STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335309	A. Building B. Wing	05/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Steuben Center for Rehabilitation and Healthcare	7009 Rumsey Street Extension Bath, NY 14810

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure medications and treatments were provided as ordered and failed to obtain medical provider direction when ordered medications and treatments were not administered for two (2) of three (3) residents reviewed (Resident #4 and Resident #14). Specifically, Resident #14 did not receive a physician-ordered antipsychotic (prescription drugs primarily used to manage psychosis, such as delusions and hallucinations) medication on three (3) occasions when the medication was unavailable, and Resident #4 did not receive a physician-ordered pain patch on three (3) occasions when the treatment was not applied as ordered.The findings include: The facility policy, Medication Administration, last revised December 2019, included medications must be administered in accordance with physician orders, including required timeframes.1.Resident #14 had diagnoses including bipolar disorder (a mental health condition characterized by severe shifts in mood, energy, and activity levels), diabetes, and peripheral vascular disease (a slow, progressive circulation disorder involving blood). The Minimum Data Set (a resident assessment tool) dated 09/25/2025 revealed the resident was cognitively intact and received antipsychotic medications on a routine basis.Review of the Comprehensive Care Plan, initiated 09/30/2025, revealed Resident #14 used psychoactive (chemical substances that cross the blood-brain barrier to interact with the central nervous system) medications related to depression and bipolar disorder. Interventions included administering medications as ordered by the physician.Review of Resident #14's physician orders revealed an order dated 09/17/2025 for quetiapine fumarate (antipsychotic medication used to treat bipolar disorder) 400 milligrams by mouth at bedtime for bipolar disorder.Review of Resident #14's October 2025 Medication Administration Record revealed quetiapine fumarate was documented as code 9 (other/see nurse progress note) on 10/15/2025, 10/16/2025, and 10/28/2025. The medication was documented as administered on all remaining scheduled dates during October 2025.Review of Resident #14's progress notes revealed quetiapine fumarate was not administered on 10/15/2025 because it had not yet been delivered by the pharmacy and was not administered on 10/16/2025 because it remained on order. Additional record review did not include documented evidence the pharmacy was contacted, the medical provider was notified, or alternative orders were obtained when the medication was unavailable. Review of Resident #14's progress notes during this timeframe did not include documented evidence of mood changes, agitation, lethargy, or withdrawal symptoms.During an interview on 05/13/2026 at 2:50 PM, Licensed Practical Nurse #1 stated they could not remember the specific circumstances but believed the medication may not have been available from the pharmacy. Licensed Practical Nurse #1 stated medications should not be left unadministered when unavailable.During an interview on 05/14/2026 at 8:50 AM, the Director of Nursing stated when a medication is unavailable, the nurse is expected to follow up with the pharmacy and notify the medical provider. The Director of Nursing stated a medication error report should have been completed.During an interview on 05/14/2026 at 9:00 AM, Physician Assistant #1 stated when a medication is unavailable, nursing staff should contact the medical provider for alternative orders or instructions. Physician Assistant #1 stated failure to (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer quetiapine fumarate 400 milligrams could result in mood changes, agitation, lethargy, or withdrawal symptoms and an alternative medication may have been ordered until the medication became available.2.Resident #4 had diagnoses including dorsalgia (back pain), polyneuropathy (damage of multiple peripheral nerves causing numbness, tingling, or burning pain), and osteoporosis (a condition where bones become weak and brittle). The Minimum Data Set, dated [DATE] revealed Resident #4 was cognitively intact, experienced pain that occasionally limited daily activities, and received routine pain medication.Review of Resident #4's Comprehensive Care Plan, initiated 05/17/2017, revealed Resident #4 had a potential alteration in comfort related to immobility, polyneuropathy, vertebral compression fractures (occurs when the bony block in the spine collapses and can cause sudden sharp back pain and limited mobility), contractures (a permanent or prolonged shortening of muscles, tendons, ligaments, or skin causing joints to become stiff and rigid), and osteoporosis. Interventions included using appropriate non-pharmacological (the use of non-drug approaches to pain management) and pharmacological interventions (the use of medications for pain management) when the resident appeared to be in pain.Review of Resident #4's physician orders revealed an order dated 03/30/2026 for lidocaine external patch four (4) percent (medication used for pain relief), applied to the coccyx (the small triangular bone at the base of the spine) in the morning for pain and removed at bedtime.Review of Resident #4's April 2026 Medication Administration Record revealed code 5 (hold/see nurse notes) was documented for the morning administration of the lidocaine patch on 04/07/2026, 04/09/2026, and 04/13/2026.Review of progress notes revealed the lidocaine patch was not applied on 04/07/2026 because Resident #4 was out of bed early, was not applied on 04/09/2026 because the resident was already out of bed and was not applied on 04/13/2026 because the resident was out of bed before the nurse was able to apply the patch. Additional record review did not include documented evidence of later attempts to apply the patch, medical provider notification, or alternative instructions when the patch was not administered. Review of Resident #4's progress notes during this timeframe did not include documented evidence of pain or discomfort.During an interview on 05/14/2026 at 12:55 PM, Resident #4 stated the lidocaine patches were not applied because they were already up and in the wheelchair. Resident #4 stated when the patches were not applied in the morning, they experienced more pain throughout the day, especially during therapy.During an interview on 05/14/2026 at 2:20 PM, the Director of Nursing stated the medication administration notes indicated Resident #4 was out of bed before the lidocaine patch could be applied. The Director of Nursing stated the proper procedure would have been to contact the medical provider when the patch was not applied and a medication error report had not been completed for the missed administrations.Title 10 New York Codes, Rules and Regulations 415.12(m)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, the facility failed to ensure medications were properly labeled and handled according to accepted professional standards during one (1) of one (1) medication cart observations. Specifically, Licensed Practical Nurse #1 had four (4) unlabeled medication cups containing pre-poured medications intended for four (4) residents.The findings are:The facility policy, Medication Administration, last revised December 2019, included medications may not be prepared in advance.During an observation on 05/12/2026 at 11:45 AM, Licensed Practical Nurse #1 was standing at a medication cart with four (4) unlabeled medication cups containing pre-poured medications intended for four (4) separate residents. Licensed Practical Nurse #1 reviewed the medications with the surveyor and identified the intended resident and medications contained in each cup.The medications in the four (4) cups included: Carbidopa-Levodopa 25-100 milligrams, two (2) tablets (used to treat Parkinson's disease and reduce tremors, stiffness, and slow movement) Midodrine hydrochloride 2.5 milligrams, two (2) tablets (used to treat dizziness related to changes in position) Gabapentin 300 milligrams, one (1) capsule (used to treat nerve pain) and Torsemide 20 milligrams, one (1) tablet (used to treat fluid retention) Gabapentin 100 milligrams, one (1) capsuleDuring an interview on 05/12/2026 at 11:45 AM, Licensed Practical Nurse #1 stated all residents were in the dining room and the medications would be passed there. Licensed Practical Nurse #1 stated they knew which medications belonged to each resident and this was how they passed medications. Licensed Practical Nurse #1 asked if writing resident names on the medication cups would be acceptable and then stated they could place the medication cups in each resident's drawer and pass the medications one (1) resident at a time. Licensed Practical Nurse #1 discarded the medications at the direction of the surveyor.During an interview on 05/12/2026 at 12:00 PM, the Director of Nursing stated pre-pouring medications was never allowed under facility policy and the observation involving Licensed Practical Nurse #1 was unacceptable.Title 10 New York Codes, Rules and Regulations 415.18(d)