

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335628	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/15/2025
NAME OF PROVIDER OR SUPPLIER  Sullivan County Adult Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  256 Sunset Lake Road Liberty, NY 12754	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on record review and interviews the facility failed to initiate and complete a thorough investigation of an alleged violation of abuse to prevent further potential abuse. Specifically , On 3/21/25 at 12:00pm Resident #1 was at the nurse's station and 3 staff witnessed (Certified Nurse Aide #1 and #2 and Domestic Aide #1)and reported to different Registered Nurses (Registered Nurse #1 and #2) and to the Director of Nursing that they witnessed an incident where Resident #1 was picked up from behind in a bear hug and dropped on the floor and then carried to their room by Domestic Aide #2. There was no evidence that the nursing staff reported the allegation of abuse to the facility Administrator or that they conducted an investigation into the allegations of abuse.</p> <p>Resident #1 had diagnoses including Unspecified Dementia, Mood Disturbance, and Non-Alzheimer Dementia. The 12/20/24 Minimum Data Set for Resident #1 documented had moderately impaired cognition.</p> <p>Review of the facility Abuse Policy last revision date 10/24 under the section Procedure documented that any report of suspected mistreatment, neglect, misappropriation, abuse or involuntary seclusion is documented, and investigation is started immediately. This is to immediately be reported to the Administrator/Director of Nursing or Administrator. In the event that the Administrator/Director of Nursing or Assistant Director of Nursing is not in the building at the time of the allegation or suspected abuse they are to be notified, via telephone call immediately. Any allegation of abuse will be reported in keeping with the New York State Department of Health and CMS regulations. An incident report will be completed. Statements will be obtained from all staff having knowledge of the events surrounding the event and the resident.</p> <p>During interviews conducted on 3/28/2025 and 3/31/2025 facility staff (Certified Nurse Aides #1, #2, and Domestic Aide #1) reported that on 3/21/2025 at approximately 12:15 PM they were all sitting at the nurse's station on Unit 3 when they observed Resident #1 standing and playing with the clothing protectors, the resident was yelling as per their usual behavior. They all stated that they observed Domestic Aide #2 come up behind the resident and bear hug them, and then dropped them on the floor. They stated that Domestic Aide #2 then picked the resident up under their arms and removed them from the nurse's station brought them back to their room.</p> <p>During an interview on 3/28/2025 at 10:43 AM Certified Nurse Aide #1 stated, after witnessing the incident they informed Registered Nurse #2.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/31/2025 at 12:39 PM Registered Nurse #1 stated, that on the day of the incident both Certified Nurse Aide #1 and Domestic Aide #1 came to them and told them what occurred. They called the Director of Nursing who stated they would take care of it. Registered Nurse #1 did not go to the unit at that time since she had informed the Director of Nursing, but they were there later when the police came to the facility.</p> <p>During an interview on 3/31/25 at 12:52 PM Registered Nurse #2 stated, that on 3/21/2025 at 12:58 PM they received a call from the Director of Nursing requesting they go to Unit 3 to see if they needed any assistance.</p> <p>During an interview on 3/31/2025 at 10:08 AM Domestic Aide #1 stated when Registered Nurse #2 arrived on the unit, Domestic Aide #1 reported that the Domestic Aide #2 grabbed the resident from behind and carried them to their room. \They stated that Registered Nurse #2 told them that they would take care of that later, that they needed to attend to the resident. Registered Nurse #2 took the resident into the lounge, stayed with them and called 911.</p> <p>During an interview with the Director of Nursing on 4/1/2025 at 11:00 AM they stated they do not know why they did not do an investigation of suspected abuse. On the day of the incident when they spoke to the two different registered nurses (Registered Nurse #1 and #2) that is not how it came across. The Director of Nursing stated that no one used the words manhandle or abuse when describing the incident. There was no further investigation because they took their information of the event from the 2 registered nurses, they did not have a suspicion that abuse occurred.</p> <p>10NYCRR 415.4(b)(3)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record reviews, and interviews conducted during a Complaint survey (NY00376081) the facility did not ensure that services provided met professional standards of quality. This was evident for 1 (Resident #1) of 3 residents reviewed for Medication Administration. Specifically, Resident #1 was administered an intramuscular injection of Lorazepam solution 1 MG that had been prescribed for another resident.</p> <p>The findings are:</p> <p>The facility policy titled Medication Administration created 1/87 and with a revision date of 4/24, documented that it is not acceptable to share medications between residents. The policy also documented that the right medication, is given to the right resident, at the right time, by the right route in the right dose.</p> <p>Resident #1 was admitted to the facility with diagnoses that included Unspecified Dementia, Mood Disturbance, and Non-Alzheimer's Dementia.</p> <p>The admission Minimum Data Set assessment dated [DATE] documented that Resident #1 had moderately impaired cognition.</p> <p>The Medication Administration Record dated 3/1/2025 to 3/31/2025 documented that Resident #1 was scheduled to receive Lorazepam Oral Tablet 0.5 MG 1 tablet by mouth two times a day for aggressive agitation anxiety.</p> <p>The Medication Administration Record dated 3/1/2025 to 3/31/2025 documented that Resident #1 received Lorazepam Solution 2 MG/ML inject 0.5 ml intramuscularly one time only for Bipolar Disorder on 03/19/2025 at 12:02 PM.</p> <p>There was no documented evidence that Lorazepam Solution had been dispensed by the pharmacy for administration to Resident #1.</p> <p>During an interview on 03/28/2025 at 3:47 PM, the Director of Nursing stated that Resident #1 was having escalating behavior and was evaluated by the Psychiatrist who ordered an immediate intramuscular injection of Lorazepam 1 MG which they administered.</p> <p>During an interview on 04/02/2025 at 3:57 PM, the Nurse Educator stated they do not administer medication, and they do not believe that Lorazepam Solution is stocked anywhere in the facility as an emergency medication. The Nurse Educator also stated that they went to Unit 2, retrieved the medication, did not look at the name on the bag or recall who it was prescribed for, but used it because it was needed at that moment. The Nurse Educator further stated that they prepared the medication and gave it to the Director of Nursing to administer to Resident #1. The Nurse Educator stated that it was only after the incident that they learned that the Lorazepam liquid used was not house stock medication. The Nurse Educator also stated that they would not use medications prescribed for another resident and thought that the Lorazepam liquid was a stock medication for use with all residents.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In a subsequent interview on 04/03/2025 at 2:39 PM, the Director of Nursing stated that they knew what medications were in the building, and there was no liquid Lorazepam in stock, in either the emergency medication kits or in the medication refrigerators, as it was not a house stock medication. The Director of Nursing also stated that in the middle of the situation, they did not ask where the medication came from, as all they were thinking about was the safety of the resident and staff.</p> <p>10 NYCRR 415.11(c)(3)(ii)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews conducted during an abbreviated and extended survey (NY00376081), the facility did not ensure that all nursing staff were competent and trained in providing care to residents with various psychiatric/mood disorders as listed in the current facility assessment. Specifically, 1 (Resident #1) of 4 residents with psychiatric diagnoses do not have staff in the facility that are trained to provide appropriate behavioral health care. The facility was unable to provide documented evidence that they provided nursing staff education on behavioral health training other than for dementia.</p> <p>Resident #1 Minimum Data Set, dated [DATE] with diagnoses unspecified dementia, moderate with mood disturbance. non traumatic brain dysfunction, non-Alzheimer's dementia. No behaviors are noted. Resident #1 was evaluated and was found to be moderately cognitively impaired with a brief interview of mental status of 11. On PHQ2-9 a depression screening tool Resident #1 scored a 13, indicating elevated depression.</p> <p>Review of the Facility assessment revealed it was last updated on 3/27/25. The Facility assessment listed the types of psychiatric/mood disorders and other diagnoses related to behavioral health specific to their resident population This list is used to identify the types of staff and material resources necessary to meet the needs of residents living with these diagnoses. The assessment lists the following disorders and conditions: psychosis, impaired cognition, mental disorder, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, anxiety disorder, intermittent explosive disorder, adjustment disorder. The Facility assessment documented that staff training is based upon the resident population and that training topics and competencies may/will change as resident needs are identified.</p> <p>Review of the General Orientation Packet revealed no date the 17th item on the list is titled Behavioral Health Training and Trauma Informed care. Further review of the packet indicated that on page 27 it is documented that Trauma Informed Care is defined as practices that promote a culture of safety, empowerment, and healing. It is a model for systems to address the impact of trauma and Post-Traumatic Stress Disorder (PTSD). There is another section in the full training packet on page 26 titled Behavioral Health training and it documented that it was for care of residents with dementia. There is nothing in the General Orientation Packet that addresses how to care for residents with any other mental health or behavioral health diagnosis or issue that is listed in the facility assessment.</p> <p>During an interview on 3/31/25 at 12:52pm with Registered Nurse #2 they stated there is no behavioral health training, no protocols when residents act out, no one knows what to do. If a resident tries to bite or hit, none of the staff have been trained on how to handle these situations. Registered Nurse #2 stated they can call for assistance but there isn't a behavior code to call they just page for assistance.</p> <p>During an interview on 4/2/25 at 11:23am with the Staff Education Nurse they stated there is no specific training to provide care for residents with schizophrenia or bipolar disorders. They stated that they recall staff saying they felt unsafe at times, and that they wanted behavioral health training.</p> <p>(continued on next page)</p>		

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<p>F 0741</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/2/25 at 12:30pm with the Administrator they stated there is a difference between dementia care training and behavioral health training, the focus has been on training for dementia management and care.</p> <p>10 NYCRR 415.26(c)(1)(iv)</p>		