STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335685	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palatine Nursing Home	154 Lafayette Street Palatine Bridge, NY 13428

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interviews conducted during the recertification survey, the facility did not provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Specifically, there was an unidentified unpleasant odor of varying levels throughout survey.This is evidenced by:During an observation on 01/22/2026 at 10:55 AM, an odor (pungent, sewer) was noted in the hallway leading to the [NAME] Unit from the Administrator's office to the Nurse's station in front of several resident rooms.During an observation on 01/22/2026 at 1:10 PM, the same odor was noted in the hallway leading to the [NAME] Unit from the Administrator's office to the Nurse's station in front of several resident rooms as it was at 10:55 AMDuring an interview on 01/22/2026 at 1:10 PM, Licensed Practical Nurse #1 stated the odor in the hallway had been present for a while, not sure where it was coming from. They stated they did not believe it was from any of the residents.During an interview on 01/22/2026 at 1:19 PM, Administrator #1 stated a resident in that hallway had a nephrostomy and that was the cause of the odor, and it had been a persistent problem. 10 New York Codes, Rules, and Regulations 415.29

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that its medication error rate did not exceed 5% for four (4) (Resident #s 36, 49, 56 and #62) of 14 residents observed during a medication pass for a total of 25 observations. This resulted in a medication error rate of 32.0%.This is evidenced by:The facility's Policy and Procedure titled, Medication Error Policy reviewed 1/2026 documented the facility shall maintain systems to ensure medications are administered accurately, safely, and in accordance with physician orders, professional standards of practice.Medication Error: Any preventable event that may cause or lead to inappropriate medication use or resident harm, including: Wrong resident Wrong medication Wrong dose Wrong route Wrong time (outside acceptable time frame) Omission Unauthorized medication Improper preparation or documentationNear Miss: An error identified and corrected before reaching the resident.Resident #36Resident #36 was admitted to the facility with a diagnoses of anxiety (excessive fear of or apprehension about real or perceived threats, leading to altered behavior), depression (persistently low mood, loss of interest or pleasure in activities, and, often, low energy), and morbid obesity (a chronic, life-threatening condition defined by excessive weight-typically 100 pounds or more over ideal body weight). The Minimum Data Set (an assessment tool) dated 12/27/2025 documented the resident usually could understand and was understood by others with intact cognition.Resident # 49Resident #49 was admitted to the facility with a diagnoses of alcoholic cirrhosis of liver (permanent scarring that damages your liver related to alcohol use), type 2 diabetes mellitus (where the pancreas cannot make or fail to use insulin properly and eventual insulin deficiency) and gait abnormality (difficulty walking). The Minimum Data dated 07/21/2025 documented the resident usually could understand and was understood by others with intact cognition.Resident #56Resident #56 was admitted to the facility with a diagnoses of type 2 diabetes mellitus (where the pancreas cannot make or fail to use insulin properly-and eventual insulin deficiency), unspecified intervertebral disc disorder (damage, degeneration, or undisclosed disorders of the spine's cushioning discs, commonly causing chronic back or neck pain), and chronic kidney disease (long-term, progressive, and irreversible loss of kidney function). The Minimum Data Set (an assessment tool) dated 10/10/2025 documented the resident usually could understand and was understood by others with moderate cognitive impairment.Resident # 62Resident #56 was admitted to the facility with a diagnoses of unspecified sequelae of cerebral infarction (long-term, lasting effects or complications following a stroke (ischemic brain injury), hemiplegia and hemiparesis left non-dominant side (motor impairments affecting one side of the body following a stroke) and generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 10/7/2025 documented the resident usually could understand and was understood by others with intact cognition.During an observation on 1/20/2026 at 11:15 AM, Licensed Practical Nurse #2 was observed drawing up 15 units of Humalog insulin to administer to Resident # 56 and proceeded to administer the insulin. Writer asked, Licensed Practical Nurse #2 if they had checked for the expiration date. Licensed Practical Nurse #2 then looked at the bottle for the expiration date. At that time, they provided surveyor with the preprinted expiration date on the vial of insulin. When asked, Licensed Practical Nurse #2 when the vial of insulin was opened, they stated they were not sure and were not aware of shortened expiration dates after opening for insulin vials. Licensed Practical Nurse #2 discarded the insulin vial after being prompted and stated they would get a new vial to administer the insulin.During an observation on 1/20/2026 at 11:20 AM, the 8:00 AM dose of Lidocaine 4% patch was highlighted not given for Resident #36. Licensed Practical Nurse #2 stated they did not give the medication because it was not available. They stated they called pharmacy the previous day and were waiting for the medication. Licensed Practical Nurse #2 stated the physician or Director of Nursing had not been notified because they were waiting for the medication. They stated they were aware the medication was late but were going to administer when available. During an observation on 1/20/2026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 11:30 AM, Licensed Practical Nurse #2 stated Resident #49 was to self-administer their medication in preparation for discharge to home. Licensed Practical Nurse #2 entered Resident #49's room and handed resident Insulin Aspart Flex Pen and told them to administer 12 units. Licensed Practical Nurse #2 was prompted to advise resident to prime pen prior to drawing up insulin as ordered. Licensed Practical Nurse #2 then instructed Resident #49 to prime pen with 1 unit of insulin prior to drawing up 12 units as ordered. Licensed Practical Nurse #2 was provided with manufacturer's instructions to prime with 2 units instead of 1 unit. Licensed Practical Nurse #2 stated they were unaware they should prime pen prior to use. Resident #49 had no physician order to self-administer medication.During an observation on 1/21/2026 at 9:20 AM, Licensed Practical Nurse #3 was observed administering medication to Resident #62. Licensed Practical Nurse #3 stated they administered Aspirin 81 milligrams, Keppra 250 milligrams, Losartan 25 milligrams, Metoprolol Extended Release 25 milligrams, Pantoprazole Delayed Release 40 milligrams, Potassium Chloride Oral Solution 60 milligrams / 22.5 milliliters all were due at 8:00 AM. The Medication Administration Record dated January 2026 for Resident #62 documented give the following medications at 07:00AM Aspirin 81 milligrams, Keppra 250 milligrams, Losartan 25 milligrams, Metoprolol Extended Release 25 milligrams, Pantoprazole Delayed Release 40 milligrams, Potassium Chloride Oral Solution 60 milligrams / 22.5 milliliters which were previously signed as given at 8:07 AM by Licensed Practical Nurse #3 although, Licensed Practical Nurse #3 was actually observed administering the medications at 9:20 AM.During an interview on 1/21/2026 at 9:30 AM, Licensed Practical Nurse #3 stated Resident #62 used to receive these medications at 8:00 AM, and there must have been a change in the order to give at 7:00 AM. During an interview on 1/20/2026 at 12:13 PM, Director of Nursing #1 stated Resident #49 self-administer medications. The nursing staff had been observing them self-administer in preparation for discharge to home. Director of Nursing #1 stated prior to self-administering medications the resident is assessed for capacity by a multidisciplinary team, a physician writes order to self-administer medication and care plan updated to reflect resident can self-administer medications. The resident is educated and nurse observing resident documents observation. Director of Nursing #1 was unable to locate any documentation of a physician order, assessment by interdisciplinary team and or care plan for resident #49 to self-administer medications. Consequently, a medication error occurred because there is no physician order for this resident to self-administer medication. Director of Nursing #1 also was unable to verbalize medications that may have shortened expiration dates after opening. They stated they would follow up with pharmacy services.During an interview on 1/21/2026 at 10:00 AM, Director of Nursing #1 stated some resident's medication times were changed to 7:00 AM and some at 8:00 AM to even out the medication pass. They stated the nurse administering medication should follow policy and check for the right patient, right medication, right time, right dose and right route. 10 New York Codes, Rules, and Regulations 41

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palatine Nursing Home	154 Lafayette Street Palatine Bridge, NY 13428

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure a resident was assessed by the interdisciplinary team to determine a resident's ability to safely administer their own medications if clinically appropriate for one (1) (Resident #49) of 22 residents reviewed. Specifically, Resident #49 was observed self-administering insulin without an interdisciplinary team assessment, care plan or physician order. In addition, Licensed Practical Nurse #2 provided wrong instructions when Resident #49 looked to them for directions.This is evidenced by:The facility's Policy and Procedure titled, Self-Administration of Medication, undated, documented the purpose is to provide a standardized process for evaluating, approving, and monitoring resident self-administration of medications, supporting resident independence while ensuring safety and regulatory compliance. The facility may permit residents to self-administer medications when the interdisciplinary team (IDT) determines it is safe and clinically appropriate. The facility retains responsibility for oversight, storage safety, and documentation of all medications self-administered.Eligibility & Assessment:1. A comprehensive assessment must be completed prior to approval, evaluating:o Cognitive ability and judgmento Physical ability (vision, dexterity, mobility)o Understanding of medication regimeno Ability to safely store medications2. The Registered Nurse and Interdisciplinary team must document all findings in the electronic medical record.3. The attending physician/Nurse Practitioner must provide a written order authorizing self-administration.1. Provider order must specify:o Medications approved for self-administrationo Required supervision level (independent, cueing, partial assist)o Storage requirements2. The resident's care plan must reflect self-administration goals, education, and monitoring intervals.Nursing staff must educate the residents on: Medication name, purpose, dose, route, frequency Possible side effects and when to report symptoms Safe handling and infection-control principles Facility-approved medication storage methods Education must be documented. Resident #49 was admitted to the facility with a diagnoses of alcoholic cirrhosis of liver (permanent scarring that damages your liver related to alcohol use), type 2 diabetes mellitus (where the pancreas cannot make or fail to use insulin properly and eventual insulin deficiency) and gait abnormality (difficulty walking). The Minimum Data Set (an assessment tool) dated 07/21/2025 documented the resident usually could understand and was understood by others with intact cognition.The Comprehensive Care Plan for Resident #49 last revised, 10/17/2025 did not have documented evidence of a focus, goal and or intervention for resident to self-administer medication.The Medication Administration Report for Resident #49 dated January 2026 documented give FlexPen Subcutaneous Solution Pen, injector 100 Unit/ml (Insulin Aspart) Inject 12 units subcutaneously before meals for diabetes. Start date 11/19/2025 at 4:30 PM.The Physician orders for Resident #49 documented FlexPen Subcutaneous Solution Pen, injector 100 Unit/ml (Insulin Aspart) Inject 12 units subcutaneously before meals for diabetes. There was no documented evidence of physician order for Resident #49 to self-administer their medications.There was no documented evidence of assessments by the interdisciplinary team for Resident #49 to self-administer medications.During an observation on 1/20/2026 at 11:30 AM, Licensed Practical Nurse #2 stated Resident #49 was to self-administer their medication in preparation for discharge to home. Licensed Practical Nurse #2 entered Resident #49's room and handed them Insulin Aspart Flex Pen and told them to administer 12 units. During an interview on 1/20/2026 at 12:13PM, Director of Nursing #1 stated Resident #49 self-administer their medications. The nursing staff had been observing resident self-administer in preparation for discharge home. Director of Nursing #1 stated prior to self-administering medications the resident would be assessed for capacity by a multidisciplinary team, a physician writes order to self-administer medication and care plan updated to reflect resident could self-administer medications. The resident would be educated and nurse observing resident documents observation. Director of Nursing #1 was unable to locate any documentation of a physician order, assessment by interdisciplinary team and or care plan for Resident #49 to self-administer medications. 10 New York Code Rules and Regulations 415.3(e)(1)(vi)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during a recertification survey, the facility did not ensure that residents received treatment and care in accordance with professional standards of practice for two (2) (Resident's #66 and 67) of 22 residents reviewed. Specifically, Resident 66's continuous tube feed pump was stopped for more than 20 minutes, and Licensed Practical Nurse #2 did not receive instruction from the Medical Provider when Resident #67 gagged or had difficulty swallowing their medications and crushed resident's medication. This is evidenced by: The facility policy titled Medical Practitioner Notification of Change in Condition reviewed/updated on 1/2026, documented the facility would ensure quality of care for all residents by notifying the Primary Care Practitioner or the on- call Practitioner with changes in resident condition to prevent a delay in treatment. Resident #66 Resident #66 was admitted to the facility with diagnoses of acute respiratory failure (lungs cannot release enough oxygen into the blood), type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe). The Minimum Data Set (an assessment tool) dated 10/20/2025, documented the resident was moderately cognitively impaired, could be understood and understand others.Resident #66's Comprehensive Care Plan for Tube Feeding initiated 11/25/2025, documented the resident required tube feeding related to dysphagia. Goals included: the resident would maintain adequate nutrition and hydration status as evidenced by weight stable, no signs or symptoms of malnutrition or dehydration through review date and the resident would remain free of side effects or complications related to tube feeding through next review date. Some interventions included: monitor/document/report as needed any signs of symptoms of aspiration, fever, shortness of breath, tube dislodged, infection at tube site, self-extubating tube dysfunction or malfunction, abnormal breath/lung sounds, abnormal lab values, abdominal pian, distension, tenderness, constipation or fecal impaction, diarrhea, nausea/vomiting, dehydrationA Physician Order dated 11/25/2025 at 6:00 AM, documented enteral feed order every shift enteral nutrition via continuous: novasource renal amount:40 cubic centimeters per hour via gastrostomy tube (G-tube).During an observation on 1/04/2026 at 12:45 PM, Resident #66 was observed in bed and their tube feed pump was stopped with an error message and alarm sounding for more than 10 minutes. Call light was put on and there was no response for another 10 minutes. Surveyor then found a staff member and alerted them that the pump needed attention. Resident #67Resident #67 was admitted to the facility with diagnoses of Wernicke's Encephalopathy (a severe, acute neurological condition caused by a critical deficiency of thiamin (vitamin B1), dementia (a group of conditions that cause a progressive decline in cognitive abilities), and adult failure to thrive (a geriatric syndrome characterized by complex multi-factorial decline in physical, mental, and functional health). The Minimum Data Set, dated [DATE], documented the resident was usually understood , usually understand others, and had severe cognitive impairment. A nursing progress note dated 7/16/2025 at 2:31 PM written by Registered Nurse #1, documented Resident #67 appeared weak and continued to refuse food. The Nurse Practitioner was made aware and ordered clysis (a safe method of delivering fluids into the subcutaneous fatty tissue). It further documented that they spoke with the resident's representative and Resident #67's Medical Orders for Life Sustaining Treatment (MOLST) was changed to Do Not Resuscitate (DNR), Do Not Intubate (DNI), Comfort Care, no feeding tube, no dialysis, use antibiotics, intravenous fluids, and send to the hospital if pain cannot be controlled. A nursing progress note dated 7/25/2025 at 6:10 PM written by Registered Nurse #1, documented lab results were reviewed with the Nurse Practitioner and new orders were obtained for Cipro, Flagyl, and probiotic for colitis. Resident #67's appetite remained poor and fluids were encouraged. They required extensive assistance for activities of daily living, were dependent on toileting, and refused to get out of bed. A nursing progress note dated 7/26/2025 at 10:02 PM written by Licensed Practical Nurse #2, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented Resident #67 started gagging when medications were put in their mouth and the resident spit them out. If further documented that Licensed Practical Nurse #2 crushed the resident's medication and reattempted to give them to the resident. Resident #67 started gagging and brought them back up.There was no documented evidence that Licensed Practical Nurse #2 received instruction from the medical provider to crush the resident's medications on 7/26/2025. There was not documented evidence that the Medical Provider was informed of Resident #67's gagging or swallowing difficulties when taking their medications on 7/26/2025.During an interview on 1/21/2025 at 12:13 PM, Nurse Practitioner #1 stated the facility would normally contact them if a medication was not administered or if a resident refused a medication.During an interview on 01/22/2026 at 11:23 AM, Licensed Practical Nurse #2 stated if a resident gagged on their medications, they would first get the medications out of the resident's mouth, then call the Medical Provider for any recommendations. They stated the Medical Provider might recommend crushing the medications. Licensed Practical Nurse #2 further stated they would never crush medication without a physician's order, because certain medication could not be crushed. During an interview on 1/20/2026 at 12:13PM, Director of Nursing #1 stated certified nurse aides are not licensed to monitor tube feeds and the Licensed Practical Nurse should have monitored the tube feed infusion.During an interview on 1/22/2026 at 11:12 AM, Director of Nursing #1 stated if a resident gagged on pills or had difficulty swallowing pills, they would hold the medication and contact the Medical Provider. They would also contact the pharmacy to see if the medications could be crushed or if they could come in a different format. They stated the Medical Provider would let them know how to proceed. Director of Nursing #1 stated that if a resident was nearing end of life, they would follow the same process. The Medical Provider might transition the resident to comfort medications at that point. 10 New York Codes, Rules and Regulations 415.12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335685	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palatine Nursing Home	154 Lafayette Street Palatine Bridge, NY 13428

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review, and interviews conducted during a recertification survey, the facility did not ensure that residents were free of any significant medication errors for two (2) (Resident #s 36 and 62) of 14 residents reviewed. Specifically, (a.) on 1/20/2026 at 08:00 AM, Resident #36's order to administer Lidocaine 4% patch was omitted. (b.) On 1/21/2026, Resident #62 had an order to receive six (6) medications at 07:00 AM; Licensed Practical Nurse #3 documented they administered the medications at 08:07 AM but was observed administering the medications at 09:20 AM.This is evidenced by:The facility's Policy and Procedure titled Medication Error Policy reviewed 1/2026 documented the facility shall maintain systems to ensure medications are administered accurately, safely, and in accordance with physician orders, professional standards of practice.Medication Error: Any preventable event that may cause or lead to inappropriate medication use or resident harm, including: Wrong resident Wrong medication Wrong dose Wrong route Wrong time (outside acceptable time frame) Omission Unauthorized medication Improper preparation or documentationNear Miss: An error identified and corrected before reaching the resident. Resident #36Resident #36 was admitted to the facility with a diagnoses of anxiety (excessive fear of or apprehension about real or perceived threats, leading to altered behavior), depression (persistently low mood, loss of interest or pleasure in activities, and, often, low energy), and morbid obesity (a chronic, life-threatening condition defined by excessive weight typically 100 pounds or more over ideal body weight). The Minimum Data Set (an assessment tool) dated 12/27/2025 documented the resident usually could understand and was understood by others with intact cognition.During an observation of the Medication Administration Record on 1/20/2026 at 11:20 AM the 8:00 AM dose of Lidocaine 4% patch was highlighted not given for Resident #36. Licensed Practical Nurse #2 stated they did not give the medication because it was not available. They stated they called pharmacy the previous day and were waiting for the medication. Licensed Practical Nurse #2 stated the physician or Director of Nursing had not been notified because they were waiting for the medication. They stated they were aware the medication was late but were going to administer when availableResident # 62Resident #56 was admitted to the facility with a diagnosis of unspecified sequelae of cerebral infarction (long-term, lasting effects or complications following a stroke (ischemic brain injury); Hemiplegia and Hemiparesis left non-dominant side (motor impairments affecting one side of the body following a stroke); and generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 10/07/2025 documented the resident usually could understand and was understood by others with intact cognition.During an observation on 1/21/2026 at 9:20 AM, Licensed Practical Nurse #3 was observed administering medication to Resident #62. Licensed Practical Nurse #3 stated they administered Aspirin 81 milligrams, Keppra 250 milligrams, Losartan 25 milligrams, Metoprolol Extended Release 25 milligrams, Pantoprazole Delayed Release 40 milligrams, Potassium Chloride Oral Solution 60 milligrams / 22.5 milliliters all were due at 8:00 AM. The Medication Administration Record for resident #62 documented give the following medications at 07:00AM Aspirin 81 milligrams, Keppra 250 milligrams, Losartan 25 milligrams, Metoprolol Extended Release 25 milligrams, Pantoprazole Delayed Release 40 milligrams, Potassium Chloride Oral Solution 60 milligrams / 22.5 milliliters which were previously signed as given at 8:07 AM by Licensed Practical Nurse #3 although, Licensed Practical Nurse #3 was actually observed administering the medications at 9:20 AM.During an interview on 1/20/2026 at 12:13 PM, Director of Nursing #1 stated Lidocaine 4% patch was available onsite if needed. It was the responsibility of the medication nurse to notify the unit manager, Director of Nursing or physician if a medication was not given.During an interview on 1/21/2026 at 9:30 AM, Licensed Practical Nurse #3 stated Resident #62 used to receive their medications at 8:00 AM, and there must have been a change in the order to now give at 7:00 AM. During an interview on 1/21/2026 at 10:00 AM, Director of Nursing #1 stated some resident's medication times were changed to 7:00 AM and some at 8:00 AM to even out the medication pass. They stated the nurse administering (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335685	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palatine Nursing Home	154 Lafayette Street Palatine Bridge, NY 13428

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication should follow policy and check for the right patient, right medication, right time, right dose and right route. 10 New York Codes, Rules, and Regulations 415.12(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the recertification survey, the facility did not maintain medical records in accordance with accepted professional standards and practices. The records were not accurately documented or completed for two (2) residents (Resident #7 and Resident #12) of 22 reviewed. Specifically, Resident #7's and Resident #12's Medication Administration Records and Treatment Administration Records were missing documentation indicating that medications and treatments were administered and completed as ordered. This is evidenced by: Resident #7 Resident #7 was admitted to the facility with diagnoses of post-traumatic stress disorder (a mental health condition triggered by experiencing or witnessing terrifying events like war, abuse, or accidents), type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and chronic atrial fibrillation (an irregular and often very rapid heart rhythm). The Minimum Data Set (an assessment tool) dated 12/27/2025, documented the resident was cognitively intact, could be understood and could understand others.The Medication Administration Record for January 2026 (1/01/2026 to 1/20/2026) documented the following medications were not documented as administered: Acetaminophen Extra Strength 500 milligrams (non-opioid pain medication) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Finasteride 5 milligrams (medication to treat obstructive uropathy) on 1/12/2026 at 6:00 PM Furosemide 80 milligrams (medication to treat congestive heart failure) on 1/19/2026 at 3:00 PM Lantus SoloStar Subcutaneous Solution Pen-Injector 100 unit/milliliter (medication to treat diabetes) on 1/12/2026 at 8:00 PM and 1/14/2026 at 8:00 PM. Metformin 1000 milligrams (medication to treat diabetes) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Metoprolol Succinate 100 milligram (medication to treat atrial fibrillation) 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Omeprazole 40 milligram (medication to treat gastro intestine) on 1/12/2026 at 8:00 PM and 1/14/2026 at 8:00 PM Potassium Chloride 40 milliequivalent (electrolyte supplement) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Pro-Stat Oral Liquid 30 milliliters (supplement) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Sertraline 100 milligram (anti-depressant) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Spironolactone 25 milligram (medication to treat congestive heart failure) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Stiolto Respimat Inhalation Aerosol Solution 2.5-2.5 micrograms per actuation (inhaler) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, and 1/19/2026 at 8:00 AM Trazadone 100 milligram (medication to treat insomnia) on 1/12/2026 at 8:00 PM and 1/14/2026 at 8:00 PM Weekly weights every Monday for congestive heart failure/fluid restriction not documented on 1/05/2026, 1/12/2026, and 1/19/2026 Apixaban 5 milligram (medication to treat atrial fibrillation) on 1/12/2026 at 8:00 PM, 1/14/2026 at 8:00 PM, and 1/19/2025 at 5:00 AM Buspirone 10 milligram (anti-anxiety medication) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, 1/12/2026 at 6:00 PM, and 1/19/2026 at 8:00 AM Ferrous Sulfate 325 milligram (supplement) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, 1/12/2026 at 8:00 PM, 1/14/2026 at 8:00 PM, and 1/19/2026 at 8:00 AM Lac-Hydrin Five External Lotion 5% (for dry skin) on 1/12/2026 on 1/12/2026 on 3-11 shift and 1/19/2026 on 7-3 shift Mucinex 600 milligram (allergy medication) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, 1/12/2026 at 8:00 PM, 1/14/2026 at 8:00 PM, and 1/19/2026 at 8:00 AM Pataday Ophthalmic Solution 0.1% (for dry eyes) on 1/12/2026 at 8:00 PM, 1/14/2026 at 8:00 PM, and 1/19/2026 at 8:00 AM Restasis Ophthalmic Emulsion (for dry eyes) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, 1/12/2026 at 8:00 PM, 1/13/2026 at 8:00 AM, 1/14/2026 at 8:00 PM, 1/19/2026 at 8:00 AM. Vitamin C 500 milligram (supplement) on 1/02/2026 at 8:00 AM, 1/06/2026 at 8:00 AM, 1/12/2026 at 8:00 PM, 1/14/2026 at 8:00 PM, and 1/19/2026 at 8:00 AM. Novolog FlexPen Subcutaneous Solution Pen Injector 100 unit per milliliter (medication to treat (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026
NAME OF PROVIDER OR SUPPLIER Palatine Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 154 Lafayette Street Palatine Bridge, NY 13428	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diabetes) on 1/02/2026 at 8:00 AM and 12:30 PM, 1/06/2026 at 8:00 AM and 12:30 PM, 1/09/2026 at 12:30 PM, 1/12/2026 at 12:30 PM and 5:00 PM, 1/13/2026 at 12:30 PM, and 1/19/2026 at 8:00 AM and 12:30 PM Pen Needles Miscellaneous 30G X 5 MM on 1/02/2026 at 8:00 AM and 12:00 PM, 106/2026 at 8:00 AM and 12:00 PM, 1/09/2026 at 12:00 PM, 1/12/2026 at 12:00 PM, 4:00P PM, and 8:00 PM, 1/13/2026 at 12:00 PM, 1/14/2026 at 8:00 PM, and 1/18/2026 at 8:00 AM and 12:00 PMThe Treatment Administration Record for January 2026 (1/01/2026 to 1/20/2026) documented the following treatments were not documented as administered or completed: Weekly Skin Check not documented on 1/01/2026 and 1/08/2026 Eucerin Daily Hydration External Lotion (for dry skin) on 1/01/2026 7-3 and 3-11 shift, 1/02/2026 7-3 and 3-11 shift, 1/03/2026 7-3 shift, 1/04/2026 7-3 shift, 1/05/2026 7-3 PM and 3-11 PM shift, 1/06/2026 7-3 and 3-11 shift, 1/07/2026 3-11 shift, and 1/08/2026 7-3 shift. Order was discontinued on 1/08/2026 at 2:09 PM Muscle rub (for pain) on 1/01/2026 7-3 and 3-11 shift, 1/02/2026 7-3 and 3-11 shift, 1/03/2026 7-3 shift, 1/04/2026 7-3 shift, 1/05/2026 7-3 and 3-11 shift, 1/06/2026 7-3 and 3-11 shift, 1/07/2026 3-11 shift, 1/08/2026 713 shift, 1/09/2026 7-3 shift, 1/10/2026 7-3 shift, 1/12/2026 7-3 and 3-11 shift, 1/13/2026 7-3 and 3-11 shift, 1/14/2026 7-3 and 3-11 shift, 1/19/2026 7-3 shiftDuring an interview on 1/21/2026 at 2:41 PM, Licensed Practical Nurse #2 stated they did not know why there were blanks or missing documentation on the Medication Administration Record and Treatment Administration Record for Resident #7, although she had worked on some of the days where there was missing documentation. Licensed Practical Nurse #2 stated Resident #7 was given their medications on the days they worked, but they probably did not sign for them. Resident #12 Resident #12 was admitted to the facility with diagnoses of an unspecified fracture of the sacrum, a break or crack in the sacrum, which is the large triangular bone at the base of the spine; cerebral infarction, a medical condition in which blood flow to the brain is interrupted, leading to brain tissue damage; and heart failure, a chronic, progressive condition in which the heart muscle is too weak or too stiff to efficiently pump enough oxygen-rich blood to meet the body's needs. The Minimum Data Set, dated [DATE] documented that the resident could be understood, could understand others, and was severely cognitively impaired.The Medication Administration Record for January 2026 (1/01/2026 to 1/16/2026) documented the following medications were not documented as administered: Aspirin 81 (blood thinner) on 1/02/2026 at 8:00 AM and 1/06/2026 at 8:00 AM Latanoprost Ophthalmic Solution 0.005% (for glaucoma) on 1/06/2026 at 6:00 PM, 1/12/2026 at 6:00 PM, and 1/14/2026 at 6:00 PM Metoprolol 25 milligram (medication to treat hypertension) on 1/02/2026 at 8:00 AM and 1/06/2026 at 8:00 AM Valsartan 40 milligram (medication to treat hypertension) on 1/02/2026 at 8:00 AM and 1/06/2026 at 8:00 AM Tylenol Extra Strength 500 milligram (non-opioid pain medication) on 1/02/2026 at 9:00 AM, 1/06/2026 at 9:00 AM and 6:00 PM, 1/12/2026 at 6:00 PM, and 1/14/2026 at 6:00 PMThe Treatment Administration Record for January 2026 (1/01/2026 to 1/16/2026) documented the following treatments were not documented as administered or completed: Vital signs weekly was not documented as completed on 1/04/2026 and 1/11/2026 Weekly skin check was not documented as completed on 1/02/2026 A Medication Error/Omission Report dated 10/03/2025 at 3:00 PM, documented Licensed Practical Nurse #2 was responsible for a transcription error with comment that the medication was dispensed to the resident on 3 different occasions and was not signed off for in the Medication Administration Record. The order was for morphine sulfate oral solution, 20 milligram per milliliter, give 1 milliliter every hour as needed.During an interview on 1/21/2026 at 11:08 AM, Licensed Practical Nurse #2 stated they worked full time on the unit. They stated if there was a blank or missing documentation in the Medication Administration Record, it meant that the medication was not passed or that the medication was passed but was not signed for. They further stated, they did not want to speak for others, but it generally meant that it was not done. Licensed Practical Nurse #2 stated if they were running late administering medication or a medication was not available, they would contact the Medical Provider, maybe get a new order, check the Omnicell, or call the pharmacy. They stated if a resident refused a medication, they would reapproach the resident a few more times and if they were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palatine Nursing Home	154 Lafayette Street Palatine Bridge, NY 13428

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsuccessful, they would contact the Medical Provider. They would also provide the resident with education as to why they should take their medications. Licensed Practical Nurse #2 stated that they were not aware of Resident #7 refusing any medications.During an interview on 1/21/2026 at 11:17 AM with Director of Nursing #1, they stated if it was not documented, then it was not done when questioned about blanks or missing documentation on the Medication Administration Record and the Treatment Administration Record. They stated staff might have missed signing for the administration of the medication or maybe the medication was not available. They would have to speak with the specific nurse surrounding the circumstances. Director of Nursing #1 stated if a medication was not given for some reason or refused, the Medical Provider should be called for new orders. It would also need to be documented as a progress note or directly in the Medication Administration Record. When asked who was responsible for reviewing the Medication Administration Records and Treatment Administration Records for completion, they stated the nurse should check their own work at the end of their shift to make sure everything was done.During an interview on 1/21/2025 at 12:13 PM, Nurse Practitioner #1 stated the facility would normally contact them if a medication was not administered or if a resident refused a medication. They stated if a minor medication such as eye drops were not administered or refused, they did not expect staff to call them for that, but rather to write it in the communication book. However, if it were a medication such as an antidepressant or insulin, they stated they should be notified and would make recommendations as appropriate. 10 New York Codes, Rules, and Regulations 415.22(a)(1-4)

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335685	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palatine Nursing Home	154 Lafayette Street Palatine Bridge, NY 13428

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation and interviews conducted during the recertification survey, the facility did not maintain all mechanical, electrical, and patient care equipment in safe operating condition. Specifically, the self-closing device on the walk-in freezer was not functioning properly as intended. This is evidenced by:During observations conducted on 1/14/2026 at 11:00 AM, as part of the inspection of the walk-in freezer, the self-closing mechanism on the main entry door was found to be inoperable and was not pulling the door closed to ensure a tight seal.During an interview on 1/15/2026 at 12:00pm, Environmental Director #1 stated that they would address the issue immediately as they were not aware of it not functioning properly. 10 New York Codes, Rules, and Regulations 415.5(e)(1)(2)