STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335592	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Massena Rehabilitation & Nursing Center	89 Grove Street Massena, NY 13662

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews (iQIES Intake 2638730), the facility failed to ensure a clean, comfortable, and homelike environment for three (3) of four (4) resident units (A1, A2, and C2 units) reviewed. Specifically, A1, A2, and C2 units had strong urine odors and unclean walls and floors; and the A2 unit had several trash cans with fluid from a leaking ceiling.Findings include: The facility policy Quality of Life – Homelike Environment, revised 12/15/2025, documented the facility staff and management should maximize the characteristics of the facility that reflect a personalized, homelike setting. The characteristics included a clean, sanitary, and orderly environment; clean bed and bath linens that were in good condition; and pleasant, neutral scents. Cleaning logs were not provided by the facility for C1 and B2 units as requested. The Daily Room Cleaning Log for 05/04/2026 was not provided as requested. No Daily Room Cleaning Log was provided for A2 unit. Terminal Cleaning Logs for the Common Areas for 05/02/2026 and 05/03/2026 for A2 unit were not provided as requested. The following observations were made: A1 Unit: -on 05/04/2026 at 9:15 AM, there was a strong odor of urine present immediately upon entering the unit. C1 Unit: -on 05/04/2026 at 9:33 AM, there were trails of a brown substance on the floor near the nurse's station. -on 05/04/2026 at 9:34 AM, the baseboards and walls in the area across from Central Bath 109 had several white marks leading from the floor up the wall. -on 05/04/2026 at 10:03 AM, room [ROOM NUMBER] Bath had a pile of soiled linens near the shower, and a garbage bag tied near the door. There was discoloration on the shower floor and the ramp leading to the shower. -on 05/04/2026 at 10:06 AM, room [ROOM NUMBER] had debris/garbage and substance/discoloration on the floor. The hallway and unit smelled of urine. The hallway outside room [ROOM NUMBER] had a dried brown substance on the floor with footprints from the area of 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substance. -on 05/04/2026 at 10:08 AM, room [ROOM NUMBER], had debris and discoloration on the floor. -on 05/08/2026 at 11:48 AM, there was a strong odor of urine at the nurse's station. A2 Unit: -on 05/04/2026 at 11:15 AM, upon entry to the unit there was a strong odor of urine. -on 05/04/2026 at 11:46 AM, there was a large blue cylindrical bucket against the wall across from room [ROOM NUMBER], the ceiling tile above the bucket had two holes in it. The bucket was collecting fluid leaking from ceiling and there was no yellow hazard sign. There was a large white bucket directly in front of room [ROOM NUMBER]. The bucket was a quarter of the way full of broken ceiling tiles and brown water. The ceiling was actively dripping. -on 05/04/2026 at 1:02 PM, upon entry to the unit there was a strong odor of urine. -on 05/05/2026 at 11:59 AM, the ceiling had leaks near resident rooms [ROOM NUMBERS], the Director of Environmental Services stated the air conditioner compressor was leaking in the ceiling and at two spots along the duct work. The air conditioning unit was turned on recently, either 04/30/2026 or 05/01/2026. They stated the vendor would be evaluating the leak on 05/06/2026 for repair. The water in the catch receptacles should be drained out daily. -on 05/06/2026 at 9:05 AM, there was a black trashcan in the hallway in front of room [ROOM NUMBER]. The ceiling tiles above the trashcan were missing, and fluid was actively dripping into the black trashcan. -on 05/06/2026 at 9:33 AM, there were three buckets in the hallway near room [ROOM NUMBER]. A large capacity clear bucket was nearly half full of brown water constantly dripping from a missing ceiling tile. The bucket contained broken pieces of ceiling tile and had a foul odor. A black garbage was catching a slow drip of water from the ceiling above. A blue can was collecting drips from the ceiling above. -on 05/07/2026 at 11:24 AM, the hallway near room [ROOM NUMBER] had a clear large capacity bucket about 1/4 full of dirty brown water that slow dripped from the ceiling (no ceiling tile seen over bucket). There was a black garbage can containing water dripping from the ceiling. The black bucket had barely any water in the bottom. -on 05/08/2026 at 9:50 AM, there was a strong odor of urine when entering the unit, the odor continued down through the unit to the nurse's station area. -on 05/08/2026 at 10:58 AM, room [ROOM NUMBER] had a dinner plate sized stain in the ceiling on the A side. The resident in room [ROOM NUMBER] A stated they were getting dripped on the previous night. They pointed to the area of discoloration and stated it was coming from that area. The B side had a mattress without linens. There was a large yellow/brown stain in the middle of the mattress. Licensed Practical Nurse #18 stated the mattress was dark blue, but the amount of urine from that resident over time had bleached and stained the mattress. Work orders should be put in the system, but nothing was done because it was not broken. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/2026 at 8:52 AM, Housekeeping Aide #44 stated they tried to mop some of the areas, but they thought the floor workers got floor stripping chemical on the new floors because they could not get the boot prints off the floor when they mopped. They stated they did their best just to keep their unit clean, but they were only there during the day. They started with the common areas first, and they had a room of the day that would get a more thorough cleaning. During an interview on 05/08/2026 at 10:30 AM, Licensed Practical Nurse #18 stated the environment was not clean. There were trash bins in the hallway for days, and it was getting worse. The leak was spreading down the hall. During an interview on 05/21/2026 at 12:51 PM, the Director of Environment Services stated they had five housekeepers on staff and were onboarding two more. They were short staffed for a while but were finally able to fill a few spots. They stated that the week the surveyors were in the building three housekeepers were not on the schedule. A homelike environment meant a clean area free of holes and debris and no widespread odors. The housekeepers had daily cleaning logs they completed each day. The expectation for a soiled/stained mattress was that a work order was put in and it would be replaced. They reviewed the work order system and did not find a work order for room [ROOM NUMBER]'s mattress. During an interview on 05/21/2026 at 1:12 PM, the Administrator stated the facility environment should be homelike. A homelike environment included cleanliness and painting. There should not be any odors. If there were odors staff should determine the origin of the odor. Bed maintenance was done by the general maintenance staff. If a mattress needed to be replaced the expectation was a work order would be placed. 10 New York Codes, Rules and Regulations 415.5(h)(4)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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, the facility failed to provide proper supervision to residents to prevent elopement and respond appropriately to wander alert alarms resulting in residents having access to unsafe areas and/or to exit the building undetected for three (3) of three (3) residents (Residents #2, #3, and #4) reviewed. Specifically, on 08/24/2025 Resident #2 had known wandering behaviors, exited the building undetected by staff, and was found by a visitor in the parking lot, asking for a ride. Resident #3, had known exit-seeking behaviors and exited the building undetected by staff on 10/06/2025 and 10/23/2025 and was found across a four-lane highway in a shopping plaza, after an undetermined period of time. Resident #4 had known wandering behaviors, and on 02/21/2026 was found in an unsecured, non-resident administrative area where there was construction and electrical equipment and floors that were not finished. This resulted in Immediate Jeopardy and Substandard Quality of Care to Residents #2, #3, and #4, and placed other residents with cognitive impairment at risk for the likelihood of serious injury, serious harm, serious impairment, or death. Findings include:The 04/05/2022 facility policy Out on Pass - Therapeutic Leave, documented a medical order was obtained for no out on pass, out on pass independent, or out on pass with responsible party based on the resident's needs and abilities at the time. A nurse would verify the medical order for current [out on pass] status. The receptionist would notify the nursing supervisor if a resident attempts to or leaves the facility without authorization. The undated facility policy Elopement Procedure, documented to immediately notify the Administrator and Director of Nursing if an elopement occurred. Initially upon inability to easily locate a resident, a page for please locate (resident's name) was completed three times. All staff would search their work area for the resident. If the resident was not located within five minutes, the supervisor would page code brown and a location three times. A complete search of the facility including the basement and roof would be conducted. The search must include all locked doors as well; it should not be assumed that a resident would not be behind a locked door. After a search of the interior of the facility, the search would extend to the outside grounds including looking in and under parked cars. Staff would search the surrounding neighborhood (one block radius). A photograph was in the wander alert device books on the units and the main office. 1). Resident #2 had diagnoses including dementia, anxiety, and depression. The 06/12/2025 Minimum Data Set assessment (a resident assessment tool) documented the resident had severe cognitive impairment, wandering behaviors for one to three days out of seven days, independent with mobility, and had a fall since their last assessment. The 12/13/2024 comprehensive care plan, revised 01/08/2025, documented Resident #2 had out on pass with responsible party privileges. Interventions included resident/representative would sign the resident out and indicate the anticipated return time. The 06/10/2025 comprehensive care plan, revised 09/12/2025 documented Resident #2 was at risk for elopement related to cognitive impairment, dementia, and voiced intentions to leave the facility; the resident often packed their belongings and sat in front of the nurse's station. The interventions included checking the function of the wander alert device per facility protocol, checking the placement of the wander alert device, and engaging in activities or tasks to keep the resident occupied. On 08/24/2025, Resident #2 eloped from the building into the parking lot and walked across the street. The 07/30/2025 Elopement Risk Evaluation completed by the Assistant Director of Nursing documented Resident #2 had prior elopement history or was currently exit seeking; wandered aimlessly; and voiced desires to leave or discontent with placement. Resident #2's total score was 36 (elopement risk is identified when there is a score greater than 10). The intervention was a wander alert device. The 08/24/2025 unsigned Facility Investigative Summary documented on 08/24/2025, at approximately 12:15 PM, Resident #2 was observed in the parking lot of the facility by a visitor. After review of the statements, it was concluded Resident #2 likely got on the elevator as visitors were arriving to the unit. When the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	resident got down to the first floor, visitors were entering the building, and because the wander alert system at the elevator was alarming, the visitors required assistance from the receptionist (Certified Nurse Aide #1) to enter the code (to disarm the alarm). While the receptionist was assisting the visitors, Resident #2 went out the sliding front door, unobserved. The 08/24/2025 Statement by Certified Nurse Aide #1 documented at approximately 12:20 PM, they went to the elevator to enter the code because the alarm was going off. When they were heading back, a visitor asked them to put the elevator code in so they could go upstairs. Then they heard the entrance door alarm. They went over and turned that alarm off, because they thought the alarm was due to another resident that was by the door. Then [the visitor that wanted to go upstairs earlier] came running to tell the receptionist there was a resident outside about to cross the road, and to call the unit for help. Staff came down to help and they were told to call the Assistant Director of Nursing to tell them what happened. Staff brought the resident back into the facility. The 08/26/2025 at 12:42 PM Assistant Director of Nursing progress note documented they were alerted Resident #2 was across the road. They went out to retrieve Resident #2. The resident was pale in color, shaking, and continuously stating they were sorry. During an interview on 05/06/2026 at 11:47 AM, Resident #2's family stated the facility notified them the resident exited the building (on 08/24/2025). The facility did not tell them the resident made it across the street until later when a staff member told them. The resident wore a wander alert device and they did not understand how the resident could leave with the device on. They stated the resident did not know how to take off the device nor did they try. During an interview on 05/06/2026 at 12:20 PM, Licensed Practical Nurse #14 stated the front entrance had alarms for when residents with wander alert devices got too close to the door. Residents could not just leave on their own. They were working on the day Resident #2 made it out of the building and all the way to the hotel parking lot across the street. Resident #2 had eloped a number of times but only made it to the parking lot. The resident packed up all their belongings every day and told them they were leaving. 2). Resident #3 had diagnoses including stroke, communication disorder, and weakness. The 08/19/2025 Minimum Data Set assessment documented the resident was cognitively intact, did not have wandering behaviors, and was independent with mobility. The 08/27/2024 Comprehensive Care Plan, revised 01/29/2026, documented Resident #3 had a care plan for their behavior problem, agitation, was aggressive at times, wandered, was exit seeking, and attempted to throw furniture. Interventions included assisting the resident with the use of the food delivery service application on their tablet, could utilize the elevators to freely move between the first and second floor, and if they were observed wearing their coat and hat, approach the resident to determine their unmet need and redirect them away from any exit doors. The 08/26/2024 physician order documented Resident #3 may go out on pass with a responsible party. The 06/06/2025 Out on Pass Determination form completed by Registered Nurse #3 documented the resident could go out on pass with a responsible party. The resident could move freely through the building and go outside without supervision. The resident could become impulsive regarding food and enjoyed fast food. A physician order was placed for out on pass. The Comprehensive Care Plan initiated 01/09/2025 documented Resident #3 had a care plan for their out on pass with responsible party privileges. Interventions included: the resident/representative will sign the resident out; refer to interdisciplinary team and social worker for concerns regarding out on pass status; and obtain out on pass order. On 06/15/2025, interventions were updated to include re-evaluate if the resident could go out on pass alone. There was no documented evidence Resident #3 was re-evaluated for out on pass privileges alone. The 09/24/2025 at 7:10 PM, Registered Nurse #2 progress note documented they were paged to the reception area where the receptionist saw Resident #3 walking out the front door. Registered Nurse #2 caught up with the resident in the front parking lot just before the road. The resident expressed anger about not having milk with their meal and not enough to eat. They had a handwritten grocery list as they were going to walk to the grocery store across the street to buy food. The resident was re-directed back into the building and onto their unit. The 10/06/2025 at 9:17 AM Social Worker #11 progress note documented they were called to (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	help with Resident #3's behavior, as they were upset about not having the correct items on their breakfast tray. The resident did not want to wait for the social worker to fix the situation, so they left the building and went across the road to the grocery store. Social Worker #11, along with other staff went and found the resident. The social worker stayed with the resident at the grocery store, while the resident obtained their grocery items. The 10/07/2025 at 10:20 AM Registered Nurse #3 progress note documented Resident #3 was upset regarding breakfast. The resident packed their backpack, put on a coat and hat, and went downstairs. Social worker #11 spoke with the resident and returned them to their room. Registered Nurse #3 left the unit after the resident returned to their room. Resident #3 left the building shortly after and the Code Brown was called by reception. Registered Nurse #3, along with other staff, located Resident #3 in the grocery store parking lot. The 10/08/2025 Out on Pass Determination signed by Social Worker #11, Registered Nurse #3, and the Director of Rehabilitation Therapy documented Resident #3 could go out on pass with a responsible party. Resident #3 would go out shopping with a responsible party once per week as scheduled. The resident was deemed to have capacity to make their own decisions, however, if they did not follow the schedule and left the building without staff, privileges of shopping would be revoked. The 10/14/2025 Facility Reported Incident Five-Day Submission documented Resident #3 departed the facility on 10/06/2025 at approximately 9:20 AM and walked to the grocery store without notifying the charge nurse or signing out at the receptionist desk. The facility called a Code Brown and searched the facility and outside for the resident. Resident #3 was located on the sidewalk at the strip mall diagonally across from the facility at approximately 9:30 AM. Resident #3 could not effectively communicate their wants and needs verbally due to the disabling effect after their stroke. The resident would at times leave the facility without a family/staff member present and was care planned for being at risk for elopement. The resident did not wear a wander alert device due to being cognitively intact and generally leaving with a destination in mind such as a grocery store or fast-food restaurant. The Comprehensive Care Plan revised 10/12/2025 documented Resident #3 had a care plan for out on pass with responsible party privileges. Interventions included to remind the resident the privilege of scheduled shopping trips could be revoked if the policy they signed was not followed. The Comprehensive Care plan initiated 08/27/2024 and revised 10/12/2025 documented the resident had a care plan for their behavior problem, agitation, and aggression at times, wandering, and exit-seeking. Interventions included activities (staff) will bring the resident to the grocery store and fast-food restaurants at least weekly. The Nursing Home Facility Incident Report submitted on 10/23/2025 at 5:34 PM by the Administrator documented the allegation type was other, and the incident was not an elopement. The facility investigation was complete with care plan violations. The incident occurred on 10/23/2025 at 3:15 PM and the facility staff were made aware on 10/23/2025 at 4:15 PM. Resident #3 was seen by staff who were driving by in the parking lot to the shopping plaza across the street. The resident was returned to the facility in a staff vehicle. The immediate response and plan to prevent recurrence was to meet with the interdisciplinary team on 10/24/2025 to determine if the resident should be allowed to go out on leave of absence to the shopping plaza by themselves since they had shown the ability to safely navigate the crosswalk, shop independently, and had purpose. There were no progress notes in the electronic medical record related to Resident #3's exit seeking behaviors or exiting the building on 10/23/2025. There was no documented evidence that the resident was reassessed for their ability to leave the facility alone. During an observation on 05/04/2026 at 7:20 PM, the facility was located on a side street without a sidewalk. To get to the sidewalk, an individual would have to cross the street without a crosswalk between the facility and a hotel located directly across the street. The sidewalk went downhill to a large five-lane state highway. Once across the highway, there was a road and access to multiple parking areas for multiple businesses, with no sidewalk. The road and businesses within the shopping plaza were all at a downhill slope to access. The grocery store was at the far end of the shopping plaza with multiple parking areas and driving lanes. During an interview on 05/06/2026 at 9:43 AM, Certified Nurse Aide #12 stated they worked with Resident #3 and were very (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	familiar with them. The resident was known to elope and had a wander alert device for a while, but they took it off and hid it in the ceiling tiles. The resident would get upset about the food or something and just leave. Most of the time, they could catch the resident in the parking lot and they would walk with them and bring them back to the building. Resident #3 would take advantage of the busy staff and leave. There were a few times they were unable to catch the resident. They called a Code Brown and searched for the resident, and they were found at the shopping plaza across the street. Resident #3 was never on one-to-one supervision, someone would just stay alert to their room. During an interview on 05/06/2026 at 9:59 AM, Certified Nurse Aide #13 stated the resident was exit seeking since admission. They were on one-to-one supervision when they first got to the facility, then had a wander alert device. The resident learned how to take the wander alert device bracelet off and hide it. Staff found bracelets in the ceiling. Resident #3 exited the building a number of times before they made it to the grocery store. There was a time when they were found two streets over in the back parking lot by the gate, but it was still considered on the property. When they did not know where Resident #3 was, they would go out and walk the building to find them. The resident was fast and they found them in the back parking lot and staff walked with them around the front of the building and came back inside. When the wander alert device was discontinued, Resident #3 was not put on one-to-one supervision or safety checks. The day Resident #3 went to the grocery store for the first time, they were down in the lobby very upset about their breakfast. They were able to get Resident #3 back to their room and they thought they were calm with a new breakfast tray coming. They went to assist with another resident when they came out of that resident's room they heard the code for a missing resident. During an interview on 05/06/2026 at 12:12 PM, Registered Nurse #3 stated they were the Unit Manager at the time of Resident #3 elopements. Resident #3 had poor impulse control and exit seeking behaviors. Another staff member and themselves went to the grocery store to get Resident #3 one time, but social work stayed at the store and took them shopping. Resident #3 would stay in the lobby, wait for the receptionist to get busy with another resident or visitor, and just walk out. The doors were an automatic system and Resident #3 would just walk out. The receptionist would finish what they were doing and see the resident in the parking lot, but they had already left by that point. Resident #3 usually left on the evening shift. During an interview on 05/06/2026 at 12:20 PM, Licensed Practical Nurse #14 stated Resident #3 used to run out all the time. They had to chase them down with a van. The residents were not allowed to go out on their own. During an interview on 05/06/2026 at 4:39 PM, Registered Nurse Supervisor #2 stated Resident #3 had exit seeking behaviors, it was random or because the meal tray was wrong. There was a time or two they would meet Resident #3 in the parking lot. There was another time Resident #3 went across the street. They would put the resident on an unofficial one to one supervision for the shift if they saw behaviors. 3). Resident #4 had diagnoses including dementia with agitation and major depression. The 01/04/2026 Minimum Data Set documented the resident had significant cognitive impairment, exhibited wandering behaviors for one to three days out of seven days, and was independent with mobility. The Comprehensive Care Plan initiated on 12/21/2023 and revised 02/22/2026, documented Resident #4 was an elopement risk due to dementia and mobility. Interventions included a wander alert device, check the function of the wander alert device, and check the placement of alert device every shift. The 10/29/2025 Comprehensive Care Plan documented the resident was at risk for self-directed or other directed harm. Interventions included if the resident wandered or was pacing, initiate visual supervision during acute episode. The 04/28/2025 Physician Order documented to check the functionality of the wander alert device every shift for safety.The 05/01/2025 Elopement Assessment documented Resident #4 was at risk for elopement based on being fully ambulatory, wandering aimlessly, and exhibiting hallucinations/delusional thinking/confusion/paranoia, or was unpredictable. There were no attempts of elopement. The 02/21/2026 at 6:41 PM Nursing Supervisor #5 progress note documented Resident #4's spouse was unable to the locate resident, so they asked staff help look for the resident. Resident #4 was found in the building's classroom, down a wing (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	where the door should be locked. The receptionist spoke with staff and the resident's spouse that a registered nurse helped the receptionist earlier to turn off an alarm for the door, but that was it. The resident's wander alert device set the alarm off for the door leading down that hallway even though it is unlocked, and the registered nurse had not gone down the hall to look for a resident. The Assistant Director of Nursing and Maintenance were notified and statements were collected. The above 02/21/2026 at 6:41 PM Nursing Supervisor #5 progress note was struck out on 02/22/2026 at 2:11 PM with a note in error. The 02/21/2026 at 7:01 PM Assistant Director of Nursing progress note created on 02/22/2026 at 1:16 PM documented the resident's spouse came to see resident and was unable to locate them. Staff began looking for the resident. The resident was found in the classroom, down the hall in the business office area by a certified nurse aide. The resident was sitting in a calm manner on a bed, unharmed. Their spouse was at their side. The resident's skin remained intact with no new areas of concern, no bumps, lumps or bruising. The resident was able to ambulate per baseline and had no verbal/nonverbal indications of pain or discomfort. The 02/21/2026 unsigned facility investigation documented Resident #4's spouse came to see the resident and was unable to locate them. Staff began looking for Resident #4. The resident was found in the business office area, by Certified Nurse Aide #9, in the education room. The area was secured with a keypad (and an alarm to activate against wander alert device). Registered Nurse #8, who was covering the reception area, noted Resident #4 was wandering in the front lobby area, which they did often before dinner, waiting for their spouse to come in. Registered Nurse #8 noted prior to the incident, an alarm was activated, and it was not the front door. Registered Nurse #8 notified Licensed Practical Nurse #6. Licensed Practical Nurse #6 cleared the alarm on the administration wing by entering the code. Licensed Practical Nurse #6 was not engaged to check the area as nobody was around when they looked down the hall and the alarm would sound if a resident with a wander alert device got close to the alarm. At the instruction of the Administrator, Environmental Services completed a system check on the door in question and it was determined the door was not locking when the system was engaged. The keypad was serviced and the system was back in working order to lock when the wander alert device engaged it. The doorway that led to the old business office was not used by staff. Witness Statements included with the investigation documented: - by Registered Nurse #7, Resident #4's spouse asked if they saw Resident #4 as they were unable to locate them. They notified the surrounding staff to help look for the resident. When they went to the front reception area, Registered Nurse #8 stated they saw the resident walking towards the dining room earlier. - by Registered Nurse #8, shortly after arriving to the front reception area for their shift, they observed Resident #4 standing in the front lobby. When the resident approached the white railing, the door alarm sounded. After they reset the door code, Resident #4 headed down the hallway towards the dining room. They did not see Resident #4 return to the front lobby. The front door alarm sounded a second time when a visitor attempted to push the door open. They were able to reset the alarm, five minutes later, they heard the door alarm again, Licensed Practical Nurse #6 entered the area, and tried to reset the alarm to no avail. Licensed Practical Nurse #6 went down the C-1 hallway, and Registered Nurse #8 did not visualize Licensed Practical Nurse #6, but heard them say, oh, it's this door alarm. I shut it off. Approximately, 30-45 minutes later, a staff came to reception area to inquire if they had seen Resident #4.- by Licensed Practical Nurse #6, while they were downstairs, on their way up to B2 unit, Registered Nurse #8 asked them if they could help them, and they walked over to the front door main entrance. Registered Nurse #8 was trying to shut off the alarm that was going off. They listened and walked towards the alarm noise. They told Registered Nurse #8, oh, it was this door by the Administrator's office. To their knowledge that door was always locked and to get in you had to put in a code. So, they put the code in and went back up to their assigned unit.- by Certified Nurse Aide #9, they walked by the door to the old business wing and saw Resident #4 down the hallway. They went and got help to get Resident #4. They found the resident unharmed. During an interview on 05/06/2026 at 12:07 PM, Registered Nurse #10 stated Resident #4 wandered all the time. For (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	example, Resident #4 was just on the unit on the other side of the building and the unit manager called the unit to let Registered Nurse #10 know. They knew Resident #4 was safe on that unit, so they just kept track of Resident #4's location with each other. During a telephone interview on 05/06/2026 at 2:17 PM, Registered Nurse Supervisor #5 stated they recalled Resident #4. The resident was usually nonsensical (medical term used for senseless or irrational) and could not follow directions. They wandered and picked up things along the way. They were working the night Resident #4 got into the old business office area. They knew the door did not lock, everyone used it to get back to the classroom, or the back side of the front desk area. They were not provided training for their position and were not taught how to use the work order system. The supervisor computer did not have an icon for work orders. Resident #4 wore a wander alert device. The wander alert device would alarm, but there was no way to tell where it was coming from, they just had to walk around and find where the noise was coming from. They were not sure how the resident got back there, but figured they just opened the door and walked in. Registered Nurse Supervisor #5 was not there when the resident was found. Registered Nurse Supervisor #5 had only gone back to that area a few times on other nights. The area has a long hallway that ended with multiple rooms. There was construction and electrical equipment back there and floors that were not finished. Resident #4 was known to grab doors and anything they could. During an interview on 05/05/2026 at 8:52 AM, Receptionist #28 stated residents could sign out in the binder with a friend or family. They could not sign themselves out. Residents were allowed to sit on the patio, and they would watch them when they were out there. If a resident could not be located, they thought they would call the supervisor, but they were not sure. They had never had that happen, so they were not sure what would happen. During an interview on 05/05/2026 at 5:15 PM, Certified Nurse Aide #29 stated they were a certified nurse aide on the unit and went on transports with residents primarily, but they also picked up the 4:00 PM to 8:00 PM front desk coverage to help out. If a resident wanted to leave on their own, they would ask where they were going first. They were not sure if residents could leave alone. If a resident was an elopement risk, they would wear a wander alert device. They did not have a book of residents that were at risk of elopement or a book of residents in the building for identification. During an interview on 05/06/2026 at 3:51 PM, Assistant Director of Nursing stated elopement was when a resident went out one of the doors without staff knowing or without a witness. They generally had a full-time receptionist and a weekend person, but certified nurse aides that knew how to answer the phone could cover the front desk area. They were given a list of extensions. When a staff member was covering the front desk, they knew the at-risk residents by wander alert devices being a part of their in-service training, and they knew the codes for a missing resident. They stated they printed the supporting documents, so they must have been the one that did Resident #2's elopement investigation. Whoever completes the accident and incident report was the person that did the investigation. Resident #2 eloped on 08/24/2025. Based on the investigation, they did not know who the resident was in the lobby near the door when the receptionist turned off the alarm. They were unable to outline how the resident was able to exit the building. They stated that some families had the code to stop the alarm, so they did not have to bother the staff when they wanted to take residents downstairs or out for a visit. They stated there was a book with all the residents with a wander alert device and elopement risk residents. Certified Nurse Aide #1 was covering the front desk and should have known Resident #2 as they worked on that unit. When the Assistant Director of Nursing got to the resident outside on 08/24/2025, they were pale and shaking, they were scared. They did not know what to do once they were outside, they were just scared. They were not sure that Resident #3 eloped as they were of sound mind. The interdisciplinary team would discuss and agree if a resident was able to go out on pass, and then there would be a physician order for it. The interdisciplinary team had to agree that the resident was safe to go out on pass. There was an out on pass assessment, they thought nursing staff and a medical provider had to sign the assessment and it was done on admission. The Assistant Director of Nursing stated they would have to ask the Administrator if residents could leave without (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	supervision. If the out on pass assessment documented the resident could leave on pass with a responsible party, they would not be able to leave alone. Resident #3's care plan documented their out on pass privileges would be reassessed if they went out alone again. They did not know if the resident was re-assessed after the second elopement. Resident #4 was found in the old business office area. The area was supposed to be locked, but it was not locked at the time. The keypad was not working. The door allowed the resident to go in, but the wander alert system alarmed. During a telephone interview on 05/07/2026 at 9:59 AM, the Medical Director stated out on pass privileges were nurse driven privileges if the resident had decision-making capacity. They did not sign the out on pass assessments. Resident #2 left in the middle of the night; they had an underlying dementia diagnosis. They were found at a motel next door. They did not think Resident #2 could leave without supervision; there was a risk to this resident. Resident #3 had a brain injury and was at risk for elopement. They had fluctuating behavior with poor impulse control; they nearly needed one to one supervision. They would wait for the receptionist not to be looking and then they would leave. They were not safe to leave without supervision. They were at high risk of being assaulted in public due to their behavior. They should have been on a closed unit. They were not familiar with Resident #4, however, stated Resident #4 could not leave without supervision. All three residents had underlying dementia or cognitive disorder, which put them at risk for negative outcomes such as harm to self and harm to others. They did not take part in investigations, but only if it were a recurring issue, then it would come to the Quality Assurance meetings. During an interview on 05/07/2026 at 11:58 AM, the Administrator stated any resident had the ability to go out on pass. If they lacked capacity, they could go out with a health care proxy. They had to tell the nurse and sign the book in the lobby. There was a form in the computer that was completed, but they did not sign that form as part of the process. Residents could go out on the patio and they did not have to sign out for that. Elopement was when someone left the building and did not have the mental capacity and they did not know where they were. Resident #2 could not leave without supervision they did not have capacity. However, they consistently packed up to leave. They were moved to the second floor and had a wander alert device. If a resident with a wander alert device entered the elevator, the doors would stay open, and it would not function. They were not sure how Resident #2 got downstairs. Families might know the code for the elevator and they did have families that visited daily that had the code. They had resident assistants, certified nurse aides, medical records staff, or activities staff that would help at the front desk. They did not get any specific training for working the front door. They had the wander alert device and elopement training on hire and annually. There was a book that identified the residents at risk for elopement. There was no book with information about residents with out on pass privileges, nothing to identify the residents that needed a responsible party, could go alone, or did not have pass privileges. Resident #3 was previously identified as not being able to go out on their own, they took off the wander alert device, and Resident #3 went shopping with activities staff. They only went out one time without notifying anyone. Resident #3 should have told the nurse and receptionist when they left. They could leave without supervision because they had decision-making capacity. They had an elopement in June 2025, they were not aware of any attempts in September 2025 and they did not think there were any elopements in October 2025. When reminded of

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record review, and interviews (iQIES Intake 2607654), the facility failed to ensure a system of records and accounts of all controlled drugs was maintained for five (5) of five (5) residents (Residents #37, #38, #39, #40, and #41) reviewed. Specifically, Unit C1 had all the scheduled narcotic medications signed off at the beginning of the day, prior to the medication administration time.Findings include: The facility policy Controlled Substance Log, revised 11/2025, documented a record of all controlled substances would be maintained in the facility to ensure accountability and security of controlled substances. The facility's system would account for the receipt, usage, wastage, return to the pharmacy, disposition, and reconciliation of all controlled medications. The policy did not document the process for documenting medication administration of a control substance on the log. During an observation and interview on 05/04/2026 at 10:31 AM, the Unit C1 narcotic medication book was requested. Licensed Practical Nurse #30 provided the book and stated it was going to be wrong as they already signed off all the narcotic medication in the book for the entire day. The narcotic book was signed in advance for residents' controlled medications as follows:- Resident #37's oxycodone/acetaminophen (opioid) 7.5/325 milligram tablet was signed for the 05/04/2026 1:00 PM dose. - Resident #38's clonazepam (antianxiety) 0.5 milligram tablet was signed for 05/04/2026 12:00 PM dose. - Resident #39's hydrocodone/acetaminophen (opioid) 5/325 milligram capsule was signed for the 05/04/2026 12:00 PM dose. - Resident #40's oxycodone/acetaminophen (opioid) 5/325 milligram tablet was signed for the 05/04/2026 12:00 PM dose. - Resident #41's tramadol (opioid) 50 milligram table was signed for the 05/04/2026 12:00 PM dose. During an interview on 05/08/2026 at 11:50 AM, Licensed Practical Nurse #30 stated the narcotic medication book should be signed when the medications were given. The narcotic medication book should not be signed ahead of time. That was not how they were trained, and they did not normally do that, but they were the only nurse on the unit, and they were trying to get ahead of the workday. They were the only nurse for 40 residents, including 23 diabetics, many on regular insulin that required glucose monitoring several times a day. They were thankful they did not have many treatments on the unit, but it was a very heavy assignment for just one person. During an interview on 05/08/2026 at 12:02 PM, Registered Nurse Unit Manager #10 stated nurses were all taught to open the narcotic medication book, check the counts, compare the book and the medication card, open the medication, make sure the medication was taken, then sign the narcotic medication book. Nurses should not sign the narcotic medication book ahead of time. The whole shift of medications should not be signed for at the beginning of the shift, only after the medication was given. 10 New York Codes, Rules and Regulations 415.18

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations and interviews (iQIES Intake), the facility failed to provide each resident with a nourishing, palatable, well-balanced diet that met their daily nutritional needs for two (2) of two (2) meals (the 05/04/2026 lunch and dinner meals) and for one (1) of four (4) kitchenettes reviewed. Specifically, the 05/04/2026 lunch and dinner meals were not served at palatable and appetizing temperatures, were not flavorful, and had missing food items; and the Unit A2 kitchenette was not stocked with sufficient snack items available to residents. Findings include:The facility policy Food Temperature, dated 09/2018, documented the policy was to ensure safe and quality food items. The facility would obtain and record temperatures of food items prior to serving the residents. The policy did not document the appropriate serving temperatures for hot and cold food items. The facility policy Food Preparation and Service, dated 08/2025, documented food is cooked in a manner to conserve nutritive value, flavor, appearance, and texture. The danger zone for food temperatures is between 41 F and 135 F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause foodborne illnesses. Hot foods are held at 135 F or higher on the steam table. Cold foods are held at 41 F or lower. Potentially hazardous foods include meat, poultry, seafood, cut melon, eggs, milk, yogurt and cottage cheese. Potentially hazardous foods must be maintained below 41 F or above 135 F. The facility policy Frequency of Meals, revised 08/2025, documented nourishing snacks would be available for resident who needed or desired additional food between meals. Evening snacks would be available routinely to all residents. Nourishing snacks were items from the basic food groups, offered either separately or with each other. The facility would choose the snacks that were offered at bedtime. However, the dietitian and food services manager would solicit input from the residents and/or the resident council. The undated facility weekly par level for unit snacks documented 1/3 box of graham crackers, 6 boxes of fig bars, 8 packages of peanut butter crackers, 5 boxes of gingerbread cookies, 1/3 box of animal crackers, 1/3 box of cream of mushroom soup, 1/2 box of chicken rice soup, 1/2 box of chicken noodle soup, 1/2 box of vegetable soup, 1 box of tomato soup, 18 orders of ice cream. Snack Availability:On 05/05/2026 at 9:09 AM, the following was observed in the A2 kitchenette: 9 packets of graham crackers, 2 packs of peanut butter crackers, 1/2 open bag of mini marshmallows, 5 chocolate pudding cups, one 18-ounce jar of peanut butter, 1 1/2 loaves of wheat bread, 5 English muffins, hot chocolate packets, tea, condiments, sugar and sugar substitute. Refrigerated items included several containers of thickened liquids, milks, Mighty Shakes, 2 gallons of whole milk, other various juice containers, 3 sandwiches labeled PBJ. Freezer items included multiple cups of sherbert, 1 ice cream sandwich, 2 quarts of ice cream, and 5 cups chocolate ice cream. On 05/08/2026 at 10:03 AM, the following was observed in the A2 kitchenette: 23 cups of ice cream/sherbert, 2 packets of two graham crackers, 1 bag of graham cracker cookies, and an open jar of peanut butter. Meal Observations:During an interview on 05/04/2026 at 12:20 PM, Resident #36's family stated food was the biggest concern. Meals were late, not palatable, and hot meals were always cold. The meals were not good with few options. They frequently brought food in for Resident #36. During an observation and interview on 05/04/2026 at 12:55 PM, the A2 tray cart left the kitchen. Dietary Aide #33 stated the tray carts did not usually leave the kitchen with the insulated covers on, but they were using them today. During a meal observation and interview on 05/04/2026 at 1:10 PM, Resident #9's was served their lunch tray. Their lunch tray was tested, and a replacement was requested. Licensed Practical Nurse #18 observed and verified the temperatures for the meal tray at 1:11 PM. The fish was 118 degrees Fahrenheit, mashed potatoes were 121 degrees Fahrenheit, mixed vegetables were 134 degrees Fahrenheit, fruit cup was 70 degrees Fahrenheit, and the coffee was 128 degrees Fahrenheit. The fish was dry, with a jerky like texture, and the fruit cup was room temperature. Licensed Practical Nurse #18 stated beverages were normally served on the trays, but they were not served on the trays for lunch on 05/04/2026. During an observation and interview on (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	05/04/2026 at 1:10 PM, Certified Nurse Aide #16 stated the meals could be small and were often missing items. If items were missing or the resident wanted an alternative they had to go downstairs for it. Resident #45's meal ticket documented 1/2 cup of potatoes, 3 ounces of baked fish, 4-ounce Mighty Shake (nutritional supplement), 1 serving of peanut butter and crackers, 8 ounces of cola, 1/2 cup of gelatin, and 1 package of margarine. These items were not included on the tray. During an observation and interview on 05/04/2026 at 1:13 PM, Resident #43 stated they were served sandwiches for supper on most nights. Recently, they were served sandwiches for supper 5 days in a row. They were supposed to get double portions and did not usually get them. The portions were very small, and items were often missing or were wrong. Resident #43's meal ticket documented double portions. During an observation on 05/04/2026 at 1:13 PM, Resident #10's meal ticket documented 4-ounce Mighty Shake and 8-ounces of water. These items were not present on the tray. During an observation and interview on 05/04/2026 at 1:20 PM, Resident #42 stated the food was not good and the portions were small. They were supposed to get double portions but did not usually get double portions. They stated they did not drink coffee but was served coffee. For the 05/04/2026 lunch meal tray they were missing their pudding. Resident #43's meal ticket documented double portions. During an observation on 05/04/2026 at 1:21 PM, Resident #12's meal ticket documented 4-ounce Mighty Shake, 8-ounces nectar thickened water, 4-ounces nectar thickened milk, and 8-ounces nectar thickened apple juice. These items were not present on the tray. During a meal observation and interview on 05/04/2026 at 5:45 PM, Resident #23 was served their dinner tray. Their dinner tray was tested, and a replacement was provided. Certified Nurse Aide #34 observed and verified the temperatures for the meal tray. The sausage was 103 degrees Fahrenheit, the green beans were 101 degrees Fahrenheit, peppers and onions were 99 degrees Fahrenheit, milk in the carton was 53 degrees Fahrenheit, and coffee was 120 degrees Fahrenheit. Their tray was missing water and margarine. The rice was in a semi-circle scoop form, was plain white rice with no flavor or seasoning, slightly mushy, and lukewarm. The green beans were bland canned beans, lukewarm, with no seasoning. The tray had a very small portion of peppers and onions; they were barely lukewarm, overcooked and mushy. During an interview on 05/04/2026 at 5:47 PM, Resident #23 stated they liked their margarine, but typically never got it. They were often missing items from their tray, or the items did not match the tickets. They bought their own snacks and drinks and kept them in their room, because snacks were often not available. During a dinner meal observation and interviews on 05/04/2026 at 5:57 PM, Resident #42, did not receive a brownie, double portions, water, or margarine on their meal tray. The resident stated the food was okay, but not very warm. The rice was not good; it was bland and mushy with no flavor. Resident #43 stated they got their double portion, but the food was only lukewarm and did not taste good. They did not receive any margarine, and the rice and green beans had no flavor. Resident #44 stated the rice was too sticky/mushy, all in one clump, it was lukewarm at best, and the sausage was okay. During an interview on 05/05/2026 at 8:23 AM, Resident #11 stated the hot food was always served cold. The following was observed during the breakfast meal on 05/05/2026:-at 9:20 AM, Resident #9's meal ticket documented 8 ounces prune juice, 8 ounces orange juice, 4 ounces whole milk and 4 ounces cream of wheat. These items were not present on the tray.-at 9:32 AM, Resident #29's meal ticket documented 1/4 cup pureed sausage patty. The item was not present of the tray. During an observation on 05/08/2026 at 12:32 PM, an unknown resident was eating lunch at the B2 nurse's Station. The lunch for the day was fish, baked potato, and spinach. The fish was tan in color and had the same dry, jerky appearance as the fish on 05/04/2026. During an interview on 05/04/2026 at 2:51 PM, Dietary Aide #36 stated the food that was ordered by the residents was not always what they received for their meals. The unit also ran out of snacks to offer the residents. During an interview on 05/04/2026 at 5:52 PM, Certified Nurse Aide #34 stated meal trays were often missing items and the tray items did not match the meal ticket. They often bought snacks on their own for the residents because they did not have them in the evening. They were told by the facility not to, and they were not reimbursed, but they felt bad for the (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents. During an interview on 05/06/2026 at 12:20 PM, Licensed Practical Nurse #14 stated hot food was served cold, and cold food was served at room temperature. The meals tickets did not usually match the meal tray, and missing items were usually condiments. The milk was expired, but the staff caught that before it was served. The snacks were limited, because the staff helped themselves with the snacks in the unit or the items were still frozen solid when they were brought to the unit. During an interview on 05/08/2026 at 10:05 AM, Certified Nurse Aide #12 stated the residents complained the food was cold when it should be hot, and it did not have flavor. The meal tickets sometimes did not match what the resident received. If the facility was out of oatmeal, the resident just did not get it on their tray. If they were missing a beverage, they could sometimes replace it with another beverage. The trays sometimes were missing a side dish or snack, and they tried to replace them if they could. For example, the ticket would say goulash, but the resident would get meatloaf because the kitchen did not have pasta for the goulash. During an interview on 05/08/2026 at 10:30 AM, Licensed Practical Nurse #18 stated the hot food was not served hot, and the food did not follow the menu. The kitchen staff did not pay attention to the meal tickets. They would send up regular consistency trays for resident that needed pureed food. The unit staff caught those, and they would have to call for another tray. Diabetic residents got sugary items, they did not give double portions, and the food was flavorless. The weekends were the worst. They served sandwiches for two meals in a row. They never had snacks for the residents. They needed a manager or assistant manager in the kitchen. During an interview on 05/20/2026 at 9:01 AM, [NAME] #38 stated per diem Food Service Director #41 came in 2 days a week and did the ordering. They used the 4-week menu for ordering food items. They ordered food, and it was not received. The food order was reviewed by Corporate, and they would take things off the order, especially if the order was over budget. They had snacks in the facility now, but they did not for a while. If an item was needed for a meal and they did not have it, sometimes the Administrator would go to the store and buy it. They were told by the former cook that serving temperatures were between 175 and 190 degrees Fahrenheit for hot food, and between 32 and 38 degrees Fahrenheit for cold food. The fruit for the fruit cup did not come in cold. It had to be served in bowls and then the bowls went into the cooler to be chilled. The serving of the fruit was not usually done until meal service time, so they did not always have time to go in the cooler. The fish, potatoes, mixed vegetables, fruit cup, sausage, green beans, peppers and onions, or milk served at the temperature they were served at was not appropriate. Milk should not be served that warm. The last dietary aide on the service line was responsible for checking to ensure all items listed on the ticket were on the tray. During an interview on 05/20/2026 at 1:14 PM, former Food Service Director #40 stated per diem Food Service Director #41 did the food ordering now. They did it when they worked there. The food was ordered based on the 4-week menu. The order would go to a third-party company that would remove items as they saw fit, especially if the order was over the $6 per resident per day allotment. They would remove items like pasta, chicken, and ice cream. It was random what was removed. They did not know what food they were going to get until it arrived at the facility. They were not allowed to speak with the food distributor directly; they could only communicate with the third-party company. When food was missing from the order, the third-party company would say that the facility did not order it. They knew they ordered it, because they kept their own record of what the original order included. They spent their own money at the grocery store to make sure residents had what they needed. The food that was ordered was low grade food to fit the low budget of $6 to create 3 meals, 2 desserts, snacks, and beverages. They also had to order the thickened beverages within the same budget. The food they got in the orders was frequently pre-packaged low-grade food. Hot food should be served to the residents at over 160 degrees Fahrenheit, and cold food should be served under 40 degrees Fahrenheit. Any hot food served under 160 degrees Fahrenheit was not acceptable. Milk should not be 53 degrees Fahrenheit, and a chilled fruit cup would not be considered chilled if it was 70 degrees Fahrenheit. The dietary aides on the line were responsible for ensuring the meal trays had everything the meal (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Massena Rehabilitation & Nursing Center	89 Grove Street Massena, NY 13662

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ticket included. The last person on the food line was supposed to do a review of the whole tray to ensure accuracy. A third of a box of graham crackers are approximately 20 packages of 2 crackers, 8 packages of peanut butter crackers were approximately 64 servings, and a third of a box of animal crackers was approximately 33 packages of crackers. During an interview on 05/21/2026 at 9:00 AM, the per diem Food Service Director stated they were responsible for ordering food for meals, beverages, and snacks. They used the menu and ordered based on a full census of 162 residents. The order was reviewed by a third party company to find the cheapest price. If the order was within the budget the orders were placed. If the order was over budget, the third party contacted them to remove or try to change the items for a cheaper option. They did not know what the budget was, and the corporation would not tell them the budget number. They would just say how much they were over budget. Corporate got to decide if the overage would be paid, or if more cuts needed to be made. They could only order to the approved par levels. During an interview on 05/21/2026 at 11:33 AM, the Registered Dietitian #43 stated they did not provide meal oversight. The meal ticket and meal tray should match, if they did not there should be an equivalent item to replace it. They were not notified of tray accuracy issues. To their knowledge the facility had never run out of food or the main menu item. They were not aware of any issues with food service in the facility. No one informed them that meals were not following the approved menu. They were not aware of sandwiches being served regularly instead of the menu. Sandwiches were on the menu, but they would not be served twice a day, nor 5 days in a row. During an interview on 05/21/2026 at 1:12 PM, the Administrator stated their current census was 136 residents but could be up to 162 residents. Per diem Food Service Director #41 was responsible for ordering food and determining the par level of food for the facility. They placed the orders, and sometime things were back ordered but they were not notified of back orders until they did not show up at delivery. They stated they sometimes had to go to the store to get milk because it did not come with the delivery. The third-party company would let them know that the food order was over budget. They stated they were almost always over budget. The budget came from Corporate. The par list did allow for enough snacks for the residents. The staff on the units would come down about 2:00-2:30 PM to get snacks for the residents. They were not aware of every running out of snacks for the residents. They stated they were responsible for ensuring food was good quality. The cooks should not send out food that was not warm or cooked properly. The appropriate serving temperature for hot food was over 120 degrees Fahrenheit, and cold food was under 50 degrees Fahrenheit. Milk should not be greater than 38 degrees Fahrenheit and milk at 53 degrees Fahrenheit was not appropriate. The last dietary aide on the service line was supposed to check over the trays. Everything listed on the meal ticket should be located on the tray with the exception of cold beverages. Cold beverages were served on the unit by the unit staff, so they did not get warm on the meal cart. The kitchen ran out of the main dish before, and the item was substituted. The registered dietitian should be notified when items were substituted, but that was not always happening. There was a time the kitchen did not notify them of a change in the menu. They stated they started looking into it about 2 months ago, because the residents were sending them photos of their meals. 10 New York Codes, Rules and Regulations 415.14(d)(1)(2)10 New York Codes, Rules and Regulations 415.14(f)(3)(4)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review (iQIES intake 2793248), the facility failed to employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition services. Specifically, the facility did not have a Food Service Director to manage the kitchen and food service; the full-time dietetic technician did not have the required credentials for the position of Food Service Director, and the registered dietitian worked remotely and was not available on site. Refer to citations (F800 - Food and Nutrition Services and F812 - Food Safety Requirements). Findings include: The 05/04/2026 Facility Assessment documented Former Food Service Director #40 was the current Food Service Director on Medical Leave; and the Per Diem Food Service Director was Per Diem Food Service Director #41. The Current Staff List provided by the facility documented Nutrition Assistant #39 was a Dietetic Technician. The undated Food Service Director Job Description documented the purpose of the position was to develop, plan, coordinate, and execute food service for all residents, personally or through delegation of duties to dietary staff. They provided leadership, support, and guidance to ensure food quality standards, inventory levels, food safety guidelines, and customer service expectations were met. They provided overall direction and coordination of the department including direct supervisor of dietary staff. The 03/01/2014 Dietetic Technician Job Description documented the dietetic technician obtained all information necessary for nutritional care planning. Duties included interviewing all new admissions for a dietary history and recording all the information; writing monthly progress notes on appropriate residents and ensuring that care plans were implemented; monitoring meal intake on all residents and calculating food intakes when necessary; and verifying physician diet orders or changes and documenting them in the medical record. They must be a graduate of a 2-year college with associates of applied science in dietetic technology and registered or registration eligible with Commission on Dietetic Registration and membership in Academy of Nutrition and Dietetics was preferred. During an interview on 05/04/2026 at 12:18 PM, the Ombudsman Coordinator stated food was the biggest issue at the facility. The kitchen staff had no management. During an interview on 05/04/2026 at 5:47 PM, Resident #23 stated no one from dietary ever came to check on their preferences or updated their meal plan with them. During an interview on 05/04/2026 at 2:46 PM, [NAME] #42 stated there was no kitchen manager for at least the last two weeks. They stated Per Diem Food Service Director #41 came in to train new kitchen managers and ordered food and supplies while they were without a kitchen manager. Per Diem Food Service Director #41 had previously worked there a long time ago. During an interview on 05/04/2026 at 2:51 PM, Dietary Aide #36 stated staffing was good for the day shift, but the night shift for dinner usually only had 2 or 3 staff total. During an interview on 5/20/2026 at 9:01 AM, [NAME] #38 stated the kitchen did not have a supervisor. They tried to get the staff to help, but they just ignored them. They did not have the ability to write up staff for not doing their job. They stated they were kind of acting in a manager role because the kitchen duties had to get done. They stated they thought the facility had a registered dietitian; however, they had never seen them. During an interview on 05/20/2026 at 1:14 PM, Former Food Service Director #40 stated they had not worked in the facility since December 2025. They had since hired Per Diem Food Service Director #41, and another full-time food service director since they left. Per Diem Food Service Director #41 was only responsible for ordering food. The facility had a Registered Dietitian on record; however, they were never in the facility, and they never met or spoke with them. During an interview on 05/21/2026 at 9:00 AM, Per Diem Food Service Director #41 stated they were in the building once a week to review inventory and order supplies and food. They were not responsible for making food, cleaning the kitchen, or the accuracy of the meals. They did not oversee the kitchen. The facility had a registered dietitian on staff who worked remote only and they never met them personally. They did not have a contact phone number for the registered dietitian. The facility had Nutrition Assistant #39, (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	but they were currently unavailable. During an interview on 05/21/2026 at 11:33 AM, the Registered Dietitian #43 stated they were hired to provide remote dietetic support. The facility had a dietary liaison, Nutrition Assistant #39, that was full time at the facility and provided oversight. Registered Dietitian #43 stated they did nutrition assessments and followed wounds, tube feeding, and dialysis residents. If they made a recommendation, the nurse practitioner would approve it, and the nutrition assistant would add it to the meal ticket. The facility was in between Food Service Directors, and the nutrition assistant did not have any certifications or degrees in dietary or nutrition sciences. The nutrition assistant performed clerical tasks and interviewed residents for admission intake and preferences; they did not do any clinical tasks or chart on the residents. They referred to Nutrition Assistant #39 as a Dietary Aide when documenting. During an interview on 05/21/2026 at 1:12 PM, the Administrator stated they were currently responsible for managing the day-to-day kitchen operations. The last Food Service Director left about a month ago. They had a consultant registered dietitian that worked remotely and was responsible for approving menus, menu substitutions, and monitoring weights of residents and dietary notes. Nutrition Assistant #39 was the diet technician, and they communicated with the registered dietitian. Nutrition Assistant #39 was not a registered dietetic technician; they carried the title at the facility of dietary technician. They did not have any certifications or credentials in nutrition. They were previously a certified nurse aide. 10 New York Codes, Rules and Regulations 415.14(a)(1)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews (iQIES Intakes 2607654 and 2985855), the facility failed to ensure proper sanitation and food handling practices to prevent the outbreak of foodborne illness in one (1) of one (1) main kitchen. Specifically, the main kitchen had spoiled food; an unclean freezer; unclean surfaces; a steamer oven was in disrepair; and the box compactor room was piled with empty boxes.Findings include:The facility policy Kitchen Sanitization, dated 08/2025, documented food service should be maintained in a clean and sanitary manner. All utensils, counters, shelves and equipment should be kept clean and maintained in good repair. Between uses, cloths and towels used to wipe kitchen surfaces will be soaked in containers filled with approved sanitizing solution. Sanitizing solution would be changed at least once per shift or if solution becomes cloudy or visibly dirty. The Food Service Manager was responsible for scheduling staff for regular cleaning of kitchen and dining areas. Food service staff would be trained to maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.Electronic communication with the Administrator on 05/19/2026 documented the facility did not have kitchen cleaning logs for May 2026. There was no documented evidence of work orders from 04/15/2026 to 05/04/2026 for kitchen maintenance or repairs for the streamer oven or walk-in freezer. The following observations were made in the main kitchen on 05/04/2026: -at 11:24 AM, the walk-in cooler contained moldy cucumbers.-at 11:30 AM, the walk-in freezer had water dripping from the condenser with ice built up on the boxes below and on the floor. [NAME] #38 stated they had a freezer truck parked behind the facility with frozen food. The food in the walk-in freezer was removed and placed in the freezer truck when the condenser was repaired last week. However, the condenser began dripping water again.-at 11:32 AM, the utensil container was soiled.-at 11:35 AM, there were numerous drain flies by the juice system and dish washing areas.-at 11:37 AM, the wheeled garbage can bases were heavily soiled.-at 11:47 AM, there was built up food debris in the reach-in refrigerators and freezers.-at 11:48 AM, there was built up debris under and behind kitchen equipment throughout the kitchen.-at 11:52 AM, there were two sanitizer buckets for the entire kitchen; one with a very soiled cloth and liquid. The wiping cloths were disintegrated.-at 12:10 PM, the steamer oven door seal was in disrepair and boiling liquid leaked out consistently while in use. The floor drain did not have a smooth transition from the tile to the grate which puddled the liquid instead of allowing it to flow down the drain. During an observation and interview on 05/04/2026 at 3:00 PM, there were boxes piled up around the box compactor. The boxes were piled to the height of the compactor in a semi-circle around the machine. The Environmental Services Director stated the box compactor did not work for approximately a week and a half. It was repaired on 04/22/2026 and numerous empty boxes built up around it as of 05/04/2026. During an interview on 05/04/2026 at 11:41 AM, [NAME] #38 stated the old juice dispensing nozzle had maggots in it, but management changed it out the previous week, and the dispensing nozzle was new without any problems. During an observation and interview on 05/04/2026 at 2:51 PM, Dietary Aide #36 stated staff brought in their own cloths for wiping and cleaning since the facilities cloths were disintegrated. During an interview on 05/20/2026 at 9:01 AM, [NAME] #38 stated cleaning responsibilities for the kitchen were divided. The cook side was the cook's responsibility, and the side of the line was the dietary aide's responsibility and included the cooler, freezer, and stand-up refrigerators. During an interview on 05/20/2026 at 1:14 PM, the Former Food Service Director #40 stated the dietary staff was responsible for cleaning the kitchen, however, the Corporation only allowed for 30 minutes post food services for cleaning, which included all the dishes. They got in trouble for staying over or using overtime. The kitchen did not get cleaned. They hired people to clean one time, but basically the kitchen got cleaned once a year. The kitchen was cleaned last due to a previous state citation. They had put in multiple work orders for (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	repairs to the kitchen and equipment but were asked if the repairs were in the budget. The repairs were never done unless the state cited them for it. During an interview on 05/21/2026 at 9:00 AM, the Per Diem Food Service Director stated Dietary Aides were responsible for cleaning the kitchen, and cooks were responsible for cooking areas such stove and flat top. They had a job posting that documented what should be done every shift and by who for cleaning tasks and kitchen responsibilities. There was no direct supervisor for the kitchen. Two years ago, they had cleaning logs, but they did not think they were being done now. The staff told them they did not have to complete the logs; they just made sure everything was clean. During an interview on 05/21/2026 at 12:51 PM, the Director of Environmental Services stated the cardboard [NAME] was repaired. The facility lacked a Food Service Director to train people on how to use the machine. Only a few people could use it. They got a lot of freight, nearly every other day and the boxes piled up fast. During an interview on 05/21/2026 at 1:12 PM, the Administrator stated kitchen cleanliness was their responsibility at the moment. The dietary aides had a job description for cleaning, and the cooks were responsible for the cooking side of the kitchen. The staff was not documenting the cleaning tasks. The kitchen staff should advise when equipment was broken or had issues. They knew the steam tables drains were not working correctly, and the streamer oven was looked at and would probably need to be replaced. The walk-in freezer broke again, but they were still using the freezer truck in the back. If the box compactor was in working order the boxes should not be piled up in that room. There was an inservice, and all kitchen staff knew how to use it. 10 New York Codes, Rules and Regulations 415.14(h)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations, record review, and interviews (iQIES intake 2610975), the facility failed to ensure they were adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for one (1) of four (4) resident rooms observed. Specifically, Resident #9's call bell did not function as designed.Findings include: The facility policy Resident Call System, revised 02/2025, documented the facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized work area from each resident's bedside and toilet and bathing facilities. The availability of the call system or alternative method for communication was mandatory by the facility. The following observations were made of Resident #9's call bell:-on 05/05/2026 at 8:43 AM, the resident was lying in bed and stated they were wet from urine. When they pushed the call bell button the light above their door did not illuminate. They pushed their call bell button two more times and the light above the door did not illuminate. The surveyor pushed the call button and the light above the door did not illuminate. No audible beeping sound was heard at the nursing station. -on 05/05/2026 at 2:45 PM, 05/06/2026 at 9:33 AM, and 05/07/2026 at 11:24 AM the resident's call bell button was pushed, and the light did not illuminate over the door. No audible sound was heard from the nursing station to indicate the call bell was activated. During an observation and interview on 05/07/2026 at 11:30 AM, Certified Nurse Aide #23 stated they knew a resident had a request or needed assistance when the call bell light was pushed by the resident. Certified Nurse Aide #23 was asked to push the call bell button and the light above the door illuminated with one push. The aide turned the call bell off, and the surveyor pushed the call bell button 3 times with strength and was unable to get the light to illuminate. Certified Nurse Aide #23 stated sometimes you have to push really hard. They stated they were not aware the resident's call bell was not working. During an interview on 05/08/2026 at 10:30 AM, Licensed Practical Nurse #18 stated a lot of the resident call lights on the unit did not work properly. Resident #9's call light had issues since 08/2025. Maintenance fixed it once and then the problem continued without being resolved. Resident #9 could use the call bell when they were having a good day. During an interview on 05/08/2026 at 10:35 AM, the Director of Environmental Services stated the call bell system functioned when a resident pushed the call bell button and it sent a signal to the nursing station to show which resident needed assistance. They typically received a work order or by resident report if a call bell was not working. They were not notified the resident's call bell was not functioning. 10 New York Codes, Rules and Regulations 415.29