STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335520	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ideal Senior Living Center	601 High Avenue Endicott, NY 13760

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure each resident received adequate supervision to prevent accidents for one (1) of five (5) residents(Resident #36) reviewed. Specifically, Resident #36 had dysphagia (difficulty swallowing) and was not supervised during meals as ordered.Findings include: The facility policy Daily Routine, Care of Resident, revised 11/2024, documented meals would be served to each resident. Verbal, physical encouragement, and/or assistance was given as needed per resident preference and plan of care. Resident #36 had diagnoses including dysphagia. The 12/16/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, required set up assistance for eating and did not have a swallowing disorder. The 06/08/2022 physician order documented a regular diet; supervision with meals; cut meat into small pieces, encourage small bites, slow rate, and alteration of solids/liquids. The 06/08/2022 Comprehensive Care Plan documented a potential for alteration in nutrition and respiratory status due to impaired ability to swallow related to oral pharyngeal dysphagia. Interventions included encourage small bites, slow rate, and alteration of solids/liquids; regular textures; cut meat into small bites/pieces; thin liquids; and upright position as tolerated. The care plan did not include supervision at meals. The undated care instructions documented the resident required setup or clean-up assistance at meals and did not include the need for supervision. The 08/06/2025 Speech Language Pathologist #1 evaluation and plan of care documented a recommendation for supervision with meals; meat cut into small pieces; and encouragement of small bites, a slow rate, and alternation of solids/liquids. The 02/17/2026 lunch meal tickets documented supervision with meals. During an observation on 02/17/2026 at 12:19 PM, Resident #36 was eating their lunch alone in their room. At 12:23 PM, Certified Nurse Aide #3 entered the room to ask the resident if they needed anything, then exited the room. The 02/19/2026 lunch meal ticket documented supervision with meals. During an observation on 02/19/2026, Certified Nurse Aide #3 delivered Resident #36's lunch tray at 12:42 PM and exited the room, leaving the resident alone to eat. At 12:50 PM, the resident consumed (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	most of their meal. The tray was removed from the room at 1:09 PM. No staff were observed entering the resident's room between 12:42 PM and 01:09 PM. During an interview on 02/20/2026 at 01:31 PM, Certified Nurse Aide #3 stated the level of assistance a resident needed was on their care plan; it was their responsibility to make sure items on the tray matched the meal ticket; and if the ticket documented supervision with meals, then someone had to keep an eye on the resident while they ate. They stated they passed Resident #36's lunch trays on 02/17/2026 and 02/19/2026 and did not stay in the room while the resident ate and they should have. The resident preferred to eat lunch in their room and had been doing so for a while, so they thought the lack of supervision was an oversight. During an interview on 02/20/2026 at 12:31 PM, Speech Language Pathologist #1 stated they recommended Resident #36 be supervised during meals on 08/06/2025. They were not aware the resident ate lunch alone in their room. Staff should provide supervision in the resident's room. They expected their recommendations to be followed. During an interview on 02/20/2026 at 1:22 PM, Licensed Practical Nurse #2 stated the level of assistance needed with eating was in the resident's care plan. It was the responsibility of the person passing the meal tray to check the meal ticket to ensure all instructions, including supervision, were followed. Supervision meant the resident should be watched during their entire meal. On the days Resident #36 ate in their room, staff should stay with them. During an interview on 02/23/2026 at 9:48 AM, Registered Nurse Unit Manager #4 stated anyone who passed a meal tray was responsible for looking at the meal ticket and if it said supervision with meals, then supervision should be provided. If a resident preferred to eat in their room, then someone should be assigned to stay in their room with them while they ate. They were not aware Resident #36 ate alone in their room last week. If they knew they would have followed up to make sure someone was present with the resident when they ate in their room. If there was an order for supervision, then someone should supervise the resident to keep them safe. 10 New York Codes, Rules and Regulations 415.12 (h)

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of two (2) residents (Resident #9) reviewed. Specifically, Resident #9 had significant weight loss and did not have nutritional assessments reflecting current nutritional needs and interventions to prevent further weight loss; and the medical provider did not address the resident's weight loss.Findings include:The facility policy Weight and Reweight, revised 05/2025, documented monthly weights would be obtained on all residents unless an order indicated otherwise and a reweight would be obtained if a resident weight changed five pounds or more from last recorded weight. Weight changes of five pounds or more after the reweight would be reported to the charge nurse, dietitian, and provider. The facility procedure for estimating energy needs, revised 11/29/2017, documented energy needs would be estimated using Mifflin-St Jeor for all residents. Per the Academy of Nutrition and Dietetics Nutrition Care Manual for Adults, the Mifflin-St Jeor Equation is a formula used to estimate Basal Metabolic Rate (BMR), which was the number of calories the body needed at rest to maintain vital functions such as breathing and circulation. The Mifflin-St. Jeor Equations was used to estimate resting energy expenditure only. Adjustments to activity would be needed. Physical activity should be carefully considered when estimating total energy expenditure. Activity energy included activities of daily living, fidgeting, and maintaining posture. Injury factors would be assessed in addition to activity factor if indicated. The facility procedure for estimating protein needs, revised 11/29/2017, documented protein needs would be estimated at 15 to 16% for mild to moderate stress, 17 to 18% for surgical wounds and Stage 1 or 2 pressure ulcers, and 19 to 20% for stage 3 or 4 pressure ulcers and deep tissue injuries. The procedure did not designate what to calculate the percentage from, or what to do with the percentage calculated.Resident #9 had diagnoses including hip fracture, leg fracture and dementia with mood disturbance. The 11/29/2025 significant change Minimum Data Set (assessment tool) documented the resident had severe cognitive impairment, weighed 138 pounds, and had no weight changes. Resident #9's weight record documented on 07/30/2025 the resident weighed 155.8 pounds.The 08/01/2025 Registered Dietitian #6 nutrition progress note documented the resident had poor intake and their family member agreed to trial Ensure Plus (nutritional supplement).The 08/04/2025 Registered Dietitian #6 nutritional assessment documented Resident #9 was admitted for surgical repair of right hip fracture, weighed 155.6 pounds, had poor intake below 50%, and had an order for Ensure Plus three times a day, which was poorly accepted. Kilocalories were estimated as 1541 daily (Resting Metabolic Rate (1142) multiplied by a stress factor of 1.35) and protein needs were 66 grams (under one gram per kilogram body weight. No activity factor was included in calorie estimation). They documented calorie needs were increased, and protein needs were increased to 17% of calorie needs, and yogurt and pudding were added between meals.Resident #9's weight record documented on 08/13/2025, the resident weighed 145.3 pounds without a documented reweigh (6.7% severe weight loss in two weeks).The 08/14/2025 Registered Dietitian #6 progress note documented Resident #9 weighed 145.3 pounds (66 kilograms) and had a 6.6% weight loss in one month with meal intakes of 64%. They recommended decreasing the Ensure Plus supplement from three times a day to two times a day. They requested a reweight for a 4.7 pound weight loss in one week and there was no need to re-estimate needs because intake was good. They would follow up if new interventions were needed.The 09/22/2025 Registered Dietitian #10 nutrition progress note documented meal intake had declined to 42% and their weight was 145.7 pounds on 09/17/2025. They decreased the Ensure Plus from three times daily to twice a day because of stable weights.The Comprehensive Care Plan, revised 10/23/2025, documented the resident had behavioral issues with agitation and yelling out, fair intake of 58%, was overweight, was meeting needs, and had supplements in place. The resident received Ensure Plus (nutritional supplement) 237 milliliters once daily as of 09/22/2025. There was no documented evidence the care plan included severe weight (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lossResident #9's weight record documented on 08/13/2025 the resident's weight was 145.3 pounds (6.8% loss in one month).There was no documented evidence of follow-through on the reweight, estimated nutritional need changes or nutritional interventions to prevent further weight loss following the confirmation of weight loss on 08/20/2025 with a reweight of 145.1 pounds. The 08/29/2025 Nurse Practitioner #9 routine visit note documented nutrition notes had been reviewed, the resident weighed 143.8 pounds, and weights were overall stable.The 11/02/2025 Registered Dietitian #10 quarterly nutrition note documented meal intake was 51-75% daily, Ensure Plus was provided twice a day, weight was 145 pounds (66 kilograms), and the resident had a 6.9% weight loss in three months, which was a notable issue. Kilocalories were estimated as 1200 daily (Resting Metabolic Rate 994 multiplied by a stress factor of 1.2) and protein needs were 46 grams (under 0.7 grams per kilogram body weight). No activity factor was included in calorie estimation. They documented excess energy intake related to exceeding estimated needs.The 11/27/2025 documented weight was 138 pounds (4.9% loss in one month, 11.3% loss in four months).The 12/03/2025 documented weight was 135 pounds (4.2% loss in one month, 7.3% loss in three months, 13.4% loss in five months).The 12/03/2025 Registered Dietitian #6 nutritional assessment documented Resident #9 was readmitted from the hospital following surgical repair of a tibia fracture, had a deep tissue injury to the right hip, weighed 138 pounds (63 kilograms), was eating 51-75%, and had no weight changes in one, three, or six months. They received Ensure Plus once a day. Kilocalories were estimated as 1310 (Resting Metabolic Rate 971 multiplied by a stress factor of 1.35) and protein needs were 56 grams (under one gram per kilogram body weight). No activity factor was included in calorie estimation. They documented calorie needs were increased, and protein needs were increased to 17% of calorie needs because of the deep tissue injury.The 12/09/2025 Registered Dietitian #6 nutritional progress note documented the resident weighed 135 pounds, received Ensure Plus once a day, ate 86% of their meals, and exceeded their needs. There was no documented evidence of assessment of weight status or estimated needs.The 12/18/2025 Registered Dietitian #11 nutritional progress note documented the resident had significant weight loss over three months, consumed 89% of meals, received Ensure Plus twice a day, and weight gain would be beneficial. There was no documented evidence of estimated nutritional need changes or nutritional interventions to prevent further weight loss. The resident received Ensure plus once a day.The 12/23/2025 Nurse Practitioner #9 routine visit note documented nutrition notes had been reviewed, the resident weighed 136.6 pounds, and weights were slowly improving.The 12/24/2025 documented weight was 132.2 pounds (4.2% loss in one month, 9.3% loss in three months). There was no documented evidence of estimated nutritional need changes or new nutritional interventions to prevent further weight loss.The 01/07/2026 documented weight was 133.2 pounds (8.2% loss in three months, 14.4% loss in six months).The 1/20/2026 Physician #12 progress note documented the resident weighed 133 pounds and weights were stable.The 01/21/2026 Registered Dietitian #11 nutritional progress note documented the resident had significant weight loss over three months, was eating 86% of meals, and no changes were needed to the plan because weight was stabilizing. There was no documented evidence of estimated nutritional need changes or new nutritional interventions to prevent further weight loss.The 02/10/2026 documented weight was 132.6 pounds (11.6% loss in six months).The 02/13/2026 Nurse Practitioner #9 routine visit documented the dietitian noted some weight loss and added supplements and snacks. There was no documented evidence of the addition of any new nutritional supplements or snacks.During an interview on 02/20/2026 at 9:44 AM, Certified Nurse Aide #13 stated they obtained re-weights when the nurse told them to. If a resident refused a meal or snack, they would encourage, reapproach, and offer other items. If they had concerns about weight loss or poor intake they told their charge nurse. Resident #9 ate in the dining room, and they would encourage and coax them to eat. They did not see dietitians out in the dining rooms during meals.During an interview on 02/20/2026 at 9:53 AM, Licensed Practical Nurse #14 stated they compared the weights when they entered them into the electronic medical record, and requested a reweight on those with four-pound fluctuations. Resident #9 usually fed (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	themself and ate well but needed encouragement at times. They recorded solids, fluids, and supplements on a form at the nursing desk daily and the certified nurse aide entered the data into the electronic medical record. If they refused to eat something, staff encouraged and offered something else. The dietitians were not usually around for meals, but they let them know if they had any concerns. During an interview on 02/20/2026 at 10:00 AM, Registered Nurse Unit Manager #15 stated the certified nurse aides obtained weights, and the charge nurse entered them into the electronic medical record. If the weight difference was five pounds or more a re-weight was obtained that day. Resident #9 usually ate the meal themself but needed to be watched for encouragement. When the resident first came to the floor in August of 2025, they were very agitated, anxious, and could not sit still. They tried Seroquel (antipsychotic medication) but that did not help the agitation, so it was tapered off and they started Rexulti (antipsychotic) with favorable results. When the resident refused to eat, the nurses offered them strawberry ice cream and other items. They lost weight recently, after their injury and prior to starting Rexulti. Nutrition staff tried Ensure but the resident's fluid intake was not the best. They usually notified nutrition, family, and medical of any nutritional concerns. Dietitians occasionally rounded at meals, but nursing usually told them about any changes. Dietitians usually attended the interdisciplinary care plan meetings, but not always. They did not attend the significant change care plan meeting in November of 2025.During an interview on 02/20/2026 at 11:16 AM, Registered Dietitian #6 they printed a weight report every morning and looked for five-pound discrepancies. They made a re-weight list through electronic mail or the electronic medical record for nursing. They brought up any weight concerns in the daily morning meeting. The charge nurse or nurse manager entered them into the electronic medical record. If a resident had significant weight loss they were changed to weekly weights and discussed at the monthly weight management meeting. If it was new weight loss, they sent an electronic mail to the interdisciplinary team and provider, assessed why the weight loss happened, talked with resident and family, and implemented what they were willing to eat. They documented monthly on residents with significant weight loss, including diet, intake, supplements, skin, bowels, labs, and any goals. Nutritional needs were estimated on any complete nutrition assessments, weight changes, new skin issues, or referrals. Energy needs were calculated using Mifflin-St Jeor and protein needs were estimated with a percentage of calorie needs. Resident #9 needed supervision with touch assistance with meals. The resident lost weight and had poor intake on admission. They had no recent weight loss, but they had lost weight back in November of 2025 when they had a fracture and went to the hospital. They could not recall if they notified anyone of the weight loss. During the significant weight loss in August of 2025, they asked for a reweight and the resident was provided Ensure Plus, yogurt, and pudding. No additional changes were made since the weight loss in August of 2025. They did not see the resident at meals and was not taught to do meal rounds. They followed resident meal intakes and any issues through nursing and nursing documentation, and reviewed meal documentation when assessments were due. The resident's weights had stabilized recently, however when weight loss continued, they thought they were responsible for notifying the provider. Nutritional intervention changes were communicated to the interdisciplinary team through electronic mail, care plan meetings, and the morning meeting. They attended the care plan meetings on the rehabilitation floor, and another dietitian attended Resident #9's care plan meetings when they were available. Protein needs were assessed based on a percentage of calorie needs per the facility policy, which they had not seen before in practice, including their internship. Energy needs were estimated using Mifflin-St Jeor and multiplying an injury factor as needed. They did not use an activity factor because their policy did not include one. If calorie needs were underestimated, protein needs would be underestimated. If a resident's weight status was not addressed or assessed, they could continue to lose weight. Registered Dietitian #6 stated on 08/04/2025, an injury factor was used to calculate energy needs for the surgical wound. Protein needs were estimated at 17% of energy needs. On 8/14/2025, a re-weight was requested due to significant weight loss, but they did not follow up on the re-weight, assess the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight status or add an intervention other than decreasing the Ensure Plus from three times a day to twice a day. On 11/02/2025, the previous dietitian helped complete the assessment from a remote location using what was in the electronic medical record. On 12/3/2025, an injury factor was used to calculate energy needs for the surgical wound and deep tissue injury. Protein needs were estimated at 17% of energy needs. No new interventions were implemented except Ensure Plus was decreased to once a day. On 12/09/2025, when the new weight of 135 pounds (4.2% loss in one month, 7.3% loss in three months, 13.4% loss in five months) was obtained, they talked about it in the weight management meeting that month, and the resident was getting Ensure Plus daily. No changes were made, and nutritional needs were not addressed. During an interview on 02/20/2026 at 12:17 PM, Physician #12 stated they were made aware of significant weight changes through dietitian updates. Once notified they reviewed the resident to see if any medical interventions were indicated. Weights were monitored because they correlated with clinical functioning and overall wellbeing. Physician #12 did not acknowledge being notified of the resident's weight loss in August 2025, December 2025, or January 2026. They stated there were monthly weight meetings and they were open to constructive feedback regarding why the information was not reflected in the electronic medical record. 10 New York Codes, Rules and Regulations 415.12 (i)