STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335465	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Daughters of Sarah Nursing Center	180 Washington Ave Ext Albany, NY 12203

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interviews conducted during a survey, the facility failed to immediately notify the resident's legal representative of a significant change in the resident's physical, mental, or psychosocial status, for one (1) out of three (3) residents reviewed for notification of changes. Specifically, when Resident #1 experienced a vasovagal episode (a sudden, temporary drop in heart rate and blood pressure that reduces blood flow to the brain, leading to brief fainting) and episodes of vomiting on 05/14/2026, Family Member #2 was not notified. Findings include: Resident #1 wasˆadmitted ˆto the facility withˆdiagnosesˆofˆpneumonitisˆdueˆtoˆinhalationˆofˆfoodˆandˆvomit (an inflammation of the tiny air sacs in the lungs, usually triggered by inhaling foreign substances,)ˆdysphagiaˆ(difficulty swallowingˆfood, liquids, orˆsaliva)ˆandˆstage three (3)ˆchronicˆkidneyˆdiseaseˆ(moderate kidney damage).ˆThe Minimumˆ Data Set (an assessment tool) datedˆ05/06/2026,ˆdocumented the resident couldˆsometimes beˆunderstood,ˆcouldˆsometimesˆunderstandˆothers,ˆand had moderate cognitive impairment.ˆˆˆ Facility Policy titled Notification Policy, dated 02/2021, documented Attending Physician or designee and resident or resident's legal representative (or interested family member) is to be notified by the nurse of a significant change in resident condition. A significant change is defined as: significant change in the resident's physical, mental or psychosocial status. This may include change in mentation, change in behavior, change in vital signs, including fever, respiratory distress, bleeding, vomiting, sudden onset of pain accident involving injury, new pressure ulcer. ˆProgress Note dated 05/13/2026ˆatˆ10:32ˆAM byˆLicensedˆPractical Nurse #1ˆdocumentedˆAskedˆto see resident for complaint ofˆright sided abdominal pain at 7:30ˆAM, bowel sounds present butˆdiminishedˆon right lower quadrant. Physician #1ˆupdated on arrival and examined resident.ˆˆAbdominalˆx-ray ordered for Kidneys, Ureters, and Bladder orderedˆtoˆrule outˆileusˆ(temporary lack of normal muscle contractions in theˆintestines). Progress Note dated 05/13/2026 atˆ3:09ˆPM byˆRegistered Nurse#1ˆdocumentedˆResident was assessed for abdominal pain. Rebound tenderness (a clinical sign where a person experiences sharp, intense pain when manual pressure to the abdomen is quickly released) noted, no palpation performed, no bowel sounds inˆrightˆlowerˆquadrant. They were unable to detect bowel sounds in all fourˆquadrantsˆas resident jumped several times as stethoscope bothereˆthem.ˆResidentˆstatedˆthey had a bowel movement yesterday (05/12/2026) and threw up clear liquid today (05/13/2026). It further documented an x-ray was ordered,ˆwaitingˆresults, and Medical Doctor was made aware. Progress Note datedˆ05/14/2026 atˆ8:04ˆAMˆby Licensed Practical Nurse #3 documented thatˆCertifiedˆNurse Aide #1 reported resident not responding appropriately. Licensedˆ Practicalˆ Nurseˆwas notified of current situation, upon entering resident respondedˆvery little.ˆPhysician Assistant #1ˆwas notified, vitals were taken . ˆ Progress Note dated 05/14/2026 atˆ9:20ˆAMˆby Registered Nurseˆˆ#1 documented the resident had vomited and a call was placed toˆPhysician Assistant #1.ˆ There was no documented evidence that the resident's legal representative was immediately notified of the change of condition that Registered Nurse #1 recorded. Progress noteˆdated 05/14/2026 atˆ1:00PM byˆPhysician Assistant #1 documented they saw the resident for what appeared to be a syncopalˆepisode (a temporary, sudden loss of consciousness (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caused by reduced blood flow to the brain) while showering.ˆand chest x-ray ordered. There was no documented evidence that the resident's legal representative was immediately notified of the change of condition that Physician Assistant #1 recorded. During an interview on 05/26/2026 at 12:27 PM Licensed Practical Nurse #3 stated on the morning of 05/14/2026,ˆResident #1 was in the shower and had a vasovagal episodeˆbut did not completely pass out.ˆTheyˆnotified Physician Assistant #1. Physician Assistant #1 came to see Resident #1.ˆPhysicianˆAssistant #1ˆstatedˆtheyˆthought the resident had a vasovagal incident and said toˆmonitor the residentˆand notify them with any changes. They stated they offered Resident #1 their morning medication, which they accepted. A bit later Resident #1 had some brown colored vomit. They notified Physician Assistant #1 and Physician Assistant #1 ordered Ondansetron (a prescription medication used to treat nausea and vomiting).ˆ They stated the resident passed away before they were able to administer the Ondansetron.ˆˆ During an interview on 05/26/2026 at 2:35 PM Physicians Assistant #1 stated that on the morning of 05/14/2026, they were asked to see Resident #1 after they had a vasovagal incident in the shower. They stated Resident #1 had been returned to bed and was seen and assessed at that time. They also stated mid to late morning, around 10 AM, they were notified the resident had vomited and was asked to see them again. They stated they ordered Ondansetron (a prescription medication used to treat nausea and vomiting) and monitoring of vital signs. They were again contacted around 11:15 AM and notified the resident had passed away. During an interview on 05/27/2026 at 1:44 PM, Family Member #2ˆstatedˆthat on the morning of 05/13/2026, they attended a care conference via telephone for Resident #1. They stated they did discuss that Resident #1 was having fatigueˆand nausea on 05/13/2026.ˆˆFamily member #2ˆstatedˆthat on the morning of 05/14/2026, they did not receive notification that Resident #1 had had a vasovagal episode or that they vomited. The first notification they received from the facility was on 05/14/2026 at 12:07ˆPMˆwhenˆthey were informed that Resident #1 had passed away.ˆ ˆDuring an interview on 05/27/2026 at 1:38 PM, Director of Nursing #1 stated a family member or representative would be notified for any change in a resident's baseline. They stated family would be notified of incidents and accidents, any increase in pain from baseline, any new signs or symptoms the resident is displaying that show a change in medical condition. During an interview on 05/27/2026 at 2:20PM, Licensed Practical Nurse #1 statedˆthat family would be notified if there was a severe change in a resident condition, death, anyˆmedication changes, when they went to see an outside provider, or for any change in the plan of care.ˆTheyˆwould consider a severe change in a resident condition to be an altered mental status, altered respiratory status, or vital signs outside of the normal range.ˆThey stated Family Member #2 was not notified of theˆvasovagal incident that occurred on 5/14/2026 when Resident #1 was in the shower.ˆˆ During an interview on 05/29/2026 at 9:53 AM, Physician #1 stated they would expect the family of a patient to be notified if there was an unexpected change in a resident's condition, especially if a resident was one who could not make their own decisions about treatment. 10 New York Codes, Rules, and Regulations 415.3 (f)(2)(ii)ˆ