STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335830	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Margarets Center	27 Hackett Blvd Albany, NY 12208

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 43805 Based on observation, record review, and interviews during a recertification and abbreviated survey (Case #s NY00311240, NY00320508, NY00321961, and NY00329555), the facility did not ensure residents were free from neglect for 4 (Resident #s 1, 5, 6, and #45) of 19 residents reviewed for abuse and neglect. Specifically, (a.) Resident #1, was provided personal care by Certified Nurse Aide #2 instead of two staff members as their care plan indicated, and Resident #1's bed was not set up as the care plan required, subsequently, the resident hit their head and sustained a small injury to their forehead; (b.) Resident #5 sustained a fall from a mechanical lift due to improper technique; (c.) Resident #6 sustained a fractured left great toe with evidence of improper transfer found; and (d.) Resident #45 was being readied to be transferred from their wheelchair, but the Certified Nurse Aide #3 did not buckle the resident's seatbelt causing the resident to fall from their wheelchair to the floor. This is evidenced by: The facility policy titled, Abuse Prevention and Prohibition Policy, dated [DATE], documented that it was the policy of the facility to prohibit and protect residents from any form of abuse, exploitation, mistreatment, misappropriation and neglect. The policy further defined abuse as the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Neglect was defined as the failure to provide timely, consistent, safe, adequate, and appropriate services, treatment, and/or care to a resident, while such resident was under the supervision of the facility. Neglect may include but was not limited to failure to carry out physician orders, medications omission, treatment omission or failure to follow the care plan or provide emergency services; failure to adequately supervise whereabouts and activities of residents; and /or failure to provide adequate hydration and nutrition. A facility policy titled, Using the Care Plan, dated [DATE], documented under policy interpretation and implementation that failure to follow a resident's care plan as written could pose safety risks to the resident. Disregard for and failure to follow a care plan, in some cases, could be deemed neglectful. Disciplinary actions imposed by family and State licensing agencies could be imposed. Resident #1 (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 - Few	Resident #1 was admitted to the facility with the diagnoses of profound intellectual disabilities (a level of intellectual disability characterized by having an average mental age of 3 years and below), disorder of bone density and structure (a medical condition where there is an abnormality in the density and structure of bones), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs, trunk, and the face characterized by severe muscle stiffness and spasticity). The Minimum Data Set (an assessment tool), dated [DATE], documented that the resident had severe cognitive impairment, and rarely or never could be understood or understand others. Per the facility investigation, on February 18, 2023, Resident # 1 was in their bed on the North Unit. Certified Nurse Aide #2 reported that they went into Resident #1's room to do care by themselves and did not seek out assistance from another staff although they knew that Resident #1 required the assistance of two staff. Certified Nurse Aide #2 stated that they did not know why they did not seek assistance and there was no excuse. During the care given, Resident #1 rolled over and hit the wall, injuring their forehead. Resident #1's care plan and Kardex documented that the resident's bed should not have been against the wall, mats should have been on the floor on either side of the bed, and Certified Nurse Aide #2 should have had a second care giver with them. Resident #5 Resident #5 was admitted to the facility with the diagnoses of microcephaly (a condition where the head is much smaller than expected often due to abnormal brain development), dysphagia (difficulty swallowing food or liquids), and myoclonus (a sudden and involuntary muscle spasm). The Minimum Data Set, dated dated [DATE], documented that the resident had severe cognitive impairment, and rarely or never could be understood or understand others. Facility's Investigation dated [DATE], Certified Nurse Aide #4 transferred Resident #5 from the bed to the wheelchair with a full mechanical lift. During the transfer, Resident #5's bottom half slid out of the mechanical lift sling and landed on the floor. Certified Nurse Aide #4 was aware that a full mechanical lift required 2 staff members but attempted the transfer without assistance. Resident #5 was transferred to the hospital for evaluation and returned to the facility with no injuries from the incident. During an interview on [DATE] at 12:21 PM, Director of Nursing #1 stated that Certified Nurse Aide #4 was let go following their care plan violation of not using two people for resident care. Resident #6 Resident #6 was admitted to the facility with the diagnoses of epilepsy (a brain condition that causes recurring seizures), scoliosis (a sideways curvature of the spine that can cause a prominent shoulder blade, uneven waist, and back pain), and anoxic brain damage (a condition that occurs when the brain is deprived of oxygen for an extended period of time). The Minimum Data Set, dated dated [DATE], documented that the resident had severe cognitive impairment, and rarely or never could be understood or understand others. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Investigation dated [DATE], Resident #6 was found with discoloration to their left great toe. Certified Nurse Aide #1 stated they had noticed the bruise the shift before. Certified Nurse Aide #1 stated they had completed multiple transfers of Resident #6 independently (scoop transfers) that were not appropriate as the resident was care planned for fully assisted transfers with at least 2 staff members. It was determined that the independent scoop transfers put the resident at risk for injury. During an interview on [DATE] at 12:21 PM, Director of Nursing #1 stated the investigation into the resident's fractured toe showed the care plan for transfers was violated and this put the resident at risk and probably caused the fracture. Resident #45 Resident #45 was admitted with the diagnoses of diagnoses of asthma with exacerbation (a worsening of asthma symptoms, including coughing, wheezing, chest tightness, and shortness of breath), congenital hydrocephalus (a condition where there's too much cerebrospinal fluid in the baby's brain at birth that can cause brain damage and long term problems), and spastic quadriplegic cerebral palsy (a severe form of cerebral palsy that affects all four limbs, trunk, and the face characterized by severe muscle stiffness and spasticity). The Minimum Data Set, dated dated [DATE], documented that the resident had severe cognitive impairment, and rarely or never could be understood or understand others. Facility's Investigation dated [DATE], Certified Nurse Aide #3 reported that they had been preparing to transfer Resident #45 from their wheelchair to bed. Certified Nurse Aide #3 unbuckled the resident's seatbelt to place the sling for the Hoyer lift under them. Certified Nurse Aide #3 reported that when they went to turn to Resident #45 on to their side to slide sling under them, Certified Nurse Aide #3 needed to tilt the resident's wheelchair. Certified Nurse Aide #3 did not re-buckle the seatbelt and Resident #45 fell to the floor onto their knees and hit their head on the floor. During an interview on [DATE] at 12:21 PM, Director of Nursing #1 stated Certified Nurse Aide #2 was let go following their care plan violation of not using two people for resident care. Director of Nursing #1 could not speak to what happened to Certified Nurse Aide #3, but they did not believe Certified Nurse Aide #3 was employed by the facility anymore. They stated the injuries were considered abuse or neglect, cut and dry if it was a care plan violation. Each staff member was precepted for 10 days and if the staff still could not follow a care plan, then there was a problem, and the staff would not be kept on. Abuse and neglect were part of ongoing education with the staff. There was a safe handling review done house wide after the care plan violation/safe handling incidents occurred. 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i) 48744

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on record review and interviews conducted during recertification and abbreviated survey (case #NY00329555), the facility did not ensure that the development and implementation of comprehensive person-centered care plans included measurable objectives and timeframes to meet residents' medical, nursing, mental and psychosocial needs for 3 (Resident #s 4, 59, and 62) of 19 residents reviewed for comprehensive care plans. Specifically, (a.) for Resident #s 4 and 59 , the Comprehensive Care Plan did not include the use of medications with specific indication for use; (b.) for Resident #62, intervention of floor mat on the floor was not implemented to ensure safety while at play. This is evidenced by: A facility policy titled, Care Plans, dated 4/01/2019, documented under Policy Interpretation and Implementation: 1. Each resident's care plan was designed to: a. Incorporate identified problem areas; f. Identify the professional services that are responsible for each element of care; i. Reflect currently recognized standards of practice for problem areas and conditions. A facility policy titled, Using the Care Plan, dated 4/01/2013, documented under policy interpretation and implementation. Failure to follow a resident's care plan as written could pose safety risks to the resident. Disregard for and failure to follow a care plan, in some cases, could be deemed neglectful. Disciplinary actions imposed by family and State licensing agencies could be imposed. Resident #4 Resident #4 was admitted to the facility with diagnoses of septo-optic dysplasia of brain (a rare congenital malformation syndrome that features a combination of the underdevelopment of the optic nerve, pituitary gland dysfunction, and absence of the midline part of the brain), cardiomegaly (an enlarged heart), expressive language disorder (a communication disorder characterized by difficulty using expressive spoken language that is below the appropriate level for the mental age). The Minimum Data Set (an assessment tool) dated 10/13/2024, documented the resident had severe cognitive impairment, and rarely or never could be understood or understand others. A physician order dated 1/21/2020 at 3:45 PM documented an order for zinc oxide cream 22.5% - apply to buttocks/peri area topically as needed for diaper rash. Apply as needed at each brief/incontinence change. Contact medical director if no improvement within 48 hours of initiation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician order dated 3/16/2016 at 7:00 AM documented an order for albuterol sulfate u-d 2.5 milligrams per 3 milliliter vial nebulizer - 1 vial inhale orally every 4 hours as needed for wheezing. A physician order dated 9/14/2022 at 4:30 PM documented an order for Propranolol HCl Tablet 10 milligrams - give 1 tablet via gastric tube every 6 hours as needed for heart rate over 90. Hold for systolic blood pressure less than 110. There was no documented care plan focuses related to using creams after episodes of incontinence, giving respiratory treatments when Resident #4 required them for wheezing, or monitoring blood pressures to determine the need for blood pressure medication. Resident #59 Resident #59 was admitted to the facility with the diagnoses of cerebral palsy (a group of disorders that affect movement, muscle tone, balance, and posture), profound intellectual disabilities (the most severe category of intellectual disability characterized by the inability to live independently, being in need of close supervision, limited communication, and physical restrictions), and intestinal malabsorption (a digestive health condition in which the gastrointestinal tract is unable to absorb one or more nutrients). The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment, and rarely or never could be understood or understand others. A physician order dated 11/23/2023 at 10:15 AM documented an order for albuterol sulfate inhalation nebulization solution (2.5 milligrams per 3 milliliters) 0.083% - 1 vial inhale orally via nebulizer as needed for wheezing. There was no documented care plan focuses related to giving respiratory treatments when Resident #59 required them for wheezing or difficulty breathing. Resident #62 Resident #62 was admitted with the diagnoses of extreme immaturity of newborn, gestational age 24 completed weeks, bronchopulmonary dysplasia originating in the perinatal period, congenital tracheomalacia. The Minimum Data Set, dated dated dated [DATE] documented the resident had severe cognitive impairment, and rarely or never could be understood or understand others. Resident #62's Comprehensive Care Plan for Activities of Daily Living Self-Care Performance deficit related to impaired cognition, dated 5/10/2021, documented interventions of out of bed environment (3) floor mat with supervision to play on the mat, caregiver on the mat to assist if nearing edge of the mat, to avoid toys (self-hitting with toys) or other residents, and to maintain safety as they quickly rolled, crawled, sat and pulled to tall kneel. The facility reported incident dated 1/19/2023 at 11:50 AM, documented that Resident #62 was left alone on the floor mat, not attended to by staff on the mat with them, and was not engaged per the comprehensive care plan interventions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/14/2025 at 12:20 PM, Licensed Practical Nurse #3 stated that care plans were updated by the charge nurses or the social workers. It was their expectation that if a resident was on respiratory treatments, there would be a respiratory care plan for the resident. Licensed Practical Nurse #3 stated that medical interventions required care plan interventions. During an interview on 2/14/2025 at 12:24 PM, Registered Nurse #1 stated they would not expect that a resident receiving albuterol treatments would be guaranteed to have a respiratory care plan, if that was the only thing that needed to be done. For example, if the resident could clear their own secretions and had no other respiratory issues, they would not necessarily expect that there would be an active respiratory care plan. Registered Nurse #1 stated that not every medication required a care plan. During an interview on 2/18/2025 at 12:21 PM, Director of Nursing #1 stated that medications did not need to be specifically care planned for. Director of Nursing #1 confirmed that resident Kardex information was generated from the information in care plans. Director of Nursing #1 eventually stated that they could see why care planning based on medications and medical issues would be important for all the information to be contained in one place. Director of Nursing #1 stated care plan interventions for supervision and behavioral management should be followed. They would expect the Certified Nurse Aides to follow and implement the care plan as written 10 New York Codes, Rules, and Regulations 483.21(b)(1) 48744 51958

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43805 Based on records review and interviews during the recertification survey, the facility did not ensure each resident's drug/medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for 10 (Resident #s 1, 6, 10, 45, 46,48, 54, 62, 68, and 79) of 19 residents reviewed for unnecessary medications. Specifically, for Resident #s 1, 6, 10, 45, 46, 48, 54, 62, 68, and 79, as-needed psychotropic medication orders did not include end dates. This is evidenced by: A facility policy titled, Medication Management dated 12/10/2024, documented that as needed orders for psychotropic drugs were limited to 14 days. The use of psychotropic medication to treat an emergency situation must be consistent with the requirements regarding as needed orders for psychotropic medications. Resident #1 Resident #1 was admitted to the facility with the diagnoses of spastic quadriplegic cerebral palsy (movement disorder which include poor coordination, stiff muscles, and tremors), gastro-esophageal reflux disease, and neuromuscular scoliosis (a type of spinal curvature that results underlying neurological or muscular disorders). The Minimum Data Set (an assessment tool) dated 10/18/2024 documented the resident was rarely/never understood by others, rarely/never understood others, and was severely cognitively impaired. An order dated 7/24/2024 documented diazepam (a psychotropic medication) 10 milligrams per 0.1 milliliter 1 spray in nostril as needed for seizures 5 minutes or greater or 3 or more cluster seizures in 1 hour. There was no end date documented. Resident #46 Resident #46 was admitted to the facility with the diagnoses of spastic diplegic cerebral palsy (movement disorder which include poor coordination, stiff muscles, and tremors), seizures, and autistic disorder (a lifelong developmental disability that affects how people communicate and interact with the world). The Minimum Data Set, dated dated dated [DATE] documented the resident was rarely/never understood by others, rarely/never understood others, and was severely cognitively impaired. An order dated 10/02/2023 documented diazepam (a psychotropic medication) 10 milligrams per 0.1 milliliter 1 spray in nostril as needed for seizures 5 minutes or greater or 3 or more cluster seizures in 1 hour. There was no end date documented. Resident #79 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #79 was admitted to the facility with the diagnoses of cervical spinal cord injury, anxiety disorder, and acute stress reaction (a short-term psychological response to a traumatic event). The Minimum Data Set, dated dated dated [DATE] documented the resident was understood by others, could understand others, and was cognitively intact. An order dated 1/10/2025 documented diazepam 1 milligram via gastrostomy tube every 8 hours as needed for anxiety. There was no end date documented. During an interview on 2/14/2025 at 10:22 AM, Consultant Pharmacist #1 stated the facility was provided with a list of all residents who had their medications reviewed and the recommendations made. Consultant Pharmacist #1 stated they informed the physicians that as needed psychotropic medications required end dates, even if prescribed for seizures. During an interview on 2/14/2025 at 1:05 PM, Medical Director #1 stated they did not put end dates on psychotropic medications prescribed for seizure disorders. There should be a rationale in the medical provider notes, but the notes 'probably weren't present' because they think of the psychotropic (specifically diazepam) as an anticonvulsant and not a psychotropic medication. During an interview on 2/14/2025 at 1:19 PM, Medical Doctor #1 stated the nurses would give the prescriber a list of medications for renewal and they would renew the medications as needed. The Medical Doctor #1 was not able to state why there were no end dates for as needed psychotropic medications, but stated they understood the rationale behind the regulation. During an interview on 2/18/2025 at 12:25 PM, Director of Nursing #1 stated they were aware of the need for as needed psychotropic medications to have end dates. 10 New York Codes, Rule and Regulations 415.18 (c)(2) 51958

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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. 48744 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were stored properly and labeled in accordance with professional standards of practice. Specifically, opened medications had no open and/or expiration dates for 2 out of 5 medication carts reviewed for medication storage. This is evidenced by: The Facility's Medication Storage Policy, revised on 1/10/2024, documented under Medication Storage section that the nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner; medications were stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems; medications were stored separately from food and were labeled accordingly. Under Medication Labeling section, the policy documented that labeling of medication and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices; multi-dose vials that have been opened would be dated and discarded within 28 days unless the manufacturer's label specified a shorter or longer duration of use once opened. During an observation on 2/13/2025 at 9:41 AM, South Unit, medication Cart #1 contained an opened bottle of Famotidine, an opened bottle of Valproic Acid, and an opened bottle of Levetiracetam Solution. None of the opened bottles had open or expiration dates. During an observation on 2/13/2025 at 10:05 AM, North Unit, medication Cart #1 contained an opened bottle of Glycopyrrolate, 2 opened bottles of Levetiracetam Solution, and an opened bottle of Centra Vite. None of the opened bottles had open or expiration dates. During an interview on 2/13/2025 at 9:41 AM, Licensed Practical Nurse #1 stated that the opened medications should have been labeled when they were opened. During an interview on 2/13/2025 at 10:05 AM, Licensed Practical Nurse #2 stated they knew medications should be labeled with the date opened. When asked if the carts were checked for storage issues, Licensed Practical Nurse #2 stated that they only worked 3 days a week so they could not speak for other shifts. During an interview on 2/18/2025 at 12:21 PM, Director of Nursing #1 stated that nursing staff was responsible for checking medication storage areas for expired medications or medications requiring dates opened. Director of Nursing #1 stated that there were plenty of staff in the building, and there was no reason that they believed the staff could not maintain proper medication storage. 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 - Some	Provide and implement an infection prevention and control program. 21414 Based on record review and interviews during a recertification survey, the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infection. Specifically, the facility water management and sampling plan did not include a simple schematic that visually described the building water system and the identification of areas where Legionella could grow and spread. This is evidenced by: There was no documented evidence that the facility water management and sampling plan included a simple schematic that visually described the building water system and the identification of areas where Legionella could grow and spread. During an interview on 02/11/2025 at 11:46 AM, Senior Regional Director of Facilities #1 stated that the facility Legionella Management Plan would be updated to include a flow chart that described the building water system and the identification of areas where Legionella could grow and spread. 10 New York Codes, Rules, and Regulations 483.80(a)(1)(2)(4)(e)(f)