

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/18/2026
NAME OF PROVIDER OR SUPPLIER  The Pines at Glens Falls Ctr for Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE  170 Warren Street Glens Falls, NY 12801	

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)
<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on record review, observation, and interviews conducted during the survey, the facility failed to ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, residents reported during interviews that the facility was short-staffed at times, this resulted in call bells not being answered promptly with long wait times for care to be provided.</p> <p>This is evidenced by:</p> <p>The Facility Assessment Exhibit #1- Staffing, dated 07/2025, documented:</p> <p>2nd Floor Rehabilitation unit desired staffing</p> <p>Day shift: Certified Nursing Assistants five (5) and two (2) Licensed Practical Nurses seven (7) days a week.</p> <p>Evening shift: Certified Nursing Assistants four (4) and two (2) Licensed Practical Nurses (7) days a week.</p> <p>Night shift: Certified Nursing Assistants three (3) and one (1) Licensed Practical Nurse (7) days a week.</p> <p>3rd and 4th floor desired staffing</p> <p>Day shift: Certified Nursing Assistants four (4) and two (2) Licensed Practical Nurses on weekdays. Certified Nursing Assistants five (5) and two (2) Licensed Practical Nurses on weekends.</p> <p>Evening shift: Certified Nursing Assistants four (4) and two (2) Licensed Practical Nurses seven (7) days a week.</p> <p>Night shift: Certified Nursing Assistants two (2) and one (1) Licensed Practical Nurse (7) days a week.</p> <p>The facility staffing sheets provided documented that:</p> <p>On 03/03/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift. The 4th floor had one (1) Licensed Practical Nurse on the evening shift and one (continued on next page)</p>

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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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>(1) Certified Nurse Assistant for the night shift.</p> <p>On 03/04/2026, the 4th floor had one (1) Licensed Practical Nurse on the evening shift.</p> <p>On 03/05/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift. The 3rd floor had one (1) Licensed Practical Nurse on the day shift. The 4th floor had three (3) Certified Nurses Assistants for the day and evening shifts.</p> <p>On 03/06/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift. The 3rd floor had one (1) Licensed Practical Nurse with three (3) Certified Nurses Assistants for the day shift and one (1) Certified Nurse Assistant for the night shift. The 4th floor had three (3) Certified Nurses Assistants for the day and evening shifts.</p> <p>On 03/07/2026, the 2nd floor Rehabilitation unit had three (3) Certified Nursing Assistants for the evening shift and two (2) Certified Nurses Assistants for the night shift. The 3rd floor had four (4) Certified Nurses Assistants for the day shift and three (3) Certified Nurses Assistants for the evening shift.</p> <p>On 03/08/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift. The 3rd floor had three (3) Certified Nurses Assistants on the day shift, one (1) Licensed Practical Nurse and two (2) Certified Nurses Assistants for the evening shift, and one (1) Certified Nurse Assistant for the night shift.</p> <p>On 03/09/2026, the 2nd floor Rehabilitation unit had four (4) Certified Nurses Assistants for the day shift and two (2) Certified Nurses Assistants for the night shift. The 3rd floor had one (1) Certified Nurse Assistant for the night shift. The 4th floor had one (1) Licensed Practical Nurse on the evening shift and one (1) Certified Nurse Assistant for the night shift.</p> <p>On 03/10/2026, the 2nd floor Rehabilitation unit had four (4) Certified Nurses Assistants for the day shift. The 3rd floor had one (1) Licensed Practical Nurse with three (3) Certified Nurses Assistants for the day shift and one (1) Certified Nurse Assistant for the night shift. The 4th floor had one (1) Licensed Practical Nurse for the evening shift and one (1) Certified Nurse Assistant for the night shift.</p> <p>On 03/11/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift.</p> <p>On 03/12/2026, the 3rd floor had one (1) Licensed Practical Nurse with three (3) Certified Nurses Assistants for the evening shift and the night nursing supervisor covered as a floor nurse with one (1) Certified Nurse Assistant for the night shift.</p> <p>On 03/13/2026, the 2nd floor Rehabilitation unit had three (3) Certified Nurses Assistants for the evening shift and two (2) Certified Nurses Assistants for the night shift. The 4th floor had three (3) Certified Nurse Assistant for the evening shift.</p> <p>On 03/14/2026, the 2nd floor Rehabilitation unit had four (4) Certified Nurses Assistants for the day shift and two (2) Certified Nurses Assistants for the night shift. The 3rd floor had four (4) Certified Nurses Assistants for the day shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 03/15/2026, the 2nd floor Rehabilitation unit had four (4) Certified Nurses Assistants for the day shift and two (2) Certified Nurses Assistants for the night shift. The 3rd floor had four (4) Certified Nurses Assistants for the day shift and one (1) Licensed Practical Nurse with three (3) Certified Nurses Assistants for the evening shift. The 4th floor had four (4) Certified Nurses Assistants for the day shift and one (1) Certified Nurse Assistant for the night shift.</p> <p>On 03/16/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift and two (2) Certified Nurses Assistants for the night shift. The 3rd floor had one (1) Licensed Practical Nurse with three (3) Certified Nurses Assistants for the evening shift and one (1) Certified Nurse Assistant for the night shift. The 4th floor had one (1) Certified Nurse Assistant for the night shift.</p> <p>On 03/17/2026, the 2nd floor Rehabilitation unit had two (2) Certified Nurses Assistants for the night shift.</p> <p>10 New York Codes, Rules, and Regulations 415.12(h)(1)(2)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, and interviews conducted during the survey, the facility failed to ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice. Specifically, (a.) for eight (8) residents (Resident #s 2, 6, 23, 45, 50, 93, 118, and 137), medications were left at resident bedsides without orders and/or evaluations indicating residents were capable of self-administration; (b.) insulin pens were not individually stored, separating resident pens from comingling; and (c.) Tylenol and Senna (an over-the-counter herbal stimulant laxative used for short-term relief of constipation) pills were loose in medicine cups in one (1) medication cart on the Unit four (4).</p> <p>This is evidenced by:</p> <p>A facility policy titled Medication Storage, undated, documented that medications must be stored in accordance with manufacturer's specifications and secured in locked storage areas in compliance with State and Federal requirements and accepted professional standards of practice. Access to medications was limited to only authorized personnel. Storage areas may include, but were not limited to, drawers, cabinet, medication rooms, refrigerators and carts.</p> <p>A facility policy titled Medication Pass Policy, undated, documented in pertinent part, do not pre-pour medications: administer them as they were prepared; always observe resident until they have swallowed all medications that have been administered. Do not leave medication in medication cup at the bedside or on tableside.</p> <p>A facility policy titled Self-Administration, last revised 10/2024, documented to maintain the residents' rights to maintain a high level of independence, residents who requested to self-administer medications were permitted to do so if the center's self-evaluation had determined that the practice would be safe for the resident and there was a health care provider's order to self-administer medication(s)/treatments. The documented procedures were, in pertinent part, (1) If the resident requested to self-administer medications, a Self-Administration Evaluation was completed by the licensed nurse to evaluate the resident's safety and understanding of their medication/treatments; (2) If the evaluation determines it was safe for the resident to self-administer, the licensed nurse would obtain an order from the Healthcare Provider for self-administration for the specific medication(s)/treatments; and (3) Upon obtaining the order for the medication/treatment the licensed nurse would instruct the resident in the process of storing the medications safely which should include a locked box.</p> <p>Resident #2</p> <p>Resident #2 was admitted to the facility with diagnoses of atrial fibrillation (an irregular rapid heart rate), hypertension (high blood pressure), aphasia following cerebral infarction (difficulty speaking and/or swallowing after having a stroke). The Minimum Data Set (an assessment tool), dated 2/26/2026, documented the resident was usually understood, usually understood others, and was minimally cognitively impaired.</p> <p>During an observation on 3/10/2026 at 11:01 AM, Resident #2 was noted to have saline nasal spray (continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>on their bedside table.**</p> <p>During an observation on 3/16/2026 at 10:30 AM, Resident #2 was noted to have saline nasal spray on their bedside table.**</p> <p>There was no documented evidence that Resident #2 had an evaluation that allowed for medications at the bedside.**</p> <p>There was no documented evidence that Resident #2 had a physician order for saline nasal spray.^</p> <p>Resident #6^</p> <p>Resident #6 was admitted to the facility with the diagnoses of^displaced fracture of anterior wall of left acetabulum^(a broken left hip),^fracture of left pubis^(a break in one of the small bones of the pelvis),^and^age-related osteoporosis^(a condition characterized by weak, fragile bones).^The Minimum Data Set, dated [DATE], documented the resident was able to understand others, be understood, and was^mostly cognitively intact.^</p> <p>During an observation on 3/11/2026 at 8:09 AM, Resident #6 had a medication cup^on their^bedside table that^was^identified^to be Calcium Carbonate^chewable tablet.^Resident #6^stated^that this was the only pill that staff left at their bedside^because^the resident preferred to take it slowly due to^its^chalky^taste.^</p> <p>A^physician order^dated 2/24/2026 at 7:00 AM documented Resident #6^was to be given^Calcium Carbonate Antacid Oral Tablet Chewable 500 milligrams,^give^one (1) tablet by mouth^one time a day for osteoporosis.**</p> <p>There was no documented evidence that^Resident^#6 had a physician order to self-administer medications.^</p> <p>There was no documented evidence that Resident #6^had an evaluation^to self-administer medications.^</p> <p>Resident #23^</p> <p>Resident #23 was admitted to the facility with the diagnoses of^unspecified dementia^(a progressive neurological disease causing memory problems),^cortical age-related cataract, bilateral^(a condition where clouding develops in the outer layer of the lens of both eyes), and^iron deficiency anemia^(a blood disorder where the body lacks sufficient iron). The Minimum Data Set, dated [DATE], documented the resident^was able to understand others, be understood, and was mostly^significantly cognitively impaired.^</p> <p>During an observation on 3/10/2026 at^11:20^AM, Resident #23^had^a bottle of^Refresh tears^(lubricant eye drops) on their bedside table.**</p> <p>During an observation on 3/12/2026 at^1:45 PM, Resident #23 had a^bottle of antifungal powder on their bedside table.**</p> <p>There was no documented evidence that Resident #23 had physician orders for Refresh Tears (continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>two (2) sprays in each nostril every 12 hours as needed for dry nasal passages. There was no documented evidence in the order that the resident was able to keep the medication at the bedside.</p> <p>A Medication Self-Administration Safety Screen dated 8/18/2025, documented the resident was able to self-administer nasal spray and Icy Hot topical analgesic spray and keep the medication in their room.</p> <p>The was no documented physician order for Icy Hot topical analgesic spray for Resident #118.</p> <p>Resident #137</p> <p>Resident #137 was admitted to the facility with diagnoses of atrial fibrillation (a rapid uncontrolled heart rate), chronic pain (unrelieved pain), and gastro-esophageal reflux disease without esophagitis (a form of heartburn without visible damage to the esophagus). The Minimum Data Set, dated [DATE], documented the resident could make themselves understood, understood others and was cognitively intact.</p> <p>During an observation on 3/12/2026 at 9:38 AM, Resident #137 was noted to have Refresh tears eye drops on their beside table. Resident #137 stated at that time that their family had brought it in for them and they did not have a physician order for it.</p> <p>There was no documented evidence that Resident #137 had physician orders for Refresh Tears eye drops.</p> <p>There was no documented evidence that Resident #137 had a physician order to self-administer medications.</p> <p>There was no documented evidence that Resident #137 had an evaluation to self-administer medications.</p> <p>During observations on 3/13/2026 at 10:07 AM, Lantus insulin pens for multiple residents were noted to be loose in the top drawer of the South side medication cart of Unit three (3). The pens and caps were noted to be labeled; however, they were not in individual bags allowing multiple resident insulin pens to touch each other and created the opportunity for them to cross contaminate each other.</p> <p>During an interview on 3/13/2026 at 10:10 AM, Licensed Practical Nurse #11 stated that they did not know that insulin pens needed to be separated so they were not touching.</p> <p>During observations on 3/13/2026 at 10:53 AM, Lantus insulin pens for multiple residents were noted to be loose in the top drawer of the North side medication cart of Unit three (3). The pens and caps were noted to be labeled; however, they were not in individual bags allowing multiple resident insulin pens to touch each other and created the opportunity for them to cross contaminate each other.</p> <p>During an interview on 3/12/2026 at 11:00 AM, Licensed Practical Nurse #2 stated that they knew the pens needed to be labeled but did not know they needed to be stored separately.</p> <p>During observations on 3/13/2026 at 10:46 AM, two (2) medication cups were noted to (continued on next page)</p>		

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