

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335072	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/13/2026
NAME OF PROVIDER OR SUPPLIER  St. Joseph's Hospital - Skilled Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE  555 St. Joseph's Boulevard Elmira, NY 14902	
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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility did not provide maintenance services necessary to maintain a safe and comfortable environment for one (1) of one (1) automatic door reviewed (Main Entrance). Specifically, the exterior and interior accessibility (handicap) automatic door opening pads at the main entrance were not functional, requiring residents who used wheelchairs to rely on others for entry and exit from the building. The findings include: The facility policy Maintenance and Service of Medical Equipment and Service Contract Agreements last reviewed March 2024 included completion of a work order in the event of malfunctioning equipment. Resident #9 had diagnoses including polyneuropathy (damage to peripheral nerves) and osteoarthritis (degenerative joint disease). The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and used a wheelchair for mobility, independently self-propelling up to 150 feet with two (2) turns. Review of the current Comprehensive Care Plan initiated 02/10/2026 documented the resident required staff supervision for wheelchair mobility. During an interview on 02/11/2026 at 11:30 AM, Resident #9 stated the front entrance handicap pads had not worked since last summer and the doors must be held open by family members to allow exit from the building. The resident stated the doors were heavy. Resident #12 had diagnoses including left leg above-the-knee amputation, right leg below-the-knee amputation, and gait (a person's manner of walking) and mobility abnormalities. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and independently self-propelled a wheelchair 150 feet with two (2) turns. During an interview on 02/11/2026 at 10:45 AM, Resident #12 stated the entrance accessibility switch did not work and when returning to the facility, the resident must call security, flag down a security vehicle, or attempt to get someone's attention inside the building for assistance to re-enter. Resident #3 had diagnoses including traumatic brain injury and epilepsy. The Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition. During an interview on 02/11/2026 at 10:30 AM, Resident #3 stated the accessibility pads at the outside entrance had not worked in a while and the resident did not attempt to use them. During observations on 02/11/2026 at 8:15 AM and on 02/12/2026 at 8:30 AM, the surveyor pressed the exterior and interior accessibility automatic door opening pads. The automatic doors did not open on either date, and the doors had to be manually opened. During an interview on 02/11/2026 at 9:10 AM, the Administrator stated they were not aware the entrance accessibility pads were not functioning. During an interview on 02/11/2026 at 9:40 AM, the Director of Facilities stated they were not aware the entrance accessibility pads were not functioning. The Director of Facilities stated work orders are completed when equipment is reported as malfunctioning. Review of maintenance documentation did not include work orders related to the entrance accessibility pads. 10 NYCRR 415.29, 415.29(b), 415.29(j)(1)</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  335072	Facility ID:  335072  If continuation sheet Page 1 of 4

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on observations, interviews, and record review, the facility did not ensure allegations of neglect were thoroughly investigated and documented for one (1) of two (2) residents reviewed (Resident #9). Specifically, Resident #9 sustained an injury when [NAME] Elevator #5 closed on the resident's arm, and the facility did not complete an incident report, initiate an investigation, or conduct a root cause analysis following the incident. The findings include: The facility policy Accident Investigation and Analysis last reviewed December 2025 included all accidents and incidents would be investigated by the department director. Serious accidents, or any unusual frequency of accidents shall be investigated by the Safety Committee. The facility policy Equipment - Incident Investigation last reviewed October 2024 included preparing a report of findings when equipment has been involved in an injury to a patient. If it is suspected an incident was caused by equipment malfunction or caused entirely by improper use of equipment, an incident report form needed to be prepared and submitted. Resident #9 had diagnoses including polyneuropathy (damage to peripheral nerves) and osteoarthritis (degenerative joint disease). The Minimum Data Set (a resident assessment tool) dated 02/04/2026 documented the resident was cognitively intact and used a manual wheelchair for mobility. In a progress note dated 01/26/2026, Licensed Practical Nurse #1 documented Resident #9 bumped their left arm on the elevator doors during day shift. In progress notes dated 01/27/2026, Licensed Practical Nurse #2 documented Resident #9 reported left wrist and forearm pain following the elevator door closing on their arm. The left wrist and arm appeared bruised and slightly swollen. An orthopedic office visit note dated 01/27/2026 documented no acute bony abnormality on x-ray and conservative management was recommended. During an interview on 02/11/2026 at 9:40 AM, the Director of Facilities stated no work order was received related to [NAME] Elevator #5 closing on Resident #9's arm. During an interview on 02/11/2026 at 11:55 AM, Registered Nurse Manager #1 stated following the incident, the focus was on caring for the resident and notifying administration. Registered Nurse Manager #1 stated an incident report was not completed. During an interview on 02/12/2026 at 9:20 AM, the Director of Nursing stated an incident report and investigation report related to Resident #9's elevator injury could not be located and were not completed. Review of facility documentation did not include evidence an investigation was initiated, no root cause analysis was conducted, and no Safety Committee review occurred following the incident. 10 NYCRR 415.4(b)(3)-(4)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observations, interviews, and record review, the facility did not ensure the resident environment remained as free of accident hazards as possible for two (2) of five (5) residents reviewed (Resident #9 and Resident #12). Specifically, Resident #9's arm was caught in [NAME] Elevator #5 when attempting to stop the elevator door from closing, and Resident #12 was observed using their arm to prevent the elevator door from closing on their wheelchair. The elevator remained operational and accessible to residents, and the facility did not investigate, test, repair, or remove the elevator from service following the incident involving Resident #9. The findings include: The facility policy Accident Investigation and Analysis last reviewed December 2025 included all accidents and incidents would be investigated by the department director. Serious accidents, or any unusual frequency of accidents shall be investigated by the Safety Committee. The facility policy Equipment - Incident Investigation last reviewed October 2024 included preparing a report of findings when equipment has been involved in an injury to a patient. If it is suspected an incident was caused by equipment malfunction or caused entirely by improper use of equipment, an incident report form needed to be prepared and submitted. 1. Resident #9 had diagnoses including polyneuropathy (damage to peripheral nerves) and osteoarthritis (degenerative joint disease). The Minimum Data Set (a resident assessment tool) dated 02/04/2026 documented the resident was cognitively intact and used a manual wheelchair for mobility, independently self-propelling up to 150 feet with two (2) turns. Review of the current Comprehensive Care Plan initiated 02/10/2026 documented Resident #9 could self-propel in a wheelchair with staff supervision. In progress notes dated 01/26/2026, Licensed Practical Nurse #1 documented Resident #9 bumped their left arm on the elevator doors during day shift. In progress notes dated 01/27/2026, Licensed Practical Nurse #2 documented Resident #9 reported left wrist and forearm pain following the elevator door closing on their arm. The left wrist and arm appeared bruised and slightly swollen. The left arm was wrapped for comfort and pain medication was administered. An orthopedic office visit dated 01/27/2026 documented x-rays of the left wrist showed no acute bony abnormality (no fracture). Conservative management was recommended, including use of an Ace bandage or splint for comfort and a short course of narcotic pain medication. During an interview on 02/11/2026 at 11:30 AM, Resident #9 stated the elevator door did not stop when their arm was placed against it to prevent it from closing. Resident #9 stated a staff member pulled the door open so their arm could be removed. During an interview on 02/11/2026 at 12:05 PM, Sitter #1 stated the elevator door closed fully on Resident #9's wrist and did not re-open when the arm was placed across the doorway. Sitter #1 stated the door had closed on them previously and had been doing so since beginning employment five (5) years ago. During an interview on 02/12/2026 at 9:20 AM, the Director of Nursing stated an incident report related to Resident #9's elevator injury could not be located and was not completed. 2. Resident #12 had diagnoses including left leg above the knee amputation, right leg below the knee amputation, and mobility abnormalities. The Minimum Data Set, dated [DATE] documented the resident was cognitively intact and independently self-propelled a manual wheelchair up to 150 feet with two (2) turns. Review of the current Comprehensive Care Plan initiated 06/10/2025 documented Resident #12 navigated the facility independently in a wheelchair. During an observation on 02/12/2026 at 12:05 AM, Resident #12 self-propelled their wheelchair into [NAME] Elevator #5. The elevator door closed while the wheelchair was partially inside the elevator and made contact with the wheelchair. Resident #12 used their arm to stop the elevator door from closing and repositioned the wheelchair. During an interview on 02/11/2026 at 10:35 AM, Certified Nursing Assistant #1 stated staff avoid placing arms in the doorway because the</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>[NAME] Elevator doors will close quickly and slam shut. During an interview on 02/11/2026 at 10:45 AM, Resident #12 stated the elevator doors close too fast and sometimes must be stopped manually with hands to prevent them from closing. During an interview on 02/11/2026 at 9:10 AM, the Administrator stated they were aware [NAME] Elevator #5 closed quicker than the other elevator and stated Resident #9 put their arm out to stop the door and Resident #9's arm got pinched. During an interview on 02/11/2026 at 9:40 AM, the Director of Facilities stated elevator doors are inspected yearly and not checked routinely. The Director of Facilities stated work orders are completed when problems are reported. Review of maintenance documentation did not include a work order for [NAME] Elevator #5 related to door malfunction. Review of elevator inspection reports dated 02/19/2024, 08/13/2024, 12/23/2024, and 09/25/2025 identified violations for [NAME] Elevator #5. A letter from the facility's contracted elevator repair company dated 02/13/2026 referenced violations items on an inspection report from 09/25/2025 and documented some violations identified for [NAME] Elevator #5 had been completed, while others were in process of being addressed. The facility did not provide documented evidence the door sensor or closing mechanism for [NAME] Elevator #5 were tested or repaired following the incident involving Resident #9. 10 NYCRR 415.29, 415.29(b), 415.29(j)(1)</p>		