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	09/09/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, interviews, and record reviews conducted during a recertification survey, the facility did not ensure treatment with respect, dignity, and care for each resident in a manner and in an environment that promoted maintenance or enhancement of their quality of life, recognizing each resident's individuality for 3 (Resident #'s 33, 86 and 197) of 35 residents reviewed for dignity. Specifically, (a.) Resident #33 stated Certified Nurse Aide #3's tone of voice was rude, they felt rushed during care and requested Certified Nurse Aide #3 not to be assigned to them as caregiver; (b.) Resident #86 stated they waited a long time for care and then the care was rushed; (c.) Resident #197 stated Certified Nurse Aide #3 was argumentative and used inappropriate language. This is evidenced by: New York State Department of Health Division of Nursing Homes and ICF/IID Surveillance, Resident Rights Handbook, documented: As a resident in this facility, they have rights guaranteed to them by state and federal laws. This facility was required to protect and promote their rights. Resident rights strongly emphasized individual dignity and self-determination, promoting their independence, and enhancing their quality of life. Facility memorandum dated 5/01/2024, documented facility's Community for Seniors was 'privileged' to be in a position to serve their needs. It documented the facility took 'very seriously' their commitment to provide exceptional, dignified personal care to all residents, and intended to do so each and every time with compassion and acts of loving kindness. Resident #33 was admitted to the facility with diagnoses diabetes mellitus (a disease where the hormone insulin is impaired resulting in elevated levels of glucose/sugar), limited range of motion and Lower extremity edema (swelling). The Minimum Data Set (an assessment tool) dated 5/2024, documented the resident was cognitively intact, could be understood and understand others. (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: 335465	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/30/2024 at 11:31 AM, Resident #33 stated some Certified Nurse Aides were rude. There was one Certified Nurse Aide that they complained to facility leadership about and requested Certified Nurse Aide #3 not care for them anymore. Resident #33 denied feeling fearful but stated Certified Nurse Aide #3 had a bad attitude and came in rushing them after they had waited so long to be taken off the bedpan. They stated they were now more independent and could do their own transfers from chair to toilet. Although before they graduated to independent level, they used to wait a very long time for assistance. During an interview on 9/06/2024 at 2:10 PM, Registered Nurse #1 stated they had no knowledge of reported incident that an aide was rude and no restriction on who cared for Resident #33. Registered Nurse #1 stated if resident reported that a Certified Nurse Aide was rude, they would conduct a full investigation, notify Medical Doctor, report to facility leadership, and remove the Certified Nurse Aide until investigation was completed. They further stated that training on abuse and neglect was upon hire and annually. During an interview on 9/06/2024 at 2:15 PM, Licensed Practical Nurse #7 stated when Resident #33 was on the rehabilitation unit, Resident #33 did not like Certified Nurse Aide #3's approach and requested Certified Nurse Aide #3 not to care for them because they were rude. Certified Nurse Aide #3 was no longer assigned to Resident #33. Licensed Practical Nurse #7 stated there had been other complaints about Certified Nurse Aide #3 from other residents, however, those residents had been discharged . Licensed Practical Nurse #7 stated they reported complaints about Certified Nurse Aide #3 to the Unit Manager. During an interview on 9/06/2024 at 2:20 PM, Licensed Practical Nurse #5 stated so many personality things had happened but did not remember anything about Resident #33 and Certified Nurse Aide #3. They stated Certified Nurse Aide #3 could be noisy. Resident #33 was apprehensive in the beginning, and Certified Nurse Aide #3 may not have been patient with them. Licensed Practical Nurse #5 stated if they had been made aware they would have conducted an investigation. Resident #86 was admitted to the facility with diagnoses osteoarthritis (type of arthritis that occurs when flexible tissue at the ends of bones wears down), lower extremity fracture (bone break) and limited range of motion. The Minimum Data Set, dated dated dated ,d+[DATE], documented resident was cognitively intact, could be understood and understand others. During an interview on 9/09/2024 at 10:25 AM, Resident #86 stated they were generally the last resident to receive care and when staff finally got to them, staff rushed through them. Everything happens [NAME] [NAME] and you were done. Resident #86 stated staff were always in a rush, and was reluctant to specify further. Resident #197 was admitted to the facility with diagnoses including lower extremity fracture, weakness and decreased mobility. Resident #197 was alert and oriented to person, time, place, and event. Resident could understand and was understood by others. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview an 9/09/2024 at 10:10 AM, Resident #197 stated Certified Nurse Aide #3 appeared hot and cold. Some days they were okay, but there were days where Certified Nurse Aide #3 was very rude and abrasive. Resident #197 stated the previous week they put on light to get remote that had fallen on floor behind table. Certified Nurse Aide #3 answered after a long wait and stated 'what do you want' in a 'very harsh tone.' When Resident #197 replied to the staffer, Certified Nurse Aide #3 stated over their talking, 'make up your mind.' Resident #197 then stated they asked Certified Nurse Aide #3 why they had to be so nasty, and Certified Nurse Aide #3 replied, 'why do you have to be so nasty?' In another example, Resident #197 stated that on the evening of 9/05/2024, Certified Nurse Aide #3 stated 'get your ass out of the bed' while providing care to them. Resident #197 stated they did not report Certified Nurse Aide #3 because word would get out to the other aides that they had complained, and they would then not receive care from any of the Certified Nurse Aides. During an interview on 9/06/2024 at 2:37 PM, Director of Nursing #1 stated they had no knowledge of Resident #33's complaint about Certified Nurse Aide #3. They stated Certified Nurse Aide #3 was a good aide but had a rough tone to their voice. Director of Nursing #1 stated if they had been made aware, they would have conducted an investigation and provided training to staff. During an interview on 9/06/2024 at 3:45 PM, Administrator #1 stated Registered Nurse #1 and Social Worker #1 met with Resident #33 on 9/06/2024 at 3:00 PM and that Resident #33 stated they were not fearful, but had been left on a bed pan for a very long time. When Certified Nurse Aide #3 came to take them off, they were rushing and pushing things around in room to get to them and assist with bedpan. Administrator #1 stated Resident #33 did not like Certified Nurse Aide #3's attitude. Resident asked that Certified Nurse Aide #3 not to care for them anymore, and Administrator #1 and Registered Nurse #2, (Unit Manager) were not made aware of the incident or request. Administrator #1 stated Certified Nurse Aide #3 had been with the facility for a long time and received shining star comments from other residents. They stated Certified Nurse Aide #3 resigned as of 9/06/2024. Administrator #1 stated if they were notified at the time, an investigation would have been initiated. Administrator #1 stated staff received annual abuse and neglect training and with each anniversary date. During an interview on 9/09/2024 at 9:40 AM, Registered Nurse #2 stated they were not made aware of incident with Resident #33 and Certified Nurse Aide #3. In addition, they had no knowledge of other resident complaints regarding Certified Nurse Aide #3. A call was placed to Certified Nurse Aide #3 for an interview; message was left requesting a call back with no response. 10 New York Codes Rules and Regulations 415.5(a)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, interviews, and record review conducted during a recertification survey, the facility did not promoted and facilitated the residents right to self-determination through support of resident choice. Specifically, the facility did not provide accommodations for heating of food brought to residents from outside the facility. This was evident for Resident #5. This is evidenced by: Facility's policy titled, Resident Personal Food and dated 11/2021, documented resident personal food (food not provided by facility) should be ready to eat, requiring little or no preparation. Food requiring refrigeration may be stored in the unit kitchenette refrigerator or personal refrigerator provided by resident/resident representative. Resident personal food could not require re-heating. At all times, residents who were unable to access their personal food or eat independently would be assisted by facility staff, as needed. It further documented the facility was a 'Kosher' facility. All food served by the facility was prepared in accordance with traditional Jewish rules of Kashrut, and only facility-provided, kosher food was permitted in the facility's public areas. Resident personal food must be consumed in resident's room. Microwaves were not allowed in resident care areas. The policy did not document how residents would be assisted in reheating personal food brought from outside. The New York State Department of Health Nursing Home Resident Rights Booklet 2022, documented under Self-Determination, page 4: Resident had the right to: - Be offered choices and allowed to make decisions important to them. - Receive services with reasonable accommodations for individual needs and preferences. Facility Admission Agreement for Resident #5 dated 9/20/2006 documented, under section 2.1.8 Serviced Provided by the Home: Assistance and/or supervision, when required, with activities of daily living, including but not limited to toileting, bathing, feeding and ambulation assistance. Section 2.1.11 documented: Activities program, including but not limited to a planned schedule of recreational motivational, social, and other activities; together with necessary materials and supplies to make the resident's life more meaningful. During an interview on 8/30/2024 at 12:45 PM, Resident #5 inquired of their right to have food brought in from outside heated up. Resident #5 stated they often had food in a resident refrigerator that they wanted to be heated up. During an interview on 8/30/2024 at 2:45 PM, Administrator #1 stated it was the facility's policy not to heat food brought in from outside for the safety of residents, and staff would not heat up food for residents because it could 'potentially result in burns to the resident.' (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/09/2024 at 9:39 AM, a microwave oven was observed on the Red Unit, Unit Managers office. Licensed Practical Nurse #2 stated the microwave was for staff use only and had always been there. During an interview on 9/05/2024 at 11:18 AM, Registered Nurse #1 stated they used to have microwave in their office up to about one year ago; everyone used the microwave to the point where it was 'out of control,' therefore, they had it removed. Registered Nurse #1 stated previously staff would go to a staff lounge in back of building and heat items for residents, but that staff no longer heated up food for residents brought in from the outside per policy. During an interview on 9/05/2024 at 11:18 AM, Social Worker #1 stated there was a resident who had since passed away about 6 months ago, who wanted pizza warmed up, but staff did not have 'the right' to test temperature and warm food properly. Social Worker #1 stated it was the facility's policy that staff were unable to heat food brought in from outside. During an interview on 9/03/2024 at 9:00 AM, Resident #5 stated they often ordered take-out food, and saved the leftover food in refrigerator. They also stated their family member used to bring in food that they would like heated up in the evening. Resident stated they had been in the facility for over [AGE] years and previously had a microwave in their room. After they were readmitted from a hospitalization , they were told they could no longer have a microwave, and were permitted to use the microwave in unit managers office. They further stated that approximately 6 months ago they were told by several staff that they were no longer allowed to heat up food for resident because they could not test the temperature. Resident #5 stated 'that is just not right.' They stated food choices were limited at the facility and they would like to have other meals. During an interview on 9/06/2024 at 11:04 AM, Director of Maintenance #1 stated there had been no work orders to remove microwave ovens. They further stated there were some microwave ovens still in the facility, and there was a microwave in the memory care unit pantry. During an interview on 9/04/2024 at 2:45 PM, Administrator #1 stated they were not aware there was a concern about heating up food. They stated it had always been the facility's policy not to reheat food brought in from the outside. Administrator #1 concluded that Resident #5 had the concern and stated they would discuss concerns with resident. During an interview on 9/06/2024 at 11:30 AM, Resident #5 stated they met with Administrator #1 who stated a designated Certified Nurse Aide would heat food brought in from outside, specifically for them. Resident #5 further stated that if the designated Certified Nurse Aide was not at the facility on any given day, then their outside meals could not be heated. 10 New York Codes, Rules, and Regulations 415.5(b)(1-3)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48615 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. Specifically, (a.) opened medications had no open and/or expiration dates; (b.) pre-poured medication cup was noted in medication cart (c.); medication refrigerator temperature was outside of therapeutic range; and (d.) non-medication items were stored in medication cart for 2 (Green and Purple unit medication carts) of 3 medication carts reviewed and 3 (Green, Red, and Purple) of 3 medication storage rooms reviewed. This is evidenced by: The facility's Medication Administration Guidelines, last reviewed 2/2024, Section III. 6, documented each nurse was responsible to date and time all multi-dose vials, and maintain pharmacy standards regarding storage and time between opening and discarding. All scheduled medications would be signed for as administered or not administered. Reason for non-administration was required and would be noted by using the reason code on the electronic medication administration record. The facility's policy titled, Medication Refrigerators Issued 02/08, documented medications requiring refrigeration would be stored in a refrigerator which stored medications only. The temperature would be maintained between 36-46 degrees Fahrenheit. The temperature would be monitored daily by the night shift. The facility's Dispensing and Labeling Drugs and Biologicals from Pharmacy Policy revised 8/19, documented medications must be kept or stored in their originally dispensed containers and transferring between container was forbidden. During an observation on 9/03/2024 at 8:56 AM, the [NAME] Unit medication room refrigerator contained 2 open bottles of purified protein derivative with no open and or expiration dates. In an interview at this time, Licensed Practical Nurse #3 stated when administering purified protein derivative, they would label the open date and verify the expiration date. During an observation on 9/03/2024 at 9:05 AM, [NAME] Unit, Cart #2 was noted to have two pre-poured medication cups: One cup had 1 pill; the other cup had 3 pills. Both cups had no cover but written on the cup was the number 30 space and an illegible notation. In an interview at this time, Licensed Practical Nurse #3 stated when they went to give medication to the resident, they had gone to therapy. They stated they stored the medications cup in cart and would give the medication when resident returned from therapy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 9/03/2024 at 9:05 AM, [NAME] Unit, Cart #2 was noted to have two open bottles of Lidocaine solution with no open and or expiration dates: 1 open Glargine insulin pen had no open date; 2 open vials of Lispro insulin, one with illegible open and expiration dates, the second had no open and or expiration date. During an observation on 9/03/2024 at 9:58 AM, the Red Unit Medication Room refrigerator temperature was noted to be 60 degrees Fahrenheit. During an observation on 9/03/2024 at 10:54 AM, Purple Unit, Cart #2, bottom overflow drawer contained multiple non-medication items including non-skid socks, an open tube of toothpaste with no name or label, an open jar of Eucerin cream with no name or label or open date, and yellow personal protective equipment gowns. During an observation on 9/03/2024 at 10:59 AM, Purple Unit Medication Room refrigerator contained one open bottle of purified protein derivative with no open and or expiration date; one open vial of Lispro insulin with no open or expiration date. During an interview on 9/04/2024 12:28 PM, Director of Nursing #1 stated nursing staff attend mandatory orientation in person that included medication administration, and agency nursing staff were given a binder to review prior to hire. They further stated that there was a medication assessment test that was given prior to nurse passing medication for all nursing staff. Director of Nursing #1 stated it was the responsibility of each nurse to ensure their cart was clean and medications were labeled appropriately. During an interview on 9/05/2024 10:41 AM, Nurse Educator #1 stated all nursing staff attended general orientation including medication administration. They further stated agency staff were provided a binder with all nursing competencies and were complete an exam upon completion. 10 New York Codes, Rules, and Regulations 415.18(d)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observations and staff interviews during the recertification survey, the facility did not ensure infection prevention control practices were followed to help prevent the spread, development, and transmission of communicable diseases and infections. Specifically, the staff did not put on and take off personal protective equipment correctly when entering and exiting the room of a COVID-19 positive resident. This was evident for 1 of 5 resident units observed. This is evidenced by: The Centers for Disease Control document titled Sequence for Putting on Personal Protective equipment (PPE) stated the correct sequence for putting on personal protective equipment was gown, mask or respirator, goggles, or face shield, then gloves. The document stated the correct sequence for removing personal protective equipment was gloves, goggles or face shield, gown, and then mask or respirator. (https://www.cdc.gov/infection-control/media/pdfs/Toolkits-PPE-Sequence-P.pdf) During an observation on 8/30/2024 at 11:08 AM in from room [ROOM NUMBER], Licensed Practical Nurse #4 put on personal protective equipment for droplet precautions in the following order: N95 mask, gown, face shield and then gloves. Licensed Practical Nurse #4 was observed removing their personal protective equipment in the following order: face shield, gown, gloves and N95 mask. Licensed Practical Nurse #4 was observed bringing in a piece of medical equipment into the room, removing it from the room, and placing it in the hall; the equipment was not cleaned. During an interview on 9/05/2024 at 9:36 AM, Certified Nurse Aide #1 stated the facility always provided enough personal protective equipment for the staff. They stated the following order for putting on personal protective equipment: sanitize hands, gloves, gown, mask, then face shield. They stated the following order for taking off personal protective equipment: gown, first set of gloves, face shield, mask, second set of gloves, then wash hands. During an interview on 9/05/2024 at 9:43 AM, Certified Nurse Aide #2 stated they would put on personal protective equipment in the following order: N95 mask, face shield, gown, then gloves. They would take off personal protective equipment in the following order: gown, face shield, N95 mask, gloves then wash hands. During an interview on 9/05/2024 at 9:49 AM, Licensed Practical Nurse #2 stated they would put on personal protective equipment in the following order: gown, N95 mask, face shield, then gloves. They would take off personal protective equipment in the following order: gown, gloves, shield, mask, and then wash hands. They stated that a COVID-19 positive resident with droplet precautions would have their own blood pressure cuff and thermometer if possible. The sphygmomanometer (medical device that measures blood pressure) would be non-dedicated medical equipment and would need to be wiped down with wipes between uses. They stated they received training on infection control upon hire and yearly, more often if policies or guidance changed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/05/2024 at 9:58 AM, Infection Preventionist #1 stated staff training on infection control was given on hire and if there was an outbreak. There was also annual training done. They stated there were signs posted for putting on and taking off personal protective equipment posted in the bathrooms. They stated COVID-19 residents should have their own blood pressure cuff and thermometer. During an interview on 9/05/2024 at 10:41 AM, Nurse Educator #1 stated employees were given training on hire and annually upon anniversary date. The training was offered through an on-line program or on a paper version of the on-line program. They stated staff were trained on putting on and taking off personal protective equipment as part of the infection control training. They stated agency staff received the same training including the infection control trainings. They stated that any medical equipment would have to be sanitized between residents. During an interview on 9/05/2024 at 10:56 AM, Licensed Practical Nurse #5 stated that there were 3 sphygmomanometers, on the unit, each hallway had its own tower. The tower observed on 8/30/2024 was used for all residents. New York Code of Rules and Regulation 415.19(a)(1-3)