

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0689 Level of Harm - Actual harm Residents Affected - Few	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 interview during survey, the facility failed to ensure that the residents' environment remained as free of accident hazards as possible for five (Resident #s 17, 80, 151, 161, and 162) of 18 residents reviewed for accidents. Specifically, (1) on 08/17/2025, Resident #17 was provided with an alternate meal (egg salad sandwich) upon request, which was not according to the resident's prescribed diet order of puree texture (a cohesive, smooth texture free of lumps and coarse particles that does not require chewing) diet, thin consistency fluids. As a result, Resident #17 sustained a choking occurrence, their skin turned blue, and they required the Heimlich maneuver. (2) Medications were observed unattended at the residents' bedside for Resident #s 80, 151, 161, and 162, observations were made daily starting on the first day of survey 06/08/2026 through and including the last day of survey on 06/15/2026. This resulted in actual harm to Resident # 17 that was not Immediate Jeopardy. Findings include: (1) Resident #17: Resident #17 was admitted with diagnoses that included dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition where the heart's main pumping chamber weakens and cannot squeeze properly). The Minimum Data Set (a resident assessment tool) dated 08/08/2025, documented the resident had moderate cognitive impairment, was on a mechanically altered diet and required supervision or touching assistance for eating. The At Risk for Potential Alteration in Nutrition Comprehensive Care Plan initiated on 09/28/2022, documented the interventions including puree textures dated 06/17/2025. The physician's orders active on 08/17/2025, documented a diet order dated 06/17/2025, puree texture diet, thin consistency related to dysphagia. The Nursing Progress Note dated 08/17/2025 documented Licensed Practical Nurse #11 was alerted to resident choking in the dining room at 5:00-5:15 PM. Upon approaching the resident, the resident was seen flailing their arms and their spouse was yelling. Resident #17 was unable to speak, pointing to their throat. The resident appeared to be cyanotic (blueish discoloration around lips, skin, nails indicating a lack of oxygen) and the nurse began to perform Heimlich maneuver. After 45 seconds, a large piece of egg salad sandwich came up. The facility Incident Report dated 08/17/2025 documented Resident #17 was eating in the dining room and was noted to begin choking. Heimlich maneuver was performed, and food was successfully removed. The Employee Corrective Action dated 08/22/2025 documented a verbal warning to Certified Nurse Aide # 5, description included: on 08/17/2025, Certified Nurse Aide #5 gave Resident #17 an egg salad sandwich, violating their care plan. Employee comments included: when the resident asked for a sandwich, they went to the nurse and asked if the resident could have it, the nurse said it was okay. Signed and dated 09/02/2025. The Five-Day Investigation Report, dated 08/22/2025, documented the incident was a result of a care plan violation. During an interview on 06/15/2026 8:15 AM with Certified Nurse Aide #5, they stated Resident #17 was in the dining room and did not want the meal offered. After asking a nurse, Certified Nurse Aide #5 stated they gave an egg salad sandwich to Resident # 17 and went into the hall to pass trays. The nurse informed them the resident had taken one bite and started to choke and received the Heimlich maneuver. During an interview on 6/15/2026 at 11:02 AM with (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 335612	Facility ID: 335612 If continuation sheet Page 1 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0689 Level of Harm - Actual harm Residents Affected - Few	Medical Director #1, they stated that a resident who received a sandwich who was on a puree diet would be at risk of choking. They further stated that there were reasons why a resident would be on a puree diet, as the risk for aspiration is high. Medical Director #1 stated if the resident on a puree diet received an egg salad sandwich and it caused them to choke, and the Heimlich Maneuver was performed, then there was harm to the resident. (2) The facility policy titled Self-Administration of Medications initiated 05/04/2019 last revised 12/2025, documented residents have the right to self-administer medications if the Interdisciplinary Team determined that it was clinically appropriate and safe for the resident to do so. The staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate. This assessment may have the team determine that the resident cannot safely administer medications, and all medications would be administered by the nurse from the stored medications in the medication cart. It further stated that staff should identify and give the Charge Nurse any medications found at the bedside that are not authorized for self-administration. ^ Resident #80: Resident #80 was admitted to the facility with diagnoses of tinea cruris (fungal skin infection), chronic gout (long term inflammatory arthritis), and type two diabetes mellitus (body cannot use insulin correctly and sugar builds up in the blood). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was cognitively intact. Two prescription bottles of Nystatin powder labeled with dispensing information were observed on the shelf attached to the wall next to the resident's bed throughout the survey from 06/08/2026 through 06/15/2026. Review of Self Medication Assessment for resident #80 dated 05/12/2026 documented the resident was not approved to self-administer medication or keep medications at bedside. Review of prescriber orders documented an order for Nystatin External Powder 100000 UNIT/Gram (Nystatin (Topical). Apply to skin topically every day and evening shift for irritation. Resident # 162: Resident #162 was admitted to the facility with diagnoses of mild cognitive impairment of uncertain or unknown etiology (a stage of slight decline in memory and thinking skills), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in the heart's natural arteries without causing chest pain), and chronic systolic congestive heart failure (a long-term condition where the heart's main pumping chamber weakens and cannot squeeze properly) The Minimum Data Set, dated [DATE], documented the resident could make themselves understood, understood others, and had moderate cognitive impairment. ^^ Review of Resident #162's^Comprehensive Care Plan noted there was no documented evidence it was clinically appropriate or safe for^the resident to self-administer medications.^^^ Nursing Self-Administration of Medication assessment dated [DATE] documented Resident #162 required assistance for storing medication in a secure location, administering oral medications, stating the proper dosage, dispensing the proper amount, and identifying situations requiring the administration of as needed medications. It further documented the resident was not approved for self-administration of medications and they may not keep medications at the bedside. ^^ During an observation on^06/08/2026 at 3:18 PM, Resident #162 was sitting in their wheelchair in their room, which was shared with another resident.^A half-full bottle of diphenhydramine HCl (hydrochloride)^nighttime sleep aide^(an^over-the-counter^antihistamine that temporarily relieves occasional sleeplessness^by blocking histamine in the central nervous system, promoting drowsiness)^was on the resident's overbed table.^ During an interview on^06/08/2026 at 3:18 PM, Resident #162^stated^their spouse brought in the medication for them and they take it when they^cannot^sleep.^^^ During an interview on 06/10/2026 at 10:16 AM, Licensed Practical Nurse #6 stated there should be no prescribed treatment medications or over-the-counter medications at a resident's bedside. During an interview on 06/11/2026 at 12:30 PM, Licensed Practical Nurse #9 stated they did not have any residents on the unit that self-administer medications. If the resident could self-administer medications, it would be documented in the physician order for that medication and the comprehensive care plan. Residents should not have medications at their bedside if they are not approved to self-administer medications due to safety reasons. ^^ During an interview^on (continued on next page)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0689 Level of Harm - Actual harm Residents Affected - Few	06/10/2026 at 11:27 AM, Registered Nurse #1^stated^there were no residents approved for medications at bedside or^self-administration^of medication on the unit. Nystatin powder or over the counter medications should not be present in any room.^ During an interview on 06/12/2026 at 2:34 PM, Director of Nursing #1 stated residents needed to be assessed to determine if they were safe to self-administer medications. If a resident was determined not to be safe to self-administer medications, they should not have medications in their room. This applied to over-the counter-medications as well. During an interview on 06/15/2026 at^9:13 AM,^Administrator^#1^stated^there was an assessment tool to evaluate a resident's safety for self-administration^of medication. If the^resident was not safe to self-administer^medications, they should not have^medications^in their room. This applied^to over-the counter medication as well.^ ^ ^ 10 New York Codes Rules and Regulations 415.12 (h)(1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on record reviews, observations, and interviews conducted during the survey, the facility failed to provide services by sufficient numbers of staff on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans. Specifically, one Certified Nurse Aid was alone on unit H1 during the day shift on 06/09/2026, and one Certified Nurse Aid was left alone on unit H2 during the day shift on 06/11/2026. Findings include: Observations: During an observation on 06/09/2026 of Unit H2, Resident #87 placed call bell at 11:04 AM, Licensed Practical Nurse #5 answered the call bell at 11:07 AM. They then looked for an available Certified Nurse Aide to assist the Resident. There were two Certified Nurse Aides and one Licensed Practical Nurse in the break room on unit, located across hall from the resident's room. During an observation on 06/11/2026 at 11:45 AM on unit H1, there were multiple residents in the common area, there were no staff observed on the unit until 11:52 AM. Interviews: During an interview on 06/09/2026 at 11:10 AM, Licensed Practical Nurse #5 stated that the staff in the break area were on break. There were four Certified Nurse Aides and two Licensed Practical Nurses on the unit for that shift. One Certified Nurse Aide and one Licensed Practical Nurse were off the floor on break, two Certified Nurse Aides and one Licensed Practical Nurse were in the staff breakroom. Leaving one Certified Nurse Aide on the floor at that time. Subsequently, on 06/12/2026 at 9:20 AM, they stated one staff member should not be left alone on the floor while all other staff were on break. They were unaware on 06/09/2026 at 11 AM that was the case. They stated H2 generally has one Licensed Practical Nurse for each shift, and the Licensed Practical Nurse was typically late passing medications because of this. During an interview on 06/11/2026 at 11:52 AM, Certified Nurse Assistant #9 stated they were alone on the unit. There was one other Certified Nurse Aide and one Licensed Practical nurse on the unit for the shift, and they both were on break of the floor. They were still getting residents up for lunch at that time and there was no one to supervise the common area. If a Resident had a fall or anything else occurred, they would be unaware while they were providing care in a room. They stated they have difficulty getting everyone up before lunch in general with two Certified Nurse Assistants on the day shift, there had been an increase in residents that required two people to assist. During an interview on 06/11/2026 at 12:00 PM, Director of Nursing #1 stated one Certified Nurse alone on the unit was not expectable, especially during the day shift. One person should not be on the floor alone. Subsequently on 06/12/2026 at 2:35 PM, they stated medications being administered late due to one Licensed Practical Nurse on the floor for the shift was not acceptable and would indicate the unit was not adequately staffed. During an interview on 06/15/2026 at 11:45 AM, Registered Nurse #1 stated it was not acceptable for one Certified Nurse Aide to be on the unit with all other staff on break. They were not aware that one staff member was left on the floor during the day shift on H1. 10 New York Codes Rules and Regulations 483.35(a)(1)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 prepare and serve food in accordance with professional standards for food service safety in the main kitchen and 6 of 6 nourishment stations. Specifically, food was not stored properly; the automatic dishwashing machine was not operating within the manufacturer specifications; the concentration of the chemical sanitizing rinse was less than that required by the manufacturer; and food preparation area equipment, floors, walls, and ceilings required cleaning & repair. The findings include: During observations on 06/08/2026 at 9:34 AM: Pureed breakfast muffins were stored below raw beef patties in walk-in refrigerator; Director of Dining Services #1 stated that the pureed muffins were fully cooked but would be reheated before being served; [NAME] #1 did not know the temperature to reheat food (pureed muffins). The automatic dishwashing machine final rinse temperature was 120 degrees Fahrenheit at zero pounds per square inch of water pressure; dishwashing machine data plate stated that the final rinse was to be 180 degrees Fahrenheit at 15 to 25 pounds per square inch of water pressure. The concentration of quaternary ammonium compound in the 3-bay sink sanitizing rinse was zero parts per million; the label directions state solution is to be between 200 and 400 parts per million. Kitchen coving tiles and the floor by service entrance was cracked and/or broken. The bottom cover was missing from stove exposing electronic & control mechanisms. The following equipment required cleaning: can opener, knife rack, toaster, stove, convection oven, steam kettle, shelving, preparation sink, handwashing sinks, refrigerators, chest freezer, walk-in refrigerator door, wall fan, K-rated fire extinguisher. The following areas required cleaning: floor under equipment & next to walls, kitchen walls & doors, ceiling & vent ducts, food service office. During observations on 06/08/2026 at 10:42 AM, 6 of 6 nourishment station refrigerators, sinks, floors, and/or cabinetry required cleaning. During an interview on 06/08/2026 at 11:26 AM, Director of Dining Services #1 stated that they would do the following: Re-educate the cooks on reheating temperatures. Contact the vendors to adjust the dishwashing machine final temperature and adjust the concentration of sanitizer in the 3-bay sink. Follow up with the maintenance department to install the missing piece on the stove, repair the floor & coving tiles, clean the ceiling, and repair the cabinets in the nourishment areas. The kitchen equipment and floors & walls and the items in the unit nourishment stations would be cleaned. New York Codes, Rules, and Regulations Title 10 S415.14(h) Chapter 1 State Sanitary Code Subpart 14-1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews during the survey, the facility failed to establish and maintain an infection prevention and control program in accordance with professional standards of practice. Specifically, a) hand hygiene between rooms was not performed; b) sanitary transport of dirty linens and garbage was not performed; c) dressing supplies that were to be used were placed on the floor; d) urinary catheter drainage bags were observed to be resting on the floor. Findings include: The policy and procedure titled Isolation Precautions System, dated 04/2025, stated a two-tiered system of isolation was used, including standard precautions and transmission-based precautions. Enhanced barrier precautions referred to an infection control intervention designed to reduce transmission of targeted multidrug resistant organisms. Enhanced barrier precautions were to be used when a resident had an external medical device such as a urinary catheter, feeding tubes or drains, and also for wounds that typically required dressing changes (excluding small skin breaks/tears/abrasions that could be covered with a simple adhesive bandage). Contact precautions were to be used to reduce the transmission of epidemiologically important microorganisms which might be spread by direct or indirect contact. This included instructions to wear gloves and a gown before entering the room under contact precautions if direct care was anticipated. If indirect contact, like delivering a food tray, was anticipated, gloves and gown were not needed, but hands must be washed prior to leaving room. During a dining observation on 06/08/2026 at 12:21 PM, staff did not offer to sanitize/clean residents' hands prior to dining. During an observation on 06/08/2026 at 12:45 PM, Certified Nurse Aide #6 entered a room with a posted enhanced barrier precautions sign to deliver a food tray, then walked into another room to deliver a food tray, then walked into another resident's room and did not perform hand hygiene between the three rooms. The posted enhanced barrier precautions sign stated everyone was to clean hands before entering and when leaving the room. During observations on 06/08/2026 and 06/09/2026, indwelling urinary catheter drainage bags were on the floor. During an observation on 06/10/2026 at 03:09 PM, Certified Nurse Aide #7 was in a room with a dirty linen bag that was open and had an incontinence garment and gloves falling out of the bag. During a wound care observation on 06/10/2026 at 01:44 PM, Licensed Practical Nurse #7 placed dressing change supplies on a resident's overbed table without cleansing the surface or placing a drape. During a wound care observation on 06/11/2026 at 12:30 PM, Licensed Practical Nurse #6 placed the dressing change supplies on the floor. During an interview on 06/08/2026 at 01:17 PM, Certified Nurse Aide #6 stated they should have washed their hands after setting up the resident's meal tray before exiting the room. During an interview on 06/10/2026 at 01:44 PM, Licensed Practical Nurse #7 stated they didn't know when the overbed table had been cleaned last and should have placed a drape on the table before setting out the dressing change supplies. During an interview on 06/10/2026 at 06/10/2026 at 03:09 PM, Certified Nurse Aide #7 stated they had brought the linen bag in from another room and the dirty incontinence garment was from another room. During an interview on 06/11/2026 at 10:35 AM, Infection Preventionist #1 stated indwelling urinary catheter drainage bags should not touch the floor. They stated dirty linen and garbage bags should not be transported from one resident's room to another; it should be disposed of in the dirty linen room before entering another resident's room. They stated that dressing change supplies should be laid out on a clean surface which did not include the floor or an unwiped bedside table, and a drape should be used. During an interview on 06/15/2026 at 09:13 AM, Administrator #1 stated they would expect staff to offer assistance or opportunity for residents to wash their hands prior to eating. They would expect hand hygiene between resident rooms. 10 New York Codes, Rules, and Regulations 415.19 (b)(4)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, record review, and interviews conducted during a survey, the facility failed to ensure each resident was treated with respect and dignity and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life. Specifically, (a) during a dining observation on 06/08/2026, plastic utensils were provided to residents during the lunch meal. (b) Resident #65's urinary catheter drainage bag was observed to be not covered by a dignity bag. (c) Resident #201's urinary catheter drainage bag was observed to be not covered by a dignity bag. Findings include: Facility Policy titled Maintaining Resident Dignity effective 09/2024, documented the mission of the facility was to provide loving care to all residents in a timely manner that bespeaks dignity, respect, compassion, sensitivity and concern. The facility promotes care for residents in a manner and environment that maintains or enhances each resident's dignity and respect in full recognition of their individuality. In their interactions with residents, staff carries out activities that assist the resident to maintain and enhance their self-esteem and self-worth. Respecting care needs included the best practice option of using dignity-enhancing tools, such as catheter bag covers, unless resident preference dictated otherwise. The dining experience included the best practice of promoting dignity in dining, such as avoidance of day-to-day use of plastic cutlery and paper/plastic dishware. During a dining observation during the lunch meal on 06/08/2026 at 12:21 PM, on the Homeward Bound unit, all residents were provided with plastic spoons on their lunch tray. The residents were only provided with a metal fork and knife. During a dining observation during the lunch meal on 06/08/2026 at 1:05 PM, on the H-1 unit, all residents' lunch trays had a single plastic bag that contained a plastic knife, spoon, and fork. The residents were not provided with any metal silverware. During an interview on 06/11/2026 at 12:04 PM, Resident #110 stated they sometimes received plastic utensils. They do not like to use plastic utensils because the plastic utensils were weak and it was hard to cut a big piece of meat with them. During an interview on 06/08/2026 at 1:17 PM, Certified Nurse Aide #6 stated they typically work on the Homeward Bound unit, and the residents usually have metal silverware. They stated that some of the residents had regular silverware and some residents were noted to have plastic spoons on their trays. During an interview on 06/11/2026 at 11:17 AM, Certified Nurse Aide #8 stated there have been a couple of times plastic utensils were served on resident meal trays. They stated that two weeks ago when the dishwasher was down, plastic utensils were served. During an interview on 06/11/2026 at 12:28 PM, Licensed Practical Nurse #9 stated that they serve plastic utensils to residents on contact precautions or if there are safety issues relating to the resident. They stated they do not serve plastic utensils because the plastic utensils could break off while being used which could be a choking hazard. During an interview on 06/12/2026 at 11:21 AM, Director of Dining Services #1 stated that the expectation was for residents to have appropriate silverware on their trays. They stated that silverware tends to disappear and it can be difficult to keep an appropriate amount of silverware in the facility. When they run out of silverware, plastic utensils were used. They stated that plastic utensils should not have been used during meal service this week and providing the residents with plastic utensils instead of metal silverware was a dignity concern. During an interview on 06/15/2026 at 9:13 AM, Administrator #1 stated they did not expect residents to be provided with plastic utensils during meals. They stated that plastic utensils would be served only if the dish machine was down or if there was an activity with food like ice cream. They stated that it was not a homelike environment when residents were provided with plastic utensils instead of metal silverware and it was not appropriate for dining. Resident #65 Resident #65 was admitted to the facility with the diagnoses of type two diabetes mellitus (a chronic condition where the body doesn't use insulin properly or can't make enough of it), chronic (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	obstructive pulmonary disease (a progressive, incurable group of lung diseases that cause inflamed airways and airflow blockage), and obstructive and reflux uropathy (a blockage in the urinary tract that hinders normal urine flow causing urine to back up and swell the kidneys).^The Minimum Data Set (an assessment tool) documented the resident was able to be understood, could understand others, and was cognitively intact.^ During observations on 06/08/2026, 06/09/2026, 06/10/2026, and 06/12/2026, the urinary catheter drainage bag of Resident #65 was visible from the door and not covered with a dignity bag.^ During an interview on 06/08/2026 at 11:50 AM, Resident #65^stated^they were not aware the urinary catheter drainage bag should be covered and did not remember if they had been offered a cover.^ Resident #201^ Resident #201 was admitted to the facility with diagnoses of dementia (loss of cognitive function), chronic kidney disease (when your kidneys stop filtering waste from your blood), and urinary tract infection (bacteria enters the urethra and infect the urinary tract).^The Minimum Data Set, dated [DATE], documented that the resident could usually be understood, could usually understand others, and was severely cognitively impaired.^ During observations on 06/08/2026, 06/09/2026, 06/10/2026, 06/10/2026, 06/12/2026, and 06/15/2026, the urinary catheter drainage bag was visible from the door and not covered with a dignity bag.^ During an interview on 06/08/2026 at 11:33 AM, Certified Nurse Aide #13^stated^the urinary catheter draining bag should be covered.^ During an interview on 06/08/2026 at 11:40 AM, Licensed Practical Nurse #1^stated^the urinary catheter drainage bag should be covered.^ ^ During an interview on 06/12/2026 at 2:35 PM, Director of Nursing #1^stated^urinary catheter drainage bags should not be visible from the hallway and they should be covered.^ ^ 10 New York Code of Rules and Regulations 415.5(a)^ ^		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during the survey, the facility failed to ensure residents were given the right to be informed in advance, of the risks and benefits of the proposed treatment, and the ability to choose the alternative or option they preferred by the physician or other practitioner for three of five residents reviewed. Specifically, Resident #s 12, 19, and 87, were prescribed psychotropic medications without consent obtained. Findings include: The facility policy titled Psychotropic Medications-Unnecessary Use revised 05/2026 documented, there was to be documentation of discussion with the resident and /or responsible party regarding the risk versus benefit of the use of the medication. Resident #12: Resident #12 was admitted to the facility with diagnoses of bipolar disorder, in partial remission, (chronic mental health condition characterized by extreme mood fluctuations), anxiety disorder (common mental health condition that involves excessive fear, worry, or nervousness that interferes with daily life), and an infection with an inflammatory reaction due to an indwelling urethral catheter (a tube inserted through the urethra into the bladder to drain urine, prolonged use can lead to infection and inflammatory reactions). The Minimum Data Set, dated [DATE], documented that the resident could usually be understood, could understand others, and was mildly cognitively impaired. Review of provider orders documented: Doxepin HCl Oral Capsule 100 Milligrams (Doxepin HCl) Give 1 capsule by mouth at bedtime for Depression Quetiapine Fumarate Oral Tablet 25 Milligrams (Quetiapine Fumarate) Give 1 tablet by mouth at bedtime Paroxetine HCl Oral Tablet 30 Milligrams (Paroxetine HCl) Give 1 tablet by mouth at bedtime for Depression Divalproex Sodium Oral Tablet Delayed Release 250 Milligrams (Divalproex Sodium) Give 1 tablet by mouth three times a day Divalproex Sodium Oral Tablet Delayed Release 500 Milligrams (Divalproex Sodium) Give 1 tablet by mouth three times a day Lithium Carbonate Oral Capsule 300 Milligrams (Lithium Carbonate) Give 1 capsule by mouth two times a day Psychotropic medication consents requested from the facility for Resident #12 on 06/10/2026 and 06/11/2026, received by facility 06/12/2026 at 8:29 AM. Consents were signed and dated 06/11/2026. Resident #19 Review of provider orders documented: Mirtazapine Oral Tablet 7.5 Milligrams Give 1 tablet by mouth at bedtime for depression Prazosin HCl Oral Capsule 5 Milligrams Give 2 capsules by mouth at bedtime for Post-Traumatic Stress Disorder Seroquel Oral Tablet 25 Milligram Give 25 milligram by mouth two times a day for schizoaffective disorder Sertraline HCl Oral Tablet 50 Milligram Give 1 tablet by mouth one time a day for Depression There was no documented evidence of Psychotropic medication consent. Resident #87 Resident #87 was admitted to the facility with diagnoses of major depressive disorder, recurrent (a mood disorder that causes a persistent feeling of sadness and loss of interest), chronic respiratory failure with hypoxia (when the respiratory system fails to maintain adequate gas exchange, resulting in low oxygen levels), and dependence on supplemental oxygen (medical condition in which a person requires oxygen therapy for an extended period to maintain adequate oxygen levels in the blood). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was mildly cognitively impaired. Review of provider orders documented orders for: Escitalopram Oxalate Oral Tablet 10 Milligrams (Escitalopram Oxalate) Give 10 milligrams by mouth one time a day for depression give with 20 milligram tab for Total Dose=30mg Escitalopram Oxalate Oral Tablet 20 Milligrams (Escitalopram Oxalate) Give 20 milligrams by mouth one time a day for depression give with 10 milligram tab for Total Dose=30mg Trazadone HCl Oral Tablet 50 Milligram (Trazodone HCl) Give 50 milligram by mouth at bedtime for depression Klonopin Oral Tablet 0.5 Milligram (Clonazepam) Give 1 tablet by mouth four times a day for anxiety for 14 Days Psychotropic medication consents requested from the facility for Resident #87 on 06/10/2026 and 06/11/2026, received by facility 06/12/2026 at 8:29 AM. Consents were signed (continued on next page)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and dated 06/11/2026. Interviews: During an interview 06/12/2026 at 9:20 AM, Licensed Practical Nurse #5 stated they had worked in the facility 32 years and had never been made aware until yesterday consents for psychotropic medications needed to be obtained. During an interview 06/15/2026 at 11:02 AM, Medical Director #1 stated medication including psychotropic medication required consents are to be obtained prior to starting and/or if a change has been made. The family needs to be notified of any new medication or medication changes. During an interview on 06/12/2026 at 2:35 PM, Director of Nursing #1 stated psychotropic medications were to be completed with the start of a new medication, the facility was not completing psychotropic medication consents prior to 06/11/2026. Moving forward gradual dose reduction attempts will trigger notification and consents. 10 New York Codes Rules and Regulations 415.3(e)(1)(i)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews conducted during the survey, the facility failed to provide effective housekeeping and maintenance services on six of 6 resident units and the service areas. Specifically, floors, walls, ceilings, and dining tables were not clean and/or maintained; plumbing was in disrepair. The findings include: During observations on 06/11/2026 at 10:40 AM through 12:17 PM and again on 06/12/2026 at 9:15 through 12:00 PM: The main kitchen had an open drain and standing water under pre-rinse sink; the pre-rinse sink was plumbed to a sump pump system in the Boiler Room. The S unit Boiler Room had leaking pipes with standing water on the floor, was littered with trash, and had a sump pump system with an open wastewater collection tub. The dietary employee locker room floors, walls, doors, and lockers were heavily soiled; the walls below the sinks in the men's room had unfinished & unsealed repair work. The following areas were soiled with dirt, grime, food particles, or a black build-up: service area door thresholds, undersides of all dining room tables, ceiling vents. Ceiling tiles were stained in the H-1 unit nurse station. Throughout the S-2 unit, ceiling tiles were stained; corridor walls had small holes, scratch marks, and patched repairs were not painted, handrails were scratched, and heat registers in resident rooms were rusty. Throughout the N unit, walls & doors were scraped (door to room [ROOM NUMBER] was very badly scraped) and patched repairs were not painted; the floors room #s #2269 & 3369 were covered with dust balls. During an interview on 06/12/2026 at 12:09 PM, Director of Facilities #1 stated that they would: Clean the tables, floors, and vents. Repair & paint the walls. Replace the stained ceiling tiles. Have a licensed plumber repair the leaks in the boiler room to address the standing water and in the main kitchen, address the standing water, seal the open drain, and repair the prerinse sink drain to have the sump pump and open wastewater collection tub removed from the boiler room. New York Codes, Rules, and Regulations Title 10 S415.5 (h)(4); 415.29 (g), (i)(2)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 observations, record reviews, and interviews during the survey, the facility failed to ensure drug records were in order. Specifically, narcotic shift to shift count sheets were not completed every shift for two of five narcotic shift to shift count books reviewed. The policy and procedure titled Controlled Substances, dated 12/2021, stated that each narcotic dose is removed from the package to be noted on the control record as follows: date, time, dose, balance of remaining, and name/title. The policy and procedure titled Controlled Medication Storage, effective 08/2025, stated, At the beginning and end of each shift, all controlled substances would be accounted for by having two nurses (one from the present and one from the oncoming shift) count and sign the appropriate accountability records. Review of the narcotic shift to shift count book on unit H-1 on 06/10/2026 at 10:16 AM documented multiple missing signatures. There were no signatures for any shift from 06/08/2026 to 06/10/2026 at the time of the observation and review. Review of the narcotic shift to shift count book on unit H-3 on 06/10/2026 at 11:20 AM documented multiple missing signatures between 06/02/2026 and 06/10/2026. During an observed medication pass on 06/10/2026 at 10:16 AM, Licensed Practical Nurse #6 did not immediately sign the narcotic record that two narcotic medications were administered. During an interview on 06/10/2026 at 10:46 AM, Licensed Practical Nurse #8 stated the shift-to-shift book should be signed each shift with the appropriate count. They stated the book should have double signatures on each line for each shift. They stated they should have signed the narcotic sheets when they gave the narcotic, but stated that, as there was one book at the nursing station for both carts, it was harder to sign for individual needs. During an interview on 06/10/2026 at 11:07 AM, Licensed Practical Nurse #6 stated the narcotic books should be signed every shift but the book had run out of papers so there were no signatures. They stated that individual narcotic medications should be documented when they were given. During an interview on 06/10/2026 at 11:27 AM, Registered Nurse #1 stated the book should be signed with every shift and at the time of medication administration. During an interview on 06/10/2026 at 12:49 PM, Director of Nursing #1 stated the expectation was the count should be done and signed every time the narcotic keys were exchanged. They stated the books should be signed with every medication administration at that time. During an interview on 06/12/2026 at 09:20 AM, Licensed Practical Nurse #5 stated the narcotic counts should be done and signed for every shift and medications should be signed for individually when they were administered throughout the shift. 10 New York Codes, Rules, and Regulations 415.18(d)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations, record reviews, and interviews during the survey, the facility failed to store all drugs and biologicals in locked compartments under proper temperature controls. Specifically, treatment carts were left unlocked, a medication (pain-relieving cream) was left unattended on top of a cart, an inhaler was undated and unlabeled, and temperature logs were not completed on two of three medication refrigerators. Findings include: The policy and procedure titled Storage of Medications, dated 09/2024, stated drugs and biologicals used in the facility were to be stored in locked compartments under proper temperature, light, and humidity controls. Nurses were responsible for maintaining medication storage and preparation areas in a clean, safe, and solitary manner. During an observation on 06/10/2026 on a medication cart on H-1, a pain-relieving cream was on top of a medication cart unattended, insulin pens were not in bags, and five tablets were loose (out of package) inside the medication cart. During an observation on 06/10/2026 at 11:00 AM, the medication room on H1 had a medication refrigerator with incomplete temperature logs. During an observation on 06/10/2026 at 11:26 AM, a treatment cart on H-3 was observed to be unlocked and unattended. During an observation on 06/10/2026 at 10:46 AM, a medication cart on H-2 an inhaler was undated and unlabeled. During an observation on 06/11/2026 at 12:35 PM, a treatment cart on H-3 was observed to be unlocked and unattended. During an observation on 06/12/2026 at 9:10 AM, a medication cart on H-1 was left unlocked and unattended. Licensed Practical Nurse #6 was observed to be in a resident's room and could not see the medication cart. During an observation on 06/12/2026 at 09:16 AM, the medication room on H3 had a medication refrigerator with incomplete temperature logs. During an interview on 06/10/2026 at 10:16 AM, Licensed Practical Nurse #6 stated the temperature in the medication refrigerators were checked by the overnight shift. During an interview on 06/12/2026 at 09:20 AM, Licensed Practical Nurse #5 stated medication and treatment carts should always be locked when not in use and should not be left unlocked in the hallway. During an interview on 06/12/2026 at 02:39 PM, Director of Nursing #1 stated that medication and treatment carts should be locked, and temperature log sheets should be filled out as directed. During an interview on 06/15/2026 at 09:54 AM, Registered Nurse #1 stated all medication, and treatment carts should be locked. They stated the overnight shift should be checking and documenting the temperature of the refrigerators in the medication rooms. 10 New York Codes, Rules, and Regulations 415.18 (e) (1-4)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, record review, and interviews conducted during a survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature. Specifically, (a.) five out of five residents during the resident council meeting on 06/09/2026 stated that the food was cold; (b.) Resident #80 stated that cold food was room temperature and hot food was cold; (c.) Resident #99 stated that sometimes the food was cold; and (d.) for Resident #110, food was not served at an appetizing temperature during a lunch meal on 06/11/2026 and stated that food was cold. Findings include: Facility policy titled Mealtime Management, General Principles Of revised 08/2025, documented the facility will provide nutritious, well-balanced meals to all residents/patients three times a day in a pleasant atmosphere. Under key points, it is documented to accommodate preferences as much as possible. During a surveyor-led resident council meeting on 06/09/2026 at 1:30 PM, five out of five residents stated and agreed that by the time food was served to them, the food was cold. Resident #80 Resident #80 was admitted to the facility with the diagnoses of dysphagia (difficulty swallowing), type two diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels), and unspecified diastolic (congestive) heart failure (a chronic condition where the heart is unable to pump blood effectively). The Minimum Data Set (an assessment tool) dated 06/16/2026, documented the resident understood others, was able to be understood, and was cognitively intact. During an interview on 06/08/2026 at 11:43 AM, Resident #80 stated that cold food was served at room temperature and hot food was served cold. Resident #99 Resident #99 was admitted to the facility with the diagnoses of Parkinson's Disease without dyskinesia (movement disorder of the nervous system that gets worse over time, without involuntary movements), pulmonary hypertension (a condition characterized by abnormally high blood pressure in the arteries of the lungs, which increases the workload on the right side of the heart), and unspecified diastolic (congestive) heart failure (a chronic condition where the heart is unable to pump blood effectively). The Minimum Data Set dated 04/08/2026, documented the resident understood others, was able to be understood, and was cognitively intact. During an interview on 06/08/2026 at 12:12 PM, Resident #99 stated that sometimes the food was served cold. Resident #110 Resident #110 was admitted to the facility with diagnoses of iron deficiency anemia (a condition in which the body lacks sufficient iron to produce healthy red blood cells, leading to reduced oxygen delivery to tissues), gastro-esophageal reflux disease without esophagitis (chronic digestive disorder in which stomach acid or contents flow back into the esophagus), and hypertension (high blood pressure). The Minimum Data Set dated 05/13/2026, documented the resident understood others, was able to be understood, and was cognitively intact. During an observation on 06/11/2026 at 12:17 PM, Resident #110's lunch meal contained the following items with temperatures measured as follows: Barbeque chicken thighs were 118.8 degrees Fahrenheit, rice pilaf was 114.3 degrees Fahrenheit, sauteed zucchini was 105.8 degrees Fahrenheit, orange juice was 68.4 degrees Fahrenheit, whole milk was 56.1 degrees Fahrenheit, and frosted banana cupcake 67.5 degrees Fahrenheit. After tasting the food and drink, the temperature of the entree was lukewarm, orange juice was barely chilled, and the milk was slightly cooler than the orange juice. During an interview on 06/08/2026 at 12:16 PM, Resident #110 stated that the food was served cold, and they did not receive hot food or drinks while at the facility. During an interview on 06/12/2026 at 11:21 AM, Director of Dining Services #1 stated that there were complaints about food temperatures from the residents. There were more complaints about hot foods not being hot. They were working towards getting new equipment to prevent foods from getting to an undesirable temperature. During an interview on 06/15/2026 at 9:13 AM, Administrator #1 stated that there were complaints from the residents about wanting food to be hotter when it was served to them. (continued on next page)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The complaints were typically that food was not hot enough. On the units with complaints, they encouraged residents to eat in the dining room since residents in the dining room tended to be served their meal trays immediately. They would like to have the food trucks replaced to help keep the meal trays at a more desirable temperature.^^ 10 New York Code of Rules and Regulations 415.14(d)(1)(2)^^		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. During observations on 06/12/2026 at 11:35 AM, the facility grounds were overgrown with vegetation as follows:Weeds were growing in the gap between the asphalt and the building foundation.Weeds, grape vines, and tree saplings were growing in the landscape gardening found at the facility entrances and in the resident garden sanctuary courtyard.A large tree sapling was growing over the pad-mounted electrical transformer. During an interview on 06/12/2026 at 12:09 PM, Director of Facilities #1 stated that they would address the landscaping overgrowth. New York Codes, Rules, and Regulations Title 10 S415.5(h)(4)Based on observation and interviews conducted during the survey, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, the exterior of the facility building and grounds were not maintained. The findings include:		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 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. Based on interviews and record review conducted during a survey, the facility failed to promptly notify the resident and the resident representative when there was a change in room for one (Resident #138) of two residents reviewed. Specifically, Resident #138 had a room change and the residents' representative was not given prior notice. The facility policy titled Resident Rights effective 10/2017, documented it was the facility's policy to protect the rights of all residents which included, but was not limited to the right to a dignified existence and self-determination. All residents must be supported and promoted, their right to self-determination in order to assist them in achieving their highest, practicable well-being. The resident representative had the right to exercise the resident rights to the extent those rights are delegated to the representative. The facility would treat all decisions made by the designated representative as the decisions of the resident. In regard to medical care, the resident had the right to participate in the decisions that affected their care. Resident #138 Resident #138 was admitted to the facility with diagnoses of vascular dementia (a decline in thinking and memory skills caused by restricted or blocked blood flow to the brain), encephalopathy (a broad term for brain dysfunction, disease, or damage, characterized primarily by an altered mental state, confusion, personality changes, and potential cognitive decline), and adjustment disorder (a short-term mental health condition that occurs when an individual develops emotional or behavior symptoms in response to a specific, identifiable life stressor). The Minimum Data Set (an assessment tool) dated 5/01/2026, documented the resident was usually understood by others, usually able to understand others, and had severe cognitive impairments. During an interview on 6/08/2026 at 1:12 PM, Family Member #1 stated Resident #45 had a room change on 5/28/2026 that they were not made aware of. They stated their children went to visit Resident #45 and discovered that they were on a different unit. They stated there was very poor communication. A social work progress note dated 4/29/2026, documented Family Member #1 was under the impression that Resident #138 would be moved to another room on the S2 unit on that date. Family Member was okay with the move, should the staff decide it was best for the resident. They understood the resident's dementia and sundowning, as they were cared for Resident #138 at home prior. Social Worker #2 advised Family Member #1 that some of Resident #138's behaviors may be due to their admission to the facility. It further documented that per the unit manager, they would see whether Resident #138 adjusted before deciding to move the resident. A late entry health status note dated 5/28/2026, written by Licensed Practical Nurse #1, documented transferred to S2. Resident #138 had a room change to the S2 unit on 5/28/2026. There was no documented evidence that Family Member #1 was provided information regarding the room change, including the resident's new room number, prior to the transfer. Additionally, there was no documented evidence that Family Member #1 was informed that the room change would occur on 5/28/2026. During an interview on 6/10/2026 at 10:06 AM, Social Worker #1 stated that the facility held room change meetings every Tuesday and Thursday to discuss potential resident room transfers. They stated that families were contacted to ensure they were aware of and agreeable to any proposed room change. Social Worker #1 stated that when a room change occurred, the resident's care plan was updated and a progress note was written; however, a room change form was not utilized. They further stated that families were notified of the unit and room number to which the resident would be relocated. Regarding Resident #138, Social Worker #1 stated that the resident had cognitive impairments and that the family was agreeable with a room change to the memory care unit if the facility determined it was appropriate. However, the room change occurred without prior notification to the family. Social Worker #1 stated that Resident #138 was transferred to the unit they cover, and they were unaware of the transfer until after the resident had arrived. They stated that Family (continued on next page)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Member #1 expressed dissatisfaction with the communication process. Social Worker #1 further stated that although Family Member #1 was agreeable with the transfer to memory care, they should have been notified before the move occurred and provided with the resident's new unit and room number. Social Worker #1 stated Resident #138 has had a hard time adjusting. During an interview on 06/10/2026 at 10:45 AM, Administrator #1 stated they were not directly involved in room changes. They explained that room change meetings were held every Tuesday and Thursday and included Social Services, Ward Clerks who coordinated room changes, housekeeping staff responsible for completing the moves, and, at times, Medical Providers. Administrator #1 stated Social Services communicated with residents' families regarding room changes and obtained consent. They stated that no resident should be moved until Social Services has distributed an email confirming the room change and any necessary consent. Administrator #1 further stated they would expect the room change to be documented in the resident's progress notes. They would also expect the designated responsible party to be notified prior to the room change. 10 New York Code of Rules and Regulations 483.10(g)(14)(iii)(A)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a survey, the facility failed to ensure that all alleged violations involving abuse were reported immediately, or no later than two hours after the allegation was made for one out of four incidents reviewed for abuse. Specifically, the facility did not report an incident with the allegation of sexual abuse between Resident #131 and Resident #151 within the two-hour reporting timeframe. Findings include: (1) Resident #17: Resident #17 was admitted with diagnoses that included dysphagia (difficulty swallowing) and congestive heart failure (a long-term condition where the heart's main pumping chamber weakens and cannot squeeze properly). The Minimum Data Set (a resident assessment tool) dated 08/08/2025, documented the resident had moderate cognitive impairment, was on a mechanically altered diet and required supervision or touching assistance for eating. The At Risk for Potential Alteration in Nutrition Comprehensive Care Plan initiated on 09/28/2022, documented the interventions including puree textures dated 06/17/2025. The physician's orders active on 08/17/2025, documented a diet order dated 06/17/2025, puree texture diet, thin consistency related to dysphagia. The Nursing Progress Note dated 08/17/2025 documented Licensed Practical Nurse #11 was alerted to resident choking in the dining room at 5:00-5:15 PM. Upon approaching the resident, the resident was seen flailing their arms and their spouse was yelling. Resident #17 was unable to speak, pointing to their throat. The resident appeared to be cyanotic (blueish discoloration around lips, skin, nails indicating a lack of oxygen) and the nurse began to perform Heimlich maneuver. After 45 seconds, a large piece of egg salad sandwich came up. The facility Incident Report dated 08/17/2025 documented Resident #17 was eating in the dining room and was noted to begin choking. Heimlich maneuver was performed, and food was successfully removed. The Employee Corrective Action dated 08/22/2025 documented a verbal warning to Certified Nurse Aide # 5, description included: on 08/17/2025, Certified Nurse Aide #5 gave Resident #17 an egg salad sandwich, violating their care plan. Employee comments included: when the resident asked for a sandwich, they went to the nurse and asked if the resident could have it, the nurse said it was okay. Signed and dated 09/02/2025. The Five-Day Investigation Report, dated 08/22/2025, documented the incident was a result of a care plan violation. During an interview on 06/15/2026 8:15 AM with Certified Nurse Aide #5, they stated Resident #17 was in the dining room and did not want the meal offered. After asking a nurse, Certified Nurse Aide #5 stated they gave an egg salad sandwich to Resident # 17 and went into the hall to pass trays. The nurse informed them the resident had taken one bite and started to choke and received the Heimlich maneuver. During an interview on 6/15/2026 at 11:02 AM with Medical Director #1, they stated that a resident who received a sandwich who was on a puree diet would be at risk of choking. They further stated that there were reasons why a resident would be on a puree diet, as the risk for aspiration is high. Medical Director #1 stated if the resident on a puree diet received an egg salad sandwich and it caused them to choke, and the Heimlich Maneuver was performed, then there was harm to the resident. (2) The facility policy titled Self-Administration of Medications initiated 05/04/2019 last revised 12/2025, documented residents have the right to self-administer medications if the Interdisciplinary Team determined that it was clinically appropriate and safe for the resident to do so. The staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate. This assessment may have the team determine that the resident cannot safely administer medications, and all medications would be administered by the nurse from the stored medications in the medication cart. It further stated that staff should identify and give the Charge Nurse any medications found at the bedside that are not authorized for self-administration. Resident #80: Resident #80 was admitted to the facility with diagnoses of tinea cruris (fungal skin infection), chronic gout (long term (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inflammatory arthritis), and type two diabetes mellitus (body cannot use insulin correctly and sugar builds up in the blood). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was cognitively intact. Two prescription bottles of Nystatin powder labeled with dispensing information were observed on the shelf attached to the wall next to the resident's bed throughout the survey from 06/08/2026 through 06/15/2026. Review of Self Medication Assessment for resident #80 dated 05/12/2026 documented the resident was not approved to self-administer medication or keep medications at bedside. Review of prescriber orders documented an order for Nystatin External Powder 100000 UNIT/Gram (Nystatin (Topical). Apply to skin topically every day and evening shift for irritation. Resident # 162: Resident #162 was admitted to the facility with diagnoses of mild cognitive impairment of uncertain or unknown etiology (a stage of slight decline in memory and thinking skills), atherosclerotic heart disease of native coronary artery without angina pectoris (plaque buildup in the heart's natural arteries without causing chest pain), and chronic systolic congestive heart failure (a long-term condition where the heart's main pumping chamber weakens and cannot squeeze properly) The Minimum Data Set, dated [DATE], documented the resident could make themselves understood, understood others, and had moderate cognitive impairment. ^^ Review of Resident #162's Comprehensive Care Plan noted there was no documented evidence it was clinically appropriate or safe for the resident to self-administer medications.^^ Nursing Self-Administration of Medication assessment dated [DATE] documented Resident #162 required assistance for storing medication in a secure location, administering oral medications, stating the proper dosage, dispensing the proper amount, and identifying situations requiring the administration of as needed medications. It further documented the resident was not approved for self-administration of medications and they may not keep medications at the bedside. ^^ During an observation on 06/08/2026 at 3:18 PM, Resident #162 was sitting in their wheelchair in their room, which was shared with another resident. A half-full bottle of diphenhydramine HCl (hydrochloride) nighttime sleep aide (an over-the-counter antihistamine that temporarily relieves occasional sleeplessness by blocking histamine in the central nervous system, promoting drowsiness) was on the resident's overbed table. During an interview on 06/08/2026 at 3:18 PM, Resident #162 stated their spouse brought in the medication for them and they take it when they cannot sleep.^^ During an interview on 06/10/2026 at 10:16 AM, Licensed Practical Nurse #6 stated there should be no prescribed treatment medications or over-the-counter medications at a resident's bedside. During an interview on 06/11/2026 at 12:30 PM, Licensed Practical Nurse #9 stated they did not have any residents on the unit that self-administer medications. If the resident could self-administer medications, it would be documented in the physician order for that medication and the comprehensive care plan. Residents should not have medications at their bedside if they are not approved to self-administer medications due to safety reasons. ^^ During an interview on 06/10/2026 at 11:27 AM, Registered Nurse #1 stated there were no residents approved for medications at bedside or self-administration of medication on the unit. Nystatin powder or over the counter medications should not be present in any room. During an interview on 06/12/2026 at 2:34 PM, Director of Nursing #1 stated residents needed to be assessed to determine if they were safe to self-administer medications. If a resident was determined not to be safe to self-administer medications, they should not have medications in their room. This applied to over-the counter-medications as well. During an interview on 06/15/2026 at 9:13 AM, Administrator #1 stated there was an assessment tool to evaluate a resident's safety for self-administration of medication. If the resident was not safe to self-administer medications, they should not have medications in their room. This applied to over-the counter medication as well.^^ 10 New York Codes Rules and Regulations 415.12 (h)(1)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 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 record review and interviews conducted during a survey, the facility failed to ensure that comprehensive care plans were developed and implemented for residents according to professional standards for three (Resident #'s 12, 15, and 87) of 41 residents reviewed. Specifically, (a.) Resident #87 did not have a care plan for their respiratory diagnosis or use of oxygen; (b.) Resident #15 had a 16.25% weight loss from 10/28/2025-04/15/2026 and there was no care plan for it; (c.) Resident #12 was care planned for super-pubic urinary catheter care including daily dressing changes; it was not implemented in 10/2025 when the dressing was not changed for multiple days. The findings include: The facility policy titled Interdisciplinary Care Plan reviewed 9/2025, documented that the objective was to provide a person-centered plan of care that would establish continuity between all departments and maintain objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that were identified. The facility would (1.) develop and implement a baseline care plan; (2.) assess and evaluate the resident's conditions; (3.) perform specific assessments/evaluations per policy and procedures for admissions; (4.) utilize assessments/evaluations and other related information, imitate appropriate care plan; (5.) individualize each care plan noting resident specific needs, measurable goals, and approaches and responsible disciplines; (6.) assess resident goals; (7.) and include interventions/approaches to direct care delivery. (a.) Resident #87~ Resident #87 was admitted to the facility with diagnoses of major depressive disorder recurrent (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life),^chronic respiratory failure with hypoxia (when the respiratory system fails to maintain adequate gas exchange, resulting in low oxygen levels), and dependence on supplemental oxygen (medical^condition in which a person requires oxygen therapy for an extended period to maintain adequate oxygen levels in the blood).^The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was mildly cognitively impaired.^ Review of prescriber orders documented, Oxygen continuously at 2^Litters^via nasal^cannula^every shift for hypoxia (condition where body's tissues and cells do not receive enough oxygen to function properly).^Review of the comprehensive care plan revealed no documented evidence of any respiratory care area or use of oxygen therapy. Resident #15 Resident #15 was admitted to the facility with the diagnoses of pulmonary hypertension (high blood pressure in the arteries of the lungs), protein-calorie malnutrition (potentially life-threatening condition caused by an inadequate intake of protein, calories, or both), and chronic atrial fibrillation (continuous, irregular and often rapid heartbeat). The Minimum Data Set (an assessment tool) dated 4/15/2026, documented the resident could be understood, could understand others, and was moderately cognitively impaired. The Weight Summary dated 10/25/2025-05/05/2026 documented a 16.25% weight loss from 10/28/2025-04/15/2026. The Nutrition/Dietary Note dated 4/22/2026 documented significant weight loss for 6 months. A review of the Comprehensive Care Plan documented no care plan for actual weight loss or alteration in nutritional status. Interviews: During an interview on 06/12/2026 at 9:20 AM, Licensed Practical Nurse #5 stated care plans should be updated in real time with the onset of new issues. They would expect if residents were started on oxygen there would be a respiratory care plan. They would notify a Registered Nurse of any new diagnosis onsets for the care plan to be initiated During an interview 06/15/2026 at 11:45 AM, Registered Nurse #1 stated they would expect there to be a care plan with interventions in place for significant weight loss. They stated they did attend care conferences and participated in reviewing and updating care plans. They would assess if care plan interventions were being followed by reviewing documentation. They gave an example of a signature on the certified nurse aide accountability form, medication administration record, or treatment administration record would be (continued on next page)		

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: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	present for the specific intervention. They further stated that if there was no signature, that would indicate the care plan was not followed. During an interview on 06/11/2026 at 12:00 PM, Director of Nursing #1 stated any resident using oxygen, should have a respiratory care plan that includes the use of oxygen. ^ 10 New York Code of Rules and Regulations 415.11(c)(1)^		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 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 observation, interview, and record review, during the survey, the facility failed to ensure residents who were unable to carry out activities of daily living received the necessary assistance with eating, maintaining personal hygiene, and adequate grooming, for two (Residents #77 and #188) of five residents reviewed. Specifically, Resident #77 was observed unkept with dirty fingernails; Resident # 188 was not offered or provided the opportunity to get out of bed until the surveyor pointed it out to the assigned Certified Nurse Aide at lunchtime, despite the resident being awake and wanting to eat breakfast. The resident was observed on 6/08/2026 throughout the morning to be pleasantly confused, awake, in bed and to have a breakfast tray that remained in the room, until lunchtime when staff replaced it with a lunch tray. Staff interview confirmed that Resident # 188 did not receive the required assistance to access and consume breakfast. Resident interview confirmed he would like to have eaten breakfast. Findings include: The facility policy titled, Shower Procedure last revision date of 12/2025 documented residents will be offered a shower when indicated by the plan of care. The facility policy titled Activities of Daily Living Mobility dated 9/2024, documented that based on the comprehensive assessment of each resident, care and services will be provided to maintain their current activities of daily living status. Care and services for the following activities of daily living included hygiene (bathing, grooming, and oral care), mobility, elimination, and dining (eating). Staff must talk with each other about what their residents are doing. Resident #77 Resident #77 was admitted to the facility with diagnoses of type 2 diabetes (a chronic condition where the body either doesn't produce enough insulin or cannot properly use the insulin it produces, leading to high blood sugar levels), Alzheimer's Disease and Hypertension. The Minimum Data Set, dated [DATE], documented the resident had severe cognitive impairment and is sometimes understood. The Activities of Daily Living Comprehensive Care Plan dated 3/13/2026 documented that Resident #77 had an activity of daily living self-care deficit related to Alzheimer's Disease, weakness and an inability to walk. The resident required substantial assistance for bathing, and partial assistance for personal hygiene. The Kardex dated 06/15/2026 documented Resident #77 required a Hoyer lift for transfer, partial assistance with personal hygiene, substantial assistance of one for bathing. The record did not indicate a day of the week for a shower/bath. The Certified Nurse Aide Documentation Record dated 06/01/2026-06/10/2026 documented; personal hygiene including washing drying face/hands for Resident #77 and lacked documented evidence of any staff initials for 6/08/2026 & 06/10/2026. The record lacked documented evidence of a bath or shower provided from 06/01/2026- 06/10/2026. During an observation on 06/08/2026 at 11:34 AM Resident #77 was observed sitting in his wheelchair, the residents' nails were observed with brown material under all of them. During an observation on 06/11/2026 at 11:30 AM, Resident #77 was observed sitting in their wheelchair in their room. The resident was observed with brown material under the bilateral fingernails and was unshaven. Licensed Practical Nurse #10 was present and stated yes, there was a brown substance under the resident's nails of both hands. During an interview with Licensed Practical Nurse #10 on 06/11/2026 11:35 AM, they stated the resident was scheduled for Wednesday's day shift showers, and there was no documentation that the resident got a shower yesterday. They are unsure of who cared for Resident #77, as the unit assignment sheet was not correct. Licensed Practical Nurse #10 stated the resident did not get his scheduled shower, and the resident's hands and nails should be cleaned with am care and as needed. Resident #188 Resident #188 was admitted to the facility with diagnoses of unspecified dementia (progressive disorder that affects memory), heart failure (chronic condition in which the heart is unable to pump blood effectively) and spinal stenosis (narrowing of the spinal (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	canal). The Minimum Data Set, dated [DATE], documented the resident had moderate cognitive impairment, is understood and able to understand others, required supervision or touching assistance with eating, substantial/maximal assistance with toileting hygiene, shower/bathe, dressing and transfers. The Kardex dated 06/09/2026 documented to encourage and assist Resident out of bed prior to breakfast and out of bed for all supervised intake in room. The resident required supervision for eating. The Activities of Daily Living Comprehensive Care Plan dated 12/29/2023 documented intervention included, (12/1/2025) to ensure Resident #188 is out of bed before breakfast, supervision after set up for eating with scoop plate/built up utensils. (5/29/2026) supervision after set up, prompt and encourage resident to be up in wheelchair for all meals and medication administration, have head of bed elevated to 60-90 degrees, if unable to tolerate 90 degrees maintain 45 degrees head of bed elevation during intake maintain upright position more than 45 degrees for 30-45 min post meal, staff to verify positioning before meal tray delivery- monitor for coughing, wet voice, pocketing. The Certified Nursing Task dated 06/08/2026 was reviewed and breakfast intake had no entry. The task was verified with assigned Certified Nurse Aide #9 that the resident did not receive breakfast, they were not offered, and the resident did not refuse. During an observation on 06/08/2026 at 10:45 AM and 12:37 PM. Resident # 188 was observed with their breakfast tray in the room, not within reach, untouched, and unopened. The surveyor asked the resident if they wanted to eat, they stated, yes. The resident was observed to be awake, the room was dark, and the resident was confused about the time of day. During an interview on 06/08/2026 12:30 PM with assigned Certified Nurse Aide #9, they stated they were assigned Resident # 188 today. Certified Nurse Aide #9 verified Resident # 188's breakfast tray was untouched and unopened with the surveyor. Certified Nurse Aide #9 stated the resident needed assistance with meals, and the resident would not be able to reach their tray on their own and Resident # 188 required set up assistance. Resident #188 was asked if they would like to get up out of bed at 12:30 PM during the tray observation and the resident reported yes. They stated they did not deliver the resident their tray and they are not familiar with Resident #188 and did not offer the resident breakfast or offer him to get up, but they would do it now. Certified Nurse Aide #9 stated they were not aware that the resident did not eat breakfast. During an interview on 06/08/2026 12:35 PM Certified Nurse Aide #11, they stated they delivered Resident # 188 their breakfast tray, and that is how we do it every day. They stated they delivered their tray and it is supposed to be left at bedside until the resident gets up. Whenever the resident gets up then they eat or drink. If the resident is not up and lunch arrives, they take the breakfast tray and replace it with the lunch tray. During an interview on 6/15/2026 at 10:15 AM with assigned Certified Nurse Aide #5 they stated Resident # 188 does not need to be supervised when eating. During an interview on 6/15/2026 with the assigned Licensed Practical Nurse #10, they stated Resident #188 should be offered breakfast every day. If the resident is sleeping, the resident should be offered breakfast by waking them up. Everyone should be offered breakfast before lunchtime. Resident #188 stated that the resident required supervision after tray setup and cannot eat in their room alone. During an interview with the Director of Nursing on 6/12/2026 at 2:45 PM, they stated staff should observe what's left on the resident's meal tray. Staff would know if a resident did not eat breakfast by looking at what is left on the tray and offering alternatives or looking for a reason if it was not eaten. Staff should circulate the hallway and stick their heads in the residents' rooms often. Resident #188 is required to be out of bed for meals. 10 New York Codes, Rules, and Regulations 415.12(a)(2)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 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 record reviews, observations, and interviews conducted during a survey, the facility failed to ensure residents were provided with treatment and care in accordance with professional standards of practice for two of 41 residents reviewed, Residents #12 and #208. Specifically, (a) Resident #208, the bowel protocol was not initiated per physician orders after more than three days of the resident not having a documented bowel movement and (b) Resident #12 had a super-pubic catheter placed with dressing changes ordered daily, the dressing change was not changed over a period of 10 days, and a culture was obtained as ordered labeled with the wrong location causing a delay in care and the resident to be prescribed broad spectrum antibiotics empirically. Findings include: Facility policy titled Resident/Patient Bowel Program for Constipation (undated) documented the purpose was to provide residents at the facility interventions for constipation prevention and to monitor resident's bowel habits. Nurses would monitor resident bowel management daily in the electronic health record. If a resident did not have a bowel movement within three days, and had not been care planned otherwise, the charge nurse on the 3:00 PM to 11:00 PM shift initiated a resident bowel program worksheet. On day three, magnesium hydroxide (laxative to relieve constipation) is administered on the 3:00 PM to 11:00 PM shift and was documented on the Medication Administration Record and the Bowel Program Worksheet. Further steps to follow were outlined if the resident continued to not have a bowel movement. Resident #208 Resident #208 was admitted to the facility with the diagnoses of fracture of upper and lower end of left fibula (the long, slender bone located on the outer side of the lower leg), rhabdomyolysis (a serious and potentially life-threatening medical condition involving the rapid breakdown of damaged skeletal muscle) and hypertension (high blood pressure). The Minimum Data Set (an assessment tool) dated 06/05/2026 documented the resident could make themselves understood and understand others and had intact cognition. Record Review: The Comprehensive Care Plan with focus constipation initiated 06/01/2026 documented Resident is at risk for constipation related to decreased mobility. Goal was documented as Resident will have a normal bowel movement at least every one to three days through the review date. Interventions initiated 06/01/2026 included: Administer bowel medication per physician orders, follow facility protocol for bowel management, and record bowel movement pattern each day. Describe amount and consistency. Review of Certified Nurse Aide documentation for Bowel Task Sheet documented the following: On 06/03/2026 at 9:30 PM, Resident #208 had a medium sized bowel movement. On 06/04/2026 at 5:35 AM and 7:45 PM, Resident #208 was documented to not have a bowel movement. On 06/05/2026 at 5:23 PM, Resident #208 was documented to not have a bowel movement. At 9:24 PM, not applicable was documented regarding size of bowel movement. On 06/06/2026 at 4:33 AM, Resident #208 was documented to not have a bowel movement. At 10:46 PM, not applicable was documented regarding size of bowel movement. On 06/07/2026 at 6:19 AM and 2:06 PM, Resident #208 was documented to not have a bowel movement. At 9:30 PM, not applicable was documented regarding size of bowel movement. On 06/08/2025 at 5:01 AM, Resident #208 was documented to not have a bowel movement. At 2:33 PM, it was documented that the resident had a large bowel movement. Review of the Medication Administration Record documented a physician order for magnesium hydroxide give 30 cubic centimeters (cc) by mouth every 24 hours as needed for constipation as per bowel program, Day #3 of no bowel movement. Give on 3:00PM- 11:00PM shift. This medication was not marked as administered to the resident on 06/03/2026 through 06/08/2026. Interviews: During an interview on 06/08/2026 at 12:58 PM, Resident #208 stated they were having issues with constipation, and it has been a couple of days since they had a bowel movement, but they were not sure exactly how long it has been. They stated they were (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only provided with prune juice to help with constipation, and they were not given any other medications or treatments for constipation. During an interview on 06/11/2026 at 11:18 AM, Certified Nurse Aide #8 stated aides were expected to document in the electronic health record on bowel movements for the residents on their assignment each shift, even if the resident did not have a bowel movement. They stated they documented what size bowel movement the resident had. They stated the nurses could see in the electronic health record if a resident has not had a bowel movement in three days, and then the nurses initiated the bowel protocol. During interviews on 6/11/2026 at 12:30 PM and 06/12/2026 at 10:07 AM, Licensed Practical Nurse #9 stated certified nurse aides documented daily if residents had a bowel movement. If after three days there were no bowel movements documented for a resident, they started the bowel protocol. They stated it was not documented that Resident #208 had a bowel movement on 06/04/2026 through 06/07/2026. After reviewing their electronic health record, there was no documentation the bowel protocol was initiated for this resident. They would have expected the bowel protocol to have been initiated for Resident #208. During an interview on 06/12/2026 at 2:34 PM, Director of Nursing #1 stated the bowel protocol was initiated after a resident did not have a bowel movement for three days. After the third day of the resident not having a bowl movement, magnesium hydroxide was administered to the resident on the evening shift. Residents had standing orders for the bowel protocol. Resident #12 Resident #12 was admitted to the facility with diagnoses of bipolar disorder, in partial remission, most recent episode hypomanic (chronic mental health condition characterized by extreme mood fluctuations), anxiety disorder (common mental health condition that involves excessive fear, worry, or nervousness that interferes with daily life), and infection and inflammatory reaction due to indwelling urethral catheter (a tube inserted through the urethra into the bladder to drain urine, prolonged use can lead to infection and inflammatory reactions). The Minimum Data Set, dated [DATE], documented that the resident could usually be understood, could understand others, and was mildly cognitively impaired. The facility policy titled Notification of Change in Resident/Patient Condition reviewed 09/2025, documented the Registered Nurse and/or Nursing supervisor where responsible to timely notify the practitioner regarding an acute change of condition, including the change in health condition of a resident. Record Review: Progress Note title Visit Encounter by Nurse Practitioner #1 dated 10/08/2025, documented a visit for drainage at super-pubic catheter site. The resident's family member was consulted via telephone and reported to Nurse Practitioner #1 on 10/06/2025 they had reported to the nurse there was drainage with blood tinge present on the dressing. They then removed the dressing and noted foul smelling blood-tinged purulent drainage at site. They then ordered a culture to be obtained the site and dressing to be closely monitored with dressing changes as ordered. Review of Facility Incident report documented, Resident #12 had surgical placement of a super-pubic catheter on 09/22/1016, the dressing was changed on 09/29/2025 as ordered and then not changed again until 10/08/2025. Registered Nurse #2 was made aware on 10/06/2025 by a family member of the resident that they were concerned about the surgical site and dressing, the dressing was not changed, and a provider was not notified. A wound culture was ordered for the super-pubic site on 10/08/2025 and was labeled incorrectly by Registered Nurse #2 as the site being right thigh, the culture came back positive for bacteria, however there were concerns about the integrity of the culture. The resident was treated empirically with an antibiotic at that time. Review of Registered Nurse #2 included in the facility investigation documented, Registered Nurse #2 placed orders on 09/26/2025 for Dry gauze over suprapubic catheter site, Change dressing and assess every evening shift for suprapubic catheter site, clean site first and on 10/06/2025 for Dry gauze over suprapubic catheter site, Change dressing and assess every night shift for suprapubic catheter site, clean site first incorrectly causing the order not to be transferred onto the Treatment Administration Record. Review of the Treatment Administration Record for 10/2025, documented: There was no documented evidence or orders (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for super-pubic catheter site dressing changes on Treatment Administration Record 10/2026 for orders placed on 09/26/2025 or 10/06/2026. Dry gauze over suprapubic catheter site, change dressing and assess every shift for suprapubic catheter site for 7 Days, clean site first, was added on 10/08/2025. There was no documented evidence of a dressing change with assessment on 10/10/2025 for the 7 AM-3 PM shift. Interviews: During an interview on 06/10/2026 at 11:27, Registered Nurse #1 stated their recollection of the incident with Resident #12 in October 2025 was an order was placed and not followed for supra-pubic catheter dressing changes and culture specimen was sent to lab with the wrong identification of site. Registered Nurse #2 had entered the orders incorrectly, not flagging them in the treatment administration record for the nurses to follow on their shifts. This caused the start of antibiotics empirically. During an interview on 06/15/2026 at 8:50 AM, Nurse Practitioner #1 stated Resident #12 had a Super-pubic catheter placed in late September of 2025 for recurrent urinary tract infections. The sister reported to them during their visit with the resident regarding changing their status in the facility from rehabilitation to long term care placement, on 10/06/2026 that they spoke with nurse manager about the dressing not being changed and their concerns there was an issue at the site. Nurse Practitioner #1 assessed the super-pubic site and noted dressing with drainage that had not been changed, they then had reported dressing not being changed to nurse manager and Director of Nursing, and had ordered cultures. Their expectation was the nurse manager was to address any issue when brought to their attention then bring to the attention of the Nurse Practitioner in the building as soon as possible, not doing so was a delay in care. Culture expectations where the culture was obtained and labeled correctly, not doing so also caused a delay in care. The resident had a high potential for sepsis after surgery. When they were made aware that the culture was not obtained and labeled properly, they started a broad-spectrum antibiotic empirically. During an interview 06/15/2026 at 11:02 AM, Medical Director #1 stated they would expect all dressing changes to be done as ordered. They were not made aware of the situation with Resident #12 in October and would have expected to have been. Expectation would be when the family member had reported to a nurse the dressing had not been changed, the nurse would change the dressing and monitor the site, as well as notify the Nurse Practitioner in the building immediately. 10 New York Codes Rules and Regulations 415.12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335612	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Baptist Health Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 297 N Ballston Ave 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. Based on observations, interviews, and record reviews conducted during the survey, the facility failed to ensure a medication error rate of less than 5 percent. Specifically, medication error rate was observed to be 12.5 percent. Findings include: The policy and procedure titled Administration of Medications - General, revised 09/2024, stated medications were to be administered within one hour before or after the prescribed time. Resident #116 was admitted to the facility with diagnoses of dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life), anemia (the lack of healthy red blood cells or hemoglobin to carry adequate oxygen to tissues), and essential hypertension (high blood pressure). During an observation on 06/10/2026 at 11:30 AM, Licensed Practical Nurse #3 was observed administering medications scheduled for 9:00 AM at 11:30 AM for Resident #116. The medications were Amlodipine oral tablet 10 milligrams give 1 tablet by mouth one time a day for hypertension at 9:00 AM Sertraline hydrochloride 25 milligrams give 12.5 milligrams one time a day for depression at 9:00 AM Ferrous sulfate 325 (65 Iron) milligrams give 1 tablet by mouth two times a day at 9:00 AM and 6:00 PM Metoprolol tartrate give 12.5 mg by mouth two times a day for atrial fibrillation at 9:00 AM and 6:00 PM. During an interview on 06/10/2026 at 11:30 AM, Licensed Practical Nurse #3 stated the medications were late because they had arrived on shift at 8:30 AM. They stated they guessed they would notify the nurse manager who would notify the provider. They stated they didn't know when they would notify the nurse manager. During an interview on 06/12/2026 at 11:16 AM, Medical Director #1 stated they are notified through text message or phone call if a medication was not available, if it were a new medication that was missed. They stated they were not notified if the medication pass is administered late; they considered that a nursing issue. During an interview on 06/12/2026 at 11:40 AM, Nurse Practitioner #1 stated they had never been notified of a late medication pass or missed medications. During an interview on 06/12/2026 at 2:39 PM, Director of Nursing #1 stated the expectation was that the provider and family would be notified if a medication was late, refused or missed. During an interview on 06/15/2026 at 09:54 AM, Registered Nurse #1 stated they expected to be informed of any late medications, held medications, or unavailable medications. They stated they would then instruct the Licensed Practical Nurse to write a note about the late medications. They stated they would inform the provider if needed. They did not recall being informed of late medications over the last month. During an interview 06/15/2026 11:02 AM, Medical Director #1 stated they were not always notified of late medications, it was documented by the nurse. They expect for one of the Nurse Practitioners to be notified of late medications, and they would be notified if there was an adverse outcome or medications were missed. 10 New York Codes, Rules, and Regulations 415.12(m)(1)		