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

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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 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 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 (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	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 decreasesˆor stops in one of theˆarteries of the heart, causingˆinfarctionˆ(tissue death) to theˆheart muscle), and hypertensive heart disease with heart failure (ˆlong-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 for dementia with delusions and negative behaviors dated 8/19/2021 documented the resident had both long term and short-term memory loss. The interventions documented included evaluating the pain and medication regimen and evaluating established routines. The comprehensive care plan for falls related to confusion dated 8/19/2021 documented that the resident would be free of falls and injuries related to falls. Interventions documented included investigating the cause of the fall immediately, maintaining a safe environment, and toileting per the resident schedule. A care plan note dated 1/12/2024 documented that the resident was found on the floor of their bathroom. Resident #7 stated they fell near their bed and scooted themselves to the bathroom. The noted documented the resident did not have to use the bathroom and was last toileted around 10:30 AM. There was no documented evidence that the resident was offered toileting opportunities every two hours. The care card for December documented Resident #7 was offered toileting opportunities once a shift, but not every two hours. Care plan titled Urinary Incontinence and Indwelling Catheter effective 4/02/2025 stated resident to be toileted every 2 hours. During an interview on 12/18/2025 at 2:00 PM, Certified Nurse Aide #5 stated Resident #7 took themselves to the bathroom but could sometimes be incontinent. Certified Nurse Aide #5 stated on the morning of 4/19/25, they found a bruise on Resident #7s right forearm and immediately notified Registered Nurse #4 and Licensed Practical Nurse #4 in charge who then checked the bruise. Certified Nurse Aide #5 stated they did not hear back anything about the incident and was later called into Director of Nursing #1s office when they were then given a care plan violation for not toileting the resident every 2 hours along with a verbal toileting education by Director of Nursing #1. Additionally, Certified Nurse Aide #5 stated the resident had not been care planned to be toileted every 2 hours at the time of incident. Certified Nurse Aide #5 met with Director of Nursing #1, and upon returning to their computer, a message for toileting every 2 hours popped up on the electronic health record for Resident #7. During an interview on 12/19/2025 at 11:05 AM, Director of Nursing #1 stated Resident #7 reported to Registered Nurse #4 that they fell outside of the building. Resident #7 was never outside of facility or outside of their unit. Directory of Nursing #1 stated Resident #7 is alert, confused at baseline and can be territorial or sometimes argumentative with other residents. Director of Nursing #1 said the Resident #7 was care planned to be toileted every two hours sometimes around the time of the incident due to the resident becoming incontinent. After the incident occurred, Director of Nursing #1 was notified and educated Certified Nurse Aide #5 on toileting residents every two hours. There was no facility wide education at the time. Additionally, Certified Nurse Aide #5 had never had any complaints regarding resident care by residents or colleagues. Minimum Data Set Coordinator #1 was on call the date of incident who reported to the Department of Health. The facility investigation, dated (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/24/2025, documented that Resident #7 was found to have some bruising that was attributed to a fall that was unwitnessed. Due to Resident #7's incontinence and inability to follow direction, Resident #7 was placed on every 2-hour continence checks. In the investigation of the bruises noted on the resident's arm on 4/19/2025, Certified Nurse Aide #5 admitted that they did not wake Resident #7 up to be toileted as care planned. Resident #105 Resident #105 was admitted to the facility with the diagnoses of vascular dementia, unspecified severity, with agitation (a decline of thinking skills from condition that damage blood vessels), Alzheimer's disease, unspecified (a progressive brain disorder that slowly destroys memory) and ventricular premature depolarization (type of abnormal heart rhythm that originates from the ventricles of the heart). The Minimum Data Set, dated [DATE], documented the resident was usually understood, sometimes understand others and was severely cognitively impaired. The comprehensive care plan for Activities of Daily Living dated 8/06/2024, documented that the resident required assistance with activities of daily living. Interventions include: assistance of two (2) persons, do not leave alone, dependent on care for bathing, bed mobility, dressing and toileting. For transfers, Resident #105 was documented as requiring the assistance of two (2) persons, dependent with gait belt and stand aid. The facility investigation dated 7/06/2024 documented that on 5/31/2024, Resident #105 was transferred to the bathroom by Certified Nurse Aide #6. Resident #105 did not follow directions of Certified Nurse Aide #6, and due to improper body mechanics, Certified Nurse Aide #6 had to lower Resident #105 to the floor. The physical therapy note dated 6/03/2024 at 4:37 PM, documented that the resident had no change in function or signs of abuse after the fall. The resident was care planned for two-person assistance for transfers with mechanical lift, and Certified Nurse Aide #6 did not follow the care plan. Resident #119 Resident #119 was admitted to the facility with the diagnoses of Parkinson's disease without dyskinesia, without mention of fluctuations (progressive neurological disorder that primarily affectedˆmovement where the patient does not experience involuntary movements (dyskinesia), unspecified dementia, unspecified severity, with agitation (a condition characterized by a decline in cognitive function) and Alzheimer's disease. The Minimum Data Set, dated [DATE], documented that the resident was usually able to be understood but rarely to never understand others with severe cognitive impairment. The comprehensive care plan for Falls, dated 8/05/2021, documented the resident was at high risk for falls related to confusion, weakness, hypertension, Parkinson's and needed assistance with ambulation. Interventions include: maintaining a safe environment by ensuring the floor was free from clutter and lighting was adequate; documented as of 3/08/2024 the use of a bed alarm. A care plan note dated 8/24/2024 at 5:10 AM, documented the resident was found on the floor next to their bed, and a bed alarm was not present on the bed. Certified Nurse Aide #7 did not follow the care plan after putting Resident #119 back to bed by not putting the bed alarm in place. New York Codes, Rules, and Regulations Title 10 S 415.4 (b)(1)(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observations, interviews, and record review conducted during the recertification survey, the facility did not develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that included measurable objectives and timeframes to meet the resident's medical, nursing, mental, and/or psychosocial needs for four (4) (Resident #'s 81 and 82) of 24 residents reviewed. Specifically, Resident #81's activities care plan was not person centered to meet the resident's activity needs and one to one visits were not provided as care planned; and Resident #82's Comprehensive Care Plan did not include the residents use of a lap belt and how to manage it. This is evidenced by: The policy titled Comprehensive Care Plan dated 4/2024, documented the facility would implement a person-centered care plan for each resident that met their needs; to include nursing, medical, rehabilitation, activities, and social services. Each resident'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. Care plans included problems, goals, and interventions. Resident #81 Resident #81 was admitted to the facility with unspecified dementia (a group of conditions that cause a progressive decline in cognitive abilities), generalized anxiety disorder (a mental health condition characterized by excessive fear or anxiety that interferes with daily activities), and major depressive disorder (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 10/10/2025, documented the resident made themselves understood, usually understand others, and had significant cognitive impairment.^^It further documented that the resident had wandering behavior at times, which significantly intruded on the privacy or activities of others. The Comprehensive Care Plan titled Activities: Limited participation dated 7/24/2025, documented Resident #81 had limited participation in recreation programs related to their mood and confusion. They participated in music, one on one visits, and outdoor visits. Resident #81 also had regular family visits and out of the facility trips with family. The interventions documented include: encourage family support/involvement; praise for all efforts made; provide social/emotional support; and communicate with interdisciplinary team any changes in mood and behavior.^^ Resident #81's Comprehensive Care Plan titled Activities: Limited participation, dated 7/24/2025 did not have documented evidence of person- centered diversional activities or interventions to aid with the resident's undesirable behaviors. There was no documented evidence that Resident #81 was provided with one to one visits as indicated in their care plan. During observations on 12/17/2025 and 12/18/2025 between 10:00 AM and 11:00 AM, Resident #81 was sitting in their wheelchair in the hallway of the unit.^^ During an interview on 12/18/2025 at 12:04 PM, Social Worker #1 stated that Resident #81 required diversion to keep them from invading other resident spaces. The Activities department did not provide one to one visits with Resident #81 due to low staffing, but they did have some groups like the men's group, coffee and news groups, and Bingo.^ During an interview on 12/18/2025 at 10:39 AM, Activity Director #1 stated they did not provide a lot of one to one visits due to lack of staff, but they tried to do them in between scheduled activities. Resident #82 Resident #82 was admitted to the facility with diagnoses of dementia, ventricular tachycardia (a type of abnormal heart rhythm that originates in the heart's lower chambers, causing them to beat rapidly), and anxiety. The Minimum Data Set, dated [DATE], documented the resident was able to make themselves understood, usually understood others, and had severe cognitive impairments. It further documented that the resident used a trunk restraint when in their chair or out of bed daily. Resident #82's Comprehensive Care Plan titled Restraint Use, documented the resident required restraints related to lack of safety awareness. The goals included: safety would be maintained with use of least restrictive device (low bed). Interventions included: skin assessment every shift for skin breakdown, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	redness, or bruising and low bed, reposition every 2 hours and as needed or toileting and direct care. Resident #82's care plan did not include use of a seat belt and instructions on how to manage or care for a resident that uses a seat belt. During an observation on 12/17/2025 at 3:53 PM, Resident #82 was observed in their wheelchair with a lap belt in place. During an observation on 12/18/2025 at 9:28 AM, Resident #82 was observed in their wheelchair with a lap belt in place. During an observation on 12/18/2025, Certified Nurse Aide #3 asked Resident #82 to remove his lap belt and the resident was not able to remove it. During an interview on 12/18/2024 at 11:04 AM, Certified Nurse Aide #2 stated lap belts were released every two (2) hours and at mealtimes. They stated Certified Nurse Aides documented this in the electronic medical record. During an interview on 12/18/2025 at 11:20 AM, Licensed Practical Nurse #1 stated lap belts should be released every 2 hours and was completed with transfers, bathroom trips, and at mealtimes. During an interview on 12/18/2024 at 11:32 AM, Registered Nurse #2 stated the interdisciplinary team would discuss a resident's potential need for a lap belt after a fall or multiple falls had occurred. They stated a physical therapy evaluation would need to be completed to assess what type of belt, if any was needed. If a lap belt was needed, a care plan should be put into place for the resident. They stated the lap belt should be released every 2 hours and was done with resident transfers, toileting, and at meals. When Registered Nurse #2 was questioned specifically about Resident #82's lap belt, they stated the lap belt was not included in the resident's care plan. During an interview on 12/19/2025 at 8:26 AM, Director of Rehabilitation Services #1 stated therapy completed assessments of residents to see if a restraint was appropriate, such as a lap buddy or a seat belt. They stated after therapy's evaluation was completed; they would discuss their recommendations at their morning interdisciplinary team meeting to make nursing aware. It was verbal and nothing was provided in writing. Director of Rehabilitation Services #1 further stated nursing was responsible for creating a restraint care plan. During an interview on 12/19/2025 at 10:57 AM, Director of Nursing #1 stated some common reasons for a lap belt included trunk strength support, sliding in the wheelchair, and frequent falls. Physical therapy would evaluate a resident to assess the least restrictive option first. They stated if a lap belt was recommended and determined to be a restraint, the resident's care plan would be updated. Director of Nursing #1 further stated, physical therapy would provide their recommendation regarding lap belts verbally and through the electronic medical record messaging to nursing. Nursing would update the care plan/Kardex and place the updated Kardex in the resident's room and the binder on the unit. 10 New York Code, 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 - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that it provided 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 well-being of each resident, encouraging both independence and interaction in the community for three (3) (Resident #s17, 79 and 81) of three (3) residents reviewed for activities. Specifically, Resident #s 17, 79 and 81 were not provided with activities that met the residents' preferences and cognitive abilities. This is evidenced by: The Policy and Procedure titled; Activity Calendar, dated 1/2024, documented the facility would provide opportunities for residents to use their mental and physical capabilities through participation (on an individual or group basis) in recreational, social, or other meaningful activities. The Policy and Procedure titled; Activity Curriculum for the Cognitively Impaired, dated 1/2024 documented that residents who demonstrated a decline in cognition or who were identified as cognitively impaired would have an opportunity to take part in structured therapeutic recreational activities. The activity would empower them to utilize intact skills based on individual assessments done by the Interdisciplinary Team. Resident #17 Resident #17 was admitted to the facility with the diagnoses of unspecified dementia, unspecified severity, with agitation, Alzheimer's disease with early onset, hypertensive chronic kidney disease (a slow, long-term loss of kidney function where damaged kidneys can't properly filter waste and fluid from the blood). The Minimum Data Set (an assessment tool) dated 9/21/2025, documented the resident was usually understood, was usually understand others and was severely cognitively impaired. During general observations every day between 12/15/2025 and 12/19/2025, Resident #17 was seen ambulating alone on the unit or sitting alone in a common area off to the side. Resident #17 was unresponsive to any communication efforts made by the surveyor. During unit observations on 12/18/2025 at 9:39 AM, the activity schedule in the common area had noodle ball listed as the 9:30 AM activity for the unit. There was no activity observed on the unit at that time. Resident #17 was noted to be pacing the hall alone. The Comprehensive Care Plan titled, Activities: Inability to participate/passive observer/limited, dated 1/02/2025, documented Resident #17 would accept one to one visits and continue to observe activities in their unit to maintain interaction level and leisure awareness. The interventions listed included communicate with interdisciplinary team any changes in mood and behavior; encourage lower-level activity such as reading a book, Television, etc.; evaluate resident likes, dislikes and preferences in activities; provide one to one visits; provide monthly calendars; provide needed supplies for preferred activities of choice; provide stimulation using radio or television. There was no documented evidence of activities being done with Resident #17 in the electronic medical record. Resident #79 Resident #79 was admitted to the facility with the diagnoses of unspecified dementia, severe, without behaviors, Alzheimer's disease with late onset, and fracture of unspecified neck of left femur (a break in the thighbone). The Minimum Data Set, dated [DATE], documented that the resident was rarely or never understood, rarely or never understand others and was severely cognitively impaired. During general observations every day between 12/15/2025 and 12/19/2025, Resident #79 was seen sitting in a wheelchair in the common area of the unit. Resident #79 was unresponsive to any communication efforts made by the surveyor. During unit observations on 12/18/2025 at 9:39 AM, the activity schedule in the common area had noodle ball listed as the 9:30 AM activity for the unit. There was no activity observed on the unit at that time. Resident #79 was noted to be sitting, mumbling to themselves and picking at their lap blanket. The Comprehensive Care Plan titled, Activities: Inability to participate/passive observer/limited, dated 9/25/2025, documented Resident #79 would maintain socialization was evidenced by participating in music events, one to one visits, outdoor visits and spend time in the common area when they got to observe activities on the unit. The interventions (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented included communicating with interdisciplinary team any changes in mood and behavior; evaluate resident likes, dislikes and preferences in activities; provide one to one visits; and provide stimulation using radio or television. There was no documented evidence of activities being done with Resident #79 in the electronic medical record. Resident #81 Resident #81 was admitted to the facility with unspecified dementia, moderate, with agitation, generalized anxiety disorder, and major depressive disorder. The Minimum Data Set, dated [DATE], documented the resident was able to be understood and usually understood others with significant cognitive impairment. During observations on 12/17/2025 and 12/18/2025 between 10 and 11 AM, Resident #81 was sitting in their wheelchair in the hallway of the unit. The Comprehensive Care Plan titled, Activities: Limited participation dated 7/24/2025, documented Resident #81 had limited participation in recreation programs related to their mood and confusion. They participated in music, one on one visits, and outdoor visits. Resident #81 also had regular family visits and out of the facility trips with family. The interventions documented included encourage family support/involvement; praise for all efforts made; provide social/emotional support; and communicate with interdisciplinary team any changes in mood and behavior. There was no documented evidence of activities being done with Resident #81 in the electronic medical record. During an interview on 12/18/2025 at 12:04 PM, Social Worker #1 stated that Resident #81 required diversion to keep them from invading other resident spaces. Activities did not do one to one visits with Resident #81 due to low staffing, but they did have some groups like the men's group, coffee and news groups and Bingo. During an interview on 12/18/2025 at 9:30 AM, Licensed Practical Nurse #3 stated that there was a children's choir for the activity the day before. When asked if the residents needed more stimulation or activities, Licensed Practical Nurse #3 stated that the residents did need more to do. Licensed Practical Nurse #3 stated that lack of things to do was one of the reasons that residents would have bad interactions. During an interview on 12/18/2025 at 10:39 AM, Activity Director #1 stated that on the dementia unit specifically, they tried to do activities before lunch so that residents were awake for lunch and in the evening to provide distraction when residents might be starting to sundown. When asked about what kind of activities were done on the dementia unit, Activity Director #1 stated that they did a lot of music and sing along, sometimes manicures and massages as well. In the summer they try to take residents into the enclosed courtyard when there were staff available. Activity Director #1 stated they did not do a lot of one-to-one visits because of lack of staff, but they tried to do them in between scheduled activities. Stated they had two full time activity personnel and that they relied heavily on volunteers. Activity Director #1 stated they had asked for more staff but believed that there was a budgetary issue preventing hiring more people. Activity Director #1 stated they knew which residents were and were not joiners, so they would not try to include residents that did not like group activities to participate. During an interview on 12/19/2025 at 11:29 AM, Director of Nursing #1 stated that they were aware that activities was struggling due to low staffing but stated that they were doing their best to keep the residents occupied. 10 New York Codes, Rules, and Regulations 415.5(f)(1)h

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, record review and interviews conducted during a recertification survey, the facility did not ensure residents were free from physical restraints imposed for purposes of discipline or convenience that were not required to treat the resident's medical symptoms, used for the least amount of time, and did not document ongoing re-evaluation of the need for restraints for one (1) (Resident #82) of three (3) residents reviewed for physical restraints. Specifically, Resident #82 did not have a physician's order for the use of a wheelchair lap belt restraint and there was no evidence of a quarterly assessment/evaluation being completed for its use. The is evidenced by: The facility Policy and Procedure titled Restraints, dated 12/2002 and released 6/2024, documented a physical restraint was defined as any manual, physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual could not remove easily and that restricted freedom of movement or normal access to one's body. An example of standard restraints used included and were not limited to, lap belts and seat belts. Some devices could be used to promote safety but were considered a restraint if the resident could not remove it independently and required a Physician order for use. A care plan for a restraint would be created to identify the use of restraint and Certified Nurse Assistant task would be generated to document placement. The use of restraints must be discussed at the Interdisciplinary team meetings and documented in the resident's record. Alternatives to restraints must be tried with the resident's response documented in the resident record. The least restrictive restraint device must be used to achieve the desired care goal of the resident, as assessed by the Interdisciplinary care team. Resident restraints should be released at a minimum of every 2 hours or more frequently as assessed by the Interdisciplinary team. The release of restraints should be documented in the resident medical record. The restraint must be terminated at the earliest possible time. Resident #82 was admitted with a diagnoses of unspecified dementia, unspecified with mood disturbance (describes a group of symptoms affecting memory, thinking and social abilities and mood); hypertensive heart disease with heart failure (heart conditions caused by high blood pressure); and anxiety disorder due to unknown physiological conditions (feelings of anxiety and panic interfere with daily activities, were difficult to control, were out of proportion to the actual danger). The Minimum Data Set (an assessment tool) dated 10/02/2025, documented Resident #82 was understood and usually understand others with moderate cognitive impairment. Resident #82 required the use of a wheelchair for locomotion, partial to moderate assistance of staff for dressing, and was dependent on staff for transfers, toileting, and bathing. The comprehensive care plan for At High Risk for Falls related to deconditioning, recent fracture, and diagnosis of peripheral vertigo, visual deficits, osteoporosis, confusion, lack of safety awareness. Interventions include: Anticipate resident needs with regard to activities of daily living. Occupational or Physical therapy evaluation and treatment per Physician/Family Nurse Practitioner orders. Education on safety techniques. Maintain safe environment by ensuring that floor is free from clutter, lighting is adequate. Safety Precautions: Elopement Falls Protective Measures: Floor mats, Low bed.; Notes: self-releasing seat belt with front and rear anti-tippers when in wheelchair;. encourage resident to look for items by turning his head to the left; Call bell within reach; appropriate footwear. Care plan for Restraint dated 6/26/2024: use of low bed, related to lack of safety awareness was added to care plan on. During an observation on 12/17/2025 at 11:19 AM, Resident #82 was in their wheelchair with a lap belt/seat belt in place. During an observation on 12/17/2025 at 3:53 PM, Resident #82 was in their wheelchair with a lap belt/seat belt in place. During an observation on 12/18/2025 at 9:28 AM, Resident #82 was in their wheelchair with a lap belt/seat belt in place. During an observation on 12/18/2025 at 11:18 AM, Certified Nurse Aide #3 asked Resident #82 to release lap belt/seat belt, and the resident was unable to do so. During an observation on 12/18/2025 at 12:09 PM, Resident #82 was in their wheelchair at the dining room table with a lap belt/seat belt in place. Registered Nurse #2 asked (continued on next page)

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	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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #82 to release seat belt. Resident #82 was unable to do so. Registered Nurse #2 removed Resident #82 lap belt/seat belt at that time. Physical therapy treatment encounter note dated 1/18/2024 documented that Resident #82 had been care planned for the use of a self-releasing seat belt in wheelchair related to the prevention of falling out of the wheelchair. Resident #82 was documented as able to self-release belt; therefore, the seat belt was not considered a restraint. Certified Nurse Aide documentation records dated November 2025 and December 2025 documented wheelchair restraint/lap belt was in use while Resident #82 was out of bed. Treatment Administration Records dated December 2025. There was no documented evidence of a physician order for Seat belt use. Medication Administration Records dated for December 2025, documented no evidence of physician order for seat belt use. There was no documented evidence of discussions in the Interdisciplinary team meetings for the continued need or use of a seat belt in Resident #82's medical chart. There was no documented evidence of continued assessments of the Resident being able to self-release their seat belt in the medical records. During an interview on 12/18/2025 at 11:18 AM, Certified Nurse Aide #3 stated that lap belts should be released every 2 hours for toileting, transfers, bedtime, and mealtimes. There were different types of lap belts used at the facility. One of the requirements was that the residents were supposed to be able to release lap belt without assistance. During an interview on 12/18/2025 at 11:20 AM, Licensed Practical Nurse #1 stated, lap belts should be released every 2 hours and were released with transfers, bathroom trips or at mealtimes. Residents with lap belts should be able to self-release for them not to require a physician's order, and staff were responsible to check belt placement. Licensed Practical Nurse #1 stated they were not sure how often residents with lap belts were evaluated for self-release. Consent from a resident or health care proxy would need to be obtained for the use of any restraints. During an interview on 12/18/2025 at 11:32 AM, Registered Nurse #2 stated that lap belts could be considered a restraint if a resident was unable to self-release, and the use of restraints was only considered and discussed after a resident had multiple falls. The falls would be discussed at the daily morning Interdisciplinary team meeting and a physical therapy evaluation would be needed to assess the type of belt that was appropriate. If a resident was unable to self-release the belt, there should be a Physician order and care plan in place for that individual. Lap bands/seat belts should be released every 2 hours and was done so with resident transfers, toileting and meals. Re-evaluation for continued use of lap belts should be completed every 3 months by the nursing and physical therapy departments at the interdisciplinary team quarterly meetings. Registered Nurse #2 stated they were not familiar with Resident #82 having a lap belt. After reviewing the medical records, Registered Nurse #2 stated that they did not see a physician order or care plan for a lap belt, only for a low bed. During an interview on 12/19/2025 at 8:26 AM, Rehabilitation Director #1 stated that restraints were considered by the interdisciplinary team after a resident had multiple falls, and less restrictive interventions had not been effective. A Resident would have a physical therapy assessment that was signed by the therapists completing the evaluation. Prior to the implementation of a restraint, there should be a doctor's order and care plan implemented by the nurse manager. The ongoing need of a restraint should be evaluated every 3 months at the care planning meeting. Communication between nursing and physical therapy was conducted typically in person at the daily morning interdisciplinary team meeting or via phone call. There should always be a note in the electronic medical chart regarding resident assessments and doctors' orders. Nursing staff typically would monitor for ongoing need of ?restraint' and discuss at the care planning meeting and communicate with the Resident's family members. During an interview on 12/19/2025 at 10:57 AM, Director of Nursing #1 stated that the facility looked at the risk level of the Resident during interdisciplinary team meetings/care plan meetings at minimum quarterly to assess for the need of a lap belt. A physical therapy evaluation would be needed to assess the resident to determine the appropriate, least restrictive option was used first. The resident should be able to release a lap belt on command, if they were able to release the lap belt, it was not considered a restraint. The physical therapy department evaluated the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident for self-release ability on a quarterly schedule or with any significant change in health status. A Physician order was needed if the lap belt is considered a restraint (if the Resident is unable to self-release the lap belt), restraint consent was needed from either the Resident or family for use, the Resident care plan would be updated to include a lap belt restraint, and the Kardex would be updated to reflect all changes. All updates should be completed as quickly as possible depending on family response to granting consent. The facility had full coverage with a Physician and Nurse Practitioner on shift during the week and off hour on call coverage for any change in health needs. Director of nursing #1 stated Certified Nurse Aides documented on restraint usage each shift, daily. Documentation included the usage of restraints in and out of bed, release of seat belt and resident skin check. Any concerns would be reported to the Licensed Practical Nurse or Registered Nurse. The nurse manager would complete a referral that would be sent to the physical therapy department with any care interventions or concerns. The physical therapy department communicated its recommendations to the nursing staff via in person 24-hour morning report or daily interdisciplinary care meeting, the Licensed Practical Nurse would give their units report to the nurse manager about the past 24 hours, in which the nurse manager would discuss any concerns/needs at the morning interdisciplinary meeting. The physical therapy department would add the residents' evaluation into the electronic medical record and would add a progress note with detailed interventions or changes and inform nursing. The bedside care card/ Kardex would be updated in the resident room and binder on unit. Changes would be updated/implemented as soon as possible. If the divisional clerk was not available to ensure all changes had been made, the discipline/individual making changes to the resident's care would be responsible to ensure the necessary changes have been made in all the appropriate locations. 10 New York Codes, Rules, and Regulations 415.4(a)(2-7)

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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. 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 the event on 5/16/2024. Director of Nursing #1 stated once Licensed Practical Nurse #2 realized they had administered the medications to the wrong resident, they immediately reported it to the Registered Nurse, Resident #46 was assessed, and the Medical Provider and family were notified. The Medical Provider gave new orders and Resident #46 was put on 15- minute checks for additional safety. Director of Nursing #1 stated they believed a house wide education on medication administration was completed. They also completed a root cause analysis and reported the medication error to the Chief Nursing Officer who reported it to New York State Board of Education. They further stated medication audits were completed which included the 5 Rights to Medication Administration and the audits were reviewed at the Quality Assurance Performance Improvement Committee. Director of Nursing #1 stated they were still completing medication audits. Based on the following corrective actions taken, there was sufficient evidence that the facility corrected the noncompliance and was in substantial compliance for this specific regulatory requirement at the time of this survey: Upon discovery of the medication error, a Registered Nurse assessment was completed immediately. The medication error was reported to the resident's representative and the physician with new orders obtained. The Licensed Practical Nurse who was responsible for the medication error was suspended during the investigation and later terminated. The Board of Education was notified of the nurse's error. The medication error was reported to the New York State Department of Health Medication Administration education was initiated on 7/09/2024 to all nursing staff including Licensed Practical Nurses and Registered Nurses on the Medication Administration policy and procedure, the 6 (six) rights, and documentation. Education was completed on 12/12/2024. For Quality Assurance, medication administration audits were initiated and reviewed monthly. Medication administration audits were still being conducted at time of survey. 10 New York Codes, Rules, and Regulation 415.12(m)(2)