

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922</p> <p>Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure each resident was treated in a dignified manner for 4 (Resident #'s 46, 57, 59, and 74) of 24 residents reviewed. Specifically, (a.) for Resident #'s 46, 57, and 59, stated staff did not knock on their doors prior to entering their rooms. Specifically, (b.) for Resident #59, staff distributed meals to all residents at each table before serving residents eating in their rooms; and (c.) Certified Nurse Aide #13 delayed assisting the resident with their meal while using their personal phone in the dining room for over 20 minutes; and (d.) for Resident #74's personal items were disturbed by Resident #44.</p> <p>This is evidenced by:</p> <p>Finding #1:</p> <p>The facility did not ensure all residents were served timely at joining tables and that staff engaged with the residents requiring assistance at mealtime.</p> <p>Resident #59:</p> <p>Resident #59 was admitted with diagnoses Non-Alzheimer's Dementia, heart failure (a syndrome caused by an impairment in the heart's ability to fill with and pump blood), and dementia. The Minimum Data Set (an assessment tool) dated 12/16/2024, documented that the resident was rarely understood by others and could rarely be understood with severely impaired for cognition for daily decision making.</p> <p>During an observation on 2/26/2024 at 9:00 AM, Resident #59 was observed sitting at the dining table without any nourishment while other tables and residents were served at their table.</p> <p>During an observation on 2/26/2025 at 9:35 AM, Certified Nurse Aide #13 was observed between two residents in the dining area using their personal phone. Resident #59 required assistance with feeding and had been observed with no food while other resident around them were served for 20 minutes. When the resident's tray was placed in front of them, Certified Nurse Aide #13 continued to be engaged on their cellphone placed under the table on their lap. This continued for 15 minutes until the surveyor asked Certified Nurse Aide #13 who was supposed to assist the resident. Then they began to feed the resident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 9:56 AM, Certified Nurse Aide #13 stated they should not have been using their phone. Residents requiring assistance with meals required full attention. They stated Resident #59 did not eat often and refused most offerings of drinks and food.</p> <p>During an interview on 2/26/2025 at 10:07 AM, Licensed Practical Nurse #7 stated they had not seen the aide using their phone. When staff was supposed to be assisting the residents they were not supposed to be using their phones. The Licensed Practical Nurse #7 stated the residents at the tables should be served before residents were served in their rooms.</p> <p>During an interview on 3/03/2024 at 11:12 AM, Registered Nurse Manager #4 stated no one should be using their phones in the dining room and the staff would need to be reeducated.</p> <p>Finding #2:</p> <p>Resident #46:</p> <p>The resident was admitted with diagnoses Non-Alzheimer's Dementia, heart failure (a syndrome caused by an impairment in the heart's ability to fill with and pump blood), and anemia. The Minimum Data Set, dated dated [DATE], documented the resident was understood and could understand others with intact cognition for daily decision making.</p> <p>During an observation on 2/26/2025 at 9:45 AM, Certified Nurse Aide #12 walked into the resident's room without first knocking on the resident's door.</p> <p>During an interview on 2/26/2025 at 9:55 AM, Certified Nurse Aide #12 stated they usually knocked when they entered into the room to get the food trays if the door was closed.</p> <p>During an interview on 2/27/2025 at 10:12 AM, Resident #46 stated the staff usually do not knock before entering their room. They stated they participated in resident council and had reported this, but it continued. They stated there were lots of new staff and some were respectful, but others did not treat the residents with the dignity they deserved. The resident stated they reported it to the nurse if residents got disrespected and they tried to watch out for the residents that were confused and could not speak for themselves.</p> <p>During an interview on 3/03/2024 at 11:23 AM, Registered Nurse Manager #4 stated staff should be knocking on the doors prior to entering the resident's room. Staff should be knocking on doors even if the door is opened and even if a resident has impaired cognition.</p> <p>Resident #57</p> <p>Resident #57 was admitted to the facility with diagnoses Non-Alzheimer's Dementia, peripheral vascular disease (a disease or disorder of the circulatory system outside of the brain and heart) with a vascular wound to the right foot, and anemia. The Minimum Data Set, dated dated [DATE], documented the resident was understood and could understand others with severely impaired cognition for daily decision making.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/28/2025 at 10:45 AM, Certified Nurse Aide #8 and Licensed Practical Nurse #7 provided care to Resident # 57. Certified Nurse Aide #8 assisted Licensed Practical Nurse #7 in providing care. The Certified Nurse Aide #8 and Licensed Practical Nurse #7 entered the room without knocking or announcing themselves to the resident room to provide care to the resident</p> <p>During an interview on 2/28/2025 at 11:07 AM, Certified Nurse Aide #8 stated they should have knocked before entering the room.</p> <p>During an interview on 2/28/2025 at 11:22 AM, Licensed Practical Nurse #7 stated they tried to remember to knock but they got rushed and forgot.</p> <p>During an interview on 3/03/2025 at 1:57 PM, Registered Nurse #4 stated staff should knock prior to entering the resident's room. Staff would need to be reeducated.</p> <p>Resident #74</p> <p>Resident #74 was admitted with diagnosis of achalasia (a rare swallowing disorder that affects the esophagus); aphasia (a disorder that affects how you communicate. It can impact your speech, as well as the way you write and understand both spoken and written), and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set, dated dated dated [DATE], documented cognitive patterns could not be assessed. Resident able to nod and shake head for yes/no questions.</p> <p>During an interview on 2/26/2025 at 12:13 PM, Resident Representative #3 stated Resident #44 frequently wanders into Resident #74's room. They were concerned since Resident #74 was non-verbal that Resident #74 would not be able to call for help and or may have tube feedings pulled out by Resident #44. Resident Representative #3 stated on 2/23/2025, Resident #44 wandered into Resident #74's room and pulled out garbage, personal books, magazines, and plants. Resident #44 then left the room and closed the door. The incident was discovered when Resident Representative #3 came in for a visit. Resident Representative #3 reported the incident to Certified Nurse Aide #7 who appeared to be aggravated by the report and stated there was nothing that could be done as this was a dementia unit. They stated a red Stop Sign was subsequently placed but Resident #44 continues to enter the room.</p> <p>During an interview on 2/26/2025 at 12:32 PM, Administrator #1 stated they had tried several different things with Resident #44 to kept them engaged. They were working with the Alzheimer's Association on a sensory room. They stated Resident #44 was redirected by staff.</p> <p>10 New York Codes Rules and Regulations 415.3(c)(1)(i)</p> <p>51317</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413</p> <p>Based on record review and interview during the recertification and abbreviated survey (Case #s, NY00319900 and NY00344983), the facility did not ensure each resident's right to be free from neglect for 2 (Resident #s 53 and 112) of 7 residents reviewed for abuse/neglect. Specifically, (a.) for Resident #53, the resident had a fall out of bed with injuries and staff did not follow the care plan by placing the fall mats next to the resident's bed. Specifically, (b.) Resident #112 had a fall on 5/31/2024 and complained of back pain post fall and X-ray was ordered . Assistant Director of Nursing #2 reviewed the radiology report, which verified the resident had a thoracic (back) #12 vertebrae fracture (bone break), but documented that there was no fracture. This delayed care necessary to avoid the resident's pain.</p> <p>This is evidenced by:</p> <p>Resident #53</p> <p>Resident #53 was admitted to the facility with orthostatic hypotension (low blood pressure might cause dizziness, lightheadedness or fainting when rising from sitting or lying down), atrial fibrillation (an irregular and often very rapid heart rhythm), and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set (an assessment tool) dated 11/29/2024 documented Resident #53 had severe cognitive impairment, could be understood, and understand others.</p> <p>The Comprehensive Care Plan for Safety Awareness, dated 7/07/2022, documented Safety awareness deficit related to history of falls, weakness, orthostatic hypotension, episodic dizziness, & age-related changes. The Comprehensive Care Plan and Certified Nurse Aide care card dated 4/23/2023 documented the following interventions for safety awareness: bed next to the wall to maximize living space, toilet every 2-4 hours and as needed, provide verbal cues for safety, encourage resident to call for all needs, nonskid socks when in bed, gray fall mat at bedside, and place bed in lowest position.</p> <p>The facility's Investigative Report dated 7/11/2023 documented Resident #53 had a fall from bed on 7/10/2023, which resulted in a skin tear to right arm, bruising and swelling to face. Certified Nurse Aide #6 provided bedtime care to Resident #53 on the evening of 7/10/2023. Certified Nurse Aide #6 stated they did not follow the care plan and place the fall mattress at bedside after they assisted Resident #53. Certified Nurse Aide #6 was terminated on 7/14/2023 for Neglect, not following the care plan that resulted in an injury to the resident's arm, head and back.</p> <p>Resident #112</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #112 was admitted to the facility with diagnoses of dementia without behavioral disturbance (cognitive decline related to memory, thinking, and reasoning, but does not exhibit any noticeable behavioral changes like agitation, aggression, paranoia, or mood swings), benign neoplasm of the brain (a non-cancerous tumor that grows within the brain), and age-related osteoporosis without fractures (a condition that weakens bones and increases the risk of fractures). The Minimum Data Set, dated dated dated [DATE], documented that the resident could usually be understood and usually understand others and had significant impaired cognition for daily living decisions.</p> <p>A review of progress notes dated 6/01/2024 at 10:26 PM written Assistant Director of Nursing #2 documented x-ray results had been received for spine and hip. Assistant Director of Nursing #2 documented that both were negative for acute fractures, but did show degenerative changes. They further documented that they notified Medical Doctor, no new orders at that time.</p> <p>A review of the facility's reported incident dated 6/11/2024 documented that the resident had a fall on 5/31/2024 and a complaint of back pain status post fall. Radiology report after x-ray received on 6/01/2024. Assistant Director of Nursing #2 reported and documented that the x-rays were negative for fractures. Resident was continuously complaining of back pain and was seen by the Nurse Practitioner, who reviewed the radiology report and found that the resident had a confirmed fracture of thoracic #12 vertebrae.</p> <p>A review of the corrective action report dated 6/11/2024 conducted by Director of Nursing #1 documented that Assistant Director of Nursing #2 stated that they were not sure if they even looked at the diagnostic report, even though they signed the report. They further noted that the family was never notified of the resident's change in condition, which caused a delay in patient services as well as pain management for the resident.</p> <p>A review of the medical provider progress notes date 6/04/2024 at 1:24 PM documented that Nurse Practitioner #1 saw resident for complaint of back pain. Nurse Practitioner #1 ordered Lidoderm patch and morphine 2.5 milligrams by mouth every 4 hours as needed.</p> <p>During an interview on 3/04/2024 at 11:16 AM, Director of Nursing #1 stated that the Assistant Director of Nursing #2 did document in the resident's medical record that the resident's x-rays were negative for fracture when it had been documented that they did have a confirmed fracture of thoracic #12 vertebrae.</p> <p>10 New York Codes, Rules and Regulations 415.4(b)(1)(i)</p> <p>48615</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>48615</p> <p>Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure assessments were coordinated with the Pre-Admission Screening and Resident Review (PASARR) program under Medicaid for 1(Resident #78) of 24 residents reviewed. Specifically, Resident #78 with a new diagnosis of a serious mental disorder was not referred for a PASARR Level II Evaluation.</p> <p>This is evidenced by:</p> <p>The facility's Policy and Procedure titled, Pre-Admission Screening and Resident Review (PASSAR), effective 9/10/2022, documented All individuals seeking admission will undergo a PASRR Level I screening prior to admission to determine if they have a mental illness or intellectual disability. Screening would be conducted in accordance with New York State Department of Health guidelines and Centers for Medicare and Medicaid Services regulations. Level II Evaluation: If the Level I screening indicates potential mental illness or intellectual disability, a Level II evaluation would be completed by a qualified mental health professional. The evaluation would assess the individual's needs, preferences, and the appropriateness of nursing facility placement.</p> <p>Resident #78 was admitted to the facility with primary diagnoses of chronic obstructive pulmonary disease (restricted airflow and breathing problems); dementia (loss of memory, language, problem-solving and other thinking abilities); and Bipolar I (a mental health condition that causes extreme mood swings). The Minimum Data Set (an assessment tool) dated 1/24/2025 documented Resident #78 had severe cognitive impairment, could be understood, and understand others. The Minimum Data Set Admission Assessment Signed 11/07/2023 at 07:44:06 AM documented an active diagnosis of Bipolar I.</p> <p>The Comprehensive Patient Centered Care Plan for Psychotropic Medication dated 1/12/2023, documented resident was taking psychoactive medications for symptoms/diagnosis of bipolar disorder, depression, anxiety and skin picking disorder.</p> <p>A SCREEN dated 01/09/2023 documented that Resident #78 did not have a diagnosis of a serious mental illness.</p> <p>Psychiatry consults dated 2/17/2023, 3/24/2023, 6/16/2023, 9/12/2023, 2/27/2024, 5/21/2024 8/13/2024, and 12/03/2024 documented resident had diagnosis of major depressive disorder, recurrent, moderate ICD-9 (the official system of assigning codes to diagnoses and procedures) code F33.1 and Bipolar disorder, unspecified F31.9. Continued medication regime. Gradual dose reduction not recommended at this time.</p> <p>During an interview on 02/28/2025 at 11:35 AM. Social Worker #1 stated when a resident is admitted from hospital, it was the hospital's responsibility to complete the Pre-Admission Screening and Resident Review (PASSAR). The accepting facility's admission department would then review the screen. Social Worker #1 stated they believed a Level II screen should have been initiated if a resident was diagnosed with a serious mental illness after admission to a skilled nursing facility.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10 New York Codes, Rules, and Regulations 415.11(e)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922</p> <p>Based on observation, record review, and interviews conducted during a recertification and abbreviated survey (case #'s NY00319900, NY00349063, and NY00372837), the facility did not develop and implemented a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframe's to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment for 8 (Residents #s 20, 22, 46, 57, 101, 109, 113, and,114) of 24 residents reviewed for Care Plans. Specifically, (a.) for Resident #20, oxygen administration was not implemented according to the resident's care plan; (b.) for Resident #22, the right blue [NAME] posey splint was not consistently applied as indicated in the Resident's Comprehensive Care Plan; (c.) for Resident #46 did not have a care plan in place that addressed their incontinence concerns; (d.) for Resident #57, a Comprehensive Care Plan for hospice was not implemented when the resident transitioned to Hospice care after a significant change in condition on 2/06/2025; (e.) for Resident #101 who was dependent for all care due to quadriplegia that a care plan for potential victim of abuse was not developed and implemented at the time of admission and when an allegation of abuse after the Resident #101 reported verbal abuse and rough treatment on 1/03/2025; (f.) Resident #109 did not have a care plan in place for aggressive behavior for documented history of aggressive behavior; (g.) Resident #113 care plan was not implemented for their aggressive behaviors; and (h.) Resident #114 did not have a care plan developed and implemented for a new wound.</p> <p>This is evidenced by:</p> <p>A facility policy titled Interdisciplinary Care Conference and Care Planning effective 6/27/2023 documented it is the policy of the facility to develop a baseline interdisciplinary, resident centered plan of care within 48 hours of admission and a comprehensive resident centered plan of care within 14 days of admission and provide follow-up evaluation based on admission/readmitted s or a significant change in condition. The purpose of this policy was to promote effective and person-centered care, continuity of care, communication among nursing facility staff, increase resident safety, and safeguard against adverse events that are most likely to occur in the transition between levels of care or providers. At a minimum the baseline care plan would include healthcare information necessary to properly care for each resident immediately upon admission and address resident-specific health and safety concerns. The plan would include initial goals, physician orders, medications, dietary orders, therapy orders, social services, and any applicable preadmission screening and resident review recommendations. A comprehensive care plan would be completed within 7 full days of the initial comprehensive assessment. The results of the assessment would be used to update the baseline plan of care. The plan would be updated quarterly and with any significant change thereafter.</p> <p>Resident #22</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #22 was admitted to the facility with diagnoses of hemiplegia and hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body) following cerebrovascular disease affecting right non-dominant side, intracranial hemorrhage (a life-threatening medical emergency that occurs when blood leaks inside or between the brain and skull), and type 2 diabetes mellitus (a chronic condition that happens when a person has persistently high blood sugar levels). The Minimum Data Set (an assessment tool) dated 1/10/2025 documented the resident had moderate cognitive impairment, could be understood, and understand others.</p> <p>Comprehensive Care Plan with focus Alteration in Mobility related to neurologic condition, cerebral vascular accident, balance deficits, and femur fracture initiated 5/21/2015 revised 9/22/2022 documented an intervention Apply right blue [NAME] posey in the morning and remove before bed.</p> <p>During an observation on 2/25/2025 at 11:07 AM, Resident #22 was dressed and out of bed sitting in their wheelchair. There was no splint on their right arm.</p> <p>During an observation and interview on 2/26/2025 at 10:03 AM, Resident #22 was dressed and out of bed sitting in their wheelchair. There was no splint on their right arm. When Resident #22 was asked if staff put a splint on their right arm, they said no. When Resident #22 was asked if staff was supposed to put a splint on her right arm they responded yes.</p> <p>During an observation on 2/28/2025 at 10:19 AM, Resident #22 was dressed and out of bed sitting in their wheelchair. There was no splint on their right arm.</p> <p>Bedside Kardex (resident care card followed by Certified Nurse Aides) Report dated 2/27/2025 documented under Activities of Daily Living Apply right blue [NAME] posey in morning and remove before bed.</p> <p>\</p> <p>During an interview on 2/28/2025 at 10:20 AM, Certified Nurse Aide #4 stated Resident #22 had a splint for their right arm/hand. It goes between their fingers, but it was not applied this morning as they could not locate it. They stated they put it in the chart that they did not apply the splint, but they did not tell anyone. They stated they would tell the Registered Nurse Unit Manager #1.</p> <p>During an interview on 2/28/2025 at 11:03 AM, Licensed Practical Nurse #1 stated Resident #22 had a splint for their right arm, but Resident #22 did not like to wear it and they usually refused to wear it. They stated currently, there was no splint on Resident #22's right arm and Resident #22 usually did not wear any splint on their right arm. They stated they were not prompted by the computer to check to see if Resident #22 was wearing a splint on their right arm.</p> <p>During an interview on 2/28/2025 at 1:30 PM, Director of Nursing #1 stated splints should be applied or removed according to what was written on the resident's Kardex (resident care card used by certified Nurse Aides) and care plan.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/28/2025 at 11:30 AM and 3/03/2025 at 1:07 PM, Registered Nurse Unit Manager #1 stated Resident #22 had a care plan for a splint to be applied to their right arm each day to keep their hand open and it was removed at bedtime, but the resident did not like to wear it, and they would take it off. They stated Resident #22 would hide the splint. When asked why it was marked that the Certified Nurse Aides applied the splint but Resident #22 was observed without the splint, Registered Nurse Unit Manager #1 stated Resident #22 may have removed the splint. They had removed the splint in the past and placed it in the garbage. They stated an assessment to determine why Resident #22 removed the splint had not been completed, and there was no care plan or documentation that stated Resident #22 had refused to wear the splint or removed the splint on their own after it was applied by staff.</p> <p>Resident #57</p> <p>Resident #57 was admitted to the facility with diagnoses Non-Alzheimer's Disease (cognitive disorder that causes decline in memory thinking and behavior, malnutrition (state of poor nutritional status), and anxiety (intense, excessive, persistent worry and fear about everyday situations). The Minimum Data Set, dated dated [DATE] documented the resident was understood and could understand others with severely impaired cognition for daily decision making.</p> <p>Comprehensive Care Plans reviewed on 3/03/2025 did not document a care plan was developed and implemented for Hospice care that began on 2/06/2025.</p> <p>Record Review on 3/03/2025 documented Resident #57 was admitted to Hospice per the family wishes on 2/07/2025.</p> <p>During an interview on 3/03/2025 at 9:30 AM, Hospice Registered Nurse #1 stated that the resident had been placed on hospice care on 2/07/202 after evaluation for a decline in condition. The resident had been at the facility for a few years and the family wanted to discontinue medications and therapy that had not proved helpful. Transitioning to hospice care was in the facility's contract with the Hospice Provider. The facility continued providing monitoring and notified the hospice provider with changes and took orders for medications from the hospice providers. The facility continued to care plan the resident at the direction of the hospice provider.</p> <p>During an interview on 3/04/2025 at 9:45 AM, Registered Nurse Unit Manager #1, stated they reviewed the comprehensive Care Plans for Resident #57 and could not provide a Hospice Comprehensive Care Plan. They stated once the resident transitioned to Hospice a care plan should have been developed and implemented within 14 days as many things change with care, hospitalization , treatments, labs, and medications.</p> <p>Resident #101</p> <p>Resident #101 was admitted to the facility with diagnoses of Guillain-Barre syndrome (a condition in which the immune system attacks the nerves) with resulting paralysis of lower and upper extremities, malnutrition (state of poor nutritional status), and anxiety (intense, excessive, persistent worry and fear about everyday situations). The Minimum Data Set, dated dated [DATE], documented the resident was understood and could understand others with intact cognition for daily decision making.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review on 2/27/2025 demonstrated Resident #101 had no person-centered comprehensive care plan for at risk of abuse and had no comprehensive care plan implemented once they reported concerns with care that include profanity by Certified Nurse Aide #5 along with rough treatment on 1/03/2025.</p> <p>Residents #101 Care Plan reviewed on 2/27/2025 documented that on 1/02/2025 the resident was a two person assist and required the use of a baby monitor to be able to communicate with staff for assistance.</p> <p>The facility investigation summary documented the investigation was started on 1/06/2025 at 10:50 AM. The report documented Resident #101 had episodes of uncontrollable diarrhea. Certified Nurse Aide #5 upon responding to the resident to provide care used profanity upon discovery of the incontinence. The Certified Nurse Aide #5 cleaned the resident and the resident reported they handled them roughly while providing that care. The aide did not enlist the help of any other staff.</p> <p>The was no documented evidence that a care plan for abuse was developed and implemented when Resident #101 made an allegation of abuse on 1/03/2025.</p> <p>During an interview on 2/28/2025 at 3:15 PM, Resident #101 stated they had felt frightened and [NAME] with care due to the inability to move from their paralysis. They stated they had discussed this with Social Worker #1 on 1/03/2025 and again with Administrator #1 and Director of Nursing #1 on 1/06/2025. They had assured the resident that Certified Nurse Aide #5 would not care for them again. Resident #101 stated their condition still left them with fear and anxiety and at risk to be a victim of mistreatment.</p> <p>During an interview on 3/03/2025 at 11:30 AM, Registered Nurse #101 stated there should have been a comprehensive care for at risk for abuse given the level of their disability. The resident was unable to care for themselves and had difficulty in using a call bell and low vocalization. The resident had a concern with a staff and expressed rough treatment which should have been addressed by the social worker to develop and implement a care plan for victim of abuse.</p> <p>10 New York Code of Rules and Regulations 415.11(c)(1)</p> <p>48413</p> <p>51317</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>48413</p> <p>Based on observations, record review, and interviews conducted during a recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised by interdisciplinary team after each assessment based on changing goals, preferences, and needs of the resident and in response to current interventions for 1 (Resident #20) of 3 residents reviewed. Specifically, for Resident #20, the Comprehensive Care Plan for Respiratory Therapy was not reviewed and revised to include changes in the resident's oxygen liter flow to reflect the medical order.</p> <p>This is evidenced by:</p> <p>A review of the facility policy titled Oxygen Administration dated 01/2019 documented the facility was to provide oxygen by oxygen mask/cannula to residents with deficiencies or abnormalities of pulmonary function, to prevent or reverse hypoxia, and improve tissue oxygenation. The procedure documented that the tubing was to be attached, labeled, and dated, as well as following the orders for oxygen in the electronic record system to guide staff.</p> <p>Resident #20 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), dependence on supplemental oxygen, and coronary atherosclerosis (damage or disease in the heart's major blood vessels usually cause by the buildup of plaque causing the coronary arteries to narrow, limiting blood flow to the heart). The Minimum Data Set (an assessment tool) dated 11/22/2024, documented that the resident could be understood and understand others and had moderately impaired cognition for daily living decisions.</p> <p>During an observation on 2/25/2025 at 11:16 AM, the resident was receiving oxygen at 4.5 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen).</p> <p>During an observation on 2/27/2025 at 9:45 AM, the resident was receiving oxygen at 4.5 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen).</p> <p>During an observation on 2/28/2025 at 12:01 PM, the resident was receiving oxygen at 4.5 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen).</p> <p>A review of Resident #20's medical orders documented that the resident was to receive oxygen at 2 liters per minute via nasal cannula (a device that gives additional oxygen through the nose) continuously, every shift.</p> <p>A review of Resident #20's Treatment Administration Record dated February 2025, documented that the oxygen was being checked daily, and the resident was on 2 liters via nasal cannula.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident #20 Care Plan created by Assistant Director of Nursing #1 dated 4/19/2024 documented the resident had shortness of breath related to chronic obstructive pulmonary disease and pleural effusion (a buildup of fluid between the tissues that line the lungs and chest) and wears continuous oxygen at 3 liters per minute via nasal cannula.</p> <p>During an interview on 2/28/2025 at 12:31 AM, Licensed Practical Nurse #3 stated that they believed the order for the residents' oxygen was at 3 liters per minute. When they had looked at the order in the medical records, they corrected themselves and stated the order was 2 liters per minute. The surveyor discussed their findings dated 2/25/2025, 2/27/2025, and 2/28/2025. Upon showing Licensed Practical Nurse #3 Resident #20's oxygen concentrator set at 4.5 liters, they had stated that the concentrator should have been set at the resident's ordered amount of 2 liters Licensed Practical Nurse stated that the orders and the care plan for residents should match and be updated whenever there was a change to the residents' status.</p> <p>During an interview on 3/04/2025 at 09:50 AM, Assistant Director of Nursing #1 stated that they would expect the nursing staff to know the orders and review the orders daily in case there was a change. They had stated that the nursing staff verified that the resident was receiving the right amount of oxygen that was ordered by the physician. If the resident was not on the correct amount, they stated that the staff should be in contact with the physician to determine if a change was made and not updated in the electronic medical records. They stated that once that was completed, the resident should be adjusted to the appropriate level of oxygen ordered by the physician. The surveyor had discussed their findings dated 2/25/2025, 2/27/2025, and 2/28/2025. Assistant Director of Nursing #1 stated that the oxygen administration was inappropriate for the residents and could be harmful if not corrected by the staff.</p> <p>During an interview on 3/04/2025 at 10:15 AM, Director of Nursing #1 stated that nursing staff should be closely monitoring the correct amount of oxygen being given to residents. They stated that staff should be following the orders provided by the physician, and if there were any exceptions, staff should be contacting the physician for clarification. They stated that care plans need to be revised whenever there was a change in the resident's status.</p> <p>10 New York Code of Rules and Regulations 483.21 (b)(2)(iii)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observations, interviews, and record review during the recertification survey, the facility did not ensure dependent residents was provided with appropriate treatment and services to maintain or improve their language and communication for 2 (Resident #s 13 and 74) of 5 residents reviewed. Specifically, (a.) for Resident #13, nursing staff did not ensure there was consistent access to their communication dry/erase board so staff could use it to write down what they wanted to express as Resident #13 had hearing loss, and for (b.) Resident #74, who was nonverbal, communication board was not used to allow resident to express their wants and needs.</p> <p>This is evidenced by:</p> <p>Facility's Policy titled Effective Communication with Residents with Hearing, Vision and Verbal Impairments effective 2023 documented the purpose of the policy was to ensure all residents including those with vision, hearing, and verbal impairments receive respectful and appropriate communication that supports their well-being and dignity. When communicating with residents with hearing impairments, use written communication when necessary, including large print notes, communication boards, dry-erase boards, or any assistive materials that best allows the resident to understand your communication. When communicating with residents with verbal impairment, use alternative methods, such as writing, gestures, communication boards, or any assistive materials that best allows the resident to understand your communication.</p> <p>Facility's Policy titled Communication Strategies (undated) documented establishment of functional communication was a goal of care.</p> <p>Resident #13</p> <p>Resident #13 was admitted to the facility with diagnoses of traumatic subdural hemorrhage with loss of consciousness (a serious medical condition where blood collects beneath the outermost membrane surrounding the brain), paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hearing loss. The Minimum Data Set (an assessment tool) dated 11/29/2024 documented Resident #13 had severe cognitive impairment, they could be understood and, could usually understand others. The Minimum Data Set documented Resident #13's hearing was highly impaired (absence of useful hearing) and they did not use a hearing aid or other hearing appliance.</p> <p>Comprehensive Care Plan with focus Resident #13 is pleasantly confused, very hard of hearing, but it very active in most activities initiated 09/28/23 documented an intervention: Resident #13 needed help at times with communication and needed a white board with staff writing notes for clarification.</p> <p>Comprehensive Care Plan with focus Alteration in communication related to hearing loss initiated 9/22/23 documented use communication board as an intervention.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Kardex (Certified Nurse Aide care card for resident) dated 2/27/2025 documented for sensory/communication use communication board and use communication board to write out what you would like me to know. Speak slow and simple directions.</p> <p>During an observation and an interview on 2/25/2025 at 12:59 PM, Resident #13 was eating in the dining room. The surveyor approached Resident #13 and attempted to converse with them. Resident #13 stated to surveyor, I'm partially deaf. Licensed Practical Nurse #2 stated Resident #13 used a communication board (white dry/erase board) and staff wrote on it for Resident #13 to read. The board was not with Resident #13. The surveyor asked Licensed Practical Nurse #2 to locate the board. Licensed Practical Nurse #2 went into Resident #13's room and stated they could not locate the board.</p> <p>During an observation on 2/26/2025 at 9:51 AM, Resident #13 was in their wheelchair in the common area known as the [NAME] Room Resident #13's communication board was not with them.</p> <p>During an interview on 2/28/2025 at 12:20 PM, Certified Nursing Aide #4 stated they were not aware of a communication board or white board that was used to communicate with Resident #13. They stated they they had not used one when communicating with the resident as they got close to Resident #13's ear.</p> <p>During an interview on 2/28/2025 at 11:03 AM, Licensed Practical Nurse #1 stated they used hand signaling when communicating with Resident #13 because Resident #13 could not hear. They stated Resident #13 had a white board in their room, but Resident #13 did not spend a lot of time in their room as they liked to be out around others. Licensed Practical Nurse #1 stated they would not have had access to Resident #13's communication board if they needed to converse as the board was in the resident's room but the resident was not in their room. Licensed Practical Nurse #1 stated they would need to walk away from Resident #13 to go to their room to retrieve the communication board for it to be used.</p> <p>During an interview on 2/28/2025 at 11:30 AM, Registered Nurse Unit Manager #1 stated they used a dry erase board to assist with communicating with Resident #13. The board was typically kept in the dining room or activities, but it was not the best way to make sure a board was always with the resident. It would have been better to keep the board attached to the resident's wheelchair.</p> <p>During an interview on 2/28/2025 at 1:30 PM, Director of Nursing #1 stated the communication board should be used as stated on the care plan and Kardex (Certified Nurse Aide care card for resident) when communicating with Resident #13. The board should have been available for the staff to use wherever the resident went, and the resident should be able to take the board with them. If the board was not with the resident, staff should go and get it. It would have been easier if the board had stayed with the resident.</p> <p>Resident #74</p> <p>Resident #74 was admitted to the facility with diagnoses of achalasia (a rare swallowing disorder that affects the esophagus), aphasia (a disorder that affects how you communicate. It can impact your speech, as well as the way you write and understand both spoken and written language), and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set, dated dated dated [DATE] documented resident was unable to complete, and cognitive patterns could not be assessed. Resident was able to nod and shake head for yes/no questions.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The Communication Comprehensive Care Plan titled Alteration in Communication related to dementia, hearing loss, and aphasia, uses one-word response to yes/no questions, dated 07/08/2024 documented s. resident can respond to you by shaking head yes or no. Use simple yes/no questions in order to effectively communicate with resident. Present Picture Communication Board (at bedside) for ease of facilitation of communication among resident and caregivers.</p> <p>During an interview on 2/28/2025 at 11:40 AM, Resident Representative #3 stated Resident #74 was nonverbal. They stated that the resident could understand but was unable to speak. Resident #74 was provided with an 8 x10 paper communication sheet in a plastic sleeve. Items were small, cumbersome, and difficult to identify. Resident Representative #3 stated this communication sheet was not used. The communication sheet was observed across room, underneath other objects.</p> <p>During an interview on 3/03/2025 at 11:24 AM, Certified Nurse Aide #7 stated it was difficult to communicate with Resident #74 due to their nonverbal status. They stated Resident #74 was unable to make their needs known. Certified Nurse Aide #7 stated they tried to ask closed ended yes/no questions, but most of the time they communicated based on resident's facial expressions. Certified Nurse Aide #7 was not aware a communication board was to be used.</p> <p>During an interview on 3/03/2025 at 11:49 AM, Speech Language Pathologist #1 stated Resident #74 was nonverbal and no longer received speech language therapy. Based on an assessment, the resident had plateaued. The primary focus of therapy had been to provide an alternative method of communication, such as picture board and/or alphabet board. No other modalities had been explored. They were not aware the picture board was not in use.</p> <p>10 New York Codes, Rules, and Regulations 415.12(a)(2)</p> <p>51317</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observation, record review, and interviews during the recertification survey, the facility did not ensure a resident who was unable to carry out activities of daily living received the necessary services to maintain good grooming, personal and oral hygiene for 1 (Resident #74) of 24 residents reviewed. Specifically, Resident #74 was observed in bed, without morning care provided on two separate dates, 2/28/2025 and 3/03/2025 at 11:10 AM and 10:20 AM respectively, while other residents on the unit were attending meals and activities.</p> <p>This is evidenced by:</p> <p>The facility's Policy and Procedure titled Resident's Rights, effective 5/28/2024, documented that the resident had the right to be dressed in clothing, accessories, or cosmetics that were permitted for other residents. The resident had the right to choose activities, schedules (including sleeping and waking times), healthcare and providers of healthcare consistent with his or her interests, assessments, and plan of care.</p> <p>Resident #74 was admitted to the facility with diagnoses of achalasia (a rare swallowing disorder that affects the esophagus), aphasia (a disorder that affects how you communicate. It can impact your speech, as well as the way you write and understand both spoken and written language), and dementia (loss of memory, language, problem-solving and other thinking abilities). The Minimum Data Set, dated dated [DATE] documented resident was unable to complete, and cognitive patterns could not be assessed. Resident was able to nod and shake head for yes/no questions.</p> <p>The Comprehensive Care Plan for Activities of Daily Living, dated 1/02/2025, documented actual impaired ability to perform Activities of Daily Living (Bathing, Grooming, Dressing, Mouth Care) due to balance problems, limited range of motion, weakness, dementia and anxiety. The interventions included: Hand roll in the right hand after morning care to assist with prevention of contractures. Wear Right hand roll at all times and take off for morning care. Resident on Tube feed. Resident preferred to be out of bed by 09:30-10:00 every day in the morning and dressed. May place in recliner chair daily. Resident required a complete one person assist .</p> <p>During an observation on 2/28/2025 at 11:10 AM, Resident Representative #1 arrived and found Resident #74 still in bed, wearing nightclothes. Tube feed bottle was at the bedside, half completed. Resident Representative #1 located Assistant Director of Nursing #1, who then located 2 Certified Nurse Aides for assistance. It was also observed that other residents on unit were attending BINGO or watching television in common area.</p> <p>During an observation on 3/03/2025 at 10:20 AM, Resident #74 was noted to still be in bed, wearing overnight clothing.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/26/2025 at 11:33 AM, Resident Representative #1 stated, Resident #74 got up after 10:00 AM, then back to bed about 8:30 PM. They stated they had discussions with staff about getting resident up early, as resident preferred to be up early. Staff were receptive with a plan to have resident out of bed no later than 10:00 AM. After conversations, they arrived a couple of times still found Resident #74 in bed after 11:00 AM. Resident Representative #1 stated they had to remind staff to place dentures and brush teeth for Resident #77.</p> <p>During an interview on 2/28/2025 at 12:18 PM, Assistant Director of Nursing #1 stated resident's tube feed had been disconnected. The unused portion should have been discarded. They stated they were not aware which certified nurse aide was assigned to Resident #74. Certified Nurse Aide #7 interjected and stated they were assigned to Resident #74. Certified Nurse Aide #7 stated at first, they were unaware that they had Resident #74 on their assignment, as they were following the assignment from a previous day.</p> <p>During an interview on 3/03/2025 at 10:25 AM, Assistant Director of Nursing #1 stated they were unaware of who was assigned to Resident #77 as they were short staffed that morning. Staffing included 2 Certified Nurse Aides and 3 Licensed Practical Nurses. They proceeded to provide morning care for Resident #74.</p> <p>During an interview on 03/03/2025 at 10:30 AM, Director of Nursing #1 stated they were not informed of a staffing shortage on the unit. Director of Nursing #1 stated Licensed Practical Nurses and Registered Nurses were to assist in patient care, as patient care was the priority.</p> <p>10 New York Codes, Rules, and Regulations 415.12(a)(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>48413</p> <p>Based on observation, record review, and interviews during a recertification survey, the facility did not ensure each resident had an environment that was as free of accident hazards as possible and that each resident received adequate supervision to prevent accidents for 1 (Resident #11) of 10 residents reviewed for accident hazards. Specifically, Resident #11 was left alone while in the bathroom despite signs posted in their room saying not to leave resident alone in the bathroom, care plan, and Kardex (Certified Nurse Aide resident care card) documented resident was not to be left alone in the bathroom.</p> <p>This is evidenced by:</p> <p>Resident #11 was admitted to the facility with diagnoses of Alzheimer's Disease (a type of dementia that affects memory, thinking, and behavior), chronic systolic (congestive) heart failure (a condition in which the heart doesn't pump blood as well as it should) and history of falling. The Minimum Data Set (an assessment tool) dated 2/07/2025 documented the resident was cognitively intact, could be understood, and understand others.</p> <p>The Policy titled interdisciplinary care conference and care planning effective date 6/27/2023 documented a comprehensive resident centered plan of care was developed within 14 days of admission. The purpose of the care plan was to promote effective and person-centered care, continuity of care, communication among nursing facility staff, increase resident safety, and safeguard against adverse events that are most likely to occur in the transition between levels of care or providers.</p> <p>Care Plan titled Alteration in Elimination as evidenced by functional incontinence: initiated 06/20/2017 revised 09/16/202 listed as an intervention includes: assistance with my personal hygiene. Do not leave alone in the bathroom.</p> <p>Care Plan with focus Safety Awareness deficit related to decreased strength/endurance, history of falls, limited mobility, initiated 06/20/2017 revised 1/16/2025 listed as an intervention: Toilet every 2 hours and upon request. Be sure to stay with me to assist in personal hygiene needs.</p> <p>Kardex (Certified Nurse Aide resident care card) dated as of 2/27/2025 documented under toileting do not leave resident alone in the bathroom. Under safety it was documented Resident #11 was to have a chair alarm, the resident should be encouraged to rise from sitting to standing slowly, and to toilet every 2 hours and upon request and be sure to stay with the resident to assist in personal hygiene needs.</p> <p>During an observation on 2/25/2025 at 1:24 PM and 1:40 PM, a sign was noted to be taped to resident's armoire that was seen when walking into the room and another sign was taped to the medicine cabinet on the left wall upon entrance into the room that documented do not leave resident in the bathroom. At 1:24 PM, Resident #11 was in the bathroom and stated they were alone in the bathroom. At 1:40 PM, Resident #11 was in their wheelchair in their room, and no longer in the bathroom. Between 1:24 PM and 1:40 PM, no staff entered Resident #11's room to assist Resident #11 in the bathroom or assist the resident with leaving the bathroom and getting back into their wheelchair.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/04/2025 at 9:24 AM, Resident #11 stated they took themselves to the bathroom alone all the time. When asked if they hear an alarm go off when they rise from the wheelchair or if they turn the alarm off, they stated they do not hear anything and they do not turn any alarm off. Resident #11 stated staff were not always with them when they used the bathroom, and they had not had anyone tell them they needed to have a staff member with them when they used the bathroom.</p> <p>During an interview on 2/28/2025 at 10:39 AM, Certified Nursing Aide #1 stated sometimes Resident #11 took themselves to the bathroom without assistance and they had found Resident #11 alone in the bathroom. Certified Nursing Aide #1 stated they checked on Resident #11 every 2 hours to see if they needed to use the bathroom.</p> <p>During an interview on 2/28/2025 at 11:30 AM, Licensed Practical Nurse #1 stated that they do not leave Resident #11 alone in the bathroom but Resident #11 would use the bathroom independently. Resident #11 had a chair alarm that sounds when they were getting out of their wheelchair but they believed Resident #11 could turn it off because they would hear the alarm and then a Certified Nursing Aide went into the room and Resident #11 was already in the bathroom. Licensed Practical Nurse #1 stated they did safety checks every 2-3 hours on Resident #11 to make sure Resident #11 was not on the floor, their oxygen was on, and they were safe.</p> <p>During an observation and interview on 03/03/2025 at 11:24 AM, Licensed Practical Nurse #2 stated Resident #11 should not be left in the bathroom alone. Resident #11 had a fall last year while they were in the bathroom. Licensed Practical Nurse #2 stated Resident #11 would turn the chair alarm off. Licensed Practical Nurse #2 instructed Resident #11 to call for help when they needed to use the bathroom. They stated Resident #11 was on safety checks every 2-3 hours while in their room. Licensed Practical Nurse #2 entered Resident #11's room and took the resident into the bathroom. Licensed Practical Nurse #2 then left Resident #11 in the bathroom and exited Resident #11's room to speak with surveyor in the hallway. When asked why Licensed Practical Nurse #2 left Resident #11 in the bathroom alone, they stated they knew the resident was going to be busy in there and they were only leaving the resident alone in the bathroom for 10 seconds. When surveyor again asked why Licensed Practical Nurse #2 left Resident #11 alone in the bathroom, they stated they were going back in to assist the resident, and the resident should not have been left alone in the bathroom.</p> <p>During an interview on 2/28/2025 at 11:30 AM and 3/04/2024 at 9:24 AM, Registered Nurse Unit Manager #1 stated that Resident #11 needed assist while in the bathroom for safety reasons. Resident #11 had a chair alarm for safety and to let staff know they were trying to use the bathroom without assistance. Resident #11 should not be left alone in the bathroom, but it did happen.</p> <p>During an interview on 2/28/2025 at 1:30 PM, Director of Nursing #1 stated a resident should not be left alone in the bathroom if it was indicated on their care plan, Kardex, or signs in their room.</p> <p>10 New York Codes, Rules, and Regulations: 415.12 (h)(2)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48413</p> <p>Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure that each resident received the necessary respiratory care and services that were following professional standards of practice, for 3 (Resident #s 20, 60, and 75) of 3 residents reviewed for oxygen administration. Specifically, (a) supplemental oxygen tubing was not dated and labeled to reflect when the tubing was changed; and (b) supplemental oxygen was not provided as ordered by the physician.</p> <p>This is evidenced by:</p> <p>A review of the facility policy titled Oxygen Administration dated 1/2019 documented the facility was to provide oxygen by oxygen mask/cannula to residents with deficiencies or abnormalities of pulmonary function, to prevent or reverse hypoxia, and improve tissue oxygenation. The procedure documented that the tubing was to be attached, labeled, and dated, as well as following the orders for oxygen in the electronic record system to guide staff.</p> <p>Resident #20</p> <p>Resident #20 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), dependence on supplemental oxygen, and coronary atherosclerosis (damage or disease in the heart's major blood vessels usually cause by the buildup of plaque causing the coronary arteries to narrow, limiting blood flow to the heart). The Minimum Data Set (an assessment tool) dated 11/22/2024, documented that the resident could be understood and understand others and had moderately impaired cognition for daily living decisions.</p> <p>During an observation on 2/25/2025 at 11:16 AM, the resident was receiving oxygen at 4.5 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed.</p> <p>During an observation on 2/27/2025 at 9:45 AM, the resident was receiving oxygen at 4.5 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed.</p> <p>During an observation on 2/28/2025 at 12:01 PM, the resident was receiving oxygen at 4.5 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed.</p> <p>A review of medical orders dated February 2025, documented the resident was to receive oxygen at 2 liters per minute via nasal cannula (a device that gives additional oxygen through the nose) continuously every shift.</p> <p>A review of the Treatment Administration Record dated February 2025, documented that the oxygen was being checked daily by and that the resident was on 2 liters via nasal cannula</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Treatment Administration Record dated February 2025, documented the oxygen tubing (nasal cannula) was to be changed one time weekly and was documented as being changed on 2/23/2025.</p> <p>During an interview on 2/28/2025 at 12:31 AM, Licensed Practical Nurse #3 stated that they believed the order for residents' oxygen was at 3 liters per minute. When they looked at the order in the medical records, they corrected themselves and stated the order was 2 liters per minute. The surveyor discussed their findings dated 2/25/2025, 2/27/2025, and 2/28/2025. Upon showing Licensed Practical Nurse #3 Resident #20 oxygen concentrator set at 4.5 liters, they stated that the concentrator should be set at the resident's ordered amount of 2 liters. Surveyor asked whether Resident #20 could adjust their oxygen on their own and they stated that they had never seen the resident adjust the oxygen. Licensed Practical Nurse #3 was shown the tubing for Resident #20 from concentrator. They stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift on Sundays and should have a label on it when it was changed. Licensed Practical Nurse #3 was asked what the potential problems were of oxygen tubing that was dirty or not changed, and they stated a multitude of issues for the resident, including but not limited to respiratory infections.</p> <p>Resident #60</p> <p>Resident #60 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs resulting in swelling and irritation inside the airways that limit airflow into and out of the lungs), essential hypertension (high blood pressure), and peripheral vascular disease (circulatory condition in which narrowed blood vessels reduce blood flow). The Minimum Data Set, dated dated dated [DATE] documented that the resident could be understood and understand others and had moderately impaired cognition for daily living decisions.</p> <p>During an observation on 2/25/2025 at 11:22 AM, the resident was receiving oxygen at 3 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed.</p> <p>During an observation on 2/27/2025 at 9:54 AM, the resident was receiving oxygen at 3 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed.</p> <p>During an observation on 2/28/2025 at 11:48 AM, the resident was receiving oxygen at 3 liters via a nasal cannula that was connected to an oxygen concentrator (a device that provides a continuous supply of oxygen). There was no dated label on the oxygen tubing when it was changed.</p> <p>A review of medical orders dated February 2025, documented the resident was to receive oxygen at 2 liters per minute via nasal cannula (a device that gives additional oxygen through the nose) continuously every shift related to chronic obstructive pulmonary disease.</p> <p>A review of the Treatment Administration Record dated February 2025, documented the oxygen was being checked daily by staff that the resident was on 2 liters via nasal cannula.</p> <p>A review of the Treatment Administration Record dated February 2025, documented the oxygen tubing (nasal cannula) was to be changed one time weekly and was documented as being changed on 2/23/2025.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 2/28/2025 at 12:31 PM, Licensed Practical Nurse #3 stated that the order for oxygen was 2 liters per minute. The surveyor discussed their findings dated 2/25/2025, 2/27/2025, and 2/28/2025, they stated that the concentrator should be set at the resident's ordered amount of 2 liters. They stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift on Sundays and should have a label on it when it was changed.</p> <p>Resident #75</p> <p>Resident #75 was admitted to the facility with diagnoses of hypertensive heart failure (a condition where prolonged high blood pressure (hypertension) damages the heart muscle, leading to impaired pumping ability), end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids) and paroxysmal atrial fibrillation (a condition of having an irregular heartbeat). The Minimum Data Set, dated dated [DATE] documented that the resident could be understood and usually understand others and had a severe impact on cognition for daily living decisions.</p> <p>During an observation on 2/26/2025 at 12:31 PM, the resident was sitting at a table in the dining area receiving oxygen via a nasal cannula that was connected to a portable oxygen bottle. The resident's oxygen regulator was set to zero. There was no dated label on the oxygen tubing when it was changed.</p> <p>During an observation on 2/28/2025 at 12:07 PM, the resident was sitting at a table in the dining area receiving oxygen via a nasal cannula that was connected to a portable oxygen bottle. The resident's oxygen regulator was set to 4 liters per minute, and the oxygen regulator was observed to be in the red area indicating the oxygen bottle needed to be changed. There was no dated label on the oxygen tubing when it was changed.</p> <p>A review of medical orders dated February 2025, documented the resident was to receive oxygen at 4 liters per minute via nasal cannula (a device that gives additional oxygen through the nose) continuously every shift related to chronic diastolic (congestive) heart failure.</p> <p>A review of the Treatment Administration Record dated February 2025, documented the oxygen tubing (nasal cannula) was to be changed one time weekly and was documented as being changed on 2/23/2025.</p> <p>During an interview on 2/28/2025 at 12:12 PM, Certified Nurse Aide #2 stated that they do nothing with the oxygen as it was a nurse's responsibility to set the liter flow of the oxygen, place and change tubing, and adjust if needed. They stated they did occasionally look at oxygen levels of residents who were on portable oxygen to ensure that the tank was full and delivered oxygen. They stated that if the oxygen was running low on the tanks, they would notify a nurse to get the thank changed.</p> <p>During an interview on 2/28/2025 at 12:31 AM, Licensed Practical Nurse #3 stated that Certified Nurse Aides are not allowed to touch oxygen levels or adjust flow rates on concentrators or bottles. They stated that they would expect Certified Nurse Aides to come to them so that the bottle could be changed. They stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift on Sundays and should have a label on it when it was changed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/04/2025 at 09:50 AM, Assistant Director of Nursing #1 stated the oxygen tubing change was usually done weekly during the 11 PM - 7 AM shift. They stated that the day the oxygen tubing is changed is dependent on the resident as it varies day to day for each resident. They stated that they would expect the nursing staff to know the orders and review the orders daily in case there was a change. They stated that the nursing staff verified that the resident was receiving the right amount of oxygen that was ordered by the physician. If the resident was not on the correct amount, they stated that the staff should be in contact with the physician to determine if a change was made and not updated in the electronic medical records. They stated that once that was completed, the resident should be adjusted to the appropriate level of oxygen ordered by the physician. The surveyor discussed their findings dated 2/25/2025, 2/27/2025, and 2/28/2025. Assistant Director of Nursing #1 stated that the oxygen administration was inappropriate for the residents and could be harmful if not corrected by the staff. They stated that the tubing should have been labeled with the last date changed. When asked if the oxygen tubing was changed on the treatment record of 2/23/2025, they stated that they would assume that it was but have no proof as it was not labeled, but stated it was documented on the Treatment Administration Record.</p> <p>During an interview on 3/04/2025 at 10:15 AM, Director of Nursing #1 stated that nursing staff should closely monitor the correct amount of oxygen being given to residents. They stated that staff should follow the orders provided by the physician, and if there were any exceptions, staff should contact the physician for clarification. They stated that staff should change the oxygen tubing once a week. They stated that staff should be labeling the oxygen tubing as it was the policy of the facility to do so. Mentioned the labeling observations with Director of Nursing #1 and they stated that the tubing should not be unlabeled.</p> <p>10 New York Code of Rules and Regulations 415.12(k)(6)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</p> <p>Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice for 3 ([NAME] Unit Cart A, [NAME] Hills Unit Carts A and B) of 3 medication carts, and 1 ([NAME] Hills Side B) of 3 medication rooms reviewed. Specifically, (a.) 2 open bottles of ear drops had no open dates and or expiration dates (b.) 1 bottle of ear drops had expired; (C.) 3 bottles of open eye drops had expired; (d.) 4 inhalers had no expiration dates; (e.) 2 vials of insulin had no open date and or expiration dates and; (f.) 1 bottle of purified protein derivative (PPD) had no open and or expiration date.</p> <p>This is evidenced by:</p> <p>The facility's Policy and Procedure titled Storage and Expiration Dating of Medications and Biologicals, revised 8/01/2024, documented facility should ensure medications and biologicals that:(1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Once any medication or biological package is opened, facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (i.e., vial, bottle, inhaler) when the medication has a shortened expiration date once opened. Facility staff may record the calculated expiration date based on date opened on the primary medication container. If a multi-dose vial of an injectable medication has been opened or accessed (e.g., needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. When an ophthalmic solution or suspension has a manufacturer shortened beyond use date once opened, facility staff should record the date opened and the date to expire on the container. Facility staff should evaluate the continued sterility of the product based on clinical judgment or contamination of the dispenser after contact with eye, eyelid, lashes or finger.</p> <p>During an observation on 2/27/2025 at 10:12 AM, [NAME] Unit Medication Cart #1 contained 2 bottles of wax removal ear drops with no open and or expiration dates, and 1 Breo inhaler with open date of 01/25 and no expiration date.</p> <p>During an observation on 2/27/2025 at 03:11 PM, [NAME] Hills Unit Cart A contained 1 expired bottle of ear wax removal dated 01/2024; 1 open vial of Lantus insulin with no open date; 1 open vial of Fiasp insulin with no open date and no expiration date; 1 open Trelegy inhaler; Anoro Ellipta inhaler; and Advair HFA (hydrofluoroalkane) inhaler, all with no open and or expiration dates.</p> <p>During an observation on 2/27/2025 at 3:30 PM, [NAME] Hills Unit Cart B contained 3 expired bottles eye drops as follows: Timolol opened 12/17/2024; Latanoprost 0.005% opened 11/01/2024; Bimatoprost 0.03% opened 9/22/2024. Manufacturer label stated expiring date shown on the bottle and within 4 weeks of opening.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 2/27/2025 at 3:40 PM, [NAME] Hills Medication Room refrigerator contained 1 purified protein derivative (PPD) with no open and or expiration date.</p> <p>During an interview on 2/27/2025 at 10:12 AM, Licensed Practical Nurse #3 stated they were unaware of medication shortened expiration dates after opening. They stated they go by what was preprinted on the bottle.</p> <p>During an interview on 2/27/2025 at 3:11 PM, Licensed Practical Nurse #4 stated expired medications should be returned to the pharmacy.</p> <p>During an interview on 2/27/2025 at 3:40 PM, Licensed Practical Nurse #5 stated they would discard expired medications and place new orders with pharmacy.</p> <p>During an interview on 2/28/2025 at 10:14 AM, Director of Nursing #1 stated the nurse assigned to pass medication was responsible to ensure medication cart was clean and orderly. Although at times Nurse Managers would give this assignment to overnight medication nurse. Medication administration included verifying expiration date prior to administering medication. Medication that had shortened expiration dates after opening should be labeled upon opening. All nursing staff received this training during orientation.</p> <p>10 New York Codes, Rules, and Regulations 415.18(d)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>51317</p> <p>Based on record review and interviews during a recertification survey, the facility did not ensure that a resident received routine and 24 -hour emergency dental care for 1 (Resident #76) of 1 resident reviewed for dental services. Specifically, Resident #76 reported having pain on their lower gum making it difficult for them to chew their food on 2/25/2025. Resident #76 was not assisted in obtaining emergency dental care and had not been seen by the dentist since 3/15/2023.</p> <p>This is evidenced by:</p> <p>Resident #76 was admitted to the facility with diagnoses of cerebral infarction (a medical condition where blood flow to the brain is interrupted, causing brain tissue to die), paroxysmal atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and epilepsy (a brain disease where nerve cells do not signal properly that causes seizures). The Minimum Data Set (an assessment tool) dated 01/10/2025, documented the resident could be understood and could understand others and had intact cognition.</p> <p>The Policy and Procedure Manual titled Dental Services, reviewed/revised 2023, documented Residents/patients may consent to or refuse recommended care of treatment. Vendor would provide comprehensive, on-site dental care for all residents/patients of the facility. Facility would establish and maintain satisfactory arrangements or oral screenings, admission exams, annual exams, routine and emergency dental care. It also documented if pain or infection is present or a dental emergency exists, the facility staff shall immediately refer the resident/patient to the dentist. Any emergency brought to the attention to the dental staff would receive priority treatment.</p> <p>Comprehensive Care plan for Actual/Potential Impaired Ability/Inability to perform Activities of Daily Living due to weakness, cerebrovascular accident with left sided weakness initiated and revised 02/27/2023. Interventions included that the resident would perform mouth care with partial/moderate assist with one person. It documented the resident had dentures and to ask resident if they wanted to take the out at hour of sleep to soak overnight.</p> <p>Physician order dated 02/27/2023 documented Resident #76 was to have a dental exam on admission, yearly, and as needed.</p> <p>Dental progress notes dated 03/01/2023 documented the dentist attempted to evaluate Resident #76 as the resident was a new admit to the facility. Resident #76 refused to be evaluated. The dentist attempted to complete a dental evaluation on 03/15/2023 and Resident #76 refused twice. There were no other dental progress notes for Resident #76 after this date.</p> <p>During an interview on 02/25/2025 at 11:29 AM, Resident #76 stated they were having pain in their lower gum, and it was making it difficult for them to chew their food. They stated they had the gum pain on and off for a few weeks and they had asked a nurse to look at it this morning on 02/25/2025.</p> <p>During an observation and interview on 02/26/2025 at 12:15 PM, Resident #76 did not eat the ham that was served for lunch but consumed the other side dishes. Resident #76 stated the ham caused gum pain when they tried to chew it.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 03/03/2025 at 11:24 AM, Licensed Practical Nurse #2 stated last week Resident #76 reported their lower gum was bothering them. Licensed Practical Nurse #2 looked at their gums and did not see anything; they thought it was a one-time incident and that it had resolved. They stated Resident #76 was taking out the lower denture because it was bothering their gums and leaving the top denture in place. Licensed Practical Nurse #2 stated they thought the top denture could be rubbing against the lower gum, so they instructed the resident to remove both the upper and lower denture at night and reinsert them in the morning.</p> <p>Review of nursing progress notes from 01/28/2025 through 02/27/2025, there was no documented evidence of resident's gum pain or difficulty chewing.</p> <p>During interviews on 02/28/2025 at 11:30 AM and 03/04/2025 at 10:26 AM, Registered Nurse #1 stated they were not aware of the gum pain or difficulty chewing food Resident #76 was experiencing. They stated Resident #76 wore upper and lower dentures, and staff encouraged Resident #76 to remove the dentures at night. Registered Nurse #1 stated the dentist was at the facility weekly, and if a resident had an acute issue, they were put on the list to see the dentist. They stated the last time Resident #76 was seen by the dentist was 03/15/2023 and if Resident #76 had these complaints about their gums, they should have been put on the list to see the dentist. Registered Nurse #1 stated if a resident reported they were having gum pain to a Licensed Practical Nurse, the Licensed Practical Nurse should inform a Registered Nurse so the Registered Nurse could do an assessment and determine if a doctor needed to be notified.</p> <p>During an interview on 2/28/2025 at 1:30 PM, Director of Nursing #1 stated residents were seen by the dentist annually for a cleaning. If any needs outside of that occurred, additional appointments for residents to see the dentist could be made. They stated they expected residents to be seen by the dentist every 6 months or annually for a review, or to check the status of their gums. Any other oral hygiene needs could be addressed as needed.</p> <p>10 New York Code of Rules and Regulation 415/17 (c)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>51317</p> <p>Based on observation, record review, and interview during the recertification survey, the facility failed to ensure each resident received drinks, including water and other liquids, consistent with resident needs and preferences and sufficient to maintain resident hydration. Specifically, Residents on Saratoga Hills unit were not offered beverages of their preference during a lunch meal observation.</p> <p>This is evidenced by:</p> <p>The facility policy Hydration effective date 10/15/2021 documented it is the policy to provide residents with sufficient fluids to maintain adequate hydration and health, including fluids served at mealtimes and between meals, offered consistent with care plan, preferences, and choice.</p> <p>The facility policy Resident Food Services date issued 05/1995, revised 01/2025 documented residents will be offered menu choices for all meals, beverages and snacks based on their prescribed diet, food preferences, allergies, intolerances, preferences and consistent with their plan of care.</p> <p>During the lunch meal observation on 02/26/2025 at 12:23 PM on Saratoga Hills unit, Resident # 29 was eating in their room. They did not have the 8 ounces of water on their tray that was documented on their meal ticket. Resident #29 reported they were in their room when their lunch meal was brought to them, and they were not asked if they wanted the water.</p> <p>During the lunch meal observation on 02/26/2025 at 12:30 PM on Saratoga Hills unit, Resident #9 was eating in their room. They did not have the 6 ounces of coffee that was documented on their meal ticket. Resident #9 reported they were in their room when their lunch meal was brought to them, and they were not asked if they wanted the coffee.</p> <p>During an interview on 02/25/2025 at 12:15 PM, Certified Nursing Aide #3 stated they look at the ticket to make sure what is listed on the ticket is on the meal tray. They stated the drinks listed on the meal ticket may be different than the drinks the residents were provided as they asked the residents what drinks they wanted and then poured the residents their preferred beverage.</p> <p>During an interview on 2/28/2025 at 11:30 AM, Registered Nurse Unit Manager #1 stated staff pour ed coffee, juice, milk, and water for residents. They expected staff to ask residents what they wanted, pour the beverages, and put them on the tray. Staff should follow this same process for residents who ate meals in their rooms.</p> <p>During an interview on 3/03/2025 at 12:42 PM, Licensed Practical Nurse #2 stated when meal trays were sent to the unit, they made sure everything on the ticket was on the tray. They checked the meal to make sure it was the correct consistency, and they poured the beverages. Licensed Practical Nurse #2 stated they asked the residents if they wanted the beverage on their ticket or a different beverage.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/04/2025 at 10:53 AM, Clinical Nutrition Manager #1 stated meal tickets were printed out and the main components of the meal were assembled in the kitchen and delivered to the units. The drinks were poured on the units. The person pouring the drinks should use the ticket as a guide for what beverage to pour, but at times another drink may be poured due to resident preferences. Residents should be offered what was on their ticket.</p> <p>10 New York Code of Rules and Regulation 415.14(d)(4)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21414</p> <p>Based on observation and interview during the recertification survey, the facility did not ensure food was stored, prepared, distributed or served in accordance with professional standards for food service safety for 3 of 5 resident unit kitchenettes and the main kitchen. Specifically, walls were not in good repair and microwave ovens, refrigerators, and tables were not clean.</p> <p>This is evidenced by:</p> <p>During observations on 2/25/2025 at 10:21 AM:</p> <p>10 wall coving tiles were broken in the dishwashing machine area.</p> <p>Seven wall coving tiles were broken in the main kitchen.</p> <p>The microwave ovens, the refrigerators including door gasket, and the underside of dining tables were soiled with food particles on the [NAME] kitchenette, [NAME] A kitchenette, and [NAME] B kitchenette.</p> <p>During an interview on 2/25/2025 at 11:38 AM, Executive Chef #1 stated that they would contact housekeeping to clean the tables and would remind the maintenance department of the work order they submitted to repair the coving tiles. Executive Chef #1 stated that they would have the microwave ovens and refrigerators cleaned.</p> <p>10 New York Codes, Rules, and Regulations 415.14(h)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36922</p> <p>Based on observation, record review, and interviews during a recertification survey, the facility did not ensure an infection control prevention and control program was implemented to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for 2 (Resident #s 57 and #77) of 5 residents. Specifically, (a.) for Resident #57, staff did not perform proper doffing and donning of personal protective equipment between care of residents; and (b.) for Resident #77, the staff did not perform proper infection control procedures while conducting wound care.</p> <p>This is evidenced by:</p> <p>A review of the 2025 Infection Prevention and Control Plan documented that the plan's purpose is to provide an effective system-wide program for the surveillance, prevention, and control of infection and infectious diseases. The goals of the Infection Prevention and Control Program were to assist in maintaining a safe environment and improve resident outcomes as part of a multi-disciplinary team by preventing or interrupting the transmission of infectious and communicable diseases as well as antibiotic-resistant organisms. Staff would monitor for the occurrence of infection and support the implementation of control measures as needed, offer guidance to minimize risks associated with procedures, medical devices, and equipment, and sustain compliance with regulatory bodies related to infection prevention.</p> <p>Resident #57</p> <p>Resident #57 was admitted to the facility with diagnoses Non-Alzheimer's Dementia, peripheral vascular disease with a vascular wound (a disorder of the circulatory system), and anemia (a condition in which the body does not have enough healthy red blood cells). The Minimum Data Set (an assessment tool) dated 2/17/2025, documented the resident was understood and could understand others with severely impaired cognition for daily decision making.</p> <p>During an observation on 2/28/2025 at 10:45 AM, Certified Nurse Aide #8 and Licensed Practical Nurse #7 provided care to Resident # 57 who was on enhanced Precautions. Certified Nurse Aide #8 assisted Licensed Practical Nurse #7 in providing care. Certified Nurse Aide #8 entered the room without a gown with gloves on after having gone to several outside bins on the unit to get gowns and did not change gloves or wash their hands before taking off a gown that was handed to them by Licensed Practical Nurse #7. Both entered the room, putting on gowns and gloves without sanitizing their hands. After finishing care, Certified Nurse Aide #8 removed their gown without first removing their gloves and went to room [ROOM NUMBER] across the hall with the rolled-up gown in their hands with the gloves on. Certified Nurse Aide #8 disposed of the gown in the receptacle and pulled the bin across the hall with dirty gloves still on.</p> <p>During an interview on 2/28/2025 at 11:07 AM, Certified Nurse Aide #8 stated they should have removed their gloves and gown and put them in the receptacle. A gown and glove disposal receptacle should have been outside the room before care began. And hand sanitizing should have been done before donning and doffing personal protective equipment.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/3/2025 at 1:57 PM, Registered Nurse #4 stated the expectation was that the carts to dispose of the Personal Protective Equipment were either in the rooms or outside the room. Soiled gowns should never have been removed and carried across the rooms through the hallways. Handwashing to prevent spreading infections from resident to resident needed to be done between each resident before and after the resident's care. They stated they had just started and had a lot of work to do to ensure compliance with the delivery of care to the residents. Staff would need to be reeducated.</p> <p>Resident #77</p> <p>Resident #77 had a diagnosis of Dementia (loss of memory, language, problem-solving, and other thinking abilities); Atrial Fibrillation (an irregular and often very rapid heart rhythm); and unstageable pressure ulcer on the foot (when the stage is not clear. In these cases, the base of the wound is covered by a layer of dead tissue). The Minimum Data Set, dated dated [DATE] documented that Resident #77 had severe cognitive impairment, could be understood, and understand others. Resident had one unstageable pressure ulcer that was not present upon admission.</p> <p>The Skin Comprehensive Care Plan dated 1/23/2025, documented an unstable wound to the Heel (foot); Wound; treatments as ordered.</p> <p>The Infection Comprehensive Care Plan dated 1/11/2025 documented Enhanced Barrier Precautions; Enhanced Barrier Precautions signage would be clearly displayed outside the room.</p> <p>o Enhanced Barrier Precautions include:</p> <p>Wear gloves and a gown for the following care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting. Device care or use: central line, urinary catheter, feeding tube, tracheostomy. Wound care: any skin opening requiring a dressing.</p> <p>o Perform hand hygiene before entering and upon leaving the room.</p> <p>The Physician Order dated 2/19/2025 documented to cleanse the foot wound with normal saline, pat dry, applying a small amount of bacitracin mixed with a small amount of triad to 10:00 and 6:00 of the peri-wound, continuing with Medi honey, and wrapping it with gauze daily and as needed if it was soiled.</p> <p>During a dressing change observation on 3/04/2025 at 08:21 AM, Licensed Practical Nurse #6 gathered supplies for dressing change and left the cart and supplies outside Resident #77's room. Nurse Practitioner #1 assessed the wound and measured it as 3 centimeter x 2 centimeter x 0.4 centimeter edges intact, with no edema. Licensed Practical Nurse #6 proceeded to remove the old dressing from Resident #77 and apply the new dressing. They did not put on gown upon removing existing dressing and did not wash or sanitize hands upon removal of gloves.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335774	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Seton Health at Schuyler Ridge Residential H C		STREET ADDRESS, CITY, STATE, ZIP CODE 1 Abele Drive Clifton Park, NY 12065	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview at the time of observation, Licensed Practical Nurse #6 stated that the wound drainage was soaked through the dressing. Licensed Practical Nurse #6 stated they were not aware gowning was required. They stated they were unfamiliar with Enhanced Barrier Precautions as this was new to the facility. They were unable to sanitize hands because there was no hand sanitizer in the resident's room.</p> <p>During an interview on 3/04/2025 at 10:46 AM, Nurse Educator #1 stated that all staff received Infection Control training along with Enhanced Barrier Precautions training upon hire. More recently, nurse managers provided updated training on Enhanced Barrier Precautions. In addition, random infection control audits are conducted.</p> <p>10 New York Codes, Rules, and Regulations 415.19(a)(1-3)</p> <p>48413</p> <p>51317</p>		