

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Fulton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 847 County Highway 122 Gloversville, NY 12078	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review during a survey, the facility failed to provide a safe, clean, comfortable, and homelike environment. Specifically, the facility failed to maintain sanitary bedside care equipment, ensure clean and orderly bedside food storage, safeguard and properly distribute resident-owned personal property, systematically track and investigate missing personal items, and maintain the structural integrity of physical plant walls. Findings were identified across four sampled residents (Resident #17, Resident #25, Resident #26, and Resident #29) and throughout facility-wide areas as detailed below: Findings include: `Review of Facility Policies Home Like Environment (Dated 9/19/2022): Documented that residents must be provided with a safe, clean, comfortable, and homelike environment. Staff shall provide person-centered care maximizing characteristics reflecting a personalized setting, explicitly including (a.) cleanliness and order and (e.) pleasant, neutral scents. Personal Property (Revised 12/17/2025): Documented that residents are permitted to retain and use personal possessions and clothing. The facility must inventory personal possessions upon admission and promptly investigate any complaints of misappropriation or mistreatment of resident property. `Resident-Specific Findings (Ordered Sequentially by Resident) `Resident #17 Resident #17 was admitted with diagnoses including Schizoaffective Disorder (bipolar type), peripheral vascular disease, and dementia. The Minimum Data Set (an assessment tool) dated 3/26/2026, documented the resident was communicative and cognitively intact. `Observations: `During an observation on 5/21/2026 at 1:10 AM, Resident #17's bedside commode was observed to be visibly soiled with urine and stool smears. `During an observation on 5/28/2026 at 10:39 AM, the bedside commode bucket was observed improperly placed and crooked on its frame. A small amount of urine sat in the bottom, and stool was smeared up the interior side of the bucket. `Interviews: `During an interview on 5/21/2026 at 1:10 PM, Resident #17 stated they cannot walk to the bathroom and must slide to the commode. They stated Certified Nurse Aides empty it but sometimes take up to an hour to respond, adding, it does get smelly. `During an interview on 5/28/2026, at 10:40 AM: Resident #17's roommate stated staff gave [Resident #17] a hard time about emptying the bucket, did not want to clean it, and could be rude to the resident about the task. `During an interview on 5/28/2026, at 12:41 PM: Certified Nurse Aide #4 stated they cleaned the commode bucket at the beginning and end of each shift and as needed by spraying and rinsing it. `During an interview on 5/28/2026, at 1:23 PM, 5/29/2026, at 11:24 AM, and 5/29/2026, at 11:41 AM, Licensed Practical Nurses #2, #6, and #5 corroborated that commodes must be emptied, wiped down, and sanitized with germicide wipes immediately after every single use. Licensed Practical Nurse #5 emphasized there should be no residual matter left behind. `During an interview on 5/29/2026 at 10:49 AM, Licensed Practical Nurse #10 stated each shift must check the commodes, there should never be obvious stool smears, and both Certified Nurse Aides and housekeepers share cleaning responsibilities. Licensed Practical Nurse #10 explicitly stated that uncleaned commodes present an absolute infection control concern and an environmental issue. `During an interview on 5/29/2026 at 12:48 PM, Director of Nursing #1 stated commodes must be emptied and rinsed after each use. Director of Nursing #1 acknowledged (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that dirty commodes were both an infection control concern and homelike environment concern. ^Resident #25 Resident #25 was admitted with diagnoses including diastolic heart failure, Stage 4 chronic kidney disease, and bipolar disorder with psychotic features. The Minimum Data Set, dated [DATE], documented that the resident was communicative and cognitively intact. ^Observations (Food Sanitation and Order in room [ROOM NUMBER]-West): ^On 5/22/2026, 5/26/2026, 5/27/2026, and 5/28/2026 (four consecutive days), multiple covered, unlabeled containers and an open, large bottle of unlabeled orange juice containing an inch of separated, decomposing fluid were allowed to remain on the resident's bedside table alongside old food remnants. ^Observations (Property Integrity): ^On 5/22/2026, 5/26/2026, 5/27/2026, 5/28/2026, 5/29/2026, and 6/01/2026, Resident #25's personal property, a bottle of Dove Men's Body Wash clearly labeled with Resident #25's name and room number-was missing from their room and located on another resident's over-the-bed table across the facility. ^Interviews: ^ During an interview on 5/26/2026 at 10:00 AM, Resident #25 stated family members bring outside food items as an alternative to facility food, and they rely on housekeeping to clear away the dirty dishes. ^ During an interview on 5/28/2026 at 10:40 AM, Director of Housekeeping #1 stated housekeepers were expected to dispose of old food daily. Director of Housekeeping #1 confirmed they were only notified of the decaying items by staff on 5/28/2026, at which point they had to step in and assist with a deep cleaning of room [ROOM NUMBER]-West. ^ During an interview on 5/29/2026 at 10:40 AM, Certified Nurse Aide #2 confirmed all resident food and drink items must be labeled or immediately thrown out, and staff must report resident refusals to the charge nurse. ^During an interview on 5/29/2026 at 11:30 AM, Licensed Practical Nurse #6 stated they were completely unaware Resident #25's body wash was missing or had been misappropriated. They confirmed a missing items form should have been filled out to replace the item for Resident #25. ^Resident #26 Resident #26 was admitted with diagnoses including chronic obstructive pulmonary disease (a progressive disease that makes it hard to breathe), heart failure (the heart muscle does not pump blood as well as it should), and Restless Leg Syndrome (a neurological condition that causes an irresistible urge to move your legs). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact and communicative. ^Record Review: ^A Resident Property Drop Off Form dated 10/23/2026, documented a 1 red rose 3xL button down sweater cardigan owned by the resident. ^Review of facility records revealed zero (0) misappropriation or missing items forms were completed by staff for Resident #26 regarding missing clothing. ^Interviews: ^During an interview on 5/21/2026, at 12:05 PM, Resident #26 stated laundry goes missing frequently. They reported missing four items, including an oversized sweater, forcing them to purchase a replacement out-of-pocket. They reported this to the Head of Housekeeping, who told them it could not be found. The resident was never reimbursed. ^During an interview on 5/27/2026, at 12:42 PM,: Director of Social Work #1 stated missing clothing should be logged on a missing item form. ^During an interview on 5/28/2026, at 12:41 PM and 5/28/2026, at 1:23 PM: Certified Nurse Aide #4 stated they were completely unaware a form existed for missing items. Licensed Practical Nurse #2 stated they usually just leave a note for the unit manager, adding there used to be a form. ^During an interview on 6/1/2026 at 10:14 AM, Director of Housekeeping #1 acknowledged Resident #26 reported the missing sweater a while ago. Director of Housekeeping #1 admitted they failed to follow up with the resident. Director of Housekeeping #1 further acknowledged that items were only replaced if there was a paper trail, admitting that the facility's lack of documentation directly prevented the resident from receiving reimbursement. ^During an interview on 6/1/2026 at 12:07 PM, Administrator #1 stated anyone can accept a grievance or misappropriation form, including Housekeeping. They stated a seven-day turnaround investigation is expected. ^Resident #29 Resident #29 was admitted with diagnoses including necrotizing fasciitis (is a rare but severe bacterial infection that destroys the tissue beneath the skin, including the fascia and muscles) and an open wound of the upper arm requiring assistance with personal care. The Minimum Data Set, dated [DATE], documented that the resident was communicative and cognitively intact. ^Observations: ^During an observations on 5/22/2026, (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on record review and interviews during a survey, the facility failed to ensure that residents were free from abuse and or neglect for three (Resident #114, 156, and #181) of seven residents reviewed. Specifically, (a.) Resident #'s 114 and 181 were involved in a resident-to-resident altercation where Resident #181 pushed Resident #114's wheelchair from behind causing the resident to fall from their wheelchair; (b.) Resident #156 was admitted to the hospital with a Discharge summary dated 11/2025 documenting a compression fracture of the lumbar spine level 1. The hospital recommendation were to follow up with Orthopedics because they had recommended a kyphoplasty for the Lumbar 1 compression fracture and Resident #156 should be referred to neurosurgery for the procedure. There was no documentation of orthopedic, or neurosurgery follow up. Furthermore, the Director of Nursing and Administrator were not aware that Resident #156 had a compression fracture. Findings include: The facility's Policy and Procedure titled Abuse Policy,, revised 07/18/2025 documented The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. The facility prohibits any exploitation of the mentally and physically disabled resident in the facility. The facility had designed and implemented processes, which strived to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Neglect was define as f ailure of the facility, its employees or service providers to provide goods and services necessary to avoid physical harm, pain, mental anguish or distress. Resident #114 Resident #114 was admitted to the facility with diagnoses of cervical spinal cord injury (damage to the uppermost part of the spine (the neck)), quadriplegia (a condition characterized by the partial or complete loss of motor and sensory faction in all four limbs), and multiple sclerosis (a chronic autoimmune disease that affects the central nervous system (brain, spinal cord, and optic nerves). The Minimum Data Set (an assessment tool) dated 04/14/2026, documented the resident was cognately intact, could be understood, and could understand others. Resident #181 Resident #181 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), bipolar disorder (a mental health condition that causes extreme shifts in mood, energy, and activity levels), and type two diabetes (an endocrine dysfunction causing unregulated blood glucose levels). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and could usually understand others. A complaint received by the New York State Department of Health on 03/12/2026, documented Resident #114 was seated in their wheelchair at the nurse's station when Resident #181 violently pushed the wheelchair forward causing Resident #114 to fall out of the wheelchair with the wheelchair falling on top of them. Resident #114 suffered from a neck fracture as a result of this. A Psychiatric Consult note dated 9/04/2025, documented Resident #181 had a history of bipolar disorder that was being managed with Lamotrigine and Wellbutrin. Resident #181 was on Seroquel but it was discontinued upon admission to the facility. Resident #181 expressed concern that the Seroquel was discontinued as it had been very helpful in controlling their mania symptoms which tended to include physical aggression and extreme emotional lability with agitation and anger. Resident #181 stated that if they were discharged within a week, they would restart their Seroquel on their own. However, if they were to stay at the facility, Resident #181 would want to restart the medication. The Facility Investigation dated 9/08/2025, documented on the evening of 9/08/2025, Resident #114 was in A wing hallway in their wheelchair speaking to a nurse when Resident #181 came up from behind and made contact with Resident #114's wheelchair causing the resident to fall from the wheelchair. Both residents were immediately separated. A statement written by Resident #114 on 9/08/2025, documented that they were talking with Licensed (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#114 had a lot of false beliefs. Director of Nursing #1 stated Resident #114 was in their wheelchair, Resident #181 hit the wheelchair, and then Resident #114 went to the floor. Staff intervened immediately and a room change was completed. Director of Nursing #1 stated they were made aware of the altercation immediately. X-rays were performed and Resident #114 was found to have no injuries. Director of Nursing #1 stated they started the investigation right away and spoke to residents and staff. Director of Nursing #1 stated they were not sure if Resident #181 was intentionally trying to hurt Resident #114, but it was considered a resident-to-resident altercation. They stated if someone was intentionally trying to hurt someone, then it would be considered abuse. Director of Nursing #1 stated in their investigation they ruled out abuse, neglect, and mistreatment. During an interview on 06/01/2026 at 12:07 PM, Administrator #1 stated there was an allegation that Resident #181 pushed Resident #114 out of their wheelchair. Resident #114 called the police, but charges were not pressed. Administrator #1 stated the staff separated the residents, and Resident #181 discharged shortly after. Administrator #1 stated the facility completed an investigation but could not recall the outcome. Resident #156 Resident #156 was admitted to the facility with a diagnoses of end stage renal disease (the final, permanent stage of chronic kidney disease, meaning the kidneys can no longer filter waste, toxins, and excess fluids from the blood to stay alive without use of artificial means), bipolar disorder (a lifelong mental health condition that causes extreme emotional highs (mania or hypomania) and lows (depression); and major depressive disorder (a persistent feeling of sadness, emptiness, or loss of interest in once-enjoyable activities). The Minimum Data Set, dated [DATE], documented they could understand and be understood by others, and was cognitively intact. ^ Record Review of X-ray dated 11/06/2025 documented the lumbosacral spine had normal alignment with multilevel degenerative disc disease was noted throughout the spine. There was no evidence of acute fracture. There was decreased bony mineralization. Sacrum was grossly intact. Hospital Discharge summary dated [DATE] documented, Discharge Assessment: Message to outpatient provider. Resident was admitted in the setting of respiratory failure with hypoxia secondary to pneumonia. Incidental findings of acute on chronic Lumbosacral 1 (lumbar first level) compression fracture was also noted. Orthopedics recommended kyphoplasty for Lumbosacral 1 compression fracture and resident should be referred to neurosurgery for procedure. Resident diagnosis list in the facility's tracking and documentation database) documented on 12/01/2025 a diagnosis of wedge compression fracture of first lumbar vertebra (spine). Nurse Practitioner #1 progress note dated 03/01/2026 documented resident was admitted to hospital from [DATE] - 11/26/2025 for respiratory failure secondary to pneumonia. They were found to have a chronic Lumbosacral 1 compression fracture. Pain was managed. They improved and returned to facility. They were seen today for routine management. Medical Doctor #1's progress note dated 03/03/2026 documented Assessment: Low back pain with recent history of Lumbosacral 1 fracture managed non-surgically. Plan: The resident's current regimen of oxycodone ten milligrams twice daily appeared to help with their pain. However, the resident would likely benefit from having an additional ten milligrams of oxycodone available to them after their dialysis days. Recommended adding this to the resident's regimen. ^ Record review of Hospital Discharge summary dated [DATE] documented resident admitted with acute hypoxic (low oxygen) respiratory failure and shortness of breath. On presentation, they were found to be hypoxic (low levels of oxygen) with oxygen saturations in the 70's, required six Liters nasal cannula oxygen, and chest imaging revealed multifocal pneumonia. Additional issues managed during admission included moderate malnutrition and ongoing debility related to prior hip fracture and recent coccyx fracture, resulting in wheelchair dependence and need for mechanical lift transfers. Resident #156's Comprehensive Care Plan dated 07/24/2025 documented resident was at risk for falls/ has had an actual fall related to deconditioning, history of falls, immobility. Alteration in comfort related to (potential/actual) left hip fracture and compression fracture of Lumbosacral one1. Occupational Therapy note dated period of 02/16/2026 - 03/14/2026, documented resident was presenting with increased pain in left lower extremity and lower back this reporting period. Due to pain, resident had (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	declined to participate in toilet transfers. Prior to changes in pain severity level, they were able to complete toilet transfers using rolling walker for support with moderate assistance and 30-35% verbal cues for task initiation, . for proper positioning/ body mechanics, and for safety awareness. Medication Administration Record dated 10/2025 documented : Keppra (levetiracetam) Oral Tablet 500 milligrams Give one tablet by mouth every morning and at bedtime for seizure activity. Medication Administration Record dated 12/2025 documented Keppra (levetiracetam) Oral Tablet 500 milligram Give one tablet by mouth two times a day for seizures. During an interview on 05/21/2026 at 11:10AM, Resident #156 stated they stayed in bed most of the time due to back pain, Resident #156 stated their pain was ten out of ten on a scale of zero to ten, with ten being the worst. Resident #156 stated the facility had been adjusting their pain medication but still had not gotten it correct. Resident #156 stated they had a seizure in the facility and their back broke some months ago As a result, they were sent to the hospital. During an interview on 05/29/2026 at 12:15 PM, Director of Nursing #1 stated Resident #156 did not have fracture of coccyx. The X-ray was of the resident's hip which was healed. They had no knowledge of a fracture of the Lumbosacral spine, and no knowledge of Resident #156 ever falling. During an interview on 05/29/2026 at 12:54 PM, Licensed Practical Nurse #5 stated they had no knowledge of Resident #156 ever falling or having seizure activity. During an interview on 05/29/2026 at 3:28 PM, Resident #156 stated again that they had a seizure, during which used such force to hold them down, Resident #156 broke their back. Resident #156 stated that when they came out of their seizure, they were in a lot of pain and needed to be sent to the hospital. During an interview on 06/01/2026 at 9:53 AM, Administrator #1 stated they had no knowledge that Resident #156 had fractured their Lumbosacral one spine. During an interview on 06/01/2026 at 9:53 AM, Director of Nursing #1 was asked to explain discharge summary findings dated 11/26/2025 and 05/06/2026 both documenting Lumbosacral one and coccyx fractures. Director of Nursing #1 stated they were unaware that resident had any fractures. Director of Nursing #1 stated that when residents returned to the facility from a hospital admission, the unit manager reviewed the discharge summary, and they had no answer regarding why the Lumbosacral one fracture and coccyx fractures were not reported to them. The unit manager for the unit was currently on medical leave. Director of Nursing #1 was unable to provide documentation of recommended follow up with orthopedic for kyphoplasty or the neurosurgery follow up consult. During an interview on 06/01/2026 at 9:56 AM, Administrator #1 stated a documented fracture on the discharge summary should have prompted the facility to conduct an investigation once notified. Unfortunately, this was not done. In addition, documentation did not support that there was follow up on recommendations from the hospital. 10 New York Codes, Rules, and Regulations 415.4 (b)(1)(i)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record reviews and interviews conducted during the survey, the facility failed to implement a system to consistently and accurately reconcile controlled medications in accordance with professional standards of practice. Specifically, the narcotic count record signature sheet for five of eight units were signed in advance or incomplete. Findings include: A review of narcotic count record book for Unit A cart 300 documented: On 05/28/2026 at 11:02 AM the 7 AM-3 PM Licensed Practical Nurse #1 signed in advance as the off going nurse at 3 PM A review of narcotic count record book for Unit C cart 500 documented: On 5/28/2026 at 10:30 AM the 7 AM-3 PM Licensed Practical Nurse #2 had not signed as oncoming nurse at 7 AM A review of 05/2026 narcotic count record book for Unit D cart 800 documented: On coming nurse did not sign for 05/01/2026 at 3:00 PM On coming nurse did not sign for 05/09/2026 at 7:00 AM Outgoing nurse did not sign for 05/09/2026 at 3:00 PM On coming nurse did not sign for 05/26/2026 at 3:00 PM On 05/27/2026 at 2:36 PM the 3PM-11 PM Licensed Practical Nurse #3 signed in advance as the off going nurse at 11 PM A review of 05/2026 narcotic count record book for Unit C cart 900 documented: Outgoing nurse did not sign for 05/22/2026 at 3:00 PM On coming nurse did not sign for 05/23/2026 at 7:00 AM Outgoing nurse did not sign for 05/23/2026 at 3:00 PM On coming nurse did not sign for 05/24/2026 at 7:00 AM On coming or Outgoing nurse did not sign for 05/24/2026 at 3:00 PM Outgoing nurse did not sign for 05/24/2026 at 11:00 PM On coming nurse did not sign for 05/26/2026 at 7:00 AM Outgoing nurse did not sign for 05/26/2026 at 3:00 PM On coming nurse did not sign for 05/26/2026 at 7:00 AM A review of 05/2026 narcotic count record book for Unit E cart 100 documented: On coming or Outgoing nurse did not sign for 05/20/2026 at 11:00 PM On coming nurse did not sign for 05/21/2026 at 11:00 PM Outgoing nurse did not sign for 05/22/2026 at 7:00 AM On 05/27/2026 at 2:37 PM the 7AM-3 PM Licensed Practical Nurse #4 signed in advance as the off going nurse at 3 PM During an interview on 5/27/2026 at 2:35 PM, Licensed Practical Nurse #3 stated they had signed the narcotic count book in advance for 05/27/2026 at 11 PM when they would be the outgoing nurse. The narcotic book should be signed when nurses completed the narcotic count and verified the count was correct at the beginning and end of every shift. During an interview on 5/28/2026 at 10:32 AM, Licensed Practical Nurse #2 stated they had not signed the narcotic count book yet because it had been a busy morning. They stated they should have signed when they first came on shift. During an interview on 5/28/2026 at 11:02 AM, Licensed Practical Nurse #1 stated they signed the narcotic count book in advance as the outgoing nurse routinely, so they did not forget. During an interview on 5/28/2026 at 11:05 AM, Licensed Practical Nurse #5 stated the narcotic count book should never be signed in advance, that would be signing for something that was not done. During an interview on 06/01/2026 at 12:45 PM, Director of Nursing #1 stated they had been auditing the narcotic count books and would be increasing the audits due to missing signatures and nurses signing in advance. 10 New York Codes Rules and Regulations 415.22(a)(1-4)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews conducted during a survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for three (3) (Resident #'s 26, 79, and 116) of five (5) residents reviewed. Specifically, (a.) for Resident #'s 26 and 79, food was not served at an appetizing temperature during a lunch meal on 5/28/2026 and the fries were too crispy to eat; and (b.) Resident #116 was served burnt stuffed shells during a dinner meal that were not palatable. Additionally, 10 anonymous residents during a resident council meeting stated the food was not good, often cold, and was overcooked or undercooked. The findings include: The facility policy titled Food Temperatures revised 5/28/2025, documented food temperatures of cold and hot food items would be recorded on all menu items and substitutions for meal service to maintain a high level of quality assurance and to monitor potentially hazardous food temperatures as per state and federal health regulations thus ensuring that foods were provided in a safe, palatable manner. During a Resident Council interview on 5/22/2026 at 11:00 AM, 10 anonymous residents stated the food was horrible. They stated the food was often overcooked or undercooked. They stated the kitchen did not measure or weigh the food. The residents stated the food was often cold. The chicken tenders were rock hard when served. They stated an egg salad sandwich was just a glop of egg salad in the middle. The bread was often stale or dried out. Some residents stated they had to spend their own money to buy food. During an observation on 5/21/2026 at 1:15 PM, meal trays were delivered to the B unit hall 1. At 1:27 PM, the Licensed Practical Nurse from B unit hall 2 started passing trays. Certified Nurse Aides started passing trays at 1:37 PM. The last meal tray was served at 1:45 PM to room [ROOM NUMBER]. A resident in room [ROOM NUMBER] stated the food was lukewarm, but it was usually cold. Resident #26 Resident #26 was admitted to the facility with the diagnoses of chronic obstructive pulmonary disease (a progressive, long term lung disease that causes restricted airflow and breathing-related difficulties), heart failure (when the heart muscle is too stiff or weak to pump effectively), and restless leg syndrome (uncontrollable, overwhelming urge to move the legs). The Minimum Data Set (an assessment tool), dated 3/03/2026, documented the resident was able to understand others, was able to be understood, and was cognitively intact. During an interview on 5/21/2026 at 12:05 PM, Resident #26 stated the food was not the greatest and was often cold. During an observation on 5/28/2026 at 1:36 PM, the meal tray cart arrived to unit B side 1. Kitchen staff stated they were still waiting for an additional 3 meals trays. The last 3 trays arrived on the unit at 1:38 PM. During an observation on 5/28/2026 at 1:40 PM, Resident #26 meal tray was tested in the presence of Certified Nurse Aide #4, and a replacement tray was requested. Food temperatures were measured as follows: soup of the day was 124 degrees Fahrenheit, hot dog was 106 degrees Fahrenheit, waffle fries were 84 degrees Fahrenheit, mixed fruit was 57 degrees Fahrenheit, and apple juice was 57 degrees Fahrenheit. All other food and drinks provided were within normal temperature range. Some of the waffle fries were noted to be too crispy to eat. Resident #79 Resident #79 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), non-pressure chronic ulcer of skin of other sites with fat layer exposed (deep, long-lasting open sore on the skin), morbid (severe) obesity due to excess calories (weighing in excess of 100 pounds of one's ideal weight). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was cognitively intact. During an interview on 5/22/2026 at 10:48 AM, Resident #79 stated the food was not good and they had been served burnt food before. They stated sometimes a hot dog was served on a hamburger bun. During an observation on 5/28/2026 at 12:52 PM, Resident #79's meal tray was tested, and a replacement tray was requested. Food temperatures were measured as follows: cottage cheese was 58.3 degrees Fahrenheit, waffle fries were 110 degrees Fahrenheit and some were too hard to eat. All other food provided was within normal temperature range. Resident #116 Resident (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#116 was admitted to the facility with diagnoses of chronic respiratory failure (a condition where the lungs cannot adequately exchange oxygen and carbon dioxide), heart failure (a chronic, progressive condition where the heart muscle is too weak or stiff to efficiently pump enough oxygen rich blood to meet the body's needs), and depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life). The Minimum Data Set, dated [DATE], documented the resident was cognitively intact, could be understood, and could understand others. During an observation on 5/28/2026 at 5:58 PM, Resident #116's meal tray was tested, and a replacement tray was requested. The meal included stuffed shells, pudding, and milk and the temperatures were within normal limits. The stuffed shells were observed to be burnt and tough on top. During an interview on 5/28/2026 at 6:00 PM, Resident #116 stated dinner trays were always late. Resident #116 demonstrated difficulty cutting the burned stuffed shells and pointed out that they did not have teeth. Staff were made aware and ordered a new tray. During an interview on 6/01/2026 at 11:00 AM, Diet Tech #1 stated it was unacceptable for burnt food to leave the kitchen let alone make it to the residents. During an interview on 6/01/2026 at 11:48 AM, Food Service Director #1 stated they cooked to a minimum of 165 degrees Fahrenheit, then food was placed on a steam table in smaller batches due to the large size of the facility, then they have a pellet base that gets heat and a plate went on top. They stated they took temperatures and used a temp log so food was cooked to proper temperature. Food Service Director #1 stated they did not have insulated carts. They stated they started serving lunch around 11:30 AM and were usually done by 1:30 PM. They stated some meals took a little longer to put together. Food Service Director #1 stated corporate put together the menu and they just started the new spring/summer menu, which was an adjustment for the staff. They menu follows a 4 week cycle. After the first 4 weeks of the new menu, they could request changes or make suggestions to corporate. Food Service Director #1 stated they were looking to replace waffle fries on the menu. They stated they did attend the monthly food committee meeting and would identify and address resident concerns with the food. They stated they did not have chefs, they had cooks and they really were trying. During an interview on 06/01/2026 at 1:00 PM, Administrator #1 stated they had been completing audits on meal accuracy and were working with corporate to upgrade meal carts. They stated they were unaware of meals reaching residents burnt, and they would not expect burnt food to leave the kitchen. 10 New York Code of Rules and Regulations 415.14(d)(1)(2)^^		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review conducted during a survey, the facility failed to ensure residents could safely self-administer medication when clinically appropriate for one (1) (Resident #108) of one (1) resident reviewed for medication administration. Specifically, Resident #108 had an inhaler observed in their room that was not listed in the resident's orders, they reported using the medication, and they were not assessed for their ability to self-administer medication. Findings include: The facility policy titled Medication Self-Administration reviewed 7/2019, documented the resident may request to keep medications at bedside for self-administration in accordance with resident rights. The staff and practitioner would assess each resident's mental and physical abilities to determine whether self-administering medications was clinically appropriate for the resident upon request. In addition to a general evaluation of decision-making capacity, the nurse would perform a more specific skill assessment. It would be determined if the resident was able to safely store and self-administer their medication, self-administer their medication with assistance from the nurse by storing the medication in the med-cart, or was unable to safely self-administer medication. Staff should identify and give the Charge Nurse any medication found at the bedside that were not authorized for self-administration, for return to the family or responsible party. The electronic medical record and medication administration record must identify meds that were self-administered. The staff and practitioner would periodically reevaluate a residents' ability to continue to self-administer medications. Resident #108 Resident #108 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease ((a group of lung diseases that block airflow and make it difficult to breathe), asthma with acute exacerbation (a sudden, progressive worsening of asthma symptoms and a decrease in lung function), and obesity (a chronic disease characterized by excessive body fat that increased the risk of severe health problems). The Minimum Data Set (an assessment tool) dated 3/17/2026, documented the resident was cognitively intact, could be understood, and could understand others. During an observation on 05/22/2026 at 10:02 AM, there was a blue inhaler observed on Resident #108's tray table at bedside. During an interview on 5/22/2026 at 10:02 AM, Resident #108 stated the order for their inhaler was discontinued so their partner brought in their inhaler from home. They stated they needed the inhaler on occasion. Resident #108 further stated the facility discontinued the order for their inhaler because they did not use it often. A review of Resident #108's Physician Orders did not include orders for an albuterol inhaler. A review of Resident #108's medical record did not include documentation that the resident was assessed for their ability to self-administer their medications. A review of Resident #108's medical record did not include documentation from the resident's physician that the resident could self-administer their medications. A review of Resident #108's care plan did not include documentation the resident could self-administer their medications During an interview on 5/29/2026 at 10:37 AM, Resident #108 stated that the facility tried to take away their inhaler, but they told them they would slap them from here to the other side of the building if they touched it. They further stated that Director of Nursing #1 told them to hide it. Resident #108 stated it was hidden inside the tissue box observed on their tray table. During an interview on 5/29/2026 at 10:59 AM, Licensed Practical Nurse #10 stated Resident #108 had an order for an advair diskus inhaler twice daily and previously had an order for an as needed albuterol inhaler that was discontinued on 5/06/2026. They stated the order was most likely discontinued because it was not use for an extended period of time. Licensed Practical nurse #10 stated there were probably risks with Resident #108 having the inhaler if they were not using it appropriately. They stated risks could include heart racing, jitteriness, and that it was potentially a risk to others, although Resident #108 did not leave their room often. Licensed Practical Nurse #10 stated they would follow up with the resident. During an interview on 5/29/2026 at 12:53 PM, Director of Nursing #1 stated they did not believe Resident #108 was able to self-administer medication. They stated they were not aware of any residents that could (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer medication. Director of Nursing #1 stated they completed assessments for residents to self-administer medication as needed or per request. They stated the nurse would complete the assessment with the resident, the resident had to be able to lock the medication in their bedside stand, and there needed to be a physician order. Director of Nursing #1 stated a resident could suffer from respiratory complications if an inhaler was overused. 10 New York Codes, Rules, and Regulations: 415.3(f)(1)(vi) ^ ^		

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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** Based on observation, interview, and record review conducted during a survey, the facility failed to ensure residents were able to exercise the right to self-determination, including making choices regarding daily routines and preferences, for two (Resident #4 and #79) of two residents reviewed for choices. Specifically, (a.) Resident #4 was not permitted to go outside as they preferred; (b.) Resident #79 had not been able to have a shower since they were admitted to the facility. Findings include: The facility's policy, Resident Rights, revised 05/28/2024, indicated residents have the right to self-determination and are to be supported by the facility in exercising their rights. Residents have the right to communicate with and access to people and services both inside and outside the facility. The facility's policy, Out on Pass/Therapeutic Leave, revised 05/27/2026, indicated residents may leave the facility with or without an escort following an assessment of the resident's ability to do so. The policy further indicated the Out on Pass/Therapeutic Leave process should not be utilized when a resident wishes to sit outside while remaining on facility property. Resident #4 Resident #4 was admitted to the facility with diagnoses including quadriplegia (inability to actively move arms and legs), atrial fibrillation (an irregular heart rhythm), and major depressive disorder. The most recent comprehensive Minimum Data Set (a, dated 01/23/2026, indicated the resident was able to understand others and able to be understood. Their preferences included going outside and getting fresh air when the weather was nice, as very important to the resident. The care plan dated 01/28/2026 indicated the resident was able to make recreation and leisure preferences known. Documented interests included football and use of cell phone. The care plan included interventions to assist the resident in identifying activities of interest, provide a monthly activity calendar, and provide independent leisure opportunities. During an interview on 05/22/2026 at 11:06 AM, Resident #4 stated the only activity the resident wanted to participate in was to go outside especially when their friends and family came to visit. They were frequently denied because of the facility rule which had denied residents access unless activities staff was present. The resident stated there had been many nice days when family visited and they had requested to go outside and were denied access. During an interview on 05/28/2026 at 11:40 AM, Licensed Practical Nurse #9 stated the door to the outdoor patio area remained locked and residents could not go outside unless activities staff were present. Many residents desired to go out, however there was no access when activity staff were not present. Licensed Practical Nurse #9 stated residents should be able to have the choice. Independence and autonomy were very important, especially given the young population at the facility. During an interview on 05/28/2026 at 12:27 PM, Director of Recreation #1 stated residents were only allowed to go outside when activities staff were available to unlock the patio door. Director of Recreation #1 stated the door always remained locked and when activities staff were unavailable residents could not access the patio. The Activities Director acknowledged the practice limited resident access to the patio and stated many residents did not like the limitation of access. During an interview on 05/28/2026 at 2:03 PM, Administrator #1 stated residents could go outside at any time. There was no limitation on access to the patio and indicated all nursing supervisors had the key and could provide access to the patio upon request. Administrator #1acknowledged this was their home and the ability to access the nice weather was very important. They further stated the resident would need to be evaluated for safety prior to allowing them to be out side but they should be given access if safety had been accessed. During an interview on 05/28/2026 at 4:36 PM, Registered Nurse Supervisor #2 stated that if a resident wanted to go outside, the resident would have to wait until someone from activities was available to unlock the door. Registered Nurse Supervisor #2 stated the patio door remained locked unless activities staff were present and reported that administration had not provided a key or informed them that access could be provided independently of activities staff. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Registered Nurse Supervisor #2 stated residents who wished to go outside should be able to do so as this is their home. Resident #79 Resident #79 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), non-pressure chronic ulcer of skin of other sites with fat layer exposed (deep, long-lasting open sore on the skin), morbid (severe) obesity due to excess calories (weighing in excess of 100 pounds of one's ideal weight). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was cognitively intact. Record Review: Facility work order dated 05/18/2026 documented the facility's stretcher shower had a broken frame. Interviews: During an interview on 05/22/2026 at 9:45 AM, Resident #79 stated they had not been able to have a shower since being admitted to the facility. They stated there was one shower bed for the facility and it needed repair since their arrival at the facility. They had been given bed baths routinely; however, they would feel better if they could get in the shower. They have multiple health conditions that cause the shower chair to be uncomfortable and intolerable to use. They have asked staff about the shower bed often and they were always told it was still broken. During a subsequent interview on 05/26/2026 at 10:20 AM, they stated a staff member had told them over the weekend they finally sent the shower bed for repair. ~ During an interview on 05/27/2026 at 9:37 AM, Licensed Practical Nurse #6 stated the shower bed had been out for about 1-2 weeks for repair. The residents would be offered bed baths until the shower bed was fixed. ^ During an interview on 05/27/2026 at 9:42 AM, Certified Nurse Aide #3 stated the shower bed was out for repair as of last week. They were familiar with Resident #79 and knew they would prefer a shower and would offer them one once shower bed was fixed. During an interview on 05/27/2026 at 12:04 PM Resident #79 had not had a shower in over one (1) year. During an interview on 06/01/2026 at 12:45 PM, Director of Nursing #1 stated if residents would prefer a shower they should be receiving a shower. They would be auditing the shower records in the facility. During an interview on 06/01/2026 at 1:00 PM, Administrator #1 stated they were made aware of the shower bed needing replacement last week, they had since ordered a new shower bed that had a weight capacity of 600 pounds to fit the needs of the facility. They stated that they were unaware of Resident #79 not getting their choice of a shower instead of a bed bath over the past year. 10 New York Codes, Rules, and Regulations: 415.3(b)(1)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during a survey, the facility failed to report all alleged violations involving abuse, neglect, and injuries of unknown source immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury, to the State Agency for three (Resident #'s 114, 181, and 191) of three residents reviewed. Specifically, the following incidents were not reported to the New York State Department of Health: (a.) Resident #191 had a fall with a significant injury of unknown origin; (b.) Resident #'s 114 and 181 were involved in a resident-to-resident altercation on 9/08/2025 where Resident #181 pushed Resident #114's wheelchair from behind causing the resident to fall. Staff witnessed this and police were called. Based on observation, interview, and record review conducted during a survey, the facility failed to report all alleged violations involving abuse, neglect, and injuries of unknown source immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury, to the State Agency for three (Resident #'s 114, 181, and 191) of three residents reviewed. Specifically, the following incidents were not reported to the New York State Department of Health: (a.) Resident #191 had a fall with a significant injury of unknown origin; (b.) Resident #'s 114 and 181 were involved in a resident-to-resident altercation on 9/08/2025 where Resident #181 pushed Resident #114's wheelchair from behind causing the resident to fall. Staff witnessed this and police were called. The findings include: The policy titled Accidents-Incidents reviewed 06/01/2024 documented: Any unwitnessed incident or accident or incident must be investigated for potential abuse. Determine if it is of known or unknown or known. If injury of known or unknown origin, Document the location and type of injury; Accurately document the resident's ability to explain the injury; Include documentation of a resident examination conducted by a physician or nurse practitioner, as required. If an unknown origin injury, ensure that statements from staff / parties involved include preceding shifts and days, if necessary, to assist in ruling out abuse, neglect, mistreatment or exploitation; Director of Nursing and Administrator are responsible to review Incident / Investigation and Conclusion to determine if incident requires reporting to outside agencies such as; Department of Health, Office of Inspector General, Centers for Medicare and Medicaid Services, etc The policy titled Abuse revised 07/18/2025 documented: The facility prohibits the mistreatment, neglect, and abuse of residents/patients and misappropriation of resident/patient property by anyone including but not limited to staff, family, friends and residents of the facility. Notify the local law enforcement and appropriate State Agency(s) immediately (no later than 2 hours after allegation / identification of allegation) by Agency's designated process after identification of alleged/suspected incident. Initiate process according to the Elder Justice Act and State- specific regulations. (a.) Resident #191 Resident #191 was admitted to the facility with diagnoses of unspecified dementia, unspecified severity (cognitive decline severe enough to interfere with daily life), chronic kidney disease stage 3A (when your kidneys have mild to moderate damage), unspecified abnormalities of gait and mobility (walking pattern deviates from normal). The Minimum Data Set, dated [DATE], documented that the resident could usually be understood, could usually understand others, and was severely cognitively impaired. A Nursing Progress note by Licensed Practical Nurse #7 dated 3/31/2026 at 7:30 AM, documented the resident was found on the floor by a staff member. The resident could not verbalize what happened. Resident #191 was noted to have a bruise on their mid-forehead, their eyes widened with staring glare and not focusing, and they could not follow simple directions. Registered Nurse #1 and Director of Nursing #1 were notified. A Registered Nurse Assessment by Registered Nurse #1 on 3/31/2026 at 7:24 AM, documented they (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were notified by a staff member Resident #191 was found on the floor. The resident could not verbalize what had happened. Resident #191 was noted to have a bruise on their mid-forehead, eyes widened with staring glare and not focusing, they could not follow simple directions. They placed the resident in sitting position, then assisted them to bed. The provider was notified by Licensed Practical Nurse #7, they obtained an order to send Resident #191 to the emergency room for evaluation and treatment. Review of Accident / Incident Statement form dated 3/31/2026, documented Licensed Practical Nurse #7 was notified by Licensed Practical Nurse #8 of an incident for Resident #191. Staff involved in the care for the Resident was Licensed Practical Nurse #8 and Certified Nurse Aide #1. There were no documented witnesses to the event. One statement was attached by Licensed Practical Nurse #8 that documented no witnesses to the event. There was no documented evidence of a statement from Certified Nurse Aide #1. There was no documentation of when or where the resident was last seen prior to being found on the floor. (b.) Resident #114 and #181 A complaint received by the New York State Department of Health on 3/12/2026, documented Resident #114 was seated in their wheelchair at the nurse's station when Resident #181 pushed the wheelchair forward causing Resident #114 to fall out of the wheelchair and the wheelchair fell on top of them. The complaint documented that Resident #114 suffered from a neck fracture as a result. The Facility Investigation Summary dated 9/08/2025, documented on the evening of 9/08/2025, Resident #114 was in A wing hallway in their wheelchair speaking to a nurse when Resident #181 came up from behind and made contact with Resident #114's wheelchair causing the resident to fall from the wheelchair. A statement written by Resident #114 on 9/08/2025, documented that they were talking with Licensed Practical Nurse #8 about their cell phone being stolen by Resident #181, when Resident #181 grabbed their wheelchair and flipped them out of the chair. Then Resident #181 yelled, that was what you get for accusing me of stealing your cell phone. A statement written by Resident #181 on 9/08/2025, documented they overheard Resident #114 accusing them of stealing their cell phone at the nurse's station. They documented they lost their cool and pushed Resident #114's wheelchair enough to jar him/them, which caused Resident #114 to come to somewhat of standing position, and then they fell down on their right side. It further documented they did not touch Resident #114, only the back of their wheelchair. An Accident/Incident Statement form completed by Licensed Practical Nurse #8 dated 9/08/2025, documented Resident #114 was speaking to them about another resident. Resident #181 came behind Resident #114 and pushed the resident out of the wheelchair onto the floor. They immediately removed Resident #181 from the area and checked on Resident #114. Interviews: During an interview on 5/29/2026 at 11:41 AM, Licensed Practical Nurse #5 stated if they observed or were made aware of a resident-to-resident altercation they would separate the residents, redirect them, and then inform the Assistant Director of Nursing, Director of Nursing, Medical Provider, and Administrator. They stated they would complete skin checks, obtain an order from the medical provider for behavior monitoring, and call the family. They stated depending on if it were physical or verbal abuse, they would separate the residents into different units. Licensed Practical Nurse #5 stated they would complete an Incident and Accident Report for each resident, get states from anyone that witnessed the incident, put in notes and then pass it along. Licensed Practical Nurse #5 stated resident-to-resident altercations could be considered abuse depending on the circumstances. They stated if there was injury, it was reportable to the Department of Health. During an interview on 5/29/2026 at 12:35 PM, Director of Nursing #1 stated they were not sure if Resident #181 was intentionally trying to hurt Resident #114, but it was considered a resident-to-resident altercation. They stated if someone was intentionally trying to hurt someone then it would be considered abuse. Director of Nursing #1 stated in their investigation they ruled out abuse, neglect, and mistreatment, so they did not report it to the Department of Health. They further stated if they ruled out abuse, then they did not need to report it. During an interview on 06/01/2026 at 12:45 PM, Director of Nursing #1 stated an unwitnessed fall with a significant injury would be considered an injury of unknown origin. They further stated resident-to-resident allegations and incidents would be (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Fulton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 847 County Highway 122 Gloversville, NY 12078	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse. They stated an injury of unknown origin and any accusations of abuse would need to be reported to the Department of Health within a two (2) hour time frame from when they became aware. During an interview on 6/01/2026 at 12:07 PM, Administrator #1 stated there was an allegation that Resident #181 pushed Resident #114 out of their wheelchair. Resident #114 called the police, but charges were not pressed. They stated in real time, they separated the residents, but Resident #181 discharged shortly after. Administrator #1 stated the facility completed an investigation but could not recall the outcome. Administrator #1 stated if they were able to rule out abuse, then that was why it was not reported to the Department of Health. They stated if they could not rule out abuse then it would be reported. 10 New York Codes, Rules, and Regulations 483.12 (c) (1)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ^Based on observation, interview, and record review conducted during a survey, the facility^failed to^ensure residents were discharged according to professional standards^for one (Resident #182) of one resident reviewed. Specifically, the facility refused to accept Resident #182 back to the facility following a brief hospital evaluation. ^ Findings include:^^ The facility policy, Discharge- Transfer Discharge Process,reviewed 02/2025, indicated the facility would coordinate a safe transfer or discharge for residents leaving the facility; residents were permitted to remain in the facility unless an allowable discharge criterion was met; residents and/or their representatives would receive written notice of a transfer or discharge, including appeal rights; residents who appealed a transfer or discharge would not have been discharged while the appeal was pending unless specified exceptions applied; a hospital was not an appropriate discharge destination; and residents had the right to return to the facility upon completion of a hospital stay. The facility policy, Resident Rights, revised 05/28/2024, indicated residents have the right to self-determination and are to be supported by the facility in exercising their rights. Residents had the right to communicate with and access to people and services both inside and outside the facility. The facility policy Behavior - Managing Emergencies, last reviewed 05/2020, indicated that behavioral emergencies require assessment and intervention to maintain resident and staff safety; staff are to utilize appropriate clinical and behavioral management strategies; physician notification and appropriate follow-up are required; and residents experiencing behavioral emergencies may require transfer for evaluation and treatment when clinically indicated. Resident #182 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus, paroxysmal atrial fibrillation (an irregular heartbeat), and cerebrovascular accident with left-sided hemiparesis (a stroke that caused weakness on the left side of the body). The 06/19/2024 care plan identified the resident's discharge goal as returning to the community/shelter. Interventions included interdisciplinary discharge planning and education regarding community resources. The Minimum Data Set (an assessment tool) dated 06/26/2024,^documented the resident was cognitively intact, could be understood, and could understand others.^ Review of a 07/17/2024: interdisciplinary care plan meeting documented Resident #182 had exhibited yelling, profanity, crying, and pounding fists on the table while discussing discharge planning and personal belongings. Social Services documented efforts to identify community resources and discharge options. Review of 07/17/2024 the medical provider documented the resident had a history of significant behaviors, including threatening and accusatory behavior. The resident was medically stable and had recently been sent out for aggressive behavior and returned to the facility. Review of 07/30/2024 Social Services progress note documented continued efforts to secure housing through the [NAME] Department of Social Services; the process was pending the resident's signature on a release form. Review of the 07/30/2024 Transfer/Discharge Notice identified St. Mary's Hospital as the discharge destination and cited physically aggressive behavior as the reason for discharge. The resident refused to sign the notice. Review of the 07/30/2024 Hospital records documented the resident was psychiatrically evaluated, did not require psychiatric hospitalization, and was cleared for discharge back to facility. Hospital documentation indicated the resident was discharged back to the facility via ambulance. Review of the 07/30/2024 hospital discharge documented, Resident #184 was transported to St. Mary's Healthcare for a mental health evaluation following an incident involving aggressive behavior toward facility staff. The resident was alert and oriented, cooperative, denied suicidal and homicidal ideation, denied hallucinations, and had not appeared psychotic or delusional. The resident acknowledged grabbing a staff member's shirt but denied striking anyone. The resident reported being upset with the facility however expressed a desire to return to facility. The Diagnostic and Statistical Manual of Mental Disorders (a book used by mental health professionals to diagnose mental health (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conditions) documented the resident had an appropriate appearance, cooperative attitude, stable mood, appropriate affect, good insight, normal behavior, normal thought content, intact thought processes, and normal perception. Judgment was noted as impulsive. The psychiatric evaluation determined the resident had not required a psychiatric admission Hospital documentation indicated the resident would be discharged back to facility. Review of the complaint dated 08/02/2024 received from a police officer reported, per the ambulance crew, the resident was sent to the hospital for mental evaluation, cleared to return to the facility on [DATE], was sent back to the facility and had been denied entry The facility supervisor stated that the resident was discharged to the hospital, and they would not have been accepting them back. The ambulette brought the resident back to the hospital who stated that the resident was discharged back to the facility. Resident #182 was again brought back to the facility; the doors were locked and the supervisor stated that the resident assaulted a staff, and they were a danger to others. The resident was again sent back to the hospital, left in the parking lot crying because they wanted to return home. The resident had been living in the facility for 30 days. Complainant stated that the resident was housed overnight at the hospital. ^ During an interview on 05/29/2026 1:55 PM, Administrator #1and Regional Registered Nurse #1 both had indicated the incident happened prior to their employment at the facility. Their understanding was that the resident was sent for a mental evaluation on 07/30/2024 and the hospital had discharged them into the community therefore they had not been a resident of the facility any longer. Resident #182 was not safe to be in the facility. According to the regional nurse, the resident was discharged to the department of social services. They were unable to elaborate on that statement. ^ During an interview on 06/01/2026 12:25 PM, Director of Nursing #1recalled the resident was sent out for evaluation however the incident having happened in 2024 was difficult to recall yet stated any resident sent to the hospital for a psychiatric evaluation would have been allowed back once discharged from the hospital. A one-on-one constant observation would have been initiated and psychiatric care ordered. If needed the facility could try to place them elsewhere. ^The facility was equipped to care for residents with mental health conditions and had been trained in the proper aspects of their care. ^ 10 New York Codes, Rules, and Regulations: 415.3(i)(1)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during a survey, the facility failed to ensure that Preadmission Screening and Level II Preadmission Screening and Resident Review's (PASARRs) were completed according to professional standards of practice prior to admission and as needed for two (Resident #'s 19 and 180) of three residents reviewed. Specifically, (a.) Resident #19's Preadmission Screening and Resident Review instrument indicated the resident had serious mental illness, was admitted to the facility for convalescent care, and a new screen was not completed at the end the residents convalescent care stay when the resident remained in the facility, and (b.) Resident #180 was admitted to the facility prior to receiving Level II PASARR recommendations. The facility policy titled Pre-admission Screening and Resident Review Instrument (PASARR) reviewed 10/22/2026, documented every admission to the facility would have a Preadmission Screen and Resident Review (PASARR) completed prior to admission to validate the resident was appropriate for admission to the facility. It further documented that any admission whose Level I screen indicated a level II Preadmission Screen and Resident Review (PASARR) was required must have the Level II Preadmission Screen and Resident Review (PASARR) evaluation completed prior to admission and arrival at the facility. Level II Preadmission Screen and Resident Review (PASARR) recommendations would be incorporated into the resident's plan of care. Additionally if a resident's admission Level I screen indicated they had a serious mental illness and/or intellectual disability but did not require a Level II Preadmission Screen and Resident Review (PASARR) at the time of admission due to meeting exemption criteria, but they no longer met the criteria for that exemption, a Level I Screen and Level II Preadmission Screen and Resident Review (PASARR) evaluation would be completed within the appropriate timeframe according to state regulations. Resident #19 Resident #19 was admitted to the facility with diagnoses of bipolar disorder (a mental health condition that causes extreme shifts in mood, energy, and activity levels), schizoaffective disorder, bipolar type (mental health condition that combines symptoms of schizophrenia with mood disorders such as depression), and depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life). The Minimum Data Set (an assessment tool) dated 3/13/2026, documented the resident was cognitively intact, could be understood, and could understand others. A Hospital Psychiatric admission Note dated 8/25/2025, documented Resident #19 had diagnoses of schizoaffective disorder, bipolar type, depression, and anxiety. It documented Resident #19 presented at the emergency department via ambulance for a mental health evaluation. It further documented that chart review indicated the patient was admitted to another hospital for inpatient psychiatric treatment from 7/29/2025 to 8/22/2025. Resident #19's Preadmission Screen and Resident Review (PASARR) was completed on 9/08/2025. The screen documented that Resident #19 had serious mental illness, qualified for convalescent care and was to be admitted for a brief and finite stay. There was no documented evidence that a new Level 1 Screen was completed and Level II referral was made for Resident #19 after they were in the facility for more than 120 days for convalescent care. During an interview on 5/27/2026 at 12:28 PM, Director of Social Work #1 stated they and the hospital liaison reviewed screens. In discussing Resident #19, who was identified as being at the facility longer than 120 days for convalescent care and had serious mental illness, Director of Social Work #1 stated the resident would need a new screen completed. They stated they would check when the residents' last Patient Review Instrument (PRI) was completed and initiate a new Level 1 Screen. They stated Resident #19 had a diagnosis of schizoaffective disorder since admission and was last seen by psych on 5/11/2026. Resident #180 Resident #180 was admitted to the facility on [DATE] with diagnoses of down syndrome (a genetic condition caused by an extra full or partial copy of chromosome 21), anxiety (a mental health condition characterized by excessive fear or anxiety that interferes with daily activities), and dementia (a group of conditions that cause a progressive decline in cognitive (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abilities). The Minimum Data Set, dated [DATE], documented the resident was usually able to understand others, was usually understood by others, and was severely cognitively impaired. A complaint received by the New York State Department of Health on 4/15/2026, documented the Office for People with Developmental Disabilities (OPWDD) Preadmission Screen and Resident Review (PASARR) Program had become aware that Resident #180 was admitted to the facility without a Preadmission Screen and Resident Review (PASARR) for developmental disabilities being completed prior to admission. Resident #180's Preadmission Screen and Resident Review (PASARR) was initiated on 2/24/2026 and completed on 3/04/2026 after receiving recommendations from the Level II referral for intellectual disabilities. The resident was admitted to the facility on [DATE], prior to receiving the recommendations from the Level II referral. During an interview on 5/27/2026 at 12:33 PM, Director of Social Work #1 stated the facility may take a resident that was pending a Level II referral depending on the case, what the family wanted and if everyone was in agreement on what the care was and what the resident needed. Director of Social Work #1 stated the Level II was a process and sometimes it took them a while to come back with a response. They stated the Level II referral for Resident #180 was submitted prior to admission and the Office for People with Developmental Disabilities (OPWDD) did not typically provide many recommendations. They stated Resident #180's screen indicated other services. Director of Social Work #1 stated they would let the liaison at the hospital know that they would need the Level II recommendations prior to admitting a resident to the facility. During an interview on 6/01/2026 at 12:07 PM, Administrator #1 stated the purpose of the Preadmission Screen and Resident Review (PASARR) was to make sure that the facility could take residents/meet their needs prior to admission. They stated it screened for mental illness or psychosocial issues so that the facility could care for residents properly to be admitted . They stated they believed the regulation stated a Level II should be done prior to admission. ^ 10 New York Code of Rules and Regulations S483.20(k)(1)-(3) ^^^^^^^^^^^^^^		

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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** Based on record review and interviews during the survey, the facility failed to ensure 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 four (Residents #26, 79, 161, and 175) of 43 residents reviewed for comprehensive care plans. Specifically, for (a) Resident #26, the comprehensive care plan did not include care areas that addressed the need for multiple medications including Ropinirole HCl two milligrams for restless leg syndrome, Tizanidine HCl four milligrams for muscle spasms, Kenalog-49 injection suspension 40 milligrams per milliliter for pain, and Lidocaine HCl injection solution one percent 10 milliliters to mix with Kenalog; for (b) Resident #79, the comprehensive care plan did not include a care area that addressed Resident #79's self-management of their ostomy pouch; for (c) Resident #161, the comprehensive care plan did not include a care area that addressed the resident's physical therapy needs; and for (d) Resident #175, the comprehensive care plan did not include a care area that addressed the resident's aggressive behaviors and refusal of care. Findings include: The policy and procedure titled Care Plans - Comprehensive, reviewed 8/02/2024, documented the comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs was developed and implemented for each resident. The documented procedure included (in pertinent part): (1) The Interdisciplinary Team, in conjunction with the resident and his/her family or legal representative, developed and implemented a comprehensive, person-centered care plan for each resident; (2) The care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment; (4) Each resident's care plan would be consistent with the resident's rights to participate in the development and implementation of his or her plan of care; (7) The care planning process would include an assessment of the resident's strengths and needs and incorporate the resident's personal and cultural preferences in developing the goals of care; (8) The comprehensive, person-centered care plan would include measurable objectives and timeframes, describe the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, incorporate identified problem areas, incorporate risk factors associated with identified problems, reflect the resident's expressed wishes regarding care and treatment goals, identify the professional services that were responsible for each element of care, enhance the optimal functioning of the resident by focusing on a rehabilitative program, and reflect currently recognized standards of practice for problem areas and conditions; (10) Identified problem areas and their causes, and developed interventions that were targeted and meaningful to the resident; and (13) Assessments of resident were ongoing and care plans were revised as information about the residents and the residents' conditions change. Resident #26 Resident #26 was admitted to the facility with the diagnoses of chronic obstructive pulmonary disease (a progressive, long term lung disease that causes restricted airflow and breathing-related difficulties), heart failure (when the heart muscle is too stiff or weak to pump effectively), and restless leg syndrome (uncontrollable, overwhelming urge to move the legs). The Minimum Data Set (an assessment tool), dated 3/03/2026, documented the resident was able to understand others, was able to be understood, and was cognitively intact. A Physician Order dated 4/15/2026 at 10:49 AM documented Resident #26 was ordered Kenalog-40 Injection Suspension 40 milligrams per milliliter (Triamcinolone Acetonide). Inject 40 milligrams intramuscularly as needed for pain to be administered by Medical Doctor #1. A Physician Order dated 4/15/2026 at 10:29 AM documented Resident #26 was ordered Lidocaine HCl Injection Solution one (1) percent (Lidocaine HCl (Local Anesth.)). Inject 10 milliliters intramuscularly as needed for mix with Kenalog to be administered by Medical Doctor #1. A Physician Order dated 9/24/2025 at 8:59 AM documented Resident #26 was ordered Ropinirole HCl (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oral tablet two (2) milligrams (Ropinirole Hydrochloride). Give one (1) tablet by mouth at bedtime for restless leg syndrome. A Physician Order dated 4/15/2026 at 10:49 AM documented Resident #26 was ordered Tizanidine HCl Oral Tablet four (4) milligrams (Tizanidine HCl). Give four (4) milligrams by mouth three times a day for muscle spasm. The comprehensive care plan for alteration in comfort related to aging process and skin tear, created 12/11/2024, documented that Resident #26 was able to request pain medications. There was no documented evidence that a care plan area for muscle spasms or the need for muscle relaxers had been created. Resident #161 Resident #161 was admitted to the facility with the diagnoses of chronic obstructive pulmonary disease (a progressive irreversible lung disease that restricts airflow), type 2 diabetes (a chronic condition where the body either resists the effects of insulin or doesn't produce enough of it to maintain normal glucose levels), and obesity (excessive body fat that poses a serious risk to overall health). The Minimum Data Set, dated [DATE], documented the resident was able to be understood, able to understand others and was cognitively intact. A nursing note dated 3/07/2026 documented that Resident #161 was found on the floor after sliding from their wheelchair. Resident #161 was to have a physical and occupational therapy evaluation after their evaluation. A note dated 3/09/2026 at 3:07 PM by Physical Therapist #2 documented that Resident #161 was demonstrating their baseline functional mobility and there were no changes required at that time. A note dated 5/07/2026 at 11:03 AM by Physical Therapist #1 documented Resident #161 demonstrated functional mobility status consistent with baseline level of function at that time, with no significant decline noted requiring additional skilled physical therapy intervention. Resident #161 was agreeable to participate in open gym program to support ongoing mobility, strength, and activity tolerance. Recommended nursing for application of moist heat pack to left foot prior to gym participation to assist with pain management. Suggested heat application schedule from 9:00 AM-9:30 AM, as Resident #161 typically attended gym program from 9:30 AM-10:00 AM. The comprehensive care plan related to risk for falls, dated 1/30/2025, documented the intervention of physical therapy to evaluate and treat as ordered. The comprehensive care plan related to limited physical mobility related to right below the knee amputation, dated 1/27/2026 had no documented evidence of physical therapy being utilized. There was no documented evidence of a physical therapy care area noted in the comprehensive care plan. During an interview on 5/21/2026 at 12:10 PM, Resident #161 stated that they had asked for therapy to strengthen their left lower extremity and keep their right stump strong to be ready for the prosthesis they were eventually expecting to receive. Resident #161 stated they were told by physical therapy that insurance would not cover their therapy and therefore was not initiated. During an interview on 5/28/2026 at 11:29 AM, Director of Rehabilitation #1 stated that Resident #161 was discharged from physical and occupational therapy after receiving services from 3/26/2026 to 4/16/2026. Resident #161 had also received physical and occupational therapy from 1/27/2025 through 4/23/2025 and 11/22/2024 through 12/18/2024. Director of Rehabilitation #1 stated that Resident #161 did ask for therapy so that they did not decline. Resident #161 was offered open gym after being discharged from therapy and no longer met the requirements for therapy. Resident #175 Resident #175 was admitted to the facility with the diagnoses of type 2 diabetes mellitus (the body does not produce enough insulin to maintain normal blood glucose levels), major depressive disorder (a mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), and adjustment disorder with mixed disturbance of emotions and conduct (a mental health diagnosis for individuals who develop both emotional distress and behavioral issues in response to a major life stressor). The Minimum Data Set, dated [DATE], documented the resident was usually understood, was sometimes able to understand others, and was severely cognitively impaired. A Physician Order date started 1/12/2026 and continued through 2/23/2026, documented that Resident #175 was ordered Lorazepam Tablet 0.5 milligram. Give one (1) tablet by mouth three times a day for Anxiety. A Physician Order dated 2/06/2026 at 11:37 AM, documented Resident #175 was ordered Depakote Sprinkles Oral Capsule Delayed Release Sprinkle 125 milligrams (Divalproex Sodium). Give two (2) capsules by (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth every morning and at bedtime for conduct. A Physician Order dated 2/23/2026 at 11:57 AM documented Resident #175 was ordered Klonopin Oral Tablet 0.5 milligrams (Clonazepam). Give one (1) tablet by mouth three times a day for Anxiety. A Nursing Note on 1/03/2026 at 8:55 PM documented that Resident #175 displayed behaviors such as yelling out, and outbursts and addressing their roommate in a derogatory way numerous times during the shift. A Nursing Note on 1/04/2026 at 8:55 PM documented that Resident #175 displayed behaviors such as yelling out, and outbursts and addressing their roommate in a derogatory way numerous times during the shift. A Nursing Note on 1/08/2026 at 9:48 PM documented that Resident #175 displayed behaviors such as yelling out, and outbursts and addressing their roommate in a derogatory way. A Nursing Note on 1/13/2026 at 1:57 PM documented that Resident #175 displayed behaviors such as yelling, kicking, scratching, verbally aggressive, and spitting at nursing staff. A Nursing Note on 1/13/2026 at 10:05 PM documented that Resident #175 displayed behaviors such as yelling out, and outbursts and addressing their roommate in a derogatory way for a short period of time. A Nursing Note on 1/14/2026 at 9:20 PM documented that Resident #175 displayed behaviors such as yelling out, disrobing and having delusions. A Nursing Note on 1/15/2026 at 9:24 PM documented that Resident #175 displayed behaviors such as verbal and physical outbursts, refusal of care, disturbing other residents in the hallway. Resident #175 was medicated with Tylenol and Ativan with no effect. Offered food and water, resident refused, checked and changed, resident was soiled with urine, but continued to holler out shortly after. Plan of care continued. A Nursing Note on 1/16/2026 at 2:16 PM documented that Resident #175 displayed behaviors such as yelling out, and outbursts and disrobing. A Nursing Note on 1/17/2026 at 10:10 PM documented that Resident #175 displayed behaviors such as yelling out, and outbursts and addressing their roommate in a derogatory way. A Nursing Note on 1/22/2026 at 9:48 AM documented that Resident #175 displayed behaviors such as yelling, kicking, scratching, verbally aggressive, and spitting at nursing staff. A Nursing Note on 1/23/2026 at 11:10 AM documented that Resident #175 refused to be in their wheelchair while yelling/hollering in the hallway, called staff derogatory names. Resident was reapproached by other nurses on the station but was still aggressive. Unit Manager made aware, and provider notified. Nursing notes from 1/23/2026 documented Resident #175 also refused multiple doses of medication throughout the day. A Nursing Note on 1/26/2026 at 8:14 PM documented that Resident #175 displayed behaviors such as verbal outbursts. A Nursing note on 1/28/2026 at 10:44 AM documented that Resident #175 was in the common area by the nurse's station yelling. Licensed Practical Nurse #9 came out of their office to see the resident. Resident #175 jumped forward out of their wheelchair onto the floor. They tried to obtain vital signs which they refused. Assisted back in to their chair by mechanical lift, skin intact, neuro checks initiated. Placed into bed per resident request. Request for provider to initiate a medication review. Provider and Director of Nursing aware. A nursing note on 1/31/2026 at 2:29 PM documented Resident #175 was non-stop yelling/hollering and called staff derogatory names. Resident #175 Comprehensive Care plan for activities, dated 9/16/2025, documented Resident #175 did not express an interest in recreational activities and to respect Resident #175's refusals. Resident #175 Comprehensive Care Plan for difficulty communicating with others related to low brief interview for imental satus, dated 9/12/2025, documented to engage Resident #175 to participate in simple structured activities, introduce self and explain care before doing it, present just one thought, idea, question or direction at a time, provide activities that accommodated the resident's abilities, anticipate the resident needs, monitor and document physical/nonverbal indicators of discomfort or distress, and follow-up as needed, therapy as ordered, and validate resident's message by repeating aloud. Resident #175's Comprehensive Care Plan for grief over the loss of a family member, dated 9/12/2025, documented to allow the resident to verbalize their grief and demonstrate effective coping behavior. Social Work to provide support visit as needed. Resident #175's Comprehensive Care Plan for displayed or reported mood symptoms as evidenced by high Patient Health Questionnaire-9 (a standard 9-question self-report tool used by clinicians to screen for, diagnose, and measure the severity of depression), dated 9/12/2025, (continued on next page)		

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Centers for Medicare & Medicaid Services

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NAME OF PROVIDER OR SUPPLIER Fulton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 847 County Highway 122 Gloversville, NY 12078	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that Resident #175 would remain social with peers/staff, staff would encourage activities of choice, provide opportunity for the resident to express themselves, and provide support and reassurance. During an interview on 5/29/2026 at 12:51 PM, Licensed Practical Nurse #3 stated that care plans were done by unit managers, social work and the Director of Nursing. ^ During an interview on 5/29/2026 at 12:53 PM, Licensed Practical Nurse #6 stated that the Director of Nursing and Nurse Educator did the care plans. They went over each topic, included in the care plans with staff.^ ^ During an interview on 5/29/2026 at 12:57 PM, Licensed Practical Nurse #9 stated that they were able to add interventions to the care plans but the creation of care plans wasere done by the Director of Nursing, the Minimum Data Set Nurse, and the Nurse Educator. Licensed Practical Nurse #9 stated that Resident #175 had a slow decline over time and eventually became problematic behaviorally. Resident #175 refused a lot of care. Staff had asked Psych to see the resident, but Resident #175 refused to speak with them. The providers would give staff different ideas on how to work with the resident. ^ During the interview on 5/29/2026 at 1:21 PM, Director of Nursing #1 stated that they created the care plans. The nurse educator that resigned also did care plans. Director of Nursing #1 stated that there should have been a care plan for the spasmodic medications that Resident #26 was taking and that there should be care plan areas for all medications that residents were taking. Changes in behavior should also have been reflected in the care plans. It was also expected that resident care needs would be documented in the care plan. 10 New York Codes, Rules, and Regulations 415.11 (c)(1)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review conducted during a survey, the facility failed to ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial wellbeing for two (2) (Resident #'s 105 and 110) of three (3) residents reviewed. Specifically, (a.) Resident #105 was bed bound and was not offered to attend activities or provided with activities; and (b.) Resident #110 was observed in bed on multiple occasions without stimulation or activities present and there was no documentation to support that they were offered, provided with, or attended activities. The facility policy titled Activity Program last reviewed 5/2019, documented the facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities designed to meet the interests of and support the physical, mental, and psychosocial wellbeing of each resident. Individualized and group activities were provided that: (a.) reflected the schedules, choices and rights of the residents; (b.) were offered at hours convenient to the resident; (c.) reflected the cultural and religious interests, hobbies, life experiences, and personal preferences of the residents; and (d.) appealed to men and woman as well as those of various age groups residing in the facility. It further documented that activities were not necessarily limited to formal activities being provided only by activity staff. Other facility staff, volunteers, visitors, residents, and family member may also provide activities. Resident #105 Resident #105 was admitted to the facility with diagnoses of multiple sclerosis (a chronic, often debilitating disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body), adult failure to thrive (a geriatric syndrome characterized by complex multi-factorial decline in physical, mental, and functional health), and peripheral vascular disease (a condition that affects the blood vessels outside of the heart, typically in the legs and arms). The Minimum Data Set (an assessment tool) dated 4/08/2026, documented the resident could be understood, could understand others, and was moderately cognitively impaired. Resident #105's Comprehensive Care Plan for Activities dated 1/06/2026, documented the resident was able to make recreation and leisure preferences known. Interests included all kinds of exercise, word search, painting, adult coloring, crafting, dogs, and comedy movies. Interventions included: assist Resident #105 with finding programs of interest, provide the resident with independent leisure supplies, and provide monthly calendar/daily schedule of events. During an observation on 5/22/2026 at 11:36 AM, Resident #105 was bed bound. They were observed in bed for 2 days. During an observation on 5/29/2026 at 11:42 AM, Resident #105 was observed in bed. Resident #105 was not observed out of bed during any observations made from 5/22/2026 to 5/29/2026. During an interview on 5/29/2026 at 11:45 AM, Recreation Director #1 stated residents that did not come out of their rooms received one-to-one visits. They stated the last one-to-one visit provided to Resident #105 was yesterday when they went and talked the to the resident about the weather and asked if they wanted to come to activities. Recreation Director #1 stated there was no documentation for activities. They stated the plan going forward was to get the computer program to document and in the meantime they would document on paper. Recreation Director #1 stated Resident #105 did not come to activities because staff did not bring them down. Resident #110 Resident #110 was admitted to the facility with diagnoses of Alzheimer's disease (a progressive brain disorder that causes memory loss, confusion, and other cognitive decline), depression (a mental health condition characterized by persistent sadness, loss of interest, and other symptoms that significantly impair daily life), and peripheral vascular disease. The Minimum Data Set (an assessment tool) dated 4/27/2026, documented the resident was sometimes understood, sometimes understood others, and was severely cognitively impaired. It further documented that the resident had severely impaired vision or no vision or saw only light, colors or shapes. Resident #110's Comprehensive Care Plan for Activities documented the (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was able to make recreation and leisure preferences known. Interests included: enjoys the coffee cart and music appreciation. Some interventions included: assist the resident with finding programs of interest and introduce distracting stimuli (such as music, conversation, and touch). During an observation on 5/21/2026 at 12:04 PM, Resident #110 was observed in bed, their gown was partially covering their face, and they had a half-eaten breakfast tray in front of them. The television was not on and there was no other stimulation or activities present. During an interview on 5/21/2026 at 12:04 PM, Resident #110's roommate stated that Resident #110 was technically blind. During an interview on 5/22/2026 at 10:36 PM, Resident #110 was observed in bed, using their fingers to lick leftover food off their breakfast tray in front of them, in the dark with no lights on and the blind down. The television was not on and there was no other stimulation or activities present. During an interview on 6/01/2026 at 11:25 AM, Recreation Director #1 stated Resident #110 loved music, to drum on the table, liked the refreshment cart, and came to the activities room. They stated Resident #110 was in the military and enjoyed visits with the veteran that came to the facility for visits. They stated Resident #110 was offered to attend activities such as patio time, music, and karaoke. Recreation Director #1 stated the activities department had not been documenting resident participation of activities. They had just started paper charting last week and should have the computer program to document back soon. They stated they had no excuse as to why they did not chart. Recreation Director #1 was not able to provide proof that Resident #110 was offered, provided with, or attended activities. During an interview on 5/29/2026 at 12:17 PM, Administrator #1 stated they were made aware the previous day that activities staff had not been documenting. They stated going forward they had established a manual documentation system until a computer documentation system could be in place. Administrator #1 further stated the activities department worked with nursing to ensure residents were brought to activities. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews conducted during a survey, the facility did not ensure that residents were provided with Quality of Care according to professional standards of practice for two (Residents #65, and #29) of forty-three residents reviewed. Specifically, Resident #65 was prescribed injectable medication for Diabetes Mellitus (body cannot process sugars, leading to high blood sugars) without the diagnosis of Diabetes Mellitus causing the resident to have a significant drop in blood sugar. Resident #29 had bilateral upper extremity dressings that were observed not to be intact for several hours a day after nursing was made aware. Findings include: The facility policy titled Medication Regimen Review dated 09/10/2025 documented the Consultant Pharmacist shall review the medication regimen of each resident at least monthly and will report irregularities as required by state and/or federal regulations, whichever is most stringent. The primary purpose of the medication regimen review is to validate the medications each resident receives are clinically indicated, identify irregularities, and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications prescribed for residents. As part of the medication regimen review, the Consultant Pharmacist will consider these factors: a. Whether the medication(s) have indications for use through a review of the diagnoses, progress notes, and additional health information in the resident's clinical record and/or communication with the healthcare team, b. Whether the medication dose, frequency, route of administration, and duration are consistent with the resident's condition, manufacturer's recommendations, and applicable standards of practice. The facility policy titled Wound-Treatment dated 04/29/2026 documented the facility provides safe, effective, and clinically appropriate wound and skin care treatments. Wound and skin care treatments will be performed in accordance with health care providers orders, evidence-based clinical practice, resident rights, Federal and state regulations, and state Nurse Practice Act scope of practice for a Registered Nurse and Licensed Practical Nurse. Resident #65 Resident #65 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease (an ongoing lung condition caused by damage to the lungs), morbid (severe) obesity due to excess calories (weighing in excess of 100 pounds of one's ideal weight). cellulitis of right lower limb (spreading skin infection). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was cognitively intact. Record Review: Comprehensive review of resident's diagnosis list revealed no document evidence of a diagnosis of Diabetes Mellitus. Review of provider orders documented on 04/06/2026 an order for Mounjaro Subcutaneous Solution Auto-injector 10 milligrams/0.5 milliliter (injectable medication for Diabetes Mellitus), Inject 10 milligrams subcutaneously one time a day every Wednesday for Diabetes Mellitus by Medical Director #1. Review of Registered Nurse assessment by Director of Nursing #1 on 05/26/2026 documented the resident reported they did not feel right. Skin was pale, cool and diaphoretic. Blood sugar obtained and was 56, provider was updated and order to give Glucagon 1 milligram intramuscular was obtained. Blood sugar was repeated 30 minutes later and was 71. Provider was updated and order was received to give another Glucagon 1 milligram intramuscular was obtained. Blood sugar was 81 30 minutes later; provider was notified and ordered the resident to be sent to the emergency department. Resident #29 Resident #29 was admitted to the facility with diagnoses of necrotizing fasciitis (a rare but severe bacterial infection that destroys the tissue beneath the skin), need for assistance with personal care, unspecified open wound of unspecified upper arm (an injury to the arm between the shoulder and elbow where the skin is broken). The Minimum Data Set, dated [DATE], documented that the resident could be understood, could understand others, and was cognitively intact. Record Review: Review of provider orders 05/2026 documented: Starting 05/14/2026, Cleanse right forearm surgical/graft site with normal saline pat dry. Apply xeroform cut to size of wound bed every three (3) days and as needed. Starting 05/14/2026, Cleanse left forearm surgical/graft site with normal saline (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pat dry. Apply xeroform cut to size of wound bed every three (3) days and as needed. Review of Medication Administration Record for 05/2026 revealed no documented evidence of any as needed dressing changes. Observations: During an observation on 05/22/2026 at 10:00 AM, Resident #29 was sitting on their bed in their room. [NAME] gauze dressings dated 05/21/2026 noted on bilateral upper extremities both extending elbows to hands. Dressings were noted to be loose and not intact. The right upper extremity dressing was loose at the elbow area with tape that did not adhere to dressing and loose on the hand allowing visible reddened area to be exposed on the top of the hand. The left upper extremity dressing was noted to be loose from the elbow to the hand with a reddened area exposed on the outer forearm. Subsequently at 1:30 PM, dressings on bilateral upper extremities had not been changed. At 3:30 PM dressings were changed and dated 05/22/2026. During an observation on 05/26/2026 at 10:00 AM, Resident #29 was in their room sitting on their bed talking on their phone. [NAME] gauze dressings dated 05/25/2026 noted on bilateral upper extremities both extending elbows to hands. Dressings were noted to be loose and not intact. The dressing on the left upper extremity had become loose from the hand up to the mid forearm. The dressing on the right extremity was loose at the elbow and hand, an exposed red area on the top of hand was noted, with a small amount of bright red blood. Subsequently, at 2:10 PM dressings were not changed, Registered Nurse #2 then entered the residents room. Interviews: During an interview on 05/22/2026 at 10:00 AM, Resident #29 stated that their dressings had come loose overnight and they had told the nurse that morning when they received their medications. The dressings fell off often when they slept. At 1:30 PM resident stated the nurse has not had a chance to change my dressing yet. At 3:30 PM, the resident stated the nurse had come a short time ago and changed the dressings. During an interview on 5/26/2026 at 10:00 AM, Resident #29 stated their dressing had become loose again over night. They had let the nurse know when they had their medications earlier that morning. At 1:00 PM they stated the nurse had brought in supplies a while ago but never came back. During an interview on 5/26/2026 at 2:10 PM, Registered Nurse #2 stated Resident #29's bilateral upper extremity dressings were ordered to be changed every three (3) days and as needed. They had changed the residents' dressings the day before. They stated residents should not have loose dressing left all day. They had not been working on that unit all day and were there now to change the dressing. During an interview on 05/27/2026 at 9:37 AM, Licensed Practical Nurse #6 stated Resident #29 dressing on their upper extremities fell off a lot and was to have dressing changes as ordered. If dressings were falling off and a nurse was alerted the dressing should be changed dressing within 30 minutes. During an interview on 06/01/2026 at 12:45 PM, Director of Nursing #1 stated if a residents dressing became loose, they would expect the nurse assigned would change the dressing within one (1) hour of being notified. New York Codes, Rules, and Regulations 415.12(h)(1)(2)^^		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observations, record review, and interviews during a recertification survey, the facility did not ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers and promote healing of pressure ulcers for two (2) (Resident #10 and #105) of four (4) residents reviewed. Specifically, Resident #105's left heel pressure ulcer showed significant decline. There was no daily documentation of the wound assessment and staff did not notify the provider of the decline. Resident #10 was noted with a Stage Four pressure ulcer with a care planned intervention and physicians order for wound vacuum. The wound vacuum dressing ordered was not in place. No dressing was observed on the wound bed, and no removed dressing was observed in the resident's bed linens or surrounding area. Findings include: The facility's Policy and Procedure titled Skin and Pressure Injury Prevention revised 6/2/2024, documented This facility will assess residents for risk in the development of pressure injuries and implement preventative measures in accordance with current standards of practice. Risk Assessment: 3. Weekly Skin Monitoring by Licensed Nurse 4. Staff inspect the skin when performing or assisting with personal care.a. Identify any signs of developing pressure injuries (i.e., non-blanchable erythema). For darkly pigmented skin, inspect for changes in skin tone, temperature, and consistency; Prevention: Friction and Shear - 3. Monitor the placement of splints and casts to assure they are not placing friction on the resident's skin. 4. Positioning devices should be monitored to prevent pressure. 6. Contractures should be addressed and managed to prevent skin integrity disruption. 7. Protect bony prominences as needed. Resident #10 was admitted to the facility with diagnoses of Pressure Ulcer, Sepsis (extreme life-threatening response to an infection), Acute Respiratory Failure. The Minimum Data Set (an assessment tool) dated 3/17/2026 documented severe cognitive impairment and presence of a pressure injury. The Alteration in Skin Integrity Comprehensive Care Plan dated 3/12/2026 for resident #10 documented a Stage Four Pressure Ulcer to left upper back and sacrum. Documented intervention dated 04/07/2026 included apply wound vac to back and sacrum, notify nurse if alarming. Resident #10's Active Physician's Orders were reviewed and included an order for a wound vac. The Physician's Orders lacked evidence of an as needed dressing or order. During an observation on 5/21/2026 at 11:35 AM, Resident #10 Certified Nurse Aide #5 entered the resident's room, placed gloves on, turned Resident #10 on their side, and stated they were going to do incontinent care. A large open wound was present. The wound lacked a wound vac, or evidence that a wound vac had recently been in place. The bedding did not contain any wound foam, or dressings. The tubing to the wound vac was at the foot of the bed, and wound vac was not running. During an interview on 05/28/2026 at 8:38 AM, Infection Preventionist #1, they stated, Stage three or four wounds there should always be a treatment in place and an as needed treatment order in the event it comes off. If there was no treatment in place, this could place the resident at risk for a multi-drug-resistant organism or worsening wound. If the wound vac had just come off a green foam sponge and Tegaderm would have been present. Resident #105 was admitted to the facility with diagnosis of Multiple Sclerosis (a disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain, optic nerve; Adult Failure to Thrive (a non-specific syndrome of physical, cognitive, and functional decline, primarily affecting older adults); and Non-pressure chronic ulcer of left foot. The Minimum Data Set (an assessment tool) dated 04/08/2026, documented they could understand and be understood, others, and was cognitively intact. During an observation on 05/27/2026 at 10:12 AM, Licensed Practical Nurse # 11, assisted by Licensed Practical Nurse #11 performed dressing change as ordered to left heel for resident #105. The wound was noted open with depth, irregular borders, foul smelling, moderate amount of bloody / serosanguinous (a thin, watery wound fluid with a pale pink or light red hue) drainage with white material in the bed of the wound. Resident #105 had contractures (permanent tightening or shortening of muscles, tendons, skin, or other soft tissues that causes joints to become stiff and restricts normal movement) of bilateral lower extremities with left heel pressed (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	underneath right leg. The wound was cleansed with normal saline gauze, Medihoney (a medical-grade, sterilized honey (primarily derived from Manuka/Leptospermum plants) used for advanced wound and burn care), applied and covered with a thin dry dressing equivalent to a band aid. During an interview on 05/27/2026 at 10:30 AM, Licensed Practical Nurse #5 was asked if they measured the wound? They replied, No, this resident is followed by our wound care consultants and is seen by their physician every Tuesday who measures the wound. Licensed Practical Nurse #11 added, the wound has worsened since the resident was admitted eighteen (18) months ago, i.e.: 1/3/2025. Licensed Practical Nurse #5 and #11 were asked what their next steps would be after conducting a dressing change? Licensed Practical Nurse #5 stated that the treatment is checked off in Point Click Care (the facility's tracking and documentation system) as completed. They stated no other documentation is done after wound treatments. During record review, wound care consultant note dated 5/26/2026 documented Stage 4 pressure wound of the left medial heel full thickness. Wound size: (L X W X D): 3.5 X 2 X 0.2 CM Surface Area: 7.00 CM^2 Exudate: Light Serous Granulation tissue: 100 % Wound progress: Not at goal due to generalized decline of patient. During record review, wound care consultant note dated 9/23/2025 documented Stage 4 pressure wound of the left heel, medial heel full thickness Wound size: (L X W X D): 0.5 X 0.5 X 0.1 CM; Surface Area: 0.25 CM^2 Exudate: Light Serous; Granulation Tissue: 100 %. During record review the Comprehensive Care Plan dated 3/4/2026 documented Limited physical mobility related to Contractures, Pain, Weakness, Multiple Sclerosis. Interventions: Initiate interventions to prevent skin breakdown or injury. Monitor/document/report S/S of immobility: contractures forming or worsening, thrombus formation, skin-breakdown, fall related injury. Goal: The resident will remain free of complications related to immobility, including contractures, thrombus formation, skin-breakdown and related injury through the next review date. During an interview on 05/27/2026 at 11:24 AM, Director of Nursing #1 stated the Wound Care Consultant manages all facility wounds and is in the facility every Tuesday for an assessment. In between Nurse Practitioner #1 follows wounds. Director of Nursing #1 stated it is the responsibility of the treatment nurse to document any wound changes and notify physician and or nurse practitioner with any changes. During an interview on 05/29/2026 at 12:59 PM, Nurse Practitioner #1 stated they do not routinely follow wounds. Wound updates are sent to the Nurse Practitioner weekly and if there are any concerns noted or issues with decline in the wound noted by wound care consultant, then the Nurse Practitioner would follow up as well. They stated they were not made aware of any changes in Resident #105's wound. However, they assessed the wound today and did order an x-ray to rule out osteomyelitis. ^Nurse Practitioner #1 stated it is the expectation of the nursing staff to notify them of any wound changes. 10 New York Codes, Rules, and Regulations 415.12(c)(1) ^^		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 for four (Cart A 300-hall, Cart B 400-hall, Cart D 700 hall and Cart D 800 hall) out of four medication carts reviewed. Specifically, one stock medication had expired; one bottle of Flonase was uncapped; one loose pill was found in cart; one inhaler had an open date but was never opened; one stock medication had conflicting expiration dates; one Lantus kwik pen had no open date; one Lantus vial had no open date; five inhalers had no open and or expiration dates; one inhaler had no label at all; three narcotic count sheets were signed out prior to actual count reconciliation and change of shift; another narcotic book had multiple missing signatures for shift change. The facility's Policy and Procedure titled, Medication - Storage and Labeling reviewed 1/2026 documented This facility will store Medications safely and securely and in a manner that maintains the integrity of the product in accordance with manufacturer's recommendations, current standards of practice and federal and state regulations. 4. Medications will be stored in an orderly, organized manner in a clean area. 7. Medications (including ophthalmic, otic drops and house stock medications) may be used until the listed manufacturer expiration date unless otherwise specifically indicated or labeled. 8. Medication injection pens including insulin pens and cartridges are single patient use only and will be labeled and stored for resident individual use. 9. A multi-dose vial or injection pen that has been opened or accessed (e.g., needle-punctured) should be dated and discarded within 28 days unless the manufacturer specifies a different date for that opened vial or injection pen. a. If a multi-dose vial has not been opened or accessed (e.g., needle-punctured), it should be discarded according to the manufacturer's expiration date. b. The manufacturer's expiration date refers to the date after which an unopened multi-dose vial should not be used. The beyond-use-date refers to the date after which an opened multi-dose vial should not be used. The beyond-use-date should not exceed the manufacturer's original expiration date. b. Do not use insulin beyond the expiration date stamped on the vial, pen, or cartridge that is supplied from the drug manufacturer. c. Do not use insulin beyond the Discard On date listed on the auxiliary label. 11. Expired, discontinued and/or contaminated medications will be removed from the medication storage areas and disposed in accordance with state and federal regulations. During an observation on [DATE] at 10:23 AM, Medication Cart B on 400 hall contained (1) Lantus insulin kwik pens and (1) Lantus insulin vial with no open dates; (3) albuterol inhalers (1) budesonide inhaler all with no open and or expiration dates; (1) Trilogy inhaler with no expiration date; (1) Trilogy inhaler with no label at all. During an observation on [DATE] at 11:02 AM, Medication Cart A on the 300-hall contained (1) Pro Air inhaler with an open date of [DATE], but the inhaler had not been opened for use; (1) stock bottle Vitamin D with two expiration dates, exp 3/08 and 12/26. The narcotic sheet dated [DATE], 3pm - 11pm shift change was signed as reconciled in advance of end of shift. During an observation on [DATE] at 2:35 PM, Medication cart D 800 hall contained (1) expired stock bottle of Thiamin B1 100 milligrams; (1) uncapped bottle of Flonase nasal spray; and (1) loose yellow pill identified as carbidopa/levodopa. The narcotic book shift change sheet for unit 800 had multiple missing signatures. During an observation on [DATE] at 2:35 PM Narcotic Book shift change sheet for the 100-hall had multiple missing signatures and, Licensed Practical Nurse #4 had signed for 3:00pm shift change at 2:37pm. During an interview on [DATE] at 11:02 AM Licensed Practical Nurse #1 stated they sign the narcotic count sheet in advance routinely so that they will not forget to do it at end of shift. Licensed Practical Nurse #5 stated they would never sign for any item or medication given in advance. During an interview on [DATE] at 10:50 AM, Director of Nursing #1 stated prior to administering medication, all nurses are (continued on next page)		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Fulton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 847 County Highway 122 Gloversville, NY 12078	
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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	checked off on competencies including medication administration, drugs with shortened expiration dates after opening, multi- dose vial medications and narcotic counts. It is the medication nurse's responsibility to ensure all meds are labeled with open and expiration dates. During an interview on [DATE] at 10:32 AM, Licensed Practical Nurse #2~stated~they had not signed the narcotic count book yet because it had been a busy morning. They stated they should have signed when the first came on shift. During an interview on [DATE] at 11:02 AM, Licensed Practical Nurse #1~stated~they signed the narcotic count book in advance as the outgoing nurse routinely, so they did not forget. During an interview on [DATE] at 11:05 AM, Licensed Practical Nurse #5~stated~the narcotic count book should never be signed in advance, that would be signing for something that was not done. During an interview on [DATE] at 12:45 PM, Director of Nursing #1 stated they had been auditing the narcotic count books and would be increasing the audits due to missing signatures and nurses signing in advance. 10 New York Codes, Rules, and Regulations 415.18(d)		

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews during the survey, the facility failed to ensure that food was stored, prepared, distributed, or served following professional standards for food service safety in the central kitchen. Specifically, skim milk cartons were found past expiration dates. Findings include: During inspection in the central kitchen on 5/21/2026, the following items were found to be out of compliance with New York State food safety regulations: At 11:00AM approximately 15 cartons of skim milk were identified in the walk-in cooler placed in a small plastic cooler which were past the expiration date (5/17/2026) At 12:15 PM this cooler was identified to be at the tray line, and the expired milk was being placed on the lunch trays for the residents During interview, on 5/21/2026 at 12:15PM, Director of Food Services #1 stated the milk which was in the coolers [NAME] on the tray line to be used and it [NAME] precooled and separated to maintain temperature during tray preparation. When it was pointed out that there were approximately 15 cartons of skim milk which were past expiration date (5/13/2026) by over a week the staff were instructed to dispose of the expired cartons and a dietary staff representative went through the facility to ensure none of the expired cartons had left the kitchen or remained in any nourishment rooms, 10 New York Codes, Rules, and Regulations 415.14(h)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/01/2026
NAME OF PROVIDER OR SUPPLIER Fulton Center for Rehabilitation and Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE 847 County Highway 122 Gloversville, NY 12078	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview conducted during the survey, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (Resident #10) of 43 residents reviewed for infection control practices. Specifically, 1.) Certified Nurse Aide #5 failed to utilize Enhanced Barrier Precautions during resident care, increasing the risk of cross-contamination for a resident with a stage four pressure ulcer. These deficient practices placed the residents at risk for potential infection and compromised care delivery. Findings include: The Facility's Policy and Procedure titled Enhanced Barrier Precautions dated 8/2022 (last updated 2/25/2026), documented the Enhanced Barrier Precautions is applicable for residents with Wounds (e.g., any type of wound requiring a dressing). EBP requires wearing disposable gloves and an isolation gown prior to high contact activity. High Contact care activities include transferring and providing hygiene. Resident #10 Resident #10 was admitted to the facility with diagnoses of Pressure Ulcer, Sepsis (extreme life-threatening response to an infection), Acute Respiratory Failure. The Minimum Data Set (an assessment tool) dated 3/17/2026 documented severe cognitive impairment and presence of a pressure injury. The Active Physician's Orders were reviewed and lacked an order for Enhanced Barrier Precautions. The Certified Nurse Aide Kardex (Care Guide) dated 5/28/2026 documented Resident #10 was dependent for toileting hygiene. The Kardex lacked Enhanced Barrier Precautions. During an observation on 5/21/2026 at 11:35 AM, Resident #10 Certified Nurse Aide #5 entered the resident's room, placed gloves on, turned Resident #10 on their side, and stated they were going to do incontinent care. A large open wound was present. The Certified Nursing Assistant lacked a gown. Certified Nurse Aide returned the resident to her back and exited the room. During an interview on 05/28/2026 at 8:38 AM, Infection Preventionist #1, they stated Resident #10 is on Enhanced Barrier Precautions for a wound. They stated the Certified Nurse Aide would wear a gown and gloves with high care. 10 New York Codes, Rules, and Regulations 415.19		