STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335128	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Peters Nursing and Rehabilitation Center	301 Hackett Blvd Albany, NY 12208

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during a survey, the facility failed to ensure residents were free from neglect and abuse for three (3) (Resident #s 2, 15, and 18) of 22 residents reviewed. Specifically, a.) Resident #'s 2 and 18 care plans were not followed resulting in injury; and b.) Resident #15 was prevented from leaving their room by a staff member.Findings include:The Policy and Procedure titled Abuse Prevention and Investigation Policy, dated 3/25/2025, documented abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with physical pain, harm, or mental anguish, deprivation of goods or service and neglect was defined as the failure to provide timely, consistent, safe, adequate and appropriate services, treatment and care including nutrition, medication, and therapies.The policy and procedure titled Interdisciplinary Care Conference and Care Planning, dated 06/27/2023, documented the purpose of a comprehensive care plan is to promote effective and person-centered care, continuity of care, communication among nursing facility staff, increase resident safety, and safeguard against adverse events.Resident #2Resident #2 was admitted to the facility with the diagnoses of unspecified diastolic congestive heart failure (when the heart's main pumping chamber - the left ventricle - stiffens and cannot properly relax to fill with blood), morbid severe obesity due to excess calories (chronic disease defined by a body mass index of 40 or higher resulting from complex biological and environmental factors), and chronic kidney disease (when the kidneys are damaged and cannot filer blood as they should). The Minimum Data Set (an assessment tool) dated 02/13/2026 documented the resident could be understood, could understand others, and was cognitively intact.The Comprehensive Care Plan titled Actual/Potential Impaired Ability/Inability to perform Activities of Daily Living (bathing, grooming, dressing, mouth care) due to weakness, initiated 09/23/2022 documented the resident required substantia/maximum assistance for upper body bathing and was fully dependent on staff to bath their lower body.The Kardex dated 09/09/2025 stated Resident #2 required substantial/maximal assistance by two (2) staff members with the use of enabler bars for bed mobility.The Summary of Event dated 09/09/2025 at 11:00 AM documented Resident #2 received a skin tear to their right upper arm while care was being provided. The summary documented that Certified Nurse Aide #1 provided care to Resident #2 without additional assistance.The Progress note dated 09/09/2025 at 11:30 AM documented Registered Nurse #1 was called to Resident #2's room to assess a skin tear to the right upper arm measuring 4.3 centimeters by 3 centimeters. The skin was approximated; steri-strips were applied and covered with a dry protective dressing. Certified Nurse Aide #1 stated to Registered Nurse #1 that the skin tear was obtained during care (rolling Resident #2).The Progress note dated 09/09/2025 at 4:03 PM documented Resident #2's bed mobility was 2 staff assist and the Certified Nurse Aide #1 did not roll Resident #2 with additional assistance and the resident obtained a skin tear during care.The Employee Statement completed by Certified Nurse Aide #1 on 09/09/2025 documented the skin tear occurred when they were changing Resident #2.The Resident Version of Occurrence transcribed by Registered Nurse #1 on 09/09/2025 documented Resident #2 stated the skin tear happened when Certified Nurse Aide #1 turned them.The Nursing Home Investigative Report (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Submission #18730 submitted by Director of Nursing #2 dated 09/11/2025 documented there was reasonable cause to believe that abuse, neglect, or mistreatment occurred, and the incident was a care plan violation.Resident #15Resident #15 was admitted to the facility with diagnoses of type 2 (two) diabetes mellitus (chronic metabolic disorder where the body either resists insulin or doesn't produce enough of it), major depressive disorder (a severe mood disorder causing persistent feelings of sadness, hopelessness, and a loss of interest in activities), and hypertension (a condition in which the force of blood pushing against the artery walls is consistently too high, also known as high blood pressure). The Minimum Data Set, dated [DATE], documented the resident could be understood and could understand others and was cognitively intact.On 02/02/2026 Resident #15 reported to Licensed Practical Nurse #6 that Certified Nurse Aide #4 had grabbed their arm and pushed them in their wheelchair back to their side of the semi-private room when they attempted to leave the room, stating I'm not letting you leave. Licensed Practical Nurse #6 informed the supervisor at that time and an investigation was started.The facility investigation of this facility reported incident documented numerous statements including a statement from Resident #15.The investigation report documented the incident happened on 02/02/2026 at 8:30 PM.The statement from Resident #15 dated 02/02/2026 documented the resident asked Certified Nurse Aide #4 to move linen on the floor out of their way, claiming Certified Nurse Aide #4 grabbed them by the arm and pushed them back when they attempted to leave the room. The statement from Licensed Practical Nurse #6 documented that they did not witness the incident but did receive the accusation from Resident #15 against Certified Nurse Aide #4.The Summary of Event dated 02/02/2026 documented Certified Nurse Aide #4 was sent home.Certified Nurse Aide #4's employee file documented they were terminated from employment on 02/03/2026 for substandard job performance, abuse, neglect, or mistreatment of a patient or resident, and violation of resident rights.During an interview on 5/27/2026 at 10:30 AM, Director of Nursing #1 stated Certified Nurse Aide #4 was removed from the building as soon as Resident #15 accused them of abuse and placed on suspension pending investigation. They stated the allegation was verified and Certified Nurse Aide #4 was terminated because of this incident.During an interview on 5/28/2206 at 3:10 PM, Licensed Practical Nurse #6 stated when Resident #15 reported the accusation to them, they went to Certified Nurse Aide #4 to ask what happened and called the supervisor who began the investigation. They stated Certified Nurse Aide #4 was removed from the floor and patient care within fifteen minutes of the report.Resident #18Resident #18 was admitted to the facility with diagnoses of dementia (an umbrella term for a decline in mental ability - such as memory loss, impaired judgment, and confused thinking - severe enough to interfere with daily life), anemia (a condition characterized by a lack of enough healthy red blood cells to carry sufficient oxygen to body tissues), and gastro-esophageal reflux disease (chronic digestive condition where stomach acid or bile flows back in to the esophagus, irritating and inflaming the lining of the esophagus causing discomfort). The Minimum Data Set, dated [DATE], documented the resident could be understood and could understand others. The resident was cognitively intact. The Comprehensive Care Plan titled, Alteration in mobility related to limited range of motion, limited strength, weakness, initiated 08/01/2022, included the seating intervention for a standard wheelchair with cushion and standard leg rests.The Summary of Event dated 10/15/2025 documented Resident #18 was transported from the therapy room to the unit without leg rests on their wheelchair, resulting in the resident's foot dragging and turning while being pushed in the wheelchair. The summary documented leg rests were not applied to the wheelchair by the assigned Certified Nurse Aide #4 before resident transport to the therapy room. The resident reported on 10/16/2025 that their ankle hurt. The Kardex dated 10/23/2025 documented under wheelchair bound / mobility that the seating was a standard wheelchair with cushion and standard leg rests.The acknowledgment form for Select Physical Therapy, Occupational Therapy, and Speech License Pathologist Rehabilitation documented that for resident transport in wheelchair: residents must have leg rests applied prior to being transported to the therapy department, and was signed by Rehabilitation Technician #1 on 10/24/2025.The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Communication/Medical Provider note, dated 10/16/2025, stated an X-ray of the right ankle and foot had been ordered.The Communication/Medical Provider note, dated 10/16/2025, documented the medical provider was informed of X-Ray results of right ankle indicating a right lateral ankle sprain.The Medical Provider Note dated 10/17/2025 documented the resident was seen for pain in the right ankle after the X-Ray indicated a right ankle strain. During an interview on 5/27/2026 at 10:30 AM, Director of Nursing #1 stated both the involved certified nurse aide (Certified Nurse Aide #4) and Rehabilitation Technician #1 had received education on proper transport of residents. They stated this was the first write-up for Certified Nurse Aide #4. 10 New York Codes, Rules, and Regulations 415.4

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interviews conducted during a survey, the facility failed to ensure that a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Specifically, Resident #1 did not receive ordered treatments of Santyl ointment (a prescription topical ointment used to clean and remove dead tissue form severe burns and chronic skin ulcers), and dry dressing to left foot on the dates on 12/04/2026 - 12/09/2026.Findings include:Resident #1 was admitted to the facility with diagnoses of paroxysmal atrial fibrillation (an intermittent condition where the upper chambers of the heart beat chaotically and out of sync,) history of other venous thrombosis and embolism (a blood clot that blocks the flow of blood through a vein), and diaphragmatic hernia without obstruction or gangrene (a condition where the abdominal organs push through a defect in the diaphragm and become severely trapped). The Minimum Data Set (an assessment tool) dated 02/27/2026 documented the resident could be understood and understood others, and had moderately impaired cognition.Review of policy titled Skin & Wound Care documented licensed practical nurse would change dressings per order and will document wound appearance and changes.Review of Treatment Administration Record dated December 2025 documented completion of treatment to left medial foot on the dates of 12/03/2025, 12/04/2025, 12/06/2025, 12/07/2025, 12/08/2025 and 12/09/2025.Review of nursing progress note dated 12/10/2025 at 12:46 PM written by Registered Nurse #2 documented upon completing weekly wound rounds with wound nurse, resident was found to have a dressing applied to left foot with the date 12/03/2026. Registered Nurse #2 documented upon investigation, treatment was ordered to be completed on the evening shift daily, it was found that nurses documented that treatment was complete/performed when it was not.Review of statement dated 12/10/2025 at 2:23 PM written by Registered Nurse #5 documented Resident was seen today (12/10/2025) on weekly wound rounds. Dressing that was found intact was dated 12/03/2025. Order for wound care is Santyl ointment with dry gauze daily. No signs of active infection. Now able to stage as a stage 3 (three). Wound noted to be larger in size this week. There was a very light tan film over wound bed. Review of investigation dated 10/10/2025 at 12:27 PM completed by Director of Nursing #1 included statements from Licensed Practical Nurse #1 stating they put a dressing on the bottom of the foot. They thought that was medial aspect. They could not recall which foot and also stated there wasn't a wound present.Review of investigation dated 12/10/2025 at 12:20 PM completed by Director of Nursing #1 included a statement from Licensed Practical Nurse #2 stating they did multiple treatments and omitted the treatment in error.Review of investigation dated 12/10/2025 at 12:20 PM completed by Director of Nursing #1 included statement from Licensed Practical Nurse #3 stating they had signed prior to completing the treatment and had so much to do they didn't get back to it.Review of resident version of occurrence form dated 12/10/2025 at 12:20 PM, Resident #1 stated they were unaware that treatment was not being completed as they lose track of time.Review of medication or treatment error re-education form documented re-education of Licensed Practical Nurse #'s 1, 2, and 3 on 12/10/2025 on Administration of medication and completing treatments as ordered.During an interview on 05/22/2026 at 11:10 AM, Licensed Practical Nurse #4 stated a treatment should never be signed for prior to completing the treatment. They stated they would look at the order first, change the dressing as ordered, and then document in the electronic health record.During an interview on 05/22/2026 at 11:15 AM, Licensed Practical Nurse #5 stated that any treatment they did was documented in the electronic health record after the completion of the treatment. 10 New York Codes, Rules and Regulations 415.12(c)(2)