STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335692	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Josephs Place	160 East Main Street Port Jervis, NY 12771

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification and abbreviated surveys (2796313), the facility did not ensure that residents knew how to file a grievance or were informed of the response to the grievance for 12 of 12 residents (Resident #11, Resident #29, Resident #34, Resident #13, Resident #20, Resident #24, Resident #25, Resident #8, Resident #35, Resident #41, Resident #14, Resident #26) interviewed during resident council and one (1) of three (3) residents reviewed for care planning (Resident #17). Specifically, 1) Residents interviewed during resident council were not aware of the grievance process and there was no documented evidence listing the grievances and response to grievances; 2) Resident #17's representative had multiple concerns and grievances regarding Resident #17's plan of care that were inconsistently addressed and documented. The findings included:1)The facility Grievances policy dated 11/2016 documented the purpose as supporting each resident's right to voice grievances and assuring that after receiving a complaint/grievance, the facility actively seeks a resolution and keeps the resident/resident representative appropriately apprised of its progress toward resolution. During an interview on 03/24/2026 at 9:18 AM the Social Services/Admissions Coordinator stated they were the Grievance Officer and if they received a complaint, they would interview residents. They stated they would also email Administration with related information if it was something they could not resolve. They stated they could not provide a grievance log or grievance form for grievances.During an interview on 03/24/2026 at 9:37 AM, the supervising Administrator stated the Social Services/Admissions Coordinator was the Grievance Officer and should have a record of all grievances. During a Resident Council meeting on 03/24/2026 at 10:30 AM, Resident #8 stated residents air grievances in the meeting but outside the meeting the process is unclear. Other participating residents confirmed they did not know how to file grievances. During a follow up interview on 03/26/2026 at 11:47AM, the Social Services/Admissions Coordinator stated if they were made aware of a complaint or incident they would speak to the resident and try to resolve the issue. They would forward it to the Administrator or Director of Nursing if applicable. They stated administration would complete the additional investigation and follow through on those cases. They stated there were no forms or documentation to track grievance progress and resolution.During an interview on 03/26/2026 at 12:03 PM the Director of Nursing stated grievances should be monitored by Social Services and should have the nature of the complaint and what the resolution was. They stated their process was informal and depended on circumstances. They stated they discussed issues in morning meetings and residents expressed concerns during resident council. They stated the process was not completely clear and could be improved.2) Resident #17 had diagnoses that included cerebral infarction, occlusion and stenosis of the left carotid artery (blockage of the artery supplying blood to the brain on the left side), and myocardial infarction (heart attack).The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition and that the resident and family were involved in assessment and goal setting. During an interview on 03/27/2026 at 9:10 AM Resident #17's representative stated there were multiple concerns expressed regarding Resident #17's care including miscommunication (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335692	A. Building B. Wing	03/30/2026

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	between nursing and rehabilitation, discharge planning, scheduling appointments, call bell response time, personal property, resident preferences, nutrition and proper diet. They stated they communicated everything to Administration and submitted everything via email and paper copies. They stated they had a family meeting on 03/11/2026 but felt dismissed. They stated they were not provided with updates unless they persisted. They stated communication was very poor. During an interview on 03/30/2026 at 10:59 AM, the Social Services/Admissions Coordinator stated they had a family meeting on 03/11/2026 to discuss concerns Resident #17's representative had since Resident #17 was admitted , but no documented evidence of how each grievance was addressed and/or resolved. During an interview on 03/30/2026 at 1:16 PM, the Director of Nursing stated Resident #17's representative expressed many concerns since Resident #17 was admitted . They stated most concerns were verbally discussed with the representative. They stated they did not document and investigate every complaint but did have a family meeting on 03/11/2026.10NYCRR 415.3(d)(1)(ii)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews during the recertification and abbreviated surveys (#2796313 and 2725477) the facility did not ensure that residents unable to carry out activities of daily living received the necessary assistance with toileting for one (2) of four (4) residents (Resident #27 and #17) reviewed for activities of daily living and other residents that expressed a delay in call bell times during the Resident Council meeting. Specifically, Resident #27 was not provided toileting assistance as needed to maintain or improve their ability to carry out activities of daily living. 2) Resident #17 was observed with their call bell on and not receiving care timely. 3) Other residents expressed concerns with not getting needs met due to delays in response to call bells, and delays were observed. Findings include:The facility policy Activities of Daily Living, last revised 04/2018, documented the facility shall ensure a resident is given the appropriate treatment and services to maintain or improve their ability to carry out the activities of daily living, including elimination and toileting. The facility No Pass policy last revised 06/2025 documented that patient safety is the responsibility of all employees and all staff will respond to patients or visitors in need. If they cannot help, they will find a staff member that can. Never pass the call light by, observe patient privacy, provide what they are asking for, access someone who can; safety first, smile and use the acronym-acknowledge, introduce, duration, explanation, and thank you.1) Resident #27 had diagnoses that included Parkinson's disease, dementia, and heart disease.The Annual Minimum Data Set (an assessment tool) dated 01/22/2025, documented the resident had severely impaired cognition, was dependent on staff for toileting hygiene and was always incontinent for bowel and bladder.Resident #27's care plan dated 01/19/2024 documented the resident had bladder incontinence related to impaired mobility, disease process, Parkinsons, and dementia. The intervention dated 01/19/2024 documented to check the resident for incontinence and change clothing as needed after incontinence episodes.Resident #27's care plan dated 03/06/2024 documented the resident was at risk for falls related to poor communication/comprehension/effects of Parkinson disease, poor balance, poor communication/comprehension, and unsteady gait. The intervention dated 04/24/2025 documented to anticipate toileting needs every two (2) hours and assist to the toilet.January, February and March 2026 Kardex documented the staff was to anticipate the resident's toileting needs every two (2) hours and to assist to the toilet. The resident required maximum assistance with one (1) staff member for toilet use and the resident required assistance of 2 staff for transfers.The January 2026 certified nurse aide documentation survey report had no documentation on 12 shifts for toileting the resident and on 59 occasions for performing two (2) hour checks on the resident.The February 2026 certified nurse aide documentation survey report had no documentation on 6 shifts for toileting the resident and on 27 occasions for performing two (2) hour checks on the resident.The March 2026 certified nurse aide documentation survey report had no documentation on 2 shifts for toileting the resident, and on 9 occasions for performing two (2) hour checks on the resident.A review of the 1/28/2026 Nursing Home Investigative Report documented that on 01/22/2026 at 3:00 PM, Resident #27's Family Member #1 discovered that the resident's e clothing and wheelchair cushion were saturated with urine. The Administrator was notified and confirmed the Residents #27 urine saturated clothing and wheelchair cushion. Certified Nurse Aide #13 was assigned to assist with the activities of daily living and certified nurse accountability tasks for Resident #27 from 07:00 AM to 03:00 PM on 01/22/2026. Certified Nurse Aide #13 stated they did not change the resident at all during the eight-hour shift and went home without doing any end of day cares for the resident or informing anybody at any point through the shift that they were unable to care for the resident.In an undated statement, Certified Nurse Aide #13 stated they did not check on Resident #27 until 11:00 AM on 01/22/2026.A staff assignment sheet dated 01/22/2026 documented Certified Nurse Aide #13 was not assigned to Resident #27. Certified Nurse Aide #13 was assigned 13 other residents.During an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview on 3/30/2026 at 12:04 PM, the Director of Nursing stated after Resident #27's family member reported that the resident was saturated in urine they checked on all the residents on Certified Nurse Aide #13's assignment. They stated the assignment sheet must have had a mistake as Certified Nurse Aide #13 admitted to not providing care.In an interview on 03/29/2026 at 6:05 PM, Resident #27's Family Member #2 stated they visited the facility every Sunday around 4:00 PM and had observed the resident with a strong urine smell three (3) times in the past few months. When notified of the urine, the facility staff cleaned the resident. It had been better the last six (6) weeks.In an interview on 03/30/2026 at 9:41 AM, Certified Nurse Aide #9 stated Resident #27 was checked every two (2) hours, after meals and before leaving at the end of day. They stated Resident #27 was able to stand to have their brief removed and could tell staff when they needed to be cleaned. 2) Resident #17 had diagnoses including cerebral infarction (stroke), and myocardial infarction (heart attack).The admission 5 Day Minimum Data Set, dated [DATE] documented the resident had moderately impaired cognition, no behaviors, and required maximal assistance with toileting, moderate assistance to shower, set up for upper body dressing, and moderate assist with lower body dressing.During an observation and interview on 03/23/2026 at 11:22 AM Resident #17's call bell was ringing and they stated they waited a long time for cares. They stated they had been waiting since 9:00 AM. At 11:31 AM staff responded to bell and assisted with morning cares.During an observation and interview on 03/25/2026 at 10:02 AM, upon surveyor entry to the unit, Resident #13 and Resident #17 were in bed and the call bell for their room was ringing. Resident #13 stated they had been waiting to get washed, dressed, and out of bed. They stated it was late, and they were usually up by that time. They stated they had been waiting for half an hour. At 10:20 A.M. Certified Nurse Aide #7 arrived to assist with care. During an interview on 03/27/2026 at 9:10 AM Resident #17's Representative stated call bell response time was very concerning. They stated they communicated their concerns to the staff, including specific episodes on 02/27, 02/28, and 03/07/2026, when the time exceeded one (1) hour. During an interview on 03/30/2026 at 1:16 PM the Director of Nursing stated call bells should be responded to when heard. They stated the time it took for staff to respond depended on the staff scheduled for the shift. They stated it was difficult to give a reasonable time frame, but thirty to sixty minutes was not acceptable. 3) The December 2025 Resident Council Minutes documented residents stated that call bell wait-times had improved some but continued to be answered on the longer side. They felt more nursing staff were needed. The January 2026 Resident Council Minutes documented that residents stated that call bell wait times continued to be on the longer side.The February 2026 Resident Council Minutes documented that call bell wait-times continued to be too long.Call bell audits completed by facility staff on 03/6/2026, 03/07/2026, 03/10/2026, and 03/12/2026 in response to call bell complaints documented a total of 23 observations. The longest recorded observation was 45 minutes followed by another 15 minutes for room [ROOM NUMBER] on 03/10/2026.During the Resident Council meeting on 03/24/2026 at 10:30 AM, Resident #26 stated response to call bells was too long and could be anywhere from 15 minutes to an hour regardless of the shift. Resident #8 stated on weekends they often only had 3 (three) certified nurse aides scheduled, contributing to the long call bell wait times. During an observation on 03/25/2026 at 9:36 AM, the call bell for room [ROOM NUMBER] bed was observed ringing. At 09:45 AM the bell continued to ring, and staff were observed passing the room. At 9:50 AM Certified Nurse Aide #9 entered the room and asked Resident #22 what they needed. Resident #22 stated they needed the bedpan. Certified Nurse Aide #9 asked why they had not let them know earlier when they were providing care. Resident #22 stated they did not have to use the bedpan earlier. Certified Nurse Aide #9 stated they would be back and returned at 10 AM to provide assistance.During an observation on 03/27/2026 at 11:00 AM the call bell was ringing for room [ROOM NUMBER]. A medication nurse was observed passing medications in the hallway outside of room [ROOM NUMBER]. The Social Work/Admissions Coordinator came out of their office across from the room but did not enter room [ROOM NUMBER]. At 11:11 AM Certified Nurse Aide #7 passed room [ROOM NUMBER] and Unit Clerk (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#8 passed room [ROOM NUMBER]. At 11:17 AM Unit Clerk #8 was asked to view the time on the call bell device and stated it was 27 minutes. At 11:19 AM, the call bell stopped ringing. During an interview on 03/27/2026 at 12:53 PM, Resident #22's Spouse stated they received at least 10 phone calls from Resident #22 during the overnight shift requesting that they call the nurses' station because they were waiting for someone to respond to their call bell. They stated when they called the nurses' station to get assistance for Resident #22, it took a long time for someone to answer the phone.During an interview on 03/30/2026 at 1:16 PM the Director of Nursing stated call bell response was a no pass policy. Call bells should be responded to when heard. They stated the time it took for staff to respond depended on the staff scheduled for the shift. They stated it was difficult to give a reasonable time frame, but thirty to sixty minutes was not acceptable. 10 NYCRR 415.12 (a) (3)

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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 observation, interview, and record review during the recertification and abbreviated surveys (2796313), the facility failed to ensure that residents received treatment and/or care in accordance with professional standards of practice for one (1) of four (4) residents (Resident #17) reviewed for Activities of Daily Living. Specifically, Resident #17 was not scheduled to have a follow up appointment with the cardiologist within the time frame indicated on the patient hospital discharge instructions. Findings include:Resident #17 had diagnoses that included cerebral infarction, occlusion and stenosis of the left carotid artery (blockage of the artery supplying blood to the brain on the left side), and myocardial infarction (heart attack).The Patient Discharge Instructions dated 02/05/2026 documented schedule follow up with cardiology within one (1) month. The admission Minimum Data Set, dated [DATE] documented moderately impaired cognition and the resident and family were involved in assessment and goal setting. During an interview on 03/27/2026 at 9:10 A.M., Resident #17's representative stated Resident #17 was supposed to have a follow-up appointment with the cardiologist within one month of being admitted to the facility. They stated they had discussed the hospital discharge instructions and the appointment needed with the Director of Nursing but did not receive any assistance and scheduling was delayed. With persistence, they were finally able to get the appointment scheduled for 04/01/2026.During an interview on 03/30/2026 at 1:16 P.M. the Director of Nursing stated Resident #17's representative told them that a cardiology consultation needed to be scheduled for Resident #17 after they were admitted to the facility. They stated it should have been scheduled sooner but they did not see the follow up appointment on the discharge summary. They stated they were not aware there were additional discharge papers that documented the need to schedule a follow-up appointment with cardiology. 10NYCRR 415.12