STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335127	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alice Hyde Medical Center	45 Sixth Street Malone, NY 12953

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 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews during an abbreviated survey (Case #578139, 578179, and 578120), the facility did not ensure residents were free from neglect for three (3) (Resident #s 7, 105, and 119) of seven (7) residents reviewed for neglect. Specifically, for Resident #7, the facility staff did not perform toileting activities every two (2) hours as care planned; for Resident #105, the facility staff did not use two people to transfer the resident despite being care planned for a two person assist transfer; and for Resident #119, facility staff did not put the resident's bed alarm on when they put the resident back to bed. The care plan violations led to all three residents falling. This is evidenced by: The facility policy and procedure titled Abuse Prevention and Reporting, dated 2/2023, documented that all residents of the facility were to be free from abuse, neglect, mistreatment, misappropriation of property, and involuntary seclusion. The facility shall not permit verbal, mental, sexual or physical abuse, including punishment, involuntary seclusion of residents, or misappropriation of resident property. Preventative measures documented included ongoing education; obtain knowledge of resident's history and current behavior; the Social Worker would complete a thorough psychosocial assessment which would include information regarding the resident's mental health history including history of being abused or abusive, as appropriate; and the current potential to be abused or abusive. These findings would be shared with the Interdisciplinary Team and appropriate interventions would be put in place. Documented under assessment: upon admission, readmission, quarterly and if there is a significant change, the Charge Nurse, with input from The Interdisciplinary Team, would assess the resident for potential to be an abuser and assess the resident if they have a potential to be abused. Forms had been developed and are attached to this policy. The residents scores would be tallied, and an appropriate plan of care would be developed to prevent an incident of abuse. Notification of the results of the assessment would be sent to the social worker who would coordinate a plan of care with team. Before admission, prospective residents would be screened to help determine suitable placement within facility. Upon admission and periodically after that, each resident would have a safety and vulnerability assessment completed which identified potential vulnerabilities such as cognitive, physical, and psychosocial and identify these vulnerabilities and interventions on the resident care plan. It would be the responsibility of the Administrator, the Director Nursing, and the Nurse Managers to ensure staff is supervised sufficiently to identify inappropriate behaviors. Strategies to accomplish this included making regular rounds, observations, and discussions with line staff, residents, and families. The facility policy and procedure titled Comprehensive Care Plan, dated 4/2024, documented that the facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights including measurable objectives and timeframes to meet resident's medical, nursing, mental, and psychosocial needs that are identified in comprehensive assessment. Each person's care plan would be developed based on their individual treatment plans. Care plans would be monitored and updated quarterly and with any changes in status. A comprehensive person-centered care plan will include the following components: (a) Describe services that are provided to attain or maintain the resident's highest practicable physical, mental, and psychological well-being; (b) Identify residents' ability to make informed decisions regarding care and have the ability to exercise their right to refuse treatment; (c) Describe any specialized services provided regarding Preadmission Screening and Resident Review recommendations; (d) Include the resident's stated and potential for future discharge to include referrals made to local agencies or entities to support the desire; (e) Include any identified problems, resident strengths, and resident wishes regarding care and treatment goals; (f) Identify the professional services that are responsible for each element of care; (g) Aid in preventing/reducing decline in functional status and/or functional levels. Resident #7 Resident #7 was admitted to the facility with the diagnoses of unspecified dementia of unspecified severity with agitation (a condition characterized by a decline in cognitive function without a clearly identified cause. It includes varying severities and can be recorded with or without accompanying behavioral, psychotic, mood, or anxiety disturbances), myocardial infarction (blood flow decreases or stops in one of the arteries of the heart, causing infarction (tissue death) to the heart muscle), and hypertensive heart disease with heart failure (long-term condition that develops over many years in people who have high blood pressure). The Minimum Data Set (an assessment tool) dated 10/29/2024, documented that the resident was able to be understood and usually understood others with severe cognitive impairment. The comprehensive care plan

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observations, interviews, and record review conducted during the recertification and abbreviated survey (Case #578117), the facility did not ensure residents were free from significant medication errors for one (1) (Resident #46) of seven (7) residents reviewed for significant medication errors. Specifically, Resident #46 was administered and received seven (7) medications that were ordered for another resident. This is evidenced by: Resident #46 The policy titled Medication Administration dated 6/2023, documented under supportive data: A.) the medication nurse was personally responsible for every drug they administered; B.) positively identified the resident before administering drugs with instruction to check the resident's identification and ask the resident to state their name and if unable to identify self, ask staff to identify the resident; C.) read the drug label at least 3 times; D.) properly position the resident (if necessary) before administering the drug; E.) provide privacy when administering any injection; F.) before administering any drug, review the following rights: 1.) right resident; 2.) right drug; 3.) right does; 4.) right route; 5.) right time; and 6.) right documentation. G.) check expiration dates prior to administration; and H.) observe the resident take the drug. The policy titled Medication Safety Program dated 6/2023, documented the facility supported safe medication practices and a systems improvement approach to the prevention of medication errors. The facility encouraged the reporting of medication errors, adverse drug events, potential adverse drug events, and potential adverse drug events to assess and improve systems and processes for prescribing, transcribing, dispensing, and administering medications. The goal was to enhance patient safety by decreasing the potential for medication errors. Medication errors were defined as any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication was in control of the health care professional, patient or consumer. Medication errors included, but were not limited to wrong patient, wrong drug, wrong dose, wrong route, wrong frequency, and wrong time. Resident #46 was admitted to the facility with diagnoses of dementia (a group of conditions that cause a progressive decline in cognitive abilities), hyperlipidemia (a condition that causes high levels of lipids, or fats, in your blood), and anxiety (a mental health condition characterized by excessive fear or anxiety that interferes with daily activities). The Minimum Data Set (an assessment tool) dated 4/25/2024, documented the resident made themselves understood, usually understand others, and had severe cognitive impairments. The facility Root Cause Analysis Investigation dated 5/21/2024, documented Licensed Practical Nurse #2 administered seven (7) medications to Resident #46 on 5/14/2025 at 5:30 PM. The medications that Resident #46 received in error included: Simethicone 80 milligrams, Meloxicam 15 milligrams, Protonix 40 milligrams, Risperidone 1 milligram, Melatonin 10 milligram, Buspar 15 milligram, and Amlodipine 10 milligrams. It was further documented, that Licensed Practical Nurse #2 failed to practice safe medication administration by not verifying the correct resident and not passing medications according to the ordered time. They did not perform the five rights of medication administration. During an observation on 12/18/2025 at 1:37 PM, Resident #46 was observed up, groomed, and dressed in the common area on the unit. They were approachable and engaged in conversation. During an interview on 12/18/2025 at 1:37 PM, Resident #46 was able to say their full name when asked what their name was. During an interview on 12/18/2025 at 1:42 PM, Certified Nurse Aide #4 stated that Resident #46 could tell you their name most of the time. During an interview on 12/18/2025 at 1:52 PM, Registered Nurse #3 was asked what the 5 Rights of Medication Administration were. Registered Nurse #3 stated: right patient, route, time, dose, and maybe documentation. They stated they checked the residents name bracelet or their picture in the electronic medical record to identify a resident when passing medications. Registered Nurse #3 further stated that Resident #46 was able to tell you their name if asked what it was. During an interview on 12/18/2025 at 11:32 AM, Registered Nurse #2 stated they completed all the accident and incident reports at the facility. They stated Licensed Practical Nurse #2 gave Resident #46 another resident's medications. It was a significant medication error, and the nurse was terminated. They stated, they tried to complete counseling and education for medication errors, but some errors could not be ignored such as giving medication to the incorrect resident. They did not want their residents harmed there. Registered Nurse #2 further stated the facility provided medication administration education upon hire and annually. During an interview on 12/19/2025 at 10:02 PM, Director of Nursing #1 stated on 5/14/2024 at 5:30 PM, Licensed Practical Nurse #2 popped all of the medications, gave the medications outside the window of time they were ordered, and gave them to the wrong resident. They stated Licensed Practical Nurse #2 was suspended during the investigation and then terminated related to