STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335511	A. Building B. Wing	02/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
East Side Nursing Home	62 Prospect St Warsaw, NY 14569

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 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review conducted during the survey, the facility did not ensure that newly admitted resident's and/or their representatives were provided with a written summary of a Baseline Care Plan that included the minimum healthcare information necessary to properly care for the immediate needs of the resident (including but not limited to initial goals, admission orders, dietary, therapy and social services) for eight (8) (Residents #7, #9, #32, #40, #57, #64, #80, and #89) of ten (10) residents reviewed. Specifically for all residents identified the facility did not provide the residents or their representative with a written summary of their Baseline Care Plan. The findings include but are not limited to: The facility policy titled Baseline Care Plan dated 12/19/2022, documented a baseline care plan would be developed within 48 hours of the resident's admission and the resident and their representative would be provided with a paper copy summary of the baseline care plan that includes but was not limited to a summary of the resident's medications, dietary instructions and any services or treatment to be administered by the facility. Additionally, the policy documented if a resident and their representative declined the paper copy, it must be documented. 1. Resident #57 was admitted to the facility on [DATE] with diagnoses including fracture of the femur (uppermost part of the thighbone), dementia, and anxiety. The Minimum Data Set (a resident assessment tool) dated 06/16/2025 revealed that Resident #57 had severe cognitive impairment. Review of Resident #57's Baseline Care Plan, dated 06/16/2025, revealed no documented evidence that a written summary of their initial care needs (that included admission orders, dietary, therapy and social services) had been provided to the resident representative. Review of interdisciplinary progress notes dated 06/16/2025 to 07/07/2025 revealed on 06/16/2025 at 3:29 PM, Social Worker #1 documented they met with Resident #57 to review their plan of care. There was no documentation that a summary of the baseline care plan was provided to the resident and their representative. 2. Resident #9 was admitted to the facility on [DATE] with diagnoses including dementia, congestive heart failure, and chronic obstructive pulmonary disease (a progressive, uncurable lung disease). The Minimum Data Set, dated [DATE] revealed that Resident #9 had severe cognitive impairment.Review of Resident #9's Baseline Care Plan, dated 10/21/2025, revealed no documented evidence that a written summary of their initial care needs had been provided to the resident representative. Review of interdisciplinary progress notes dated 10/21/2025 to 11/11/2025 revealed on 10/21/2025 at 12:36 PM, Social Worker #1 documented they met with Resident #9 and their family to discuss the plan of care. There was no documentation that a summary of the baseline care plan was provided to the resident and their representative. 3.Resident #64 was admitted to the facility 01/16/2026 with diagnoses including atrial fibrillation (irregular heart rate), schizoaffective disorder, and dysphagia (difficulty swallowing). The Minimum Data Set, dated [DATE] revealed that Resident #64 had moderately impaired cognition. Review of Resident #64's Baseline Care Plan, dated 01/16/2026, revealed no documented evidence that a written summary of their (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 0655 Level of Harm - Potential for minimal harm Residents Affected - Some	initial care needs had been provided to Resident #64 and/or the resident representative. Review of interdisciplinary progress notes dated 01/16/2026 to 02/06/2026 revealed on 01/16/2026 at 2:05 PM, Social Worker #1 documented they met with the resident and family to review the plan of care. There was no documentation that a summary of the baseline care plan was provided to the resident and their representative. During an interview on 02/04/2026 at 3:23 PM Social Worker #1 stated that baseline care plans get completed on admission and that they would verbally go over the baseline care plan with either the resident and/or the resident representative. Social Worker #1 stated that they would offer to provide a copy of the baseline care plan but most of the time the family would decline a copy and that they have never documented that a copy was offered. During an interview on 02/04/2026 at 5:48 PM the Director of Nursing stated that the social worker was responsible for providing a copy of the baseline care plan to the residents and/or the residents' representative upon admission. The Director of Nursing stated that they were aware that Social Worker #1 was verbally going over the baseline care plan but was not aware that copies were not being provided and stated that a copy should have been provided to the residents and/or resident representatives. 10 NYCRR 415.11

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interviews and record during a survey, the facility failed to ensure that a resident received adequate supervision and assistance devices to prevent accidents for one (1) (Resident #89) of eleven (11) residents reviewed for accidents. Specifically, on 10/10/2025 facility staff (Driver #1 and Transport Aide #1) failed to ensure that Resident #89 was safely secured in the facility's wheelchair transport van when returning from a medical appointment. The resident's wheelchair was secured to the van floor; however, the transport staff did not ensure the resident was wearing the required shoulder and lap belts, which resulted in Resident #89 being thrown from the wheelchair to the front of the van during an abrupt stop. Resident #89 suffered a nasal fracture, abrasions, and had associated pain. This resulted in actual harm to Resident #89 that was Immediate Jeopardy and Substandard Quality of Care Past Non-Compliance with the likelihood of serious harm, serious impairment, serious injury or death to resident's health and safety. The findings are: The policy titled Operation of the 2011 Ford Passenger Van dated 09/2024 documented the training included viewing the public use wheelchair lift operation video, reviewing the instructions for use on the restraint system, with hands on demonstration. The policy did not include a verification check system to ensure residents were appropriately secured prior to transport or direct staff what to do if a resident refused to comply with safety requirements. A cell phone was provided for each transports use. Resident #89 had diagnoses of post orthopedic aftercare of a hip fracture (break in the bone), congestive heart failure (chronic, progressive condition where the heart muscle cannot pump blood efficiently) and chronic obstructive pulmonary disease (chronic lung disease with persistent, progressive airflow limitation). The Minimum Data Set (a resident assessment tool) dated 09/23/2025 documented that Resident #89 was cognitively intact, understands and was understood by others. The Comprehensive Care Plan undated documented Resident #89 was admitted for rehabilitation following a left femoral fracture repair (break in the upper part of the thigh bone requiring surgery). Documented interventions included the resident was dependent on staff for wheelchair mobility off the unit. Review of a Kardex (guide used by staff to provide care) dated 10/10/2025 documented Resident #89 was dependent on staff for wheelchair locomotion off unit, and transferring required extensive assist of one staff member using a rolling walker and a gait belt (an adjustable strap worn around a resident's waist to assist staff with safe standing, transfers, and walking while reducing the risk of falls and back injuries). The Accident and Incident Report dated 10/10/2025 at 11:15 AM documented that Resident #89 was in the facility's transport van on their way back from a scheduled appointment to facility when the vehicle came to an abrupt stop, causing Resident #89 to fall forward out of their wheelchair onto the van floor. Resident #89 stated, My nose and knees hurt. The transport staff called 911 (emergency services) and notified the facility. Emergency Medical Services assumed care and transported Resident #89 to the emergency room for further evaluation. The provider and the resident's responsible party were notified. The accident and incident report included statements from Driver #1 and Transport Aide #1. Driver #1 documented they were traveling 45 miles per hour when traffic in front of them stopped abruptly, causing them to brake suddenly to avoid a crash. Resident #89 was sitting upright in the wheelchair, which was securely locked, however the resident fell forward onto the floor. Transport Aide #1 documented that Driver #1 was driving and a car in front of them braked fast. Suddenly, Resident #89 was on the floor bleeding. The accident and incident report did not document that Resident #89 refused to put on the shoulder and lap safety belts. The facility's five-day investigation submission report dated 10/15/2025 documented that after review of staff statements and staff interviews it was determined that Driver #1 admitted to not securing Resident #89 with the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	seat belts, stating No, I forgot to put it on. During an interview and observation on 02/05/2026 at 10:20 AM, the Director of Maintenance stated all drivers were trained to ensure the wheelchair restraints were properly secured and to apply the shoulder and lap belts. Residents who refuse restraints (seat belts) should not be transported. The Director of Maintenance showed the wheelchair restraint system to the surveyor. During this observation, the Director of Maintenance stated the wheelchair was secured with four anchor points to the floor at the time of the accident, however the shoulder and lap belts were not applied, which resulted in Resident #89 being thrown from their wheelchair. They stated the signage in the van prior to the accident on 10/10/2025 was small and placed on the interior side door of the van, so it may not have been as visible. After the accident, the signage was enlarged and placed in the front interior of the van. The sign stated, For the safety of all drivers and passengers everyone is required to wear seat belts at all times while the vehicle is in motion, please buckle up. During an interview on 02/05/2025 at 10:27 AM, Transport Aide #1 stated they transported Resident #89 to an outside appointment on 10/10/2025 in the facility's van. Driver #1 had to abruptly apply the brakes to avoid an accident. Transport Aide #1 stated Resident #89 was thrown from their wheelchair and slid toward the front of the van. Resident #89 was bleeding badly and had stated their nose and knees hurt. Transport Aide #1 stated they told Driver #1 that Resident #89 was not wearing a seat belt and that the resident had refused. Driver #1 had stated it was okay to proceed with the transport. Transport Aide #1 stated this was their first day working (10/10/2025) independently, and they believed that Resident #89 was exercising their rights. They further stated they should have notified their supervisor and told Driver #1 not to proceed with the drive. Attempts were made to contact Driver #1 via telephone without success on 01/29/2026 at 3:34 PM, 02/04/2026 at 4:49 PM and 02/09/2026 at 8:53 AM. During an interview on 02/05/2026 at 10:32 AM, the Assistant Administrator stated it was the driver's responsibility to ensure that all safety restraints were applied before transport. They stated Driver #1 should have refused to transport Resident #89 and called their supervisor just as they were trained to do. They stated this could have resulted in a more serious accident, and the process to correct the issue was started immediately. During an interview on 02/06/2026 at 10:40 AM, the Administrator stated the accident that occurred on 10/10/2025 was an isolated incident. Driver #1 should have contacted them and not driven the van if Resident #89 had refused to put their seat belt on. They stated drivers were trained during orientation not to move the van until all passengers were strapped in securely. The Administrator stated additional safety measures were implemented following the incident. During a telephone interview on 02/06/2026 at 9:17 AM, Resident #89 stated they were returning from a medical appointment. The wheelchair was anchored down at the rear of the facility's van, but they did not have the shoulder and lap belts in place. The driver slammed on the brakes. They flew out of the chair and landed on their face; they had bleeding from their nose and were in pain. The driver immediately contacted emergency services, they were transported to a local hospital and diagnosed with a nasal fracture. They also stated they had some abrasions to their forehead and hands. Resident #89 stated they did not refuse to fasten their seat belt and were not sure why the transport staff did not fasten their seat belts. During a telephone interview on 02/06/2026 10:36 AM, the Medical Director stated it was important for everyone to follow the guidelines of the Department of Transportation and the facility's policy for securing safety restraints to avoid a situation like this. They stated if Resident #89 was properly restrained they would not have fallen out of their wheelchair and caused the resident harm. The resident could have potentially sustained fatal injuries. During an interview on 02/09/2026 at 8:01 AM with the Assistant Administrator and the Director of Nursing, the Assistant Administrator stated that Driver #1 and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Transport Aide #1 should have known to contact their supervisor if Resident #89 had refused to put their seat belt on. The Director of Nursing agreed. Based on observations, interviews, and record review the survey team determined the facility removed immediacy as of 10/15/2025 and corrected the non-compliance. Driver #1 was terminated 10/10/2025.Transport Aide #1 was re-educated on 10/10/2025.The policy titled Operation of the 2011 Ford Passenger Van with a revised date of 10/10/2025 was updated to include a three-level safety verification process for every resident transported.The facility created transportation verification logs for each trip documenting each verification step and signature of completion.The facility enlarged and relocated safety signage inside the transport van.100 percent (%) of transportation staff were educated on 10/10/2025. 87 percent (%) of nursing, recreational, therapy, and social work staff were educated by 10/15/2025 regarding the verification system, transport policy, and resident safety. The facility continued the education and then expanded the training to include nutritional and housekeeping services staff. Transportation audits were conducted to monitor the corrective actions and to ensure the implementation of facility protocols to ensure resident safety while utilizing the facility's transportation services. These audits were reviewed weekly by the Administration and were reported during the monthly facility Quality Assurance Program (QAPI) meetings. 10 New York Code Rules and Regulations 415.12(h)(1)