STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335364	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuba Memorial Hospital Inc Snf	140 West Main Street Cuba, NY 14727

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 interviews, and record review conducted during survey, the facility failed to protect resident's rights from verbal, mental and physical abuse by another resident for one (Resident #17) of four residents reviewed for abuse. Specifically, on 10/05/2025, Resident #17 was yelled at, grabbed by their arms and thrown back into their wheelchair by Resident #3. Following the abusive interaction, Resident #17 displayed emotional distress and was observed crying. Using the reasonable person concept, as referenced on the Centers for Medicare and Medicaid Services Psychosocial Outcome Severity guide, this resulted in psychosocial harm to Resident #17, that is not Immediate Jeopardy.The findings include: The facility policy titled Abuse, Neglect, Mistreatment dated 02/2026, documented the facility recognized that each elder had the right to be free from all types of abuse including verbal, physical, mental abuse, corporal punishment, and involuntary seclusion. The American Medical Association defines elder abuse and neglect as the intentional or unintentional physical, psychological or financial mistreatment of an elderly person. Resident #17 had diagnoses including Arnold Chiari Syndrome (congenital structural defect where brain tissue expands into the spinal canal and blocks the flow of cerebrospinal fluid (clear liquid that cushions and protects your brain and spinal cord) with hydrocephalus (abnormal buildup of cerebrospinal fluid), Alzheimer's disease, and dementia without behavioral disturbances. The Minimum Data Set (a resident assessment tool) dated 05/08/2025 documented Resident #17 was severely cognitively impaired, was usually understood by others, usually understands others, and did not exhibit behaviors. Resident #17 Comprehensive Care Plan dated 07/03/2025 documented interventions related to their psychosocial well-being that included for staff to provide comfort, reassurance, and a safe, quiet, low-stimuli environment. Resident #3 had diagnoses including vascular dementia with behavioral disturbance (condition driven by cardiovascular disease rather than direct brain tissue degeneration), bipolar disorder (mental health condition that causes extreme, cyclical shifts in mood, energy, activity level, and concentration), and depression. The Minimum Data Set, dated [DATE] documented Resident #3 was moderately cognitively impaired, was understood by others, usually understands, and did not exhibit behaviors.Resident #3 current Comprehensive Care Plan, initiated on 10/17/2024, documented they were non-compliant, had poor safety awareness, self-transferred/ambulated daily, needed frequent education and reminders to call for help. Interventions included psychiatry consultations as needed, reapproach and offer different choices when they were non-compliant. The facility Incident Report Summary completed by the former Administrator dated 10/05/2025 documented at 4:15 PM, staff were assisting residents into the dining room for meal service; residents and a family member were present in the dining room. Resident #17 was located at one end of the dining room and Resident #3 was located on the other. Resident #17 had a history of making a throat clearing/grunting noise and was making the noise at the time. Resident #3 yelled across the room to Resident #17 to shut up. Resident #3 stood up and quickly walked over to Resident #17 who stood up as Resident #3 approached them. Resident #3 grabbed Resident #17 on both of their arms and threw Resident #17 back into their wheelchair. The family member who was present called for help and staff members (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 - Actual harm Residents Affected - Few	responded immediately. Resident #3 was removed from the dining room and Resident #17 was taken to their room and assessed by Registered Nurse #1. Resident #3 was interviewed in their room and stated, son of a b doesn't let up, if they have to throw me out so be it. The Medical Director, and the responsible parties for Resident #3 and Resident #17 were notified. Resident #17 was assessed by nursing and was visibly upset about the incident, had red marks on their arms where Resident #3 had grabbed them, and a scratch on their back from where they were thrown into the chair. Resident #3 was sent to the emergency room for a psychiatric evaluation, but the hospital refused to do an evaluation due to their dementia diagnosis. When Resident #3 returned to the facility, they were placed on 15-minute checks, they were not allowed to be in group settings or communal dining until the team confidently could say Resident #3 aggression was under control, and a psychiatric consultation was ordered for 10/09/2025. Resident #17 family came in to visit and provided comfort following the incident, and Resident #17 was seen by the Licensed Clinical Social Worker #1 daily for three days following the incident. A clinic note written by the Medical Director dated 10/07/2025, documented Resident #17 was being seen because another resident (Resident #3) had physically assaulted them in the facility. The Medical Director documented Resident #17 had no obvious injuries but cried a lot. They had no physical injuries but Resident #17 looked emotional. The Medical Director documented the incident was an emotional trauma to Resident #17. A clinic note written by the Medical Director dated 10/07/2025, documented Resident # 3, was seen on that date due to being the aggressor in an incident involving Resident #17. They documented, initially Resident #3 was sent out for a psychiatric evaluation, but the hospital denied one and sent the resident back to the facility. When asked about the incident, Resident #3 stated Resident #17 was making too much noise and they got annoyed. The Medical Director documented Resident #3 had a large psychiatric history, so they consulted a psychiatrist who recommended medication changes. The changes were made and Resident #3 behavior was to be monitored. During a telephone interview on 06/10/2026 at 4:08 PM, the former Administrator stated they were made aware of the incident involving Resident #3 and Resident #17 on 10/05/2025 and started their investigation. The former Administrator stated immediately following the incident that Resident #17 was upset but did not show any signs of fear. They stated the residents were kept separated. Resident #3 had a psychiatric evaluation, and their medications were adjusted and were on 15-minute checks until they felt their behavior was under control. During a telephone interview on 06/11/2026 at 8:53 AM, Resident #17's Health Care Proxy stated they were made aware of the incident on 10/05/2025 and their son went to visit immediately following the incident. Resident #17's Health Care Proxy stated when their son arrived at the facility, Resident #17 was visibly upset but the resident could not communicate why. The Health Care Proxy stated that Resident #17 typically did not show emotion due to their type of dementia, so when they were crying during the visit, their son became concerned. They stated Resident #17 would not have been accepting of something like this happening to them prior to their cognitive decline. During an interview on 06/11/2026 at 9:38 AM, Licensed Clinical Social Worker #1 stated following the incident on 10/05/2025 between Resident #3 and Resident #17 they followed up with each resident individually. Neither resident displayed any signs of fear. Social Worker #1 stated Resident #3 had a psychiatric consultation and medication adjustments. Resident #17 did not recall the incident and remained their normal self. They stated they were unaware Resident #17 was upset and had cried following the incident. During a telephone interview on 06/11/2026 at 9:57 AM, Registered Nurse #1 (former Unit Manager) stated on 10/05/2025, they were near the nurse's station when they heard a family member calling for help. They responded immediately and saw Resident #3 walking out of the dining room, mumbling under their breath. They stated the family member of another resident told them Resident #3 yelled at Resident #17 for making noise, got up, walked over to Resident #17 and Resident #3 threw Resident #17 back into their wheelchair. They stated they immediately went over and removed Resident #17 from the dining room and assessed them. Registered Nurse #1 stated when Resident #17 was brought to their room, they were sobbing uncontrollably, which was not normal (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	behavior for them. They stated Resident #17 normally spoke very little and did not often display emotion. It was so sad. Registered Nurse #1 stated it was a traumatic event for Resident #17. They reported the incident to their superiors so that the proper channels could be followed. The residents were separated and assessed. Resident #3 was sent to the hospital by the provider for a psychiatric evaluation. During an interview on 06/11/2026 at 10:23 AM, the Medical Director stated they examined Resident #17 on 10/07/2025 following a 10/05/2025 altercation with Resident #3. Resident #17 had been crying for a day or two but could not say why. The Medical Director stated they did not see any long-term effects from the altercation but in the short term it was a traumatizing event for Resident #17. The Medical Director further stated If someone grabbed someone else unwantedly you could call that abuse. 10 New York Codes, Rules, and Regulations 415.4 (d)(1)(vii)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during a survey, the facility failed to ensure that all alleged violations of abuse and neglect were thoroughly investigated for two (Residents #2 and #6) of six residents reviewed. Specifically, the facility did not maintain documentation that an alleged violation was thoroughly investigated. The findings include:The policy and procedure titled Abuse-Identification, Investigation, and Reporting reviewed 01/2026 documented when any suspicious or actual forms of abuse were witnessed by any staff member, they were immediately reported to the nurse in charge. The nurse in charge would then generate an Event Form and immediately inform the Nurse Manager, Nursing Supervisor or Director of Nursing or immediate investigation and prevention of any further potential abuse. An investigation would include staff, patient, family, elder interviews, observation, and follow up investigation.Resident #2 had diagnoses including Type 2 Diabetes Mellitus, schizophrenia, and obstructive sleep apnea. The Minimum Data Set (a resident assessment tool) dated 03/28/2026 documented Resident #2 was always understood, always understands others and was cognitively intact.Resident #6 had diagnoses including Type 2 Diabetes Mellitus, schizophrenia, and bipolar disorder. The Minimum Data Set, dated [DATE] documented Resident #6 was sometimes understood, usually understands others and was cognitively intact.Review of the Internet Quality Improvement and Evaluation System Complaint/Incident Investigation Report dated 08/27/2025 documented the Former Administrator reported an allegation of neglect to the New York State Department of Health. It further documented that Resident #6 reported that Licensed Practical Nurse #4 did not perform their blood sugar check. The Former Administrator documented that Resident #2 stated they did not think Licensed Practical Nurse #4 checked their blood sugar either.Review of the facility Incident Report Summary dated 08/26/2025 documented Resident #6 stated to the Former Director of Nursing that Licensed Practical Nurse #4 did not take their blood sugar reading. The Former Director of Nursing brought it to the attention of the Former Administrator, and a full investigation was initiated. There were no attached staff interviews or statements included in the summary.On 06/08/2026 at 10:47 AM the Facility Reported Incident was requested for Resident #2 and Resident #6.During an interview on 06/10/2026 at 8:06 AM Licensed Practical Nurse #1 stated that the glucometers (portable medical device to calculate blood sugar levels) at the facility were very finicky and from time to time would not work correctly. Either the glucometers would not accept the test strip, would shut off in the middle of a test or would not record and save the reading. They stated they remembered writing a statement about the glucometers, but they could not recall when they did that or what was included in their statement.During a telephone interview on 06/10/2026 at 9:08 AM, Licensed Practical Nurse #4 stated the glucometers at the facility were horrible and did not work half the time. They stated that they remembered one day that they were pulled into the Former Administrator's office regarding a low blood sugar reading. Licensed Practical Nurse #4 stated the Former Director of Nursing and Former Administrator would not provide any details about what they were investigating and never asked for a written statement.During an interview on 06/10/2026 at 12:22 PM, the Administrator stated they were unable to locate the facility reported investigations. Usually there would be a full investigation with statements and interviews available at the facility.During a telephone interview on 06/10/2026 at 3:38 PM, Licensed Practical Nurse #5 stated that they remembered hearing about the investigation regarding a nurse not completing blood sugar checks. They stated the Former Director of Nursing and Former Administrator did not ask them any questions or to write any statements regarding the glucometers or nurses not completing blood sugar checks.During a telephone interview on 06/10/2026 at 3:53 PM, the Former Administrator stated they remembered the incident with the glucometers and reported it as an allegation of neglect to the New York State Department of Health. They stated they remembered Licensed Practical Nurses and Registered Nurses writing statements. The Former Administrator stated they scanned the statements (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the computer at the facility. After scanning the documents, they would have shredded the hard copies.During a telephone interview on 06/11/2026 at 9:45 AM, Registered Nurse #1 stated they were the unit manager when there was an alleged incident that Licensed Practical Nurse #4 was not completing blood sugar checks. They stated that Resident #6 had a fall on the floor and stated to Registered Nurse #1 that Licensed Practical Nurse #4 did not check their blood sugar that morning. Registered Nurse #1 stated they reported that to the Former Director of Nursing, even though Resident #6 was not a reliable historian. They stated that an investigation needed to be done in the event that Resident #6 was not fabricating a story. They stated that they could not recall writing a statement and they did not remember asking any Licensed Practical Nurses or other Registered Nurses to write any statements regarding the allegation. Registered Nurse #1 stated that a full investigation would have included a report and witness statements from anyone who could have been involved.During an interview on 06/11/2026 at 11:41 AM, the Administrator stated they talked to the Former Administrator and was working on finding the Facility Reported Incidents in the computer system.During an interview on 06/11/2026 at 12:31 PM, the Administrator stated they were not able to find the Facility Reported Incident regarding an allegation of neglect for Resident #2 and Resident #6 in the computer system.During an interview on 06/11/2026 at 12:33 PM, the Administrator reviewed the facility Incident Report Summary dated 08/26/2025 and stated they felt it was not a thorough investigation. They stated that it was all very general and there were no written statements from staff attached. They stated that all staff who came in contact with Resident #2 and Resident #6 and all Licensed Practical Nurses and Registered Nurses who used the glucometers should have been interviewed and provided witness statements. They stated that the manufacturer of the glucometers should have been reached out to. There was a general statement regarding an audit, but it was unknown what the audit was about; it should have been in a file that was readily available. A thorough investigation would have captured all variables to make sure it exhausted all potential situations to keep the incident from happening again. They stated it was important to have a thorough investigation because then they could find out what caused the incident to occur and decide on how to correct it. 10 New York Codes, Rules, Regulations 415.4(b)(3)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations, interviews, and record review conducted during the survey, the facility failed to ensure the nursing staff information was posted on a daily basis and contained the required information. Specifically, the facility did not post daily the current resident census and the total number, and the actual hours worked by licensed and unlicensed nursing staff, in a prominent place readily accessible to residents and visitors for two out of five days; the facility did not complete and update the form, each shift, to include accurate resident census, and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care for five out of five days. Additionally, the facility failed to retain records for 18 months per regulation. The findings include:The facility policy titled Benefits Improvement and Protection Act (BIPA) Posting, approved 06/2026, documented the purpose of Benefits Improvement and Protection Act posting was to have staffing numbers and resident census accessible for all staff, residents, and visitors. The facility would post daily at the beginning of each shift the facility specific shift scheduled for the 24-hour period, the number and categories of nursing staff employed or contracted by the facility, as well as the total number of hours worked by licensed and unlicensed nursing staff who are directly responsible for resident care. Other posted data included facility name, current date and resident census. Data must be displayed in a clear and readable format and be posted in a prominent place readily accessible to residents and visitors. Records must be kept for 18 months or as required by State law, whichever greater.During intermittent observations made on 06/07/2026 at 10:30 AM and 06/08/2026 at 8:33 AM, the Daily Schedule was not visible and was unable to be located in the facility. Continued observations on 06/09/2026 at 1:04 PM, 06/10/2026 at 8:36 AM, and 06/11/2026 at 10:11 AM, the Daily Schedule was posted on a bulletin board across from the elevators leading to the facility units. The documents included the current census number of residents and the total number of hours worked and ratios for direct care staff. The document did not include the updated licensed and unlicensed staff hours for each shift.Review of the Daily Schedule sheets dated 06/07/2026 to 06/11/2026 revealed the hours of licensed and unlicensed staff did not reflect staff schedule changes.There was no documented evidence that the Benefits Improvement and Protection Act form was completed, updated, or posted and readily available for the public for the requested dates of 05/07/2026 to 06/06/2026.During an interview on 06/08/2026 at 3:01 PM, the Scheduler stated they just started three weeks prior and had posted their first Benefits Improvement and Protection Act on the bulletin board that morning, 06/08/2026. They stated a policy was created by the Administrator recently, and they were made aware of the Daily Schedule regulations then. The Scheduler stated prior to 06/08/2026 they were not filling out or posting the Benefits Improvement and Protection Act form in a place available for the public to see, no one was posting it. They stated they were unaware that changes needed to be made to the Benefits Improvement and Protection Act posting when schedule changes occurred each shift, they were not completing that. They stated the nursing staffing schedules (Daily Schedule) had a census, ratios, and number of direct care staff on them, but they were not readily available to the public. During an interview on 06/11/2026 at 12:44 PM, the Administrator stated the Benefits Improvement and Protection Act should be readily available, posted in a public area; it should reflect the ratio of direct care staff based upon census, with total ratios, and updated each shift with staffing changes. The Administrator stated they were unaware the Benefits Improvement and Protection Act was not being posted in a public area on 06/07/2026 and 06/08/2026, or that the Benefits Improvement and Protection Act was not updated with staffing changes each shift on 06/07/2026 through 06/11/2026. The Administrator stated they created a Benefits Improvement and Protection Act posting policy for the facility that was approved on 06/03/2026, prior to that date there was no policy for Benefits Improvement and Protection Act posting regulations. Additionally, the Administrator stated it was important for the Benefits Improvement and Protection Act to be posted in a readily accessible area, and updated with staffing (continued on next page)

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	changes as needed each shift, so that visitors, staff and residents could view it and ensure the facility was meeting their staffing ratios. 10 New York Codes, Rules, and Regulations 415.13