STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335628	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Adult Care Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
	335628	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Adult Care Center	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the abbreviated survey (544161), the facility did not ensure that adequate supervision and safety monitoring interventions were consistently implemented and documented to prevent accidents and recurrence of self-injurious behaviors for one (Resident #1) of one resident reviewed for accidents. Specifically, Resident #1 who was severely cognitively impaired and care planned as ha having behavior of chewing on nonfood items, was transferred to the hospital on [DATE] for evaluation after biting their left middle finger. Resident #1 had a portion of their left middle finger amputated and was diagnosed with self-inflicted traumatic amputation of the left finger. Resident #1 returned to the facility on [DATE] with an initial physician's order for hourly safety checks which was changed to 15 minute safety checks on 3/13/2024. Resident #1 returned to the hospital on 3/22/2024 for further amputation of the left middle finger. The facility was unable to provide documentation that the hourly or 15-minute safety checks were completed as ordered. The findings include: The facility policy titled Resident 15 Minute Safety Checks documented that the facility will implement 15-minute safety checks for any resident deemed at risk based on clinical assessment or physician order and that staff are responsible for documenting each observation promptly, accurately, and legibly. Resident #1 was admitted with diagnoses including but not limited to Alzheimer's Disease, anxiety disease, and osteoarthritis. The 01/26/2024 Quarterly Minimum Data Set (an assessment tool) documented that Resident #1 had severely impaired cognition. The 7/24/23 Behavior Care Plan documented that Resident #1 has a history of placing items in their mouth, picking at the arm rest of their wheelchair and placing foam padding in their mouth, and placing fingers in mouth and chewing, along with grinding their teeth. Interventions included to provide resident with mouth chewy daily. Monitor for items placed in mouth and remove as needed. Notify nurse The 03/09/2024 Incident Report documented that Resident #1 was visibly observed by staff biting their left middle finger. Upon assessment, the resident was noted to be bleeding from the left middle finger which had two open areas. Both areas were cleaned, and the resident was monitored. Resident #1 was then transferred to the emergency room for further evaluation. The 03/10/2024 emergency room after-visit summary documented that Resident #1 had a diagnosis of traumatic amputation of the left middle finger.The 03/10/2024 progress note documented Resident #1 returned to the facility with a diagnosis of self-inflicted amputation of the finger. Upon return, the resident was placed on 15-minute watch and visual checks.The 3/10/24 at 07:36 PM health status progress note documented that Resident #1 continues to gnaw on bandage, gown, clothes protector, and other nonfood items, several redirections needed and unsuccessful for lengthy time periods. The 03/11/2024 Physician's order documented that Resident #1 was to be placed on visual checks every hour; however, there was no documented evidence that the certified nurse aides completed or recorded the hourly visual checks as assigned. This order was discontinued on 03/13/2024 and was changed for Resident #1 to be placed on 15-minute safety checks.The 3/12/24 at 07:17 PM health Status note documented that Resident #1 was redirected several times to cease chewing on nonfood items (gown, clothing protector, and hand mitts. The 3/12/24 at 03:53 PM health status note documented that Resident #1 was observed chewing on blanket one time and was redirected. Review of the Certified Nurse Accountability form revealed no documented evidence that the certified nurse aides were completing the safety/visual checks as ordered. During an interview on 10/02/2025 at 1:57 PM, Licensed Practical Nurse #1 stated that when residents are placed on hourly or 15-minute checks, the certified nurse aides will document the checks on a paper form that is kept in a binder. Licensed Practical Nurse #1 stated that the certified nurse aides are aware of which residents are on 15-minute or hourly checks because this information is listed in their care guide, but the documentation itself is completed on paper. Review of Certified Nurse Aide Accountably records and Kardex during the onsite survey revealed no documented evidence that the certified nurse aides were documenting the checks as ordered. During an interview on 10/02/2025 at 2:00 PM, the Assistant Director of Nursing stated that when residents are placed on 15-minute checks or visual checks, the certified nurse aides are made aware during report and in their certified nurse aide care guides. The Assistant Director of Nursing stated that the certified nurse aides document the checks on paper forms, which are kept at the nurse's station. During an interview on 10/02/2025 at 2:35 PM, Certified Nurse Aide #1 stated that when a resident is placed on 15-minute or hourly visual monitoring checks, the certified nurse aides are informed during report, and the information is also listed in the certified nurse aide care guide. Certified Nurse Aide #1 further stated