STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Nursing & Rehabilitation Center, L L C	282 Riverside Dr Johnson City, NY 13790

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 34465

Based on record review and interviews during the abbreviated survey (NY00371419), the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive care person-centered care plan, and the resident's choices for 2 of 3 residents (Resident #1 and 7) reviewed. Specifically:

-Resident #1 had a feeding tube (a device that delivered liquid nutrition into the stomach or intestine through a surgically created opening in the abdomen) and had physician orders to verify placement and check residuals. There was no documented evidence that placement and residuals were checked for 4 months. The resident developed new onset diarrhea and nausea, and there was no documented evidence the resident was assessed to determine if the resident's tube feeding should have been held. Approximately 8 hours later, the resident was found deceased with vomit on their face.

-Resident #7 had an order for lorazepam 0.5 milligrams (a controlled substance medication for anxiety) by mouth every day at bedtime and the resident did not receive the medication for 7 days.

Findings include:

The facility policy, Change in a Resident's Condition or Status, revised ,d+[DATE], documented if a significant change in the resident's condition occurred (new, change worsening), a comprehensive evaluation/assessment of the resident's condition was conducted and documented.

The facility policy, Tube Feedings, revised ,d+[DATE], documented gastric (stomach) tubes were used to supply nutrition and hydration to residents unable to take liquid or food by normal means. Tube placement was verified every shift and prior to administration of each feeding. Tube placement was checked using at least two of the following techniques: monitor and evaluate for bloating, nausea, or abdominal pain; check residual (excessive amount of fluid/food remaining in the stomach after feeding through a tube) before feeding was started; and if concerns arose regarding placement or dislodgement, notify physician and obtain x-ray confirmation. When checking for gastric contents, if over 100 milliliters (or an amount specified by the physician), hold feed for 2 hours and notify physician. Feed, flushes and tube placement checks were recorded on the Medication or Treatment Administration Record. Record any unusual symptoms or response to tube feed and report as needed to supervisor.

(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: 335393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The revised ,d+[DATE] policy, Reordering Medications, documented the purpose was to prevent any missed medication doses due to failure of reordering when necessary. The Unit Coordinator was responsible for overseeing that procedure and assignment of the medication reordering process. The nurse designated for that duty would check the medication in the cart by taking a visual inventory of all resident supplies and reordering when there was a 7-day or less supply remaining. The revised [DATE] policy, Automated Drug Dispensing System, documented the purpose of the automated medication system would be to securely store emergency supplies of controlled substances and other medication needed for use by nursing home residents in the event the immediate administration of the medication was necessary, and that no alternative treatment was available. The Automated Drug Dispensing System was a locked, automated medication storage cabinet with programmable-metered drawers with controlled and limited access. Features included, but not limited to, computerized inventory tracking, controlled password mediated access and recorded drug utilization. The procedure for the Automated Drug Dispensing System included: -the Automated Drug Dispensing System would be monitored continuously using the pharmacy interface. Any action involving the Automated Drug Dispensing System would be logged by the pharmacy and upon request generated in a detailed, comprehensive report. -Class 3A pharmacy licensed facilities should be responsible for maintaining a separate record of the administration of controlled substances from the Automated Drug Dispensing System. -Initially, authorized facility staff would be provided with a personal sign-on code and a default password to allow sign-in. -All staff nurses would have station privileges that included the ability to remove, waste and witness medications from the Automated Drug Dispensing System. -All controlled substances would be stored in an individual compartment allowing the nurse access to only that medication per transaction. -The pharmacy would work closely with the Director of Nursing to resolve all stock-related problems. The revised ,d+[DATE] policy, Medication/Treatment Administration: Documentation, documented medications and treatments were checked against the prescription order before they were administered and would be administered per physician orders. If medications or treatments were not available, nursing was to inform the nursing supervisor immediately, the emergency medication kit was used, and the medical provider was notified, and immediate medication delivery was requested. 1) Resident #1 had diagnoses including dysphagia (difficulty swallowing), malnutrition and other artificial openings of the gastrointestinal tract. The [DATE] Minimum Data Set assessment documented the resident's cognition was intact, they were independent with rolling left and right and they had a feeding tube. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The [DATE] physician #18's note documented the resident was recently readmitted after hospitalization on [DATE] with mental status changes, hypotension (low blood pressure) and septic shock (life threatening condition where blood pressure drops dangerously low from infection). The resident developed dysphagia that required a feeding tube placement on [DATE]. The tube was working well and Jevity (liquid nutrition for long term tube feeding) should be continued. The [DATE] physician order documented to verify placement of feeding tube before each feeding, medication administration or flush, and record the amount of residual. The [DATE] comprehensive care plan documented the resident had a feeding tube and would remain without complications such as gastrointestinal distress, nausea/vomiting/diarrhea, abdominal distention and increased residuals through next review. Interventions included Jevity at 60 cubic centimeters per hour continuously for a total of 1440 cubic centimeters per day. Medications were to be flushed with 60 cubic centimeters of water before, during and after each administration, and residuals and signs and symptoms of intolerance checked every shift and as needed. The [DATE] at 8:24 PM Licensed Practical Nurse #7 note documented the resident had large amounts of loose stools multiple times and they complained of not feeling well. The note documented the resident's family was updated. There was no documented evidence the resident was assessed by a qualified professional. The [DATE] at 5:33 AM Licensed Practical Nurse Supervisor #8 note documented the resident was found expired, the provider was notified and orders obtained to release the body. The [DATE] through [DATE] Medication Administration Record did not contain any documentation related to checking and recording the resident's residuals before each feeding, before medication administration or before flushes per physician order. The resident's [DATE] death certificate documented the resident's immediate cause of death was acute cardiopulmonary arrest due to multiorgan failure as a consequence of Diabetes Mellitus. During a telephone interview on [DATE] at 11:34 AM, Certified Nurse Aide #9 stated they worked the night shift and was notified by the outgoing shift the resident was sick and they had an emesis basin. Most residents on the floor had a gastrointestinal illness with loose stools at that time. They checked on the resident at midnight and 2 AM and they were asleep. Around 4 AM, Registered Nurse #10 went in the resident's room to change out the tube feeding equipment and found the resident had expired. Registered Nurse #10 brought Certified Nurse Aide #9 to the resident's room, and they observed the resident's head hanging near the side of the bed with arms stretched towards the waste basket on the floor. The emesis basin was on the floor, and they observed a large amount of vomit. Registered Nurse #10 notified Licensed Practical Nurse Supervisor #8 who came to the unit. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:40 AM, Licensed Practical Nurse #7 stated when a resident had a change in condition, it was documented on the 24-hour report, the supervisor was notified, and the supervisor evaluated the resident. On [DATE], the resident was not feeling well and had not been feeling well since they returned from the hospital. The only change for them was the loose stools. The resident did not give any specifics about how they felt. They believed there was a gastrointestinal illness affecting other residents on the unit at the same time. They stated they did not recall if the resident was nauseous and did not recall if aides reported the resident was nauseous. They believed they reported loose stools to the supervisor or the other nurse on the unit and did not recall who they were. They did not recall if the resident was evaluated. They stated they did not notify the provider. They did not check a residual for the resident as it was not on the Medication Administration Record. They did not give the resident a basin and nobody reported to them the resident was given a basin. Vomiting would have been a change in condition and if they were made aware, the resident's tube feed would have been held and the provider made aware immediately. During a telephone interview on [DATE] at 11:35 AM, Certified Nurse Aide #11 stated they provided care to the resident on the evening shift on [DATE]. On [DATE], the resident was not acting themselves. They were in bed all day and that was not their normal. The resident said they did not feel well. The resident required one assist with incontinence care and could roll on their own when prompted. However, on [DATE], when they prompted the resident to roll, they instead sat up and was not following directions. A second aide had to assist them with the resident's incontinence care that night. They stated they reported to Licensed Practical Nurse #7 the resident was not acting themselves and that they also had diarrhea. They saw Licensed Practical Nurse #7 go into the resident's room sometime around 6 PM. The resident complained of nausea but did not vomit and could not recall if they reported to the nurse. They could not recall if they gave the resident an emesis basin. When they left the shift, the resident was sleeping. They did not report to the oncoming aide because they left early that night around 10:30 PM. During a telephone interview on [DATE] at 2:09 PM, Licensed Practical Nurse Supervisor #8 stated they were the supervisor on [DATE] at 7 PM through the night shift on [DATE]. On [DATE] at around 4:50 AM, they received a call from Registered Nurse #10 to come to the unit as the resident had expired. They observed the resident lying in bed, head of bed elevated, and laying on their left side. When they rolled the resident to their back, vomit was covering their face. They notified the resident's family member and that was when they first heard the resident had been nauseous that night. Nobody reported to them the resident was nauseous while they were supervisor. If they had known, they would have rounded more frequently on the resident. Because the resident had a tube feeding, the provider should have been notified when nausea started to determine if the tube feed should have been held. On [DATE] at 10:38 AM, Registered Nurse #10 was not reached in an interview. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 11:11 AM, Assistant Director of Nursing #29 stated once a physician order was obtained, the nurse entered the order into the electronic record by entering the medication, the amount, the frequency and who the ordering physician was. To determine if the order would be placed on the Medication Administration Record or the Treatment Administration Record, the nurse needed to select the Order Type, and the physician order would show up on one of those documents depending on what was chosen. They looked in the electronic record at the resident's [DATE] physician order for verifying placement of feeding tube before each feeding, medication administration or flush, and record the amount of residual. They stated Registered Dietitian #20 entered the order on [DATE] and chose Advance Directives as the Order Type. Choosing Advance Directives as the Order Type would not transfer the order to the Medication or Treatment Administration Record and was the reason the resident's feeding tube for placement or residuals was not checked. Licensed Practical Nurse #21 revised and confirmed the order on [DATE] and they should have caught the error. Checking residuals on residents with feeding tubes was important to determine if the resident was digesting the feed. If too much feed was present in the stomach when checking residual, staff needed to determine if the feed should be stopped. If a resident with a feeding tube had nausea, an assessment was needed to see if there was excessive residual. When Resident #1 had nausea on [DATE], they expected a registered nurse to be notified, and an assessment done. They were not aware the resident was not assessed. During a telephone interview on [DATE] at 12:37 PM, Registered Dietitian #20 stated the purpose of checking residuals was to see how a resident was tolerating a tube feed. If a resident had nausea, they expected a nurse to assess the resident because they would not want to continue feeding someone that was not feeling well. They were trained to enter tube feed orders into the electronic record. A nurse signed off on the order after they enter it. On [DATE], they were not aware they selected Advance Directives for the Order Type when they entered the order for verifying placement and checking residual. During a telephone interview on [DATE] at 12:46 PM, Licensed Practical Nurse #21 stated they were trained on entering physician orders into the electronic record. The purpose of confirming the order was to ensure the order was entered correctly. On [DATE], they recalled changing the Order Type from Advance Directive to the Medication Administration Record and was not sure why the changes were not saved. 2) Resident #7 had diagnoses including malignant neoplasm of the prostate and secondary malignant neoplasm of the bone. The [DATE] Minimum Data Set assessment documented the resident was cognitively intact, had no impairment to upper and lower extremities, used a walker, was independent with most activities of daily living and used an antianxiety medication. The comprehensive care plan revised [DATE] documented: Psychosocial well-being, total severity score 2, absence of mood and behavior problems. Interventions were monitor for mood and behavior change, encourage activities, encourage hobbies of interest, encourage to express emotions in a safe environment, report changes in behavior or psychosocial functioning. There was no documentation regarding the resident's lorazepam for anxiety. Physician orders documented: - on [DATE], lorazepam 0.5 milligrams one tab by mouth at bedtime for anxiety; end date [DATE] (the end date was more than 30 days). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-verbal order on [DATE], lorazepam 0.5 milligrams by mouth one time only for anxiety for one day, may pull from Automated Drug Dispensing System, approved by on-call provider. -on [DATE], lorazepam 0.5 milligrams give one tab by mouth one time a day for anxiety. -verbal order on [DATE], lorazepam 0.5 milligrams one tab by mouth one time a day for anxiety for two days. -on [DATE], lorazepam 0.5 milligrams one tab by mouth at bedtime for anxiety, start date of [DATE]. The facility Controlled Substance Medication Record for Resident #7's lorazepam 0.5 milligrams, prescription number 2700180, documented the medication was sent to the facility [DATE] with a quantity of 30 pills. The record documented the last dose of lorazepam 0.5 milligrams was administered on [DATE] by Licensed Practical Nurse #12. The vendor pharmacy Patient Usage Report for Resident #7 documented lorazepam 0.5 milligrams was dispensed from the Automated Drug Dispensing System: -on [DATE] by Licensed Practical Nurse #12. -on [DATE] by Licensed Practical Nurse #7. -on [DATE] by Licensed Practical Nurse #12. The facility Pharmacy Narcotic Access Code form documented on [DATE] lorazepam 0.5 milligrams was dispensed from the Automated Drug Dispensing System for Resident #7 by Licensed Practical Nurse #12. It also documented to attach the form to a copy of the printed narcotic order from the facility electronic health system and return to the Director of Nursing's mailbox; must be done, or it was a narcotic error. There was no documented evidence a pharmacy access code was obtained on [DATE] and [DATE] when nurses removed lorazepam 0.5 milligrams from the Automated Drug Dispensing System. The resident's February 2025 Medication Administration Record for lorazepam 0.5 milligrams, give one tablet by mouth at bedtime for anxiety for [DATE] - [DATE], documented: -on [DATE] lorazepam 0.5 milligrams administered by Licensed Practical Nurse #12 from the Automated Drug Dispensing System; no access code obtained from pharmacy prior to removal from system. -on [DATE] code 9 meaning other/see progress notes, by Licensed Practical Nurse #12, awaiting new order (medication not administered). -on [DATE] code 9, by Licensed Practical Nurse #12, awaiting pharmacy (medication not administered). -on [DATE] code 9, by Licensed Practical Nurse #13, med unavailable, reordered (medication not administered). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-on [DATE] signature block blank, staff working was Licensed Practical Nurse #12 (medication not administered). -on [DATE] lorazepam 0.5 milligrams marked as administered by Licensed Practical Nurse #17, but medication was not available, and it was not administered. -on [DATE] lorazepam 0.5 milligrams marked as administered by Licensed Practical Nurse #17, but medication was not available, and it was not administered. -on [DATE] lorazepam 0.5 milligrams marked as administered by Registered Nurse #10, but medication was not available, and it was not administered. -on [DATE] code 9, by Licensed Practical Nurse #7 from the Automated Drug Dispensing System; the nurse called the on-call provider who approved a one time lorazepam 0.5 milligrams dose for [DATE] at 7:00PM and [DATE]; the resident's primary provider to be notified to obtain a refill of the order. -on [DATE] lorazepam 0.5 milligrams administered by Licensed Practical Nurse #12 from the Automated Drug Dispensing System; protocol was followed, and an access code was obtained for the medication prior to removal from the Automated Drug Dispensing System. - Between [DATE] and [DATE], the resident received their routine lorazepam 0.5 milligrams at bedtime [DATE], [DATE] and [DATE], with an access code to obtain from the Automated Drug Dispensing System only on [DATE]. The resident did not receive their routine lorazepam 0.5 milligrams at bedtime for 7 straight days, [DATE] - [DATE]. During an interview on [DATE] at 9:00 AM Licensed Practical Nurse #3 stated they had a lot of medications during the morning medication pass that were not available because nurses did not reorder them timely. They usually reordered medications when they got down to two pills in the blister pack. If there was a medication unavailable during the medication pass, they would first check the Automated Drug Dispensing System which was in the utility room on Unit 2. If the medication was not in the Automated Drug Dispensing System, they would call pharmacy to order it. They would then sign off in the electronic medication administration record that the medication was on order, as that is what the facility had told them to do. During an interview on [DATE] at 9:29 AM Licensed Practical Nurse Unit Manager #4 stated if a medication was unavailable on the medication cart, they would first check the Automated Drug Dispensing System. If the medication was not in the Automated Drug Dispensing System they would call pharmacy to order it. During an interview on [DATE] at 12:30 PM Resident #7 stated they recalled not getting their lorazepam 0.5 milligrams at bedtime for several days recently. Nurses told them they needed a refill for the lorazepam, and they were getting locked out with the code when they tried to reorder it. The medical provider never spoke to them about the lorazepam not being available. They had done okay without the lorazepam as they also took melatonin (a supplement that helped indirectly with anxiety by improving sleep). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 9:18 AM Registered Pharmacist #5 from the facility's vendor pharmacy stated Resident #7's lorazepam 0.5 milligrams was last filled by them on [DATE] and the order was good for 30 days. There was a one-time order filled by them on [DATE] by Licensed Practical Nurse #12, who dispensed it from the Automated Drug Dispensing System. When nurses removed a controlled substance from the Automated Drug Dispensing System the protocol was for them to call the pharmacy for an access code first, before removing it from the Automated Drug Dispensing System. Then they would log into the Automated Drug Dispensing System with their login credentials to remove the medication. Nurses could still remove a controlled substance from the Automated Drug Dispensing System without an access code, but that would be considered a medication error. They stated the pharmacy's Client Access Manager told facility staff many times the procedure to follow. During a phone interview on [DATE] at 9:33 AM Registered Pharmacist Director of Operations from the facility's vendor pharmacy stated nurses needed to call the pharmacy first for an access code in order to remove a controlled substance from the Automated Drug Dispensing System. They would look up the dates between [DATE] and [DATE] for Resident #7 to verify when nurses had called for an access code for removing lorazepam 0.5 milligrams and call back. During a follow-up phone interview on [DATE] at 9:46 AM Registered Pharmacist Director of Operations stated they ran a report for Resident #7's lorazepam 0.5 milligrams for the dates [DATE] - [DATE]. On [DATE] and [DATE] lorazepam 0.5 milligrams was removed from the Automated Drug Dispensing System, but nurses did not call the pharmacy for an access code first. They sent a discrepancy code form to the facility for those two dates which were supposed to be returned to them within 24 hours, and they never heard back from the facility. They used to send the discrepancy code forms to the Director of Nursing, who was no longer at the facility as of [DATE]. They did have an access code for the lorazepam 0.5 milligrams removed from the Automated Drug Dispensing System on [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 10:40 AM Licensed Practical Nurse #12 stated they worked at the facility the last two years as an agency nurse. They usually passed medications but were sometimes the supervising nurse. They were thrown into the nurse supervisor role without any training. If a resident did not have a controlled substance medication available on the medication cart, they would call the pharmacy for an access code to the Automated Drug Dispensing System. Controlled substances were not indefinite orders; they were only good for 30 days. If controlled substance medications were past 30 days pharmacy would not provide an access code number. When on-call medical providers were called regarding a controlled substance medication order they would not return the call quickly unless it was an urgent situation, such as a resident fall. They knew about Resident #7's lorazepam 0.5 milligrams not being available. They had called the on-call medical provider, but the provider never got back to them. If an on-call medical provider was not familiar with a resident they did not feel comfortable ordering a one-time medication. The pharmacy would not give them an access code for Resident #7's lorazepam 0.5 milligrams on [DATE] because the resident's order was past 30 days. They still dispensed the lorazepam 0.5 milligrams from the Automated Drug Dispensing System and administered it to the resident. They could not remember if they wrote a nursing progress note about notifying the on-call medical provider about Resident #7's lorazepam 0.5 milligrams being unavailable. They received a medication error from the facility on [DATE] for not administering Resident #7 their lorazepam 0.5 milligrams on [DATE], [DATE] and [DATE]. They were told by the facility they should have notified the supervisor about the unavailable medication, but they stated they were the supervisor on those dates. They were aware Licensed Practical Nurse #7 put in a two-day order for lorazepam 0.5 milligrams on [DATE] (for administration on [DATE] and [DATE]). They were never initially trained on the protocol to follow for removing a controlled substance from the Automated Drug Dispensing System. Recently, Licensed Practical Nurse Unit Manager #4 went over the process of removing a controlled substance from the Automated Drug Dispensing System with them. They and other nurses recently received a random education on removing medications from the Automated Drug Dispensing System because none of them knew the process. They had spoken with Resident #7 and Resident #7's family member about the lorazepam 0.5 milligrams being unavailable and how their hands were tied in attempting to get it without success. Resident #7 had shown no outward appearances of having any adverse effects such as agitation, anxiety or complaining from not receiving their lorazepam 0.5 milligrams. On [DATE] at 12:45 PM, Registered Nurse #10 was not reached in an interview. During a phone interview on [DATE] at 12:50 PM Licensed Practical Nurse #13 stated they were an agency nurse and had only worked two shifts at the facility. If they did not have a controlled substance medication for a resident when they were passing medications, they would normally get a supervisor. They were told they had no access to the Automated Drug Dispensing System because they were an agency nurse. They were familiar with Resident #7 and recalled trying to get their lorazepam 0.5 milligrams on [DATE]. They called the Registered Nurse Supervisor (name unknown) and the floor licensed practical nurse (name unknown) but they did not do anything about it. They (the Registered Nurse Supervisor and floor licensed practical nurse) had brushed it off and had commented that they knew the lorazepam 0.5 milligrams had been unavailable. Licensed Practical Nurse #13 spoke with who they thought was the Director of Nursing the next morning about Resident #7's lorazepam 0.5 milligrams, but they did not do anything about it and told them most nurses did not have a log-in for the Automated Drug Dispensing System. They had never been educated on the process for getting a medication from the Automated Drug Dispensing System. For the two shifts they worked at the facility, many residents had medications unavailable because they were not re-ordered. They no longer worked at the facility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview on [DATE] at 2:37 PM Nurse Practitioner #14 stated for a controlled substance medication to be reordered the licensed practical nurse or registered nurse would need to send an electronic order to refill, and they would double-check to see if it was a routine order. The order notification would show up on their phone. If they were not notified a resident's medication needed to be reordered, they could not refill it. Routine medication orders were good for 30 days, and with 14-day or as needed medication orders they would re-assess to see if the resident still needed that medication. The nurses had to put the refill order under the primary provider's name for it to be refilled. Resident #7 was their patient, and they were not aware they had not received their routine lorazepam 0.5 milligrams at bedtime for seven days ([DATE] - [DATE]). They re-ordered Resident #7's lorazepam 0.5 milligrams on [DATE]. The on-call medical providers were available from 5:00 PM - 8:00 AM. If they had a day off, they would let the covering medical provider know so that the correct provider's name would be on an order. Medication orders were frequently not reordered timely at the facility. During a phone interview on [DATE] at 9:40 AM Licensed Practical Nurse #17 stated if a medication was unavailable on the medication cart, they would notify the supervisor. They worked many double shifts, and it was very busy. They remembered Resident #7 talking to them about their lorazepam 0.5 milligrams not being available because the nurses did not have an access code to the Automated Drug Dispensing System. They had never been educated on using the Automated Drug Dispensing System and there was no handbook available that Administration told them to refer to. They had no access to the Automated Drug Dispensing System. They could not remember if they had administered lorazepam 0.5 milligrams to Resident #7 on [DATE] and [DATE]; it was possible they signed for it when they never really gave it due to its unavailability. They could not remember notifying a supervisor on [DATE] and [DATE]. They remembered giving that medication to the resident in the past when they worked evening shifts. They recently received a medication error from the facility for not administering lorazepam 0.5 milligrams to Resident #7 as ordered. Resident #7 showed no signs of distress or anxiety on [DATE] and [DATE]. Resident #7's family member frequently took them out on pass. During a phone interview on [DATE] at 10:21 AM Licensed Practical Nurse #7 stated they were passing medications on [DATE] when they noticed Resident #7 did not have their lorazepam 0.5 milligrams. The resident needed an order for the lorazepam 0.5 milligrams as it had not been refilled. They called the on-call medical provider and did not get a call-back right away. They passed the information on to Licensed Practical Nurse Supervisor #8. They eventually got a call-back from the on-call provider and were able to get an order for the lorazepam 0.5 milligrams for [DATE] and [DATE]. The resident received their lorazepam 0.5 milligrams before they left their shift on [DATE]. Resident #7 had been asking about their lorazepam 0.5 milligrams earlier in the shift and if it had come in yet. They were pleasant about the situation and did not appear to be having any withdrawal symptoms from not having had the lorazepam 0.5 milligrams for several days. The resident was thankful after they received their lorazepam 0.5 milligrams on [DATE]. They had not had a training on removing a controlled substance from the Automated Drug Dispensing System and were not aware they needed an access code. 10NYCRR 415.12 37516

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Riverside Dr Johnson City, NY 13790	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 34465 Based on record review and interview during the abbreviated survey (NY00371419), the facility was not administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being for 1 of 3 residents (Resident #2). Specifically, facility Administration, including the Director of Nursing, did not ensure a complete and accurate investigation was completed following an allegtion of abuse. Additionally, the staff statements provided to the Department of Health (as part of the abuse investigation) were falsified. The staff that provided statements stated they did not author the statements or provide a verbal statement to anyone at the facility, they did not sign the statements, and the signatures on the documents were not theirs. Findings include: The facility policy, Facility Incident/Abuse Investigation and Reporting revised 6/7/2023, documented should a resident be observed with unexplained injuries or suspected/alleged abuse, neglect or mistreatment, the employee notified the supervisor who conducted an assessment. The supervisor/designee initiated an Accident/Injury Report in the electronic record and recorded information in the record. The supervisor notified the Director of Nursing immediately. The Director of Nursing initiated the investigation. In the event the Director of Nursing was not on-site, the supervisor might begin the investigation as directed by the Director of Nursing. The Director of Nursing/designee notified the Administrator immediately. For allegations of abuse, neglect, mistreatment, misappropriate or once suspicion of abuse had been formed, the Director of Nursing Services must notify the Department of Health. Facility employees that have been accused of resident abuse would be suspended or reassigned to non-resident care duties until the results of the investigation had been reviewed by the Administrator. The 11/30/2024 untimed and unsigned Investigative Summary (no Incident Report was provided) documented the resident stated a night shift nurse was rough with them and the resident could not provide details on what rough meant. Staff present did not witness any rough actions by the nurse. Staff reported the resident was unusually confused. At baseline, the resident was alert and oriented to person, place, time, and event. Staff reported the resident was combative and hit the nurse. The resident had some swelling but no bruising to their right wrist and the x-ray was negative. The resident stated they were not afraid. There was no care plan violation, and no abuse found as a result of the investigation. The investigation did not document who the accused nurse was or what action was taken with them (statements identified Licensed Practical Nurse #15). Typed statements dated 11/30/2024, with the employee signatures documented: - From Licensed Practical Nurse Supervisor #8, during the night shift of 11/29-11/30/2024, the resident was very combative and insisted they needed to find their car and pick their family members up. The resident was pacing the unit at 4:00 AM, was redirected to their room, and became combative. Licensed Practical Nurse #15 helped the resident into a wheelchair and got them to their room. The resident was very upset, did not want to return to their room, and attempted to hit Licensed Practical Nurse #15 multiple times. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Susquehanna Nursing & Rehabilitation Center, L L C	282 Riverside Dr Johnson City, NY 13790

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	

- From Licensed Practical Nurse #17, the resident was wandering the unit throughout the night and was attempting to leave to go to their car. Initially the resident was redirectable. Around 4:00 AM, Licensed Practical Nurse #15 helped the resident into a wheelchair and transported them back to their room. The resident was very confused and combative towards the nurse. The resident attempted to hit staff who were redirecting them. Licensed Practical Nurse #15 was firm in their speech with the resident in attempt to redirect them.

- From Registered Nurse #16, they spoke with the resident following their claims the night shift staff were rough with them. The resident could not recall specific details besides providing a basic description of the nurse who was rough with them. Staff members reported the resident was disoriented and combative on the night shift. An assessment was completed and the resident had no complaints of pain or discomfort.

During a telephone interview on 2/25/2025 at 2:09 PM, Licensed Practical Nurse Supervisor #8 stated on 11/30/2024 during the night shift:

- The resident was up and wandering on their shift.

- Licensed Practical Nurse #15 was the unit floor nurse and Licensed Practical Nurse #15 expected all residents to be in their rooms on the night shift. Licensed Practical Nurse Supervisor #8 had counseled the nurse in the past that residents had a right to be up as the facility was their home.

-They heard Licensed Practical Nurse #15 say to the resident it was time to go to bed and Licensed Practical Nurse #15 sounded annoyed. They did not witness Licensed Practical Nurse #15 place the resident in the wheelchair.

- The resident did not allege abuse or complain of wrist pain on their shift.

- During their shift the next day, they heard the resident alleged abuse against a night shift staff and the incident was under investigation. They stated they were surprised that nobody had spoken to them because they were present when the incident occurred. If someone had spoken to them, they would have reported Licensed Practical Nurse #15's inappropriate tone when telling the resident they needed to go to bed.

- A copy of the 11/30/2024 statement included in the Investigative Summary, with Licensed Practical Nurse Supervisor #8's name and signature was provided to them. The nurse stated they did not author the statement, or provide a verbal statement to anyone at the facility, did not sign the statement, and the signature on the document was not theirs.

During a telephone interview on 2/27/2025 at 11:35 AM, Registered Nurse #16 stated:

- On 11/30/2024, they were the supervisor on the day shift. They were asked by the former Director of Nursing to do an assessment on the resident and was not told why the assessment was needed. They were not aware the resident alleged abuse and did not know any details.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER: Susquehanna Nursing & Rehabilitation Center, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE: 282 Riverside Dr, Johnson City, NY 13790	

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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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A copy of the 11/30/2024 statement included in the Investigative Summary with Registered Nurse #16's name and signature was provided for Registered Nurse #16 to review. Registered Nurse #16 stated they did not author the statement, or provide a verbal statement to anyone at the facility, did not sign the statement, and the signature on the document was not theirs. During a telephone interview on 3/3/2025 at 7:31 AM, former Director of Nursing #2 stated incidents should be reported the supervisor, the Administrator or themselves so a thorough investigation could be completed. The staff that was accused of abuse should be suspended to keep residents safe. All staff on duty when the alleged abuse occurred should provide statements and statements were obtained by the supervisor, the Administrator, or themselves. The Administrator was responsible for completion of the Investigative Summary though they had completed them in the past. The Administrator was responsible to determine if abuse or neglect occurred and the Administrator or themselves reported abuse to the New York State Department of Health. On 11/30/2024, they reported the incident to the Administrator. They were not sure why only 3 nurses provided statements and no certified nurse aides were interviewed. They stated the certified nurse aides should have provided statements. They could not recall if they wrote the Investigative Summary for the incident. The Investigative Summary should have been signed and dated. They were not aware Licensed Practical Nurse #15 worked on 12/1/24 and depending on if the investigation was completed and abuse ruled out, they should not have worked. They could not recall if they obtained statements from Licensed Practical Nurse Supervisor #8 or Registered Nurse #16 and was not aware the statements or the signatures were not from those nurses. They did not think the facility could rule out abuse and neglect if the statements were false. They were not sure why the incident was not reported the New York State Department of Health. During a telephone interview on 3/3/2025 at 10:49 AM, the Administrator stated staff statements were obtained by the supervisor or the Director of Nursing. The Director of Nursing was responsible to complete the Investigative Summary. The Administrator reviewed all the incident documentation once completed and they, the Director of Nursing and corporate ruled out abuse and neglect. They or the Director of Nursing reported abuse to the New York State Department of Health. They stated on 11/30/2024, the Director of Nursing investigated the allegation of abuse and determined from staff statements that abuse had not occurred. Staff stated the resident was not at their baseline and was confused. Staff were concerned the resident would fall. The resident alleged they were pushed in to the wheelchair and staff statements did not support this. They stated they did not write the Investigative Summary for this incident and assumed former Director of Nursing #2 did. Former Director of Nursing #2 should have signed and dated the summary. They believed abuse and neglect was ruled out the same day and why Licensed Practical Nurse #15 returned to work on 12/1/2024. They were not aware staff alleged their statements were forged and stated they had no reason to not believe the staff. They stated abuse and neglect could not have been ruled out if staff statements were incorrect. The facility would need to reopen the case to investigate. The incident was not reported to the New York State Department of Health because the facility initially ruled out abuse and neglect. During a telephone interview on 3/4/2025 at 12:52 PM, Licensed Practical Nurse #17 stated they were not on duty on the night shift on 11/30/2024. They were provided a copy of the statement from the Investigation Summary with Licensed Practical Nurse #17's name and signature for their review. Licensed Practical Nurse #17 stated they did not author the statement, or provide a verbal statement to anyone at the facility, did not sign the statement, and the signature on the document was not theirs. 10NYCRR 415.26(a)