maintain discretion regarding resident conditions, used inappropriate and unprofessional language in resident care areas, interacted with a resident in a reprimanding manner during medication administration, and displayed non-dignified signage in a public area. These failures had the potential to cause emotional distress and negatively impact resident dignity and the facility environment. Findings include: Facility document titled, Your Rights as a Nursing Home Resident in New York State published by the New York State Department of Health, documented residents had the right to be valued as an individual, to be treated with consideration, dignity and respect in full recognition of their self-worth. Residents had the right to be cared for in a manner that enhanced quality of life, free from humiliation, harassment or threats. During an observation on 03/24/2026 at 11:12 AM, Certified Nurse Aide #5 was observed in the hallway speaking loudly about a resident's condition and care needs in a manner that could be overheard by others. The Certified Nurse Aide was simultaneously transporting soiled linens through the hallway. When questioned, the Certified Nurse Aide acknowledged the information should have been handled discreetly and not discussed aloud in the hallway. During an observation on 03/30/2026 at 2:56 PM, Certified Nurse Aide #6 made a loud, inappropriate remark toward another staff member using unprofessional language, in the presence of four (4) staff members and within approximately 20 feet of two (2) residents. During an observation on 04/01/2026 at 9:24 AM, Licensed Practical Nurse #7 interacted with Resident #143 in a reprimanding and admonishing manner. The Licensed Practical Nurse advised the resident that the way medications were being taken would result in dropping them. After the resident dropped medications, the Licensed Practical Nurse responded in a raised and corrective tone, drawing attention to the situation in the presence of other residents. The interaction was not supportive and had the potential to cause embarrassment to the resident. Record review indicated Resident #143 was admitted with diagnoses including chronic obstructive pulmonary disease, generalized anxiety disorder, and chronic respiratory failure. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and able to understand and be understood. During an observation on 04/01/2026 at approximately 11:47 AM, the B1 dementia care unit had a large sign posted on the exterior of the double doors stating, please do not let the residents off the unit. The sign was visible to residents, visitors, and staff. The wording broadly referred to residents as a group and implied restriction of movement in a manner that was not person-centered and had the potential to compromise resident dignity and create an institutional environment. During an interview on 04/01/2026 at 11:01 AM, Nurse Practitioner #1 stated the above behaviors were not acceptable and did not uphold resident rights and dignity. During an interview on 04/01/2026 at 11:39 AM, Director of Nursing #1 stated it was not acceptable to admonish residents and staff should place responsibility on themselves and use supportive approaches, such as offering assistance rather than correcting the resident. Director of Nursing #1 stated this approach aligned with de-escalation (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 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)		

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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 #1 stated 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **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 that comprehensive care plans were developed and implemented according to professional standards for three (3) (Residents #94, 132, and 192) of 41 residents reviewed. Specifically, Resident #94 did not have a care plan for Self-Administration of Medication, Resident #132 did not have a care plan for alcohol use, and Resident #192 had a care plan titled Nutrition with an intervention of lab draws yearly that was not implemented. Findings include: The policy titled Care Planning revised 07/2025, documented a comprehensive person-centered care plan would include detailed information and direction to meet an individual needs. The care plan was to have evaluation/monitoring notes with all changes and quarterly reviews. The policy titled Resident Alcohol Use last reviewed 11/12/2025, documented residents may consume alcohol in accordance with their rights, clinical condition, and individualized care plan. The policy titled Medication Administration System, Self Administration of Drugs revised 01/2025, documented a care plan would be in place for self-administration of drugs. Resident #94 Resident #94 was admitted with diagnoses Parkinson's disease (a progressive movement disorder of the nervous system), cerebral infarction (neurological deficit attributed to an acute focal injury of the central nervous system), and Polyarthrititis (inflammation in five (5) or more joints). The Minimum Data Set (an assessment tool) dated 03/13/2026, documented they could be understood, understood others, and was cognitively intact. Review of Resident #94's Comprehensive Care Plan active/effective date 12/29/2025, indicated there was no evidence of a care plan for self-administration of medication. During an observation 03/23/2026 at 11:50 AM, Resident #94 was in their wheelchair in their room eating their lunch, appearing well groomed without signs of distress. There were two (2) white bottles of nasal spray on their bedside table. During an observation 03/30/2026 at 2:40 PM, Resident #94 was in their wheelchair in their room watching television, appearing well groomed without signs of distress. There were two (2) white bottles of nasal spray on their bedside table. During an interview 03/23/2026 at 11:50 AM, Resident #94 stated they used nasal spray because the facility was so dry. Their family brings the nasal spray in from home for them. They stated they have been using the nasal spray for a long time. Resident #132 Resident #132 was admitted with diagnoses diabetes mellitus (chronic condition when the body can not properly process blood sugar), coronary artery disease (type of heart disease that occurs when the arteries of the heart cannot deliver enough oxygen-rich blood to the heart), and hyperlipidemia (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(elevated level of fats in the blood stream). The Minimum Data Set, dated [DATE], documented that they could be understood, understood others, and was cognitively intact. Physician's order dated 02/26/2026 by Medical Doctor #1, documented resident may have one (1) alcoholic beverage each evening 7:00- 11:00 PM as needed (one and a half (1.5) ounces of liquor, or 12 ounces of beer, or four (4) ounces of wine). Resident #132's Comprehensive Care Plan was reviewed. There was no documented evidence supporting Resident #132 allowance of alcohol as indicated in the physician order mentioned above. During an observation 03/23/2026 at 12:26 PM, Resident #132 was in their wheelchair in their room well-groomed without signs of distress. A 12 ounce can of beer was on their personal storage shelf next to an opened bottle labeled red wine vinegar, salt and pepper shakers, and an unopened single shot bottle of liquor was on their dresser. During an interview 03/31/2026 at 1:09 PM, Registered Dietitian #1 stated they would complete a care plan for a resident to consume alcohol They were unsure if about Resident #132 had a care plan for alcohol consumption. Resident #192 Resident #192 was admitted to the facility with diagnoses of unspecified dementia (group of symptoms affecting memory, thinking and social abilities), hypertensive heart disease (elevated bloods pressure), and gout (inflammatory arthritis that causes pain and swelling in your joints). The Minimum Data Set, dated [DATE] documented the resident was usually understood, usually understood others and was severely cognitively impaired. The Physician's Order dated 06/18/2024, documented complete blood count, complete metabolic panel, A1C, and Vitamin D level was to be obtained yearly starting 12/2024. The Comprehensive Care Plan titled Nutrition initiated 06/15/2020 and reviewed 03/25/2026, had the goal Resident's albumin will be more than 3.2 percent for 180 days. Review of laboratory results documented, there were no albumin levels to follow over 180 days. During an interview on 03/31/2026 at 11:45 AM, Registered Dietitian #1 stated the care plan was reviewed. They stated the goal should have been revised because the resident was no longer having regular laboratory tests performed. During an interview on 03/30/2026 at 3:10 PM, Registered Nurse #3 stated for residents that were alert and oriented, they did not complete a care plan for these residents to self-administer medications or to consume alcohol. r During an interview on 03/31/2026 at 11:40 AM, Director of Nursing #1 stated when care plans were reviewed, they would be updated, revised, or resolved based on current resident conditions. The process for residents to self-administer medication and to consume alcohol would include initiation of a care plan for these areas. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation record review, and interviews conducted during the survey, the facility failed to ensure that comprehensive care plans were revised according to professional standards for one (1) (Resident #192) of 41 residents reviewed. Specifically, Resident #192 had a care plan titled Nutrition that was reviewed on 3/26/2026 but not revised to reflect the resident's current status. Findings include: Resident #192 was admitted to the facility with diagnoses of unspecified dementia (group of symptoms affecting memory, thinking and social abilities), hypertensive heart disease (elevated bloods pressure), and gout (inflammatory arthritis that causes pain and swelling in your joints). The Minimum Data Set (an assessment tool) dated 12/12/2025 documented the resident was usually understood, could usually understand others, and was severely cognitively impaired. During an interview on 3/31/2026 at 11:45 AM, Dietitian #1 acknowledged they had reviewed the care plan on 3/26/2026 without revision despite no albumin levels being performed every 180 days. They stated the care plan should have been revised to reflect yearly blood draws and would revise the care plan. 10 New York Codes, Rules, and Regulations 415.11(c)(2)(i-iii)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on record review and interviews during the survey, the facility failed to ensure that residents were free of unnecessary medications for three (3) (Resident #13, 31, and 231) out of seven (7) residents reviewed. Specifically, Resident #13 and #231 had psychotropic drugs ordered on 03/04/2026 with no end and or renewal date. Resident #13 also had scheduled pain management narcotics ordered two (2) times a day routine and every four (4) hours as needed with no end dates. Findings include: Resident #231 Resident #231 was admitted with diagnoses paraplegia (paralysis of lower extremities), Parkinsonism (a progressive movement disorder of the nervous system) and neuromuscular disfunction of bladder (when a problem with your brain, nerves or spinal cord causes you to lose control of your bladder). The Minimum Data Set (an assessment tool) dated 01/15/2026, documented they could be understood, understand others, and was cognitively intact. Review of physician order by Nurse Practitioner #2 dated 03/19/2025, documented Oxycodone five (5) milligrams, give one and a half (1.5) tablets by oral route once daily for pain as needed; the Medication Administration Record documented a standing order with no documented end date. 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 (an assessment tool) dated 01/09/2026, documented that they could be understood, and understand others with intact cogitation. Review of physician order by Medical Doctor #1 dated 02/27/2025, documented Oxycodone five (5) milligrams, give one (1) tablet by oral route every eight (8) hours for pain as needed. The Medication Administration Record documented a standing order with no documented end date. Resident #13 Resident #13 was admitted to the facility with a diagnosis of Atherosclerosis (Plaque builds up in the inner lining of an artery, causing it to become narrow, stiff, and less flexible); Major Depressive Disorder (a serious mental health condition characterized by persistent, severe feelings of sadness, emptiness, or a loss of interest in activities) and status post vascular (veins/arteries) surgery of right lower extremity. The Minimum Data Set (an assessment tool) dated 03/04/2026, documented the resident usually could understand and was understood by others with intact cognition. During an interview on 03/23/2026 at 10:45 AM, Resident #13 stated they were admitted to the facility for rehabilitation after extensive surgery. They required pain medication to manage their pain. Resident #13's Comprehensive Care Plan, dated 03/04/2026, Pain Management Focus documented Administer medications as ordered by Physician. Encourage fluid intake with narcotic use. Monitor behavior and assess for pain/discomfort if change in behavior is noted. On-going assessment of the resident's pain with emphasis on the onset, location, description, intensity of pain and alleviating and aggravating factors. The Medication Administration Record documented Resident #13 had orders for Oxycodone 5 milligram tablet, give one (1) tablet two (2) times daily start date 3/5/2026, no end date. Oxycodone 5 milligram tablet, give one (1) tablet two (2) times as needed start date 3/5/2026, no end date. Lexapro 10 milligram tablet, give one (1) tablet once daily. Start date 3/4/2026 with no end or renewal date. During record review of the 2026 Medication Administration Record the resident was medicated with Oxycodone five (5) milligram tablet on 3/7; 3/9; 3/10; 3/11; 3/12; 3/13; 3/15; 3/17; 3/19; 3/20; 3/22; 3/23; 3/24; and 3/25/2026 with pain score of zero. During an interview on 03/27/2026 at 2:22 PM, Registered Nurse #4 stated as needed narcotics were reviewed on an as needed basis. Resident #13 was a subacute rehabilitation resident, and they anticipated the resident would not be at the facility for long and therefore did not enter an end date. During an interview on 03/27/2026 at 2:39 PM, Nurse Practitioner #2 stated they prescribed narcotics based on the resident's individual needs and would not necessarily give an end date. They further stated practitioners evaluated residents upon admission and as needed. 10 New York Code of Rules and Regulations 415.12(l)(1)		

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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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NAME OF PROVIDER OR SUPPLIER Van Rensselaer Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 for Oncoming 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 for Oncoming 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 for Off 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 # 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. 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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NAME OF PROVIDER OR SUPPLIER Van Rensselaer Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 85 Bloomingrove Drive Troy, NY 12180	
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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 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)		

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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 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **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 that residents were free of accident or hazards according to professional standards for three (3) (Resident #94, 132, and 231) of eight (8) residents reviewed. Specifically, Resident #94 had an over-the-counter nasal spray on their bedside table, Resident #132 had a can of unopened beer on their personal storage shelf as well as an unopened single shot of liquor on their dresser, and Resident #231 had a clear plastic bag of prescription medication in their chair located next to the doorway in their room. Findings include: The policy titled Resident Alcohol Use last reviewed 11/12/2025, documented residents could consume alcohol in accordance with their rights, clinical condition, and individualized care plan. Alcohol would be stored in the medication room to prevent misuse or diversion and provided to a resident only by their assigned nurse. The policy titled Medication Administration System, Self Administration of Drugs revised 01/2025, documented residents were permitted to self-administer medication. There would be a documented resident assessment including verification of the provider order, resident's current medical conditions, understanding of medication purpose, time of administration, reporting of side effects to nurse, and capability of locking and unlocking drawer for storage of medication. Resident #94 Resident #94 was admitted with diagnoses Parkinson's disease (a progressive movement disorder of the nervous system), cerebral infarction (neurological deficit attributed to an acute focal injury of the central nervous system), and Polyarthrititis (inflammation in five (5) or more joints). The Minimum Data Set (an assessment tool) dated 03/13/2026, documented they could be understood, understood others, and was cognitively intact. Review of Physician's Orders for Resident #94 revealed there were no documented orders for a nasal spray or self-administration of medication. Review of Resident #94's medical record indicated there was no documented assessment for self-administration of medication. During an observation 03/23/2026 at 11:50 AM, Resident #94 was in their wheelchair in their shared room eating their lunch, appearing well groomed without signs of distress. There were two (2) white bottles of nasal spray on their bedside table. During an observation 03/30/2026 at 2:40 PM, Resident #94 was in their wheelchair in their shared room watching television, appearing well groomed without signs of distress. There were two (2) white bottles of nasal spray on their bedside table. During an interview 03/23/2026 at 11:50 AM, Resident #94 stated they used nasal spray because the facility was so dry. Their family brings the nasal spray in from home for them. They stated they have been using the nasal spray for a long time. Resident #132 (continued on next page)		

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F 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #132 was admitted with diagnoses diabetes mellitus (chronic condition when the body can not properly process blood sugar), coronary artery disease (type of heart disease that occurs when the arteries of the heart cannot deliver enough oxygen-rich blood to the heart), and hyperlipidemia (elevated level of fats in the blood stream). The Minimum Data Set, dated [DATE], documented that they could be understood, understood others, and was cognitively intact. Physician's order dated 02/26/2026 by Medical Doctor #1, documented resident may have one (1) alcoholic beverage each evening 7:00- 11:00 PM as needed (one and a half (1.5) ounces of liquor, OR 12 ounces of beer, OR four (4) ounces of wine). Medication Administration Records dated 02/2026 and 03/2026 documented no alcoholic beverages were provided for consumption. During an observation 03/23/2026 at 12:26 PM, Resident #132 was in their wheelchair in their shared room well-groomed without signs of distress. A 12 ounce can of beer was on their personal storage shelf next to an opened bottle labeled red wine vinegar, salt and pepper shakers, and an unopened single shot bottle of liquor was on their dresser. Resident #231 Resident #231 was admitted with diagnoses paraplegia (paralysis of lower extremities), Parkinsonism (a progressive movement disorder of the nervous system), and neuromuscular dysfunction of bladder (when a problem with your brain, nerves or spinal cord causes loss of control of bladder). The Minimum Data Set, dated [DATE], documented they could be understood, understood others, and was cognitively intact. Review of Physician's Orders for Resident #231 revealed there were no documented orders for self-administration of medication. During an observation 03/23/2026 at 2:12 PM, Resident #231 was in their wheelchair in their shared room well-groomed without signs of distress. A clear plastic bag was noted in the chair by the doorway inside the room. The bag contained saline nasal spray, nystatin powder, and a corticosteroid nasal spray all labeled from the hospital. During an interview 03/23/2026 at 2:12 PM, Resident #231 stated the medications had come back with them from the hospital recently and had been in the chair in their room since returning to the facility. They do not administer their own medications During an interview 03/30/2026 at 2:45 PM, Certified Nursing Assistant #1 stated if they found medication at a resident's bedside they would report it to the nurse. They stated one (1) resident may know what to do with the medication, but some may not. They had residents that wander and could get into things on their unit. If they found alcohol at bedside they would report it to the nurse. During an interview 03/30/2026 at 2:48 PM, Certified Nursing Assistant #2 stated if they saw medications, including nasal spray, at a resident's bedside they would bring them to the nurse. If they saw alcohol at the bedside, they would also bring it to the nurse. During an interview 03/30/2026 at 2:52 PM, Licensed Practical Nurse #3 stated if they saw medication including nasal spray at the bedside, they would remove it and educate the resident. They (continued on next page)		

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F 0689 Level of Harm - Potential for minimal harm Residents Affected - Some	would also report finding medications at bedside to their supervisor. Licensed Practical Nurse #3 also stated, a provider order was needed for a resident to consume alcohol, and alcohol should be stored locked up in the medication room. It should not be at the resident's bedside. During an interview 03/30/2026 at 2:56 PM, Licensed Practical Nurse #6 stated they were unaware of any residents with Physician Orders to self-administer medication. They would remove medications if they saw them at a resident's bedside. Licensed Practical Nurse #6 stated, alcohol should not be at a resident's bedside. There needed to be a provider order to consume alcohol, and the alcohol should be stored locked in the medication room. During an interview 03/30/2026 at 3:10 PM, Registered Nurse #3 stated any medication, including over the counter medication, should not be at bedside without a provider order. Residents who self-administered medication would have an order for the specific medication that included instructions if medication was able to be left at the bedside. They stated there was no documented assessment or medication self-administration care plan for alert and orientated residents that they completed. They would do a mini assessment to make sure the resident knew how to administer medication. This mini assessment was not documented, although they said they probably should document it. Residents that could self-administer medications may keep it at their bedside table, although it probably should be in a locked drawer. Registered Nurse #3 stated Resident #94 did not have an order for nasal spray or for self-administration of medication. They believed the order was missed when the resident was readmitted to the facility from the hospital. Resident #94 had orders for nasal spray and for self-administration of nasal spray in the past. Registered Nurse #3 stated Resident #231 should not have any medication in their room. They stated a resident would have a provider order to consume alcohol. They were unaware of alcohol in Resident #132's room. They stated alcohol should be locked in the medication room and provided to the residents when requested. During an interview 03/31/2026 at 11:44 AM, Director of Nursing #1 stated medication should be in the resident's locked drawer if there was an order for self-administration of medication. The process for residents to self-administer medication was a provider order was documented, a care plan was put in place, and a progress note documenting a visualized assessment of the resident self-administering medication by nursing. They stated alcohol was to be kept in medication room locked up and should not be at a resident's bedside. The process for alcohol use was treated the same as an ordered medication and there would be an order from a provider and a care plan in place by either activities or dietary. 10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)		