STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335087	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Josephs Home	950 Linden Street Ogdensburg, NY 13669

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, record review, and interviews, the facility failed to ensure residents were treated with respect and dignity in a manner and in an environment that promotes maintenance or enhancement of quality of life, recognizing each resident's individuality during meal service in two (2) of two (2) dining rooms (First and Second floor dining rooms). Specifically, residents stated they were not allowed to visit residents at other tables and/or visitors were not allowed to visit in the dining rooms during and after mealtimes. Findings include: The facility policy Resident's Rights Policy, reviewed 11/2025, documented the residents were provided a homelike environment which fully provides their right to a dignified existence. The residents had a right to a homelike environment and to incorporate personal and cultural preferences within their goals of care. Residents have the right to immediate and unlimited access by friends and family. Residents had the right to interact with members of the community both inside and outside the facility and the right to make choices about their life in the facility that were significant to them. The facility policy Dining Room Management, created 02/12/2026, documented the dining room provided space for all admitted residents and may have space for family members who received permission to be in the dining room to assist their loved one or a compassionate care visit. Seating charts were prepared by the interdisciplinary team to consider the physical and social needs of the residents and the ability of the staff to manage the dining room to focus on the needs. Residents can request to move seats, and the change would be evaluated by the interdisciplinary team; the change may not be initiated if determined by the interdisciplinary team to be detrimental to others. The facility reserved the right to limit movement in the dining room during mealtime. Residents often have complications related to medical and social status which can place others at risk. If residents have difficulty with the standards and place others at risk who may not understand the risk, staff will communicate with the residents. Staff were to utilize calm and kind tones when communicating with a resident struggling with the policy and encourage them to meet up with other residents in common areas after the mean. A team approach should be utilized for any difficulty encountered.During an interview on 03/16/2026 at 12:30 PM Resident #26's adult sibling stated the resident always ate lunch in their room because the facility did not allow visitors in the dining room so they could not visit with the resident during meals.During a dining room observation and resident interview on 03/16/2026 at 12:47 PM, Resident #70 was sitting in a chair at a table that was not their assigned table, visiting with Resident #74. Resident #70 stated they wanted to visit other tables while they finished lunch but was told they could not, even if the residents at other tables did not care. Resident #74 stated they did not mind Resident #70 coming to their table to talk and visit. At 12:52 PM, Resident #70 moved their chair next to Resident #23, off to the side from the table. Other residents asked Resident #70 to come sit next to them. Registered Nurse Unit Manager #5 stated to Resident #70 to sit at their own table until lunch was over and then they could visit in the lounge area. The resident declined. Registered Nurse Unit Manager #5 stated Resident #70 should be able to visit.During an observation on 03/19/2026 at 11:57 AM Social Worker #15 was giving a facility tour and stated to the touring family the facility was flexible. The family could bring the resident to dining room, but they could not sit with the resident during the meal.During (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a dining room observation and resident interview on 03/19/2026 at 12:45 PM, Resident #70 finished their lunch and sat in an open seat at the table next to theirs. At 12:48 PM, Certified Nurse Aide #8 approached Resident #70 and asked the resident to go back and sit in their own seat. Resident #70 asked why, and Certified Nurse Aide #8 stated they were supposed to stay in their own seat. The resident declined to move. Certified Nurse Aide #8 stated they would let Licensed Practical Nurse #9 know. Resident #23 congratulated Resident #70 for not moving and stated they could visit if they wanted. At 12:49 PM Licensed Practical Nurse #9 came over and began speaking quietly with Resident #70. Licensed Practical Nurse #9 stated to the resident they could visit when the other residents were done eating and they were previously told that. Resident #70 stated everyone was done eating; two of the other three residents were done, and the third was picking at chips on a plate. Licensed Practical Nurse #9 stated it was hard because Resident #70 just wanted to visit with the table. At 12:57 PM, Resident #70 stated they were told they were not allowed to visit with their friends during meals due to germs. Resident #32 stated everyone had germs and they did not mind Resident #70 coming to visit. During an interview on 03/19/2026 3:03 PM, Resident #32 stated their adult grandchild came from out of state to visit during the dinner meal last evening on 03/18/2026 and surprised the resident and their spouse, who also resided at the facility. They stated they were just about done with dinner when their adult grandchild came over to say hello and pulled a chair up near the table. Before they could sit or say anything a staff member told their grandchild they could not sit down. Licensed Practical Nurse #9 came over, spoke with their grandchild and went to the phone to call someone about the rule. Their grandchild came back and stated they had to leave, and Resident #32 stated they had just gotten there and to pull up a chair. Their grandchild stated they were not allowed to because people were eating and the person Licensed Practical Nurse #9 had called told them they could not stay. Resident #32 stated they had been at the facility since May 2024, and this was the first time they heard the rule. They felt it was a foolish and nonsense rule. They stated if they were home and someone came to visit, they would have them sit down even if it was mealtime. Their grandchild did not ask for dinner, they just wanted to visit. The resident stated their spouse, who was also in the facility, had dementia and had not been doing well and their grandchild wanted to visit. During an interview on 03/19/2026 at 11:21 AM, Certified Nurse Aide #7 stated there was assigned seating in the dining room. If a resident wanted to sit somewhere else, staff should try and redirect the resident to the right spot. There were a few residents who liked to socialize at other tables in the dining room when they were done eating and there was one table that socialized a lot. There were no complaints from residents about Resident #70 visiting them at their table in the dining room.During an interview on 03/19/2026 at 12:01 PM, Certified Nurse Aide #8 stated if a resident wanted to sit somewhere other than their assigned seat in the dining room staff were to redirect them and explain everyone had their own seat for the dietary staff to follow. Residents were encouraged not to socialize with residents at other tables after they were done eating in the dining room. Once the residents were done eating, the dining room had to be cleared out in a timely manner, so it was best to socialize in the lounge not the dining room. Resident #70 was a very social person and had issues following the guidelines in the dining room and needed a lot of reminding and redirecting. The other residents in the dining room did not complain about Resident #70 visiting their table and they enjoyed Resident #70's company.During an interview on 03/19/2026 at 1:35 PM, Licensed Practical Nurse #9 stated if a resident wanted to sit somewhere else in the dining room the staff should not encourage it because if one resident moved, all the residents would want to move. Residents were allowed to socialize at other tables in the dining room if they were all finished eating. None of the residents at the table Resident #70 visited had any issues with Resident #70 coming to visit their table. They stated they believed the residents had a hard time with the rule because it would be no different than if they were out at restaurant and asked someone to sit down. Families were only allowed to sit with residents in the dining room if the resident was care planned for it. If a family member was just visiting at mealtime they were not allowed to sit down if the residents were eating. During an (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 03/20/2026 at 9:30 AM, Registered Nurse Unit Manager #5 stated seats were assigned in the dining room for the kitchen flow for meals and based on residents' needs. Table hopping could make things more confusing as well as cause infection control issues. Residents had the right to finish their meal before they had company. If all the residents were done eating, residents could socialize with other tables but they typically tried to clear out the dining room in a timely fashion so the kitchen could be cleaned and intakes done. Residents could visit in the lounge or in activities. The residents at the table may not be concerned with another resident visiting them while they were still eating but the staff must look at the whole picture to minimize risks and prevent issues. Extra visitors in the dining room were also minimized to keep the meal process flowing. Resident #32 could have left the dining room with their grandchild and taken their meal in their room or the grandchild could have waited in the resident's room. If the family visit was going to be on a regular basis, the interdisciplinary team would discuss it, and arrangements could be made. The rules were in place to minimize chaos in the dining room. If every resident wanted to do what Resident #70 did it would create chaos in the dining room and create risks for the residents. It would be difficult for the dietary staff if multiple residents were moving throughout the meal process.During an interview on 03/20/2026 at 10:54 AM Social Worker #15 stated residents could request to move to a different table in the dining room if they wanted but it could not always be accommodated based on care plans, personalities, and hygiene. Family members who wanted to be present during mealtimes had to be approved by the interdisciplinary team. As a standard, they asked families not to be in the dining room unless it was previously approved. Resident #32's grandchild would not have been allowed to stay with them during dinner if the facility was not aware they were coming but they could have gone to the resident's room to wait for them. The policy of no family visitors in the dining was put in place for infection control, for dignity as some residents need assistance for personal hygiene, and for residents to have a meal without interruption or people watching them. The policy for residents not visiting other resident tables in the dining room was for infection control but also because a resident may get upset with another resident for being at their table. Going table to table in the dining room created all sorts of issues. Residents could visit in other areas of facility but were asked to remain at their own table during the dining experience. There was a happy balance between homelike and having residents stay where they were assigned so residents could have their meal in peace. Other areas of the facility were homelike.During an interview on 03/20/2026 at 11:03 AM, the Administrator stated the dining room experience where visitors cannot sit in the dining room or residents visiting other tables began during the COVID-19 pandemic to maximize the experience while protecting residents. Residents visiting other residents in the dining room became a concern regarding space during dining and spreading illness. 10 New York Code Rules and Regulation 415.5(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on record review and interviews, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choice for one (1) of three (3) residents (Resident #3) reviewed. Specifically, Resident #3 had diabetes and was responsible for reading their own blood sugar results with a blood glucose sensor device (a small sensor-based system applied to the back of the arm that provides continuous glucose readings without finger sticks). The resident's twice a day weekly blood glucose finger sticks was discontinued without a medical order and their blood glucose levels and sliding scale insulin were not documented as completed two (2) times in March 2026. Findings include:The facility policy Blood Glucose Monitoring, last reviewed 12/2025, documented residents with diabetes mellitus would have their blood glucose monitored by a registered nurse or licensed practical nurse as ordered by the physician and by nursing judgement. The blood glucose would be recorded with the nurses' initials in the medication administration record. There was no documented evidence of a policy for the use of a blood glucose sensor device.The facility policy Physician's Orders, last reviewed 12/2025, documented physician orders were to be signed and dated every 60 days and kept up to date in the resident's medical record. The physician must write an order to discontinue a previous order.Resident #3 had diagnoses including diabetes with diabetic neuropathy (nerve damage). The 2/17/2026 Minimum Data Set documented the resident was cognitively intact; required moderate to set up assistance for most activities of daily living; and received insulin.The 2/12/2026 Comprehensive Care Plan, revised 2/17/2026, documented the resident had multiple medical diagnoses including diabetes with diabetic neuropathy. The resident wanted to utilize their own diabetic monitor, would supply their own sensor patches for glucose checks, and demonstrated the ability to use the monitor for glucose checks. Interventions included monitor for complications and notify the medical provider, vital signs as ordered, provide medications as ordered for medical diagnosis and notify the medical provider as needed, and labs as ordered. The 02/10/2026 physician order documented sliding scale insulin coverage (the amount of insulin administered is based on blood sugar reading) three times a day prior to meals. Administer Novolog (fast-acting insulin) for blood glucose levels as follows: 61-140 milligrams/deciliter = 0 units; 141-200 milligrams/deciliter =3 units; 201-250 milligrams/deciliter =6 units; 251-300 milligrams/deciliter 9 units; 301-350 milligrams/deciliter =12 units; 351-400 milligrams/deciliter =15 units; and greater than 400 milligrams/deciliter 15 units and update physician. The 02/17/2026 Registered Nurse Unit Manager #5 progress note documented Resident #3 had their own glucose monitor sensor with a meter in their room. The resident wished to use the monitor instead of three times a day finger sticks. The provider was updated, and an order was obtained to utilize the glucose monitor with supplies provided by the resident, changing the sensor patch every 15 days, and to use the monitor sensor for glucose checks as ordered, to use the finger stick glucose checks three times a day per the order if the supply was out or the sensor was not working and to have finger sticks twice a day weekly while utilizing the sensor per protocol. The nursing staff were educated, and the sensor patch was applied to the resident's left arm. The sensor meter was charging in the resident's room.The 02/17/2026 telephone physician order documented the resident may utilize their own glucose monitor sensor with their own supplies for their blood sugar checks three times a day and to change the sensors as directed, every 15 days, and to have two times a day weekly finger sticks. The February 2025 Medication Administration Record documented use sensor for glucose checks three times daily and fingersticks twice a day once weekly. The Medication Administration Record did not include an area to document the weekly, twice daily finger sticks.The March 2026 Medication Administration Record documented weekly fingerstick glucose checks to verify sensor at 7:00 AM and 4:00 PM on 03/10/2026 and 03/17/2026. The entry was crossed out with a handwritten error co. There was no documented order to discontinue the two times a day weekly finger sticks. The March 2026 Medication Administration (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record documented on 03/01/2026 at 4:00 PM the resident had no blood glucose level or units of insulin documented. On 03/06/2026, the resident's blood glucose level was 166 milligrams/deciliter and there were no units of insulin documented as administered per the sliding scale insulin coverage. During an interview on 03/19/2026 at 1:35 PM, Licensed Practical Nurse #9 they knew a resident was diabetic by the diagnosis in their chart and there were diabetic pages in the medication administration record. Resident #3 did their own blood glucose readings through the implanted censor pad, informed the nurse of the number, the nurse wrote the result in the medication administration record, and used the sliding scale to administer the resident their ordered insulin coverage. During a follow up interview on 03/20/2026 at 11:10 AM, they stated they worked the evening shifts of 03/01/2026 and 03/06/2026. They did not know why the blood glucose or amount of insulin given were not recorded. They stated they would have asked the resident their blood sugar result and then give the appropriate insulin. On 03/06/2026, the resident should have received six (6) units of insulin with the recorded blood sugar of 166. They did not know why they did not write it down and it must have just been a slip. They should have recorded the insulin given on both dates. During an interview on 03/19/2026 1:35 PM Registered Nurse Unit Manager #5 stated they were asked by Licensed Practical Nurse #9 if the resident had any quality checks to ensure the sensor pad device was working appropriately. Registered Nurse Unit Manager #5 stated there were orders in the Medication Administration Record. They reviewed the Medication Administration Record and stated the order for the twice a day, once weekly finger sticks must not have been carried over to March 2026. The resident was supposed to have finger sticks weekly to compare to their device. They stated the resident had been using the device but there were issues with insurance, so the resident went back solely to finger sticks until the sensor pads were able to be obtained from the local pharmacy. When they got the new order on 03/03/2026, for the sensors the provider never gave them another order to verify the blood sugar checks with finger sticks. They stated the resident could tell staff if their blood sugar was high or low or if it beeped in the night, so the finger sticks were not needed since the resident did not like them.During a follow up interview on 03/20/2026 at 9:30 AM, Registered Nurse Unit Manager #5 stated the Medication Administration Record should be filled out with the resident's blood sugar level and the number of units of insulin given for a sliding scale. They were unaware the resident did not have the units of insulin given on 03/01/2026 or 03/06/2026. 10 New York Code Rules and Regulation 415.12 (k) (1)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, and interviews the facility failed to ensure that residents who required dialysis services (filtration of blood when the kidneys do not work) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #12) reviewed. Specifically, Resident #12 received hemodialysis treatments at a community-based dialysis center, and the facility did not have a plan to adequately monitor and care for the resident pre and post dialysis. Findings include:There was no documented evidence of a dialysis policy.Resident #12 had diagnoses including chronic kidney disease and dependence on dialysis. The 12/13/2025 Minimum Data Set assessment documented the resident was cognitively intact, had end stage kidney disease, and was dependent on dialysis treatments.The Comprehensive Care Plan reviewed and revised on 03/15/2026 documented the resident had kidney failure and received hemodialysis on Monday, Wednesday, and Friday at the dialysis center. The care plan did not include any specific care instruction, interventions or potential risk factors related to dialysis. There was no documented evidence of physician orders related to assessing and monitoring the resident's condition post dialysis or how staff were to care for and monitor the resident's dialysis access site. The dialysis and nursing home communication log documented the resident attended dialysis on 02/06/2026, 02/09/2026, 02/11/2026, 02/16/2026, 02/2026, 02/23/2026, 02/25/2026, 02/27/2026, 03/02/2026, 03/04/2026, 0307/2026, 03/09/2026, 03/11/16/2026, 03/13/2026, 03/16/2026.There was no documented evidence of a pre-dialysis evaluation on 02/06/2026, 02/09/2026, 02/11/2026, 02/16/2026, 02/2026, 02/23/2026, 02/25/2026, 02/27/2026, 03/02/2026, 03/04/2026, 0307/2026, 03/09/2026, 03/11/2026, 03/13/2026, 03/13/2026, 03/16/2026, 03/2026, 03/11/2026, 03/13/2026, 03/16/2026. There was no documented evidence of a post-dialysis evaluation on 02/06/2026, 02/09/2026, 02/11/2026, 02/16/2026, 02/2026, 02/23/2026, 02/25/2026, 02/27/2026, 03/02/2026, 03/04/2026, 0307/2026, 03/09/2026, 03/11/2026, 03/13/2026, 03/13/2026, 03/13/2026, 03/16/2026, 03/13/2026, 03/16/2026. During an observation and interview on 03/18/2026 at 12:50 PM, Resident #12 was seated in their wheelchair in their room and stated they recently returned from dialysis. The resident confirmed they received dialysis on Monday, Wednesday and Friday. The resident stated the facility staff did not manage the dialysis access site and did not change the dressing as this was done at dialysis. During a telephone interview on 03/19/2026 at 8:43 AM the Patient Care Coordinator at the Dialysis site stated Resident #12 received dialysis at the dialysis center three days a week. A communication binder was shared between the nursing home and dialysis center to communicate the resident's health status, and any changes in health status, including medication changes. During an interview on 03/20/2026 at 9:16 AM, with the Director of Nursing, stated the dialysis orders were in the resident files stored in the basement. The Director of Nursing could not explain what type of dialysis treatment Resident #12 received. They were also not aware of what type of dialysis access site the resident had, or that the resident required a physician order for dialysis treatments. 10 New York Codes, Rules, and Regulations 415.12(k)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on observations, record review, and interviews, the facility failed to ensure a resident was provided medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for one (1) of one (1) resident (Resident #6) reviewed. Specifically, Resident #6 had a history of depression with episodes of night terrors and did not have a person-centered care plan to address the resident's depression and did not have social work follow up to address the resident's history of post-traumatic stress disorder or psychosocial concerns.Findings include:The facility policy Resident's Rights Policy, last reviewed 11/2025 documented the facility would ensure the residents are provided with a home like environment which fully provides their right to a dignified existence including full recognition of their individuality and privacy and to participate in their care possible. The resident has the right to make choices about all aspects of their life. The facility will meet the residents' individual needs and preference to the extent possible through centered care.The facility policy Social History, Trauma Screening, and Psychosocial Assessment and Trauma Informed Consent, last reviewed 11/2025, documented the following:-The social worker was responsible for performing a psychosocial assessment and/or social history related to issues to identify social and emotional problems for each resident admitted .-The social worker will develop an individualized comprehensive assessment and history within seven days of resident admission-The social worker was responsible for the completion of the Trauma Care Screening Tool, with the input from the residents, significant other and family.-Care plans will be updated to show specific psychosocial concerns of the residents and interventions established as needed by resident assessment and choice. Resident #6 had diagnoses including depression and post-traumatic stress disorderwith a history of hallucinations. The 06/30/2025 Minimum Data Set assessment documented the resident's cognitive status was unable to be determined; the resident had no documented behaviors; required moderate to extensive assistance with most activities of daily living; and had psychiatric/mood disorder including depression and post-traumatic stress disorder. The Comprehensive Care Plan- Part 1 initiated on 12/24/2025 documented the resident was alert to self, place, time and confused at times. The section titled, Behaviors did not have anything checked off. The behaviors listed included but were not limited to verbal aggression towards others, resistance to care, or physical aggression toward others. The 01/06/2026 Comprehensive Care Plan completed by the Social Services Manager documented Resident #6 had experienced the following traumatic events: loss of loved ones; parents and stepchild, loss of roles and identity and missed doing things they loved to do such as mowing the lawn. They had a history of post-traumatic stress disorder with regular nightmares. The documented goal was the resident would verbalize their concerns without being troubled by past trauma. There were no specific interventions identified in the resident comprehensive care plan for how to manage the resident's diagnosis. The 01/07/2026 Comprehensive Care plan completed by Registered Nurse Unit Manager #5 documented the resident had depression with post-traumatic stress disorder related to being in the war, with a history of hallucinations; was admitted to the facility on an antidepressant; the resident had made statements and thought of suicide such as going to sleep and not waking up and when asked by staff, they had no plans to harm themself and denied needing changes to their plan of care. Interventions included administering medications as ordered, psychiatry consultations as needed, monitor for hallucinations, and monitor for complications when stopping medications. This care plan documented the resident's Cymbalta (antidepressant) 40 milligrams was gradually reduced starting 10/04/2021 and eventually discontinued on 07/08/2025. The physician orders dated 02/10/2026 did not include any order for psychotropic medications. There was no documented evidence of social work progress notes from 10/01/2025 through 03/18/2026. Nursing progress notes documented:-on 01/18/2026 by Licensed Practical Nurse #10 the resident was found to be ripping (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their incontinence briefs and throwing them on the floor.-on 01/19/2026 by Licensed Practical Nurse #10 the resident continued to rip their incontinence briefs off during the night and throw them on the floor.-on 01/21/2026 by Licensed Practical Nurse #11 the resident refused their weekly shower and refused breakfast. -on 02/22/2026 by Licensed Practical Nurse #6 the resident was extremely combative at lunch, refusing to get out of bed. The resident was hitting and grabbing at multiple staff. The resident was extremely combative at lunch, refused out of bed, and remained in bed until lunch.-on 02/24/2026 by Licensed Practical Nurse #12 the resident continued to be combative with staff. They were resistive to activities of daily living care, refused to attend the dining room, and refused their supper. During an observation on 03/16/2016 at 3:09 PM, Resident #6 was lying in their bed. The resident was awake and smiled when spoken to but did not respond. The room was dark with no lights on, no television on, and no music. During an observation on 03/18/2026 at 11:09 AM, Resident #6 was lying in their bed on their left side covered in their sheet and appeared to be sleeping. The room was dark. There were no lights, television or radio on. The residents did not respond to greeting. During an interview on 03/16/2026 at 5:01 PM, the resident's representative stated they were there to visit recently and the resident just stared into space. They stated they were unhappy with medications changes, and they did not believe the resident's current medications were effective. During an interview on 03/19/2026 at 12:12 PM, the Director of Nursing stated Resident #6 was initially admitted taking Cymbalta for depression and post-traumatic stress disorder. They stated the facility was obligated to trial reductions in medications and the resident was successful with their reduction trial, and they no longer took medication. They stated the resident's status declined since admission. The resident's symptom management included one-to-one supervision or interaction, and if the resident had a behavioral symptom, staff were directed to retreat and reapproach the resident later. They stated the Comprehensive Care Plan part 1 directed the staff on how to best provide care for the resident. The plan did not address the residents' depression or post-traumatic stress disorder but directed the staff to involve the resident in activities.During an interview on 03/19/2026 12:36 PM, Social Services Manager stated the resident had a trauma care plan. The care plan documented the social worker would see the resident and discuss their feelings. The social worker would consult as needed, and the physician would be updated as needed. The resident was discussed frequently, but not because they presented themself as depressed, but with more of a flat affect. The Social Services Manager stated the resident expressed themself with head shaking and they would do a thumbs up or thumbs down. They stated that part one of the care plan did not include this or any behaviors and the resident did not always participate in activities.During an additional interview on 03/19/2026 at 3:20 PM, Social Services Manager stated they did not review any behavioral notes documented for the resident. They stated they have not known Resident #6 to wake up and have behaviors. They stated television was a trigger, and the resident's significant other shared they had nightmares every night prior to facility admission. They stated everyone had access to resident notes and they would be made aware of anything nursing had concerns about. The standard intervention response to behaviors was for staff to retreat and reapproach and ensure safety. The Social Services Manager explained a resident with this type of history they completed rounds on to see if there was something going on with them. They stated they did not write progress notes about the resident. 10 New York State Codes Rules Regulations 483.40(d)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335087	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Josephs Home	950 Linden Street Ogdensburg, NY 13669

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observations and interview the facility failed to post on a daily basis at the beginning of each shift, the current resident census and the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, in a prominent location readily accessible to residents and visitors for five (5) of five (5) days (03/16/2026-03/20/2026) reviewed. Specifically, the facility did not post staffing information at the beginning of the shift on 03/16/2026 and was posted in the afternoon. The posting included the number of staff only and on subsequent days of survey the posting did not include the current resident census, and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care.Findings include: During an observation on 03/16/2026 at 1:08 PM there was no staffing posting displayed in the lobby on the sign in table, on the bulletin board above the sign in table, in the reception area, or in the glass cases down the hall from chapel or in the breezeway.During an observation on 03/16/2026 at 3:42 PM a staffing sheet was posted above the Health Survey Results folder on the bulletin board above the sign in table in the lobby. The staffing sheet did not include the number of actual hours worked, only the number of people in each department which included a breakdown of registered nurse, licensed practical nurse, certified nurse aides, activities, laundry, dietary, maintenance, and physical therapy.During multiple observations from 03/17/2026 to 03/20/2026 the posted staffing sheet only included the date and the number of staff working in each department for applicable shifts. The nursing department numbers were broken down into nurses and certified nurse aides only. There was no facility name, no daily census, and no number of actual hours worked.During an interview on 3/20/2026 at 10:24 AM the Administrator stated they posted the facility staff every day in the morning. The purpose of posting the staff was to notify residents' families of the facility's staffing levels if they had questions. The number of hours staff worked were not posted for families to view. The schedules of the staff were posted by the vending machines if someone wanted to read it and they could get the number of hours by the shifts worked. They acknowledged they were aware of what the posting was to include but most people do not understand what the posting meant.10 New York Code Rules and Regulation 415.13(a)