STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026

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 - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review during a survey, the facility failed to ensure residents were free from abuse of any type. Specifically, (a) the facility failed to implement care planning interventions to appropriately address Resident #2 who had a documented history of sexually inappropriate behaviors. This resulted in Resident #1 being sexually assaulted by Resident #2. Using the reasonable person concept, as referenced on the Centers for Medicare and Medicaid Services Psychosocial Outcome Severity Guide, the facility's failure to protect residents from sexual abuse resulted in psychosocial harm to Resident #1 that was not Immediate Jeopardy. (b) Resident #3 had a behavior care plan that documented they demonstrated verbally and physically abusive behavior. On [DATE], a behavior care plan note documented Resident #3 was placed on 15-minute checks for safety due to shoving a staff member and telling other residents to shut up and for pointing at them. On [DATE], the facility failed to implement the care plan intervention of 15-minute checks for Resident #3 from 11:45 AM to 12:30 PM, which placed other residents at risk for abuse. At 1:04 PM, Resident #3 was found having wandered into another resident's room. This is evidenced by: Cross reference F627 The facility policy and procedure titled Abuse Prevention and Reporting, dated 06/2023, documented the purpose was to ensure that all residents of the facility were free from abuse, and that the facility shall not permit verbal, mental, sexual or physical abuse. Immediate action to protect the resident from further alleged abuse shall be taken. The orientation process will include training to ensure that new staff members were fully prepared to recognize instances of potential abuse as well as how to intervene appropriately. Annual in-services as well as ongoing education regarding specific situations would take place with appropriate staff members. The focus would be on identifying what constitutes abuse, as well as reporting of abuse without fear of reprisal. Additional education topics related to resident abuse would be periodically presented to include appropriate interventions to deal with aggressive and potentially dangerous resident behavior. A facility policy titled Safety Intervention at [Facility], dated 05/2024, documented safety interventions will be implemented on a resident centered basis to optimize care and safety for each individual resident while maintaining dignity. Safety interventions will be routinely reviewed for continued use and effectiveness through a collaborative approach with nursing staff, rehabilitation staff, medical staff, and any other staff as appropriate. The policy further documented (A) that the standard types of safety interventions used at the facility included 15 minute checks and observations; that safety measures will be evaluated to ensure the least restrictive interventions were utilized for each resident; and that as with implementation, through an Interdisciplinary Team approach, each individual safety intervention will be assessed routinely and discontinued if found to be ineffective or no longer necessary as resident condition changes. Documentation will be added into the electronic record indicating reason for discontinuation of safety measure, every 15-minute checks/observations will typically be in place for 72 hours depending on what situation or event required them to be initiated. Checks can be extended if felt necessary by the Interdisciplinary Team. Resident #1 Resident #1 was admitted to the facility with diagnoses of Alzheimer's disease (a progressive brain disorder that (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Alice Hyde Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Sixth Street Malone, NY 12953	

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F 0600 Level of Harm - Actual harm Residents Affected - Few	slowly destroys memory, thinking and reasoning skills), paralysis on one (1) side of the body, and aphasia following cerebral infarction (a language disorder caused by brain damage, affecting speech, understanding, reading and writing). The Minimum Data Set (a resident assessment tool), dated [DATE], documented the resident was usually able to understand others and made themselves understood but was severely cognitively impaired. The comprehensive care plan dated [DATE], documented the following: Behaviors: Resident #1 had a history of combative, resistant behaviors, weepiness, attempts to self-transfer and ambulate with no ability to recognize their limitations. Goals listed included not being the victim or aggressor daily. Interventions included monitoring behaviors, escalations and intervene and report as needed. Communication Impaired: Resident #1 had an altered ability to communicate related to talking few words only intermittently. The goals listed included caregivers would be able to interpret nonverbal cues/facial expressions and body language when providing care. Interventions listed included observing body language and facial expressions to determine needs. Resident #2 Resident #2 was admitted to the facility with diagnoses of Parkinson's disease with dyskinesia (a neurological disease causing stiffness and movement disorders with jerky movements caused by the medication required to treat the disease), dementia with anxiety (a progressive loss of intellectual functioning, especially impairment of memory and abstract thinking), and heart disease without chest pain. The Minimum Data Set, dated [DATE], documented the resident was usually able to understand others and made themselves understood but was significantly cognitively impaired. The comprehensive care plan for behaviors dated [DATE] documented that Resident #2 had a tendency to be sexually inappropriate, wandering, stayed awake at night and wandered the halls. The goals documented that Resident #2 would not be the aggressor and there would be no sexual talk or touching of staff. The interventions documented were to invite Resident #2 to activities, assess for behaviors, and monitor cognitive status. The care plan was updated on [DATE] to include diversion such as redirection, one-to-one (1:1) supervision (a dedicated staff member assigned to constantly monitor a resident), television, and 15-minute checks. The care plan was updated on [DATE] to again note 15-minute checks. A care plan note dated [DATE] documented that Resident #2 was sexually inappropriate with certified nurse aides on [DATE] while receiving care, Resident #2 asked staff to get into bed with them and touched staff buttocks. Resident #2 Nursing Notes Prior to [DATE] and [DATE] Incidents: A nursing note by Licensed Practical Nurse #1 dated [DATE] at 1:39 PM, documented Resident #2 was sexually inappropriate with staff that shift, making comments to staff such as, You have a nice rear end, I bet you would like if I touched it. Staff educated Resident #2 that comments like that were not appropriate, and they should not say them. The note documented Resident #2 looked the staff up and down and asked them to go to their room with them. Staff documented that they told Resident #2 that it was not appropriate. Additionally, between [DATE] and [DATE], there were 26 documented nursing notes identifying Resident #2 making inappropriate sexual comments and gestures to staff, sexually propositioning staff, and grabbing a staff member's breast. A review of Resident #2's comprehensive care plan for behaviors dated [DATE] indicated between [DATE] and [DATE], there was no documented evidence this care plan was updated to include interventions to reduce sexually inappropriate behaviors or to protect other residents and staff from sexually inappropriate behaviors demonstrated by Resident #2. Resident #2 Physician Notes Prior to [DATE] and [DATE] Incidents: A physician note on [DATE] at 2:40 PM documented Resident #2 was more short tempered than usual during a gradual dose reduction of venlafaxine medication (an antidepressant) and nursing staff reported an increase of sexually inappropriate comments to staff. A physicianˆnoteˆon [DATE] atˆ10:24 AM documented that Resident #2ˆcontinuedˆwith daily sexual inappropriateness, venlafaxine was noted to be back to 150 milligrams daily on [DATE] andˆthat trazadone would be added atˆbedtimeˆto help with sleep.ˆ A physician note dated [DATE] at 1:36 PM documented thatˆResident #2 was continuing to haveˆinappropriateˆsexual comments and agitation.ˆA conversation with Resident #2's family was documentedˆandˆthereˆwas a plan toˆadd trazadone (a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	prescription antidepressant of the serotonin antagonist and reuptake inhibitor class that is primarily used to treat major depressive disorder, as well as insomnia and anxiety off-label) in the morning andˆcontinueˆthe Ativan (a prescription benzodiazepine used short-term to treat anxiety disorders, insomnia, acute seizures, and alcohol withdrawal) as needed.ˆˆ Aˆphysician note dated [DATE] at 4:35 PM documented Resident #2 wasˆupset that they and their spouse were being held against their wills, threatened the physician but did not move to do anything, andˆaccusedˆthe physician of saying things they did not say. The physician documentedˆthe team would try to reduce some of Resident #2'sˆParkinson's medicationˆand increaseˆtrazadone andˆkeep the as needed Ativan.ˆˆ A physicianˆnoteˆon [DATE] at 5:00 PM documentedˆResidentˆ#2's family asked to speak to themˆregardingˆResident #2's ongoing anxiety and auditoryˆhallucinationsˆthat Resident #2's spouse was talking about them.ˆAlso documented was another medicationˆchange lowering trazadone becauseˆResidentˆ#2 was reportingˆurinaryˆissues andˆtrying Ativan atˆbedtimeˆto improve sleep and help lower anxiety during the day.ˆˆ A physician note dated [DATE] at 3:06 PM documented that Resident #2 was having increased sexually inappropriate behaviors with attempts at touching staff. A physician noteˆdatedˆ[DATE], documentedˆResident #2's Ativan (used to treat anxiety disorders, panic attacks, and insomnia) was identified as theˆpossible reasonˆResident #2 had become more disinhibited andˆplanned to back off the Ativan and trial some Depakote (an anticonvulsant medication also functioning as a mood stabilizer) in the evening.ˆˆ A physician's note from [DATE] documentedˆanother medication change, decreasing Ativan and increasingˆDepakoteˆto minimizeˆResident #2's mood swings. A physician note dated [DATE] at 4:35 PM documentedˆtrying to decrease primidone (an anticonvulsant to control various types of epileptic seizures) and putting valproic acid (a broad-spectrum antiepileptic drug used to treat seizures, bipolar disorder mania, and prevent migraines) on hold as it was the latest medication added. Incident on [DATE] and [DATE]: A nursing note dated [DATE] at 10:38 AM documented Certified Nurse Aide #6 entered the room of Resident #4 at 7:20 AM. The door to this room was closed. Resident #2 was in this room in their wheelchair next to the bed of Resident #4. Resident #4 was sleeping. Resident #2 appeared to be watching Resident #4 sleep. Certified Nurse Aide #6 separated the residents immediately, causing Resident #2 to become very upset insisting the sleeping resident was their spouse. When informing Resident #2's family of the incident, Resident #2's family stated that if we need to medicate them to make them more docile, then that is what I want. Medical doctor aware. A physician's note dated [DATE] at 6:10 PM documented Resident #2's family was very concerned about Resident #2's behaviorˆand gave permission to change the dose of Resident #2'sˆParkinson'sˆmedications with the understanding that the Parkinson symptoms might be more pronounced, but with the hope that theˆsexualˆbehavior would decrease.ˆˆ A physician's note dated [DATE] at 1:30 PM documented follow up Parkinson's/sexual disinhibition. Resident was alert and up in wheelchair, tells me they are looking for their spouse (deceased). Now on Sinemet 25/100 (a tablet that contains 25 milligrams of carbidopa and 100 milligrams of levodopa) 1/2 four times a day (Sinemet 25/100 take half four times a day). Will try to watch at this dose through weekend and see if Resident #2 is less likely to be grossly inappropriate physically and verbally with staff. A nursing note dated [DATE] at 1:53 PM documented that Resident #2 had been in and out of bed all shift, intrusively wandering into other rooms, stating residents were their spouse, asked staff if they were married, and was difficult to redirect. As needed Ativan was given at 11:16 AM with little effect. A care plan note for Resident #1 dated [DATE], documented that Staff Member #1 was called to Resident #1's room at approximately 4:35 PM by staff who reported Resident #1's family member came out of Resident #1's room stating someone was in their parent's room. Staff reported upon entering the room, they removed Resident #1 from the bed and placed Resident #1 in a wheelchair. When Staff Member #1 entered the room, Resident #1 was in a wheelchair and Resident #2 was lying on their right side in Resident #1's bed with their pants and brief pulled down to their knees. Resident #1 was wearing a t-shirt and briefs. Resident #1's brief was documented to be intact with no tearing noted. No bruising or injury was (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	noted to Resident #1. Resident #1 was noted to be crying and shaking. They were provided with a blanket and brought to the hallway to be with their family. Resident #1 was unable to communicate what happened. Resident #2 was removed from Resident #1's bed and taken to their room and placed on one-to-one (1:1) care (resident to receive one-to-one (1:1) supervision provided by a staff member). Assistant Director of Nursing #1 and Medical Doctor #1 were called and made aware, New York State Police and Emergency Medical Services were called, and both residents were sent to the hospital for evaluation. Fifteen (15)-minute checks were added to Resident #1's care plan. Per the facility investigation report, on [DATE] at 4:35 PM, Resident #2 was found in bed with Resident #1 by Resident #1's family member (Family Member #1). Family Member #1 immediately asked for help from facility staff to separate the residents. Resident #2 stated multiple times that Resident #1 was their spouse, was documented to be confused and upset that staff were separating them. The facility investigation and hospital documentation indicated that no penetration occurred, however, witness statements documented that Resident #2's pants were pulled down and Resident #1's left breast was exposed when they were found. Resident #1's incontinence brief was intact without signs of having been manipulated. Law enforcement was called, and both residents were sent to the hospital for examination. A care plan note written by Registered Nurse #2 dated [DATE], documented Resident #1's family member reported a bruise to Resident #1's right leg. The bruise was documented as a small faint purple bruise in the middle of their right lower leg. Bruise measured one (1) centimeter by one (1) centimeter. Skin around area intact. Resident showed no signs or symptoms of pain, no pulling away of their leg, no crying or wincing noted. Due to resident's dementia, resident unable to tell Registered Nurse #2 the origin of the bruise. Certified Nurse Aide who toileted resident and transferred resident out of bed prior did not notice the bruise. Registered Nurse #2 updated Medical Doctor #1 via electronic message on [DATE] at 4:45 PM. A care plan note written by Registered Nurse #2 dated [DATE] documented they were called to unit on [DATE] at 5:00 PM. Family Member #1 was visiting Resident #1 and reported the bruise to a licensed practical nurse who reported to writer. Registered Nurse #2 assessed the bruise. Bruise noted to be old in appearance to left lateral thigh measuring two (2) centimeters by two (2) centimeters. Center of bruise was purple and the skin around bruise was a light yellow. Surrounding skin around the bruise was intact. No signs or symptoms of pain when assessed. No guarding, wincing, crying, or pulling away from writer. Resident #1 was unable to tell writer origin of bruise due to dementia. Medical Doctor #1 was made aware via electronic message on [DATE] at 5:08 PM. Information from the facility provided 15 Minute Observation Sheets dated [DATE] revealed the following: Resident #2 was observed every 15 minutes from [DATE] at 7:30 AM until [DATE] at 6:00 PM. During the incident that occurred on [DATE] at 4:35 PM, it was documented that Resident #2 was in their room from 1:00 PM until 4:30 PM.From 4:30 PM until 5:45 PM, it was documented that Resident #2 was in their wheelchair in their room on a one-to-one(1:1) sit. During an interview on [DATE] at 8:39 AM, Certified Nurse Aide #5 stated Resident #2 became behaviorally problematic after their spouse passed away, saying sexually inappropriate things to staff and leering at them. Certified Nurse Aide #5 stated all nursing staff were responsible for 15-minute checks, and they worked together to ensure they were done. During an interview on [DATE] at 11:29 AM, Director of Nursing #1 stated that when Resident #2's spouse became ill and passed away, the resident became verbally and sexually inappropriate with staff. After Resident #2 was found in a resident's room watching them sleep, Resident #2 was put on consistent 15-minute checks. At the time of the incident when Resident #2 was found in bed with Resident #1, it was obvious to staff that Resident #2 believed they were in bed with their spouse and was very upset that staff were forcing them apart. During an interview on [DATE] at 9:43 AM, Certified Nurse Aide #4 stated 15-minute checks were done for falls, some behaviors, and resident-to-resident altercations. They stated there was no training on how to deal with sexually inappropriate behaviors from residents and that the training that was provided was not enough. During an interview on [DATE] at 9:51 AM, Registered Nurse #1 stated when residents say inappropriate things, they tell the resident to stop. If a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	resident was having inappropriate sexual behaviors, the staff monitored the resident every 15 minutes for 72 hours, notified management, discussed options with the doctor, and made sure the residents were separated. Registered Nurse #1 stated they tried to give Resident #2 same gender care givers because then the behaviors were not as frequent. During an interview on [DATE] at 11:36 AM, Nurse Educator #1 stated there was not really any sexually based behavior training. Dementia training would contain some behaviors, diversion tactics, how to deal with and redirect resistive combative residents and the walk away/reapproach tactics. For sexually based behaviors, diversion would be the main solution taught along with making sure the resident was safe, get another coworker if staff did not feel safe, and raise the alarm to the higher ups (make a supervisor aware of the situation). During an interview on [DATE] at 12:45 PM, Certified Nurse Aide #5 stated that after the incident on [DATE], every once and a while, Resident #1 would cry a little more than they usually did. Certified Nurse Aide #5 also stated Resident #1 was more emotional at night and there were days that they felt Resident #1 was a little more upset. During an interview on [DATE] at 12:46 PM, Licensed Practical Nurse #1 stated Resident #1 was more emotional after the incident, but they did not know if Resident #1 was more emotional because of what happened or because of their disease process. During an interview on [DATE] at 12:53 PM, Director of Nursing #1 stated prior to admission, the social worker did a history of the residents which included if they had behaviors or were an aggressor or a victim. Nurse Educator #1 did abuse training which included how to address sexual behaviors. They talked to the staff about redirecting residents that were problematic. Education was provided through the hospital electronic training program. It taught what to do, how to handle residents, and who to report to. They stated Family Member #1 was hysterical due to the incident between Resident #1 and Resident #2. State Police and Emergency Medical Services were called. Following the incident, Resident #2 was placed on one-to-one (1:1) supervision. They kept a same gender staff member with Resident #2, and a certified nurse aide and licensed practical nurse were with Resident #1. Skin assessments were done. They stated Resident #2 could be quick when they wanted to be, and they could not keep them on a one-to -one (1:1) sit and placing Resident #2 on 15-minute checks failed. They were not able to keep either resident safe. During an interview on [DATE] at 1:30 PM, Administrator #1 stated that the whole thing was a very sad situation. Administrator #1 stated that it made sense that this could be a traumatic event for Resident #1 despite their cognitive status. During an interview on [DATE] at 3:18 PM, Social Worker #1 stated that after the incident on [DATE], Resident #1 had increased weepiness, but Resident #1 was too demented to answer questions. During an interview on [DATE] at 10:16 AM, Nurse Practitioner #1 stated there were multiple medication changes for Resident #2 due to inappropriate sexual behaviors. They attempted to arrange counseling for Resident #2, but this was not documented in their notes and it would have had limited benefit for the resident. During an interview on [DATE] at 3:36 PM, Medical Director #1 stated Resident #2 made a number of comments to female staff, but they were unaware of inappropriate interactions with other residents. They were concerned that medication used to treat Resident #2's Parkinson's disease was contributing to their unwanted sexual behaviors. They could not recall specific interventions that were used to address Resident #2's unwanted sexual behaviors, but the best thing they could have done would have been to teach the staff how to deal with the behaviors. They stated psychological services were not initiated for Resident #2 and it would not have been helpful for this resident. Resident #3 Resident #3 was admitted to the facility with diagnoses of Alzheimer's disease, major depressive disorder (a serious mental health condition characterized by at least two weeks of persistent, severe low mood, sadness, or loss of interest/pleasure in daily activities), and hyperlipidemia (an abnormally high concentration of fats or lipids in the blood). The Minimum Data Set, dated [DATE] documented the resident was able to make themselves understood, usually understood others and was severely cognitively impaired. A comprehensive care plan for behavior dated [DATE] documented that Resident #3 had wandering behaviors and removed items from other resident rooms, aggressive verbal and physical behaviors and was exit seeking. Goals documented (continued on next page)

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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. Based on record review and interview conducted during the survey, the facility failed to allow one (1) of three (3) residents (Resident #2) to return to the facility to their previous room or immediately upon the first availability of a bed. Specifically, Resident #2, who was on leave at the hospital, was not allowed to return to the facility despite Family Member #2 wanting Resident #2 to return to the facility when they were ready to be discharged from the hospital. Family Member #2 was informed the facility would not accept Resident #2 back and was directed to speak with the social worker/discharge planner at the hospital to assist with arranging an alternative placement. Director of Nursing #1 stated Resident #2 could not be kept on one to one (1:1) supervision after 15-minute checks for safety had failed.This is evidenced by: Cross reference: F600 - Free from Abuse and Neglect The facility policy titled, Transfer and Discharge Rights created 01/2001, released 01/2024, documented its purpose was to ensure transfer and discharges were appropriate to the resident's needs and in accordance with resident's rights. The resident will remain in the nursing home unless transfer or discharge is necessary or requested by the resident. If it was felt that a resident needed to be transferred (other than hospital transfer) or discharged , the Social Worker would consult with the interdisciplinary team as well as the resident and family. Before the transfer or discharge takes place, the resident and family will be notified, preferable 30 days prior to the transfer or discharge. In cases of emergency, this might not be possible. In the case of an involuntary transfer or discharge, a notice will be given which will include a statement that the resident has the right to appeal and will include the telephone numbers of NHSDSS (unknown abbreviation), New York State Department of Health, and the Justice Center, as appropriate, to initiate the appeal. The notice will also include the name and telephone number of the New York State Long-Term Care Ombudsman. In all appeals, the Resident [NAME] of Rights will be respected as well as New York State regulations. The facility policy titled, Transfer to Acute-Hospital (Intra-facility), created 06/2007, released 10/2024, documented the decision to transfer a resident to an acute care hospital was made by a medical provider. The procedure to do so included:Receive an order from provider to send to Emergency Department or direct admission to hospital.Notify family/primary contact if not presentGive verbal report to receiving unit/facilityIf a direct admission to (named Hospital) call admitting and get a bed(Electronic Medical Record) message of transfer to the Interdisciplinary Team. Include name, date, time, and reason of transferRegistered Nurse will write a transfer note to include: where the resident was being transferred, any items that went with the resident, date and time of transfer/discharge, family/primary contact was notified or presentThe Social Worker will inquire about bed hold- payment due Resident #2 was admitted to the facility with the diagnoses of Parkinson's disease with dyskinesia (a neurological disease causing stiffness and movement disorders with jerky movements caused by the medication required to treat the disease), unspecified dementia, unspecified severity, with anxiety (a progressive loss of intellectual functioning, especially impairment of memory and abstract thinking) and atherosclerotic heart disease of native coronary artery without angina pectoris (heart disease without chest pain). The Minimum Data Set (a resident assessment tool), dated 03/31/2025, documented the resident was usually able to understand others and made themselves understood but was significantly cognitively impaired. Progress note dated 10/10/2025 at 8:58 PM documented Resident #2 was transported to Hospital #1 after being found in Resident #1's room.Resident #2's Comprehensive care plan documented a focus of behavior, with goals that included diversion, redirection, one to one (1:1), television, and 15-minute checks. Effective 04/02/2025.The progress note dated 10/13/2025 at 9:36 AM by Medical Director #1 documented the following: Spoke with Family Member #2 along with Social Worker #1. Family Member #2 is correct that I told them that we could manage Resident #2's behaviors when I spoke with him last, I believe 10/09 [sic]. Unfortunately, the events of 10/10 [sic] have changed the picture considerably and we told Family Member #2 that at least at present, we (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335127	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2026
NAME OF PROVIDER OR SUPPLIER Alice Hyde Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cannot meet their needs to be discharged from Hospital #1. Family is very much hoping that Resident #2 can be returned to this county at some point.The progress note dated 10/13/2025 at 9:52 AM by Social Worker #1 documented the following: Social Worker #1 let Family Member #2 know that the facility would need to discharge Resident #2 as the facility was unable to meet their needs at this time. Family Member #2 voiced their thoughts on how Resident #2's lack of capacity/ability should be considered in regard to possible future readmission. Family Member #2 asked questions about Resident #2's placement and where they would discharge Resident #2 to from the hospital. Social Worker #1 let Family Member #2 know that the hospital would not be able to discharge Resident #2 unsafely, so directed Family Member #2 to speak with the social worker/discharge planner [at the hospital] to assist in seeking placement. Family Member #2 then asked who they would need to speak to so they could redirect Resident #2's benefits as this facility is their payee. Social Worker #1 provided contact information for the facility biller. Social Worker #1 asked Family Member #2 if they would like to come in and pack Resident #2's belongings or if they would prefer that facility staff complete.During an interview on 12/19/2025 at 11:29 AM, Director of Nursing #1 stated after Resident #2 was found in a resident's room watching them sleep on 10/09/2025, Resident #2 was put on consistent 15-minute checks. During an interview on 01/21/2026 at 10:56 AM, Family Member #2 stated they were informed by the emergency room doctor, who was informed by the facility, that Resident #2 would not be welcomed back to the nursing home facility. Family Member #2 stated the nursing facility staff never met with them regarding discharge from the facility, and they were not provided with options for alternative placements. Family Member #2 stated they were informed that Resident #2 had to go to another hospital (Hospital #2) to wait until there was nursing home placement for them. Family Member #2 stated they would have preferred for Resident #2 to return to the nursing home facility as Resident #2 appeared to like it there and the facility was 20 minutes away from Family Member #2's home. During an interview on 01/22/2026 at 12:53 PM, Director of Nursing #1 stated Resident #2 had to be on a locked unit because of previously well-known exit seeking behaviors. The facility chose not to take Resident #2 back at the time they were cleared for discharge because the facility hadn't concluded their investigation of what happened. Resident #2 could be quick when they wanted to be, and they couldn't keep them on a sit (one (1) to one (1) supervision to ensure safety) and 15 minute checks had failed.During an interview on 01/22/2026 at 1:30 PM, Administrator #1 stated that the whole thing was a very sad situation. There was a unit at another hospital (Hospital #2) where hard to place residents could temporarily stay while placement was found. Usually because of behaviors, placement to nursing homes could be a little harder to do. The unit at the other hospital (Hospital #2) was specifically designed to hold residents with behaviors that were waiting for acceptance at another facility. 10 New York Code Rules and Regulations 415.3(i)