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	02/02/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews conducted during an abbreviated survey the facility failed to ensure that all alleged violations involving abuse, neglect, including injuries of unknown origin were reported immediately, but not later than 2 (two) hours after the allegation was made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the New York State Department of Health. This was evident for 2 (two) of 6 (six) residents reviewed for injury of unknown origin. (Resident #2 and Resident #3). Specifically, 1) On 12/26/2025, Resident #2 was provided with morning care, was unable to walk and had a significant bruise on their right hip. Resident #2 was sent out to the hospital for x-rays, and it was determined that they had a fractured right hip. There was no indication of how this occurred, no facility investigation, and no report to the New York State Department of Health. 2) On 12/15/2025, Resident #3 was noted to have a bruise on their left leg, was transferred to the emergency department on 12/19/2025 and diagnosed with a fracture of unknown origin to their left tibia and fibula. Each incident resulted in an injury of unknown origin to Resident #2 and #3 which the facility failed to report to the New York State Department of Health within the prescribed regulatory timeframe. The undated policy titled Accidents and Incidents - Investigating and Reporting documented under Policy interpretation and implementation part 2 (two) the following data, as applicable, shall be included on the report of incident/accident form: a. the date and time the accident or incident took place. b. The nature of the injury/illness. c. The circumstances surrounding the accident or incident. d. Where the accident or incident took place. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. It further documented that the Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/Accident form for each occurrence. Resident #2Resident #2 was originally admitted with diagnoses including, but not limited to, muscle weakness, insomnia, and glaucoma secondary to eye inflammation, bilateral. A diagnosis of other specified disorders of bone density and structure unspecified is indicated with an onset date of 01/03/2026.The 11/15/2025 Quarterly Review Minimum Data Set documented that Resident #2 was severely cognitively impaired. They had no need indicated for a mobility device, they required supervision or touching for most of their functional abilities like upper and lower body dressing, they were independent for rolling left and right, they required set up or clean-up for chair to bed transfer meaning they completed the activity on their own; the helper only assisted with set up prior to or following the activity.The Health Status note dated 12/22/2025 documented the resident returned from an eye doctor appointment with orders for urgent trab (trabeculectomy - a glaucoma surgery that creates a tiny drainage pathway to lower eye pressure) os (left eye) without mitomycin (the surgeon does not use the anti-scaring medication called mitomycin) surgery (NPO (nothing by mouth) after midnight, and needs to be at the hospital by 3:00 PM for surgery. Daughter in agreement. Director of Nursing notified. The Transfer to Hospital Summary dated 12/23/2025 documented the diagnosis was eye surgery procedure, resident was discharged from nursing home facility on 12/23/2025, resident was admitted to hospital for an eye (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
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surgery procedure, was kept overnight for observation, and was anticipated to return once medical issues were resolved. The Health Status note dated 12/24/2025 documented resident returned home (meaning the facility) via stretcher. Eye patch over left eye in place and remain in place until follow up appointment on 12/29/2025 at 9:45 am. No complaints of pain or discomfort. Alarm placed on bed, Resident #2 is not to ambulate without assistance, they cannot bend, or lift, warm compresses four (4) times a day. Bruising noted right hand.The 12/25/2025 Accident and Incident report for the incident with Resident #2 is report number 1931 and provides the following description: Certified Nurse Assistant called nurse to room as bruise of light to dark purple in color, size of a 50-cent piece was found on right hip. Resident unable to give description. Immediate action taken includes x-ray order placed, provider aware, Director of Nursing aware, family aware, resident recently out for eye surgery alone. Resident sent to emergency department per family request. Resident taken to hospital. Note entered at end of incident report dated 12/29/2025 documented with very limited medical history, as per family resident declined to promote health and wellness for the majority of their life and has a long-standing history of tobacco product usage. Provider reviewed medical history and notes resident with osteoporosis. No evidence of abuse, neglect or mistreatment indicated. Resident was recently at the hospital alone without family support for eye surgery. There are no statements on this incident report. Review of the x-ray image results dated 12/28/2025 documented the findings as follows: A displaced acute fracture of the right femoral neck (upper part of thigh bone). No aggressive osseous lesion (an area of abnormal growth, damage, or tissue change within a bone, effectively replacing healthy bone with abnormal tissue) is present. No erosions (localized destruction or breakdown of bone tissue) were seen. Impression displaced acute traumatic fracture (occurs when a bone breaks into two or more pieces that shift out of normal alignment, often caused by severe trauma or falls) of the right femoral neck.During an interview with the Medical Director on 01/29/2026 at 3:42 PM, they stated in this case they would think there would be more of an investigation to see what happened, maybe everyone got into the holiday mood, maybe people were on vacation. They would expect a look back of staff that provided care. They had no idea what caused the incident. It is possible that Resident #2 could have fallen and then put themself back in bed. When reviewing the x-ray result, the Medical Director stated that Resident #2 had a fracture based on the resident's history and that this is a fracture of the hip, they would not assume it is trauma related. The Medical Director stated they think the person that read the x-ray made a mistake. The Medical Director stated that it was a Type 3 fracture which means partially displaced. The Medical Director stated that it may have been from trauma and maybe the resident did fall, but a resident could also have a fracture like this just because of osteoporosis.During an interview with Certified Nurse Assistant #1 on 02/03/2026 at 1:40 PM, they stated that they found a bruise on Resident #2's right hip, they had no idea what occurred, they had just come in that Friday and found it. Certified Nurse Assistant #1 stated that Resident #2 was fine before that time. Certified Nurse Assistant #1 stated Resident #2 could not stand and stated it hurt, and normally they could stand. Certified Nurse Assistant #1 stated that the resident walked out for their surgery that Tuesday the 23rd and on the 24th they were back at the facility with an eye patch on and could still get up and move. Certified Nurse Assistant #1 stated that they did not work on Christmas and did not know what occurred. Certified Nurse Assistant #1 stated that on Friday the 26th, they did not ask Resident #2 what happened, they just asked what was wrong. Certified Nurse Assistant #1 stated that Resident #2 was just telling them that it hurt and they could not get up and could not walk. Resident #3Resident #3 was originally admitted on [DATE] with the following diagnoses including but not limited to Alzheimer's disease, intermittent explosive disorder (a chronic mental health condition characterized by recurrent sudden episodes of impulsive, aggressive, or violent behavior disproportionate to the situation), and generalized anxiety disorder. The quarterly minimum data set, an assessment tool, dated 10/19/2025 documented that Resident #3 was severely cognitively impaired, they did not have any behaviors, they were incontinent of bowel and bladder, they had a wheelchair for mobility, unable to self-transfer and needed partial moderate (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance to roll left and right in bed meaning the helper lifts, holds or supports the trunk or limbs but provides less than half the effort.The accident incident report prepared by the Infection Control Nurse dated 12/15/2025 at 8:58 am is numbered #1912 titled bruises documented that staff alerted registered nurse that Resident #3 had a large bruise to the left lower extremity. On inspection, resident has a large purple bruise noted to left lower leg. Resident #3 laughed when asked what occurred. Documented under subtitle immediate action taken description: resident shows mild discomfort when area palpated, Left Lower extremity is noted with mild swelling, no redness or warmth to the area. Resident seen by Nurse Practitioner with no further orders. After investigation, root cause analysis determined to be bumping the Hoyer during transfer. The pain level was assessed at two (2) facial grimacing. Under subheading statements: there are no statements found. The Nurse Practitioner medical visit note written on 12/15/2025 at 3:39 pm documented that resident was seen to evaluate ecchymosis (bruise) on the left lower extremity. Resident #3 was seen sitting up in bed in no acute distress, and no signs or symptoms of pain. The plan for the contusion (bruise) was to monitor area, assess for signs or symptoms of pain.The Medical Director medical visit note dated 12/17/2025 at 11:52 am documented Subjective: Patient is calm today, Patient noted with a large bruise to the left lower leg, no Nausea, vomiting or diarrhea. Objective: vital signs all listed as stable. Assessment: lists all the diagnoses. Order an xray to the lower left extremity at this time. Plan: continue present medications. Health Status note written by the Infection Control Nurse dated 12/19/2025 at 11:22 am documented Xray unable to be completed today, resident has pain on palpitation. Resident to be sent to Emergency Department at this time. Sister made aware and in agreement.Health Status note dated 12/19/2025 at 3:29 pm documented that a call was received from the Emergency Department stating that resident had a fracture of left tibia and fibula and would be transported back to the facility with a knee immobilizer, family made aware. During an interview on 01/21/2026 at 1:18 PM with Certified Nurse Assistant #3, they stated they found the bruise on 12/15/2025 and they told the infection control nurse and the overnight supervisor. They looked at it and they let the Nurse Practitioner know. Resident #3 finally got x-rays on Friday 12/19/2025. The x-ray people never came to the facility, so that Friday, the resident was sent out. Resident #3 had been complaining of pain from the moment staff found the bruise. Certified Nurse Assistant #3 stated that Resident #3 is not a very vocal person, but they said, Ow, ow, that hurts. Certified Nurse Assistant #3 stated they do not know how the bruise happened; Resident #3 gets up before they come in, and they are transferred using a Hoyer. They were last trained on a Hoyer way before Christmas time. Certified Nurse Assistant #3 counted out the number of residents that need a Hoyer for transfer and stated it was 15 to 16 residents on that unit. Certified Nurse Assistant #3 stated that no one knows how it happened. Certified Nurse Assistant #3 stated they were not sure how no one noticed, it was a huge bruise that wrapped around the leg, was swollen, and was green and purple. Certified Nurse Assistant #3 stated that it had been a while since Resident #3 had fallen. Certified Nurse Assistant #3 stated that Resident #3 has a history of sometimes resisting care, making noise and raising their hand up. During an interview with the Director of Nursing on 01/21/2026 at 12:00 PM, they stated they do not know how the Infection Control Nurse concluded that the bruise on Resident #3's leg was from a bump on the Hoyer as there are no statements in the Accident and Incident report. They further stated they do not know why they were not made aware earlier. The Director of Nursing stated that an injury of unknown origin was reported to the Infection Control Nurse on 12/15/2025 and a report was submitted by Director of Nursing to New York State Department of Health on 12/19/2025.10 NYCRR 415.4 (b) (2)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during an abbreviated survey the facility did not ensure accidents of unknown origin were thoroughly investigated for 2 (two) of 6 (six) residents reviewed for accidents (Resident #2 and Resident #3). Specifically, 1) On 12/26/2025, Resident #2 was provided with morning care, was unable to walk and had a significant bruise on their right hip. Resident #2 was sent out to the hospital for x-rays, and it was determined that they had a fractured right hip. There was no indication of how this occurred, no facility investigation, and no report to the New York State Department of Health. 2) On 12/15/2025, Resident #3 was noted to have a bruise on their left leg, was transferred to the emergency department on 12/19/2025 and diagnosed with a fracture of unknown origin to their left tibia and fibula. Each incident resulted in actual harm to Resident #2 and Resident #3 that is not immediate jeopardy.The undated policy titled Accidents and Incidents - Investigating and Reporting documented under Policy interpretation and implementation part 2 (two) the following data, as applicable, shall be included on the report of incident/accident form: a. the date and time the accident or incident took place. b. The nature of the injury/illness. c. The circumstances surrounding the accident or incident. d. Where the accident or incident took place. The Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the Director of Nursing Services within 24 hours of the incident or accident. It further documented that the Director of Nursing shall ensure that the Administrator receives a copy of the Report of Incident/Accident form for each occurrence. Resident #2 was originally admitted with diagnoses including, but not limited to, muscle weakness, insomnia, and glaucoma secondary to eye inflammation, bilateral. The 11/15/2025 Quarterly Review Minimum Data Set documented that Resident #2 was severely cognitively impaired. They had no need indicated for a mobility device, they required supervision or touching for most of their functional abilities like upper and lower body dressing, they were independent for rolling left and right, they required set up or clean-up for chair to bed transfer meaning they completed the activity on their own the helper only assisted with set up prior to or following the activity. The Health Status note dated 12/22/2025 documented the resident returned from an eye doctor appointment with orders for urgent trab (trabeculectomy - a glaucoma surgery that creates a tiny drainage pathway to lower eye pressure) os (left eye) without mitomycin (the surgeon does not use the anti-scaring medication called mitomycin) surgery (NPO (nothing by mouth) after midnight, and needs to be at the hospital by 3:00 PM for surgery. Daughter in agreement. Director of Nursing notified. The Transfer to Hospital Summary dated 12/23/2025 documented the diagnosis was eye surgery procedure, resident was discharged from nursing home facility on 12/23/2025, resident was admitted to hospital for an eye surgery procedure, was kept overnight for observation, and was anticipated to return once medical issues were resolved. The Health Status note dated 12/24/2025 documented the resident returned home (meaning the facility) via stretcher. Eye patch over left eye in place and remain in place until follow up appointment on 12/29/2025 at 9:45 AM. No complaints of pain or discomfort. Alarm placed on bed, Resident #2 is not to ambulate without assistance, they cannot bend, or lift, warm compresses four (4) times a day. Bruising noted right hand.The 12/25/2025 Accident and Incident report for the incident with Resident #2 is report number 1931 and provides the following description: Certified Nurse Assistant called nurse to room as bruise of light to dark purple in color, size of a 50-cent piece was found on right hip. Resident unable to give description. Immediate action taken includes x-ray order placed, provider aware, Director of Nursing aware, family aware, resident recently out for eye surgery alone. Resident sent to emergency department per family request. Resident taken to hospital. Note entered at end of incident report dated 12/29/2025 documented with very limited medical history, as per family resident declined to promote health and wellness for the majority of their life and has a long-standing history of tobacco product usage. Provider reviewed medical history and notes resident with osteoporosis. No evidence (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of abuse, neglect or mistreatment indicated. Resident was recently at the hospital alone without family support for eye surgery. There are no statements on this incident report. Review of the x-ray image results dated 12/28/2025 documented the findings as follows: A displaced acute fracture of the right femoral neck (upper part of thigh bone). No aggressive osseous lesion (an area of abnormal growth, damage, or tissue change within a bone, effectively replacing healthy bone with abnormal tissue) is present. No erosions (localized destruction or breakdown of bone tissue) were seen. Impression displaced acute traumatic fracture (occurs when a bone breaks into two or more pieces that shift out of normal alignment, often caused by severe trauma or falls) of the right femoral neck.During an interview with the Medical Director on 01/29/2026 at 3:42 PM, they stated in this case they would think there would be more of an investigation to see what happened, maybe everyone got into the holiday mood, maybe people were on vacation. They would expect a look back of staff that provided care. They had no idea what caused the incident. It is possible that Resident #2 could have fallen and then put themself back in bed. When reviewing the x-ray result, the Medical Director stated that Resident #2 had a fracture based on the resident's history and that this is a fracture of the hip, they would not assume it is trauma related. The Medical Director stated they think the person that read the x-ray made a mistake. The Medical Director stated that it was a Type 3 fracture which means partially displaced. The Medical Director stated that it may have been from trauma and maybe the resident did fall, but a resident could also have a fracture like this just because of osteoporosis.During an interview with Certified Nurse Assistant #1 on 02/03/2026 at 1:40 PM, they stated that they found a bruise on Resident #2's right hip, they had no idea what occurred, they had just come in that Friday and found it. Certified Nurse Assistant #1 stated that Resident #2 was fine before that time. Certified Nurse Assistant #1 stated Resident #2 could not stand and stated it hurt, and normally they could stand. Certified Nurse Assistant #1 stated that the resident walked out for their surgery that Tuesday the 23rd and on the 24th they were back at the facility with an eye patch on and could still get up and move. Certified Nurse Assistant #1 stated that they did not work on Christmas and did not know what occurred. Certified Nurse Assistant #1 stated that on Friday the 26th, they did not ask Resident #2 what happened, they just asked what was wrong. Certified Nurse Assistant #1 stated that Resident #2 was just telling them that it hurt and they could not get up and could not walk. Resident #3Resident #3 was originally admitted with diagnoses including, but not limited to, Alzheimer's disease, intermittent explosive disorder (a chronic mental health condition characterized by recurrent sudden episodes of impulsive, aggressive, or violent behavior disproportionate to the situation), and generalized anxiety disorder. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #3 was severely cognitively impaired, they did not have any behaviors, they were incontinent of bowel and bladder, they had a wheelchair for mobility, unable to self-transfer and needed partial moderate assistance to roll left and right in bed meaning the helper lifts, holds or supports the trunk or limbs but provides less than half the effort.The Accident Incident report prepared by the Infection Control Nurse dated 12/15/2025 at 8:58 AM is numbered as 1912 and is titled As bruises documented that staff alerted registered nurse that Resident #3 had a large bruise to the left lower extremity. On inspection, the resident had a large purple bruise noted to their left lower leg. Resident #3 laughed when asked what occurred. Documented under the subtitle Immediate Action Taken Description: the resident shows mild discomfort when area palpated, left lower extremity is noted with mild swelling, no redness or warmth to the area. Resident seen by Nurse Practitioner with no further orders. After investigation, root cause analysis determined bruise to be the result of bumping the Hoyer during transfer. The pain level was assessed at two (2) facial grimacing. Under subheading Statements: there are no statements found. The Nurse Practitioner medical visit note written on 12/15/2025 at 3:39 PM documented that resident was seen to evaluate ecchymosis (bruise) on the left lower extremity. Resident #3 was seen sitting up in bed in no acute distress, and no signs or symptoms of pain. The plan for the contusion (bruise) was to monitor area, assess for signs or symptoms of pain.The Medical Director medical visit note dated 12/17/2025 at (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:52 AM documented Subjective: Patient is calm today, Patient noted with a large bruise to the left lower leg, no nausea, vomiting or diarrhea. Objective: vital signs all listed as stable. Assessment: lists all the diagnoses Order an x-ray to the lower left extremity at this time. Plan: continue present medications. The Health Status note written by the Infection Control Nurse dated 12/19/2025 at 11:22 AM documented Xray unable to be completed today, resident has pain on palpitation. Resident to be sent to Emergency Department at this time. Sister made aware and in agreement.The Health Status note dated 12/19/2025 at 3:29 PM documented that a call was received from the Emergency Department stating that resident had a fracture of left tibia and fibula (bones of the leg) and would be transported back to the facility with a knee immobilizer, family made aware. During an interview on 01/21/2026 at 1:18 PM with Certified Nurse Assistant #3, they stated they found the bruise on 12/15/2025 and they told the infection control nurse and the overnight supervisor. They looked at it and they let the Nurse Practitioner know. Resident #3 finally got x-rays on Friday 12/19/2025. The x-ray people never came to the facility, so that Friday, the resident was sent out. Resident #3 had been complaining of pain from the moment staff found the bruise. Certified Nurse Assistant #3 stated that Resident #3 is not a very vocal person, but they said, Ow, ow, that hurts. Certified Nurse Assistant #3 stated they do not know how the bruise happened; Resident #3 gets up before they come in, and they are transferred using a Hoyer. They were last trained on a Hoyer way before Christmas time. Certified Nurse Assistant #3 counted out the number of residents that need a Hoyer for transfer and stated it was 15 to 16 residents on that unit. Certified Nurse Assistant #3 stated that no one knows how it happened. Certified Nurse Assistant #3 stated they were not sure how no one noticed, it was a huge bruise that wrapped around the leg, was swollen, and was green and purple. Certified Nurse Assistant #3 stated that it had been a while since Resident #3 had fallen. Certified Nurse Assistant #3 stated that Resident #3 has a history of sometimes resisting care, making noise and raising their hand up. During an interview with the Director of Nursing on 01/21/2026 at 12:00 PM, they stated they do not know how the Infection Control Nurse concluded that the bruise on Resident #3's leg was from a bump on the Hoyer as there are no statements in the Accident and Incident report. They further stated they do not know why they were not made aware earlier. The Director of Nursing stated that an injury of unknown origin was reported to the Infection Control Nurse on 12/15/2025 and a report was submitted by Director of Nursing to New York State Department of Health on 12/19/2025.10 NYCRR 415.4(b)(3)

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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 0689 Level of Harm - Actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews conducted during a survey, the facility failed to ensure that the resident environment was free of accident hazards and/or that each resident received adequate supervision to prevent accidents for three (3) of six (6) residents reviewed for accidents (Resident #1, #2, & 3). Specifically, 1) On 11/01/2024, Certified Nurse Assistant #2 did not follow the care plan and attempted to transfer Resident #1 by themself as a stand pivot and the resident fell, hit their head, and subsequently required transfer to the hospital. 2) On 12/26/2025, Resident #2 was provided with morning care, was unable to walk and had a significant bruise on their right hip. Resident #2 was sent out to the hospital for x-rays, and it was determined that they had a fractured right hip. There was no indication of how this occurred, no facility investigation, and no report to the New York State Department of Health. 3) On 12/15/2025, Resident #3 was noted to have a bruise on their left leg, was transferred to the emergency department on 12/19/2025 and diagnosed with a fracture of unknown origin to their left tibia and fibula. Each incident resulted in actual harm to Residents #1, #2 and #3 respectively, that was not Immediate Jeopardy. The undated facility policy titled Activities of Daily Living (ADL) Total Care Policy documented that the purpose of the policy is to establish guidelines for providing comprehensive assistance with Activities of Daily Living (ADLs) to residents or patients. It aims to ensure that each individual's basic needs are met while promoting dignity, independence, and comfort. Under subheading number five (5) ADL Assistance Procedures, subheading number five (5) Mobility and Transferring, the policy aims to ensure that the environment is free of hazards to prevent falls. The undated facility policy Mechanical Lift documented that the standard is a mechanical lift will be used appropriately and safely to facilitate transfer of residents. Resident #1Resident #1 was first admitted with diagnoses, including but not limited to, traumatic subdural hemorrhage (brain injury occurring when blood collects between the brain and its outer lining) without loss of consciousness, unspecified dementia mild with mood disturbance, and muscle weakness. Review of care plan initiated 07/08/2022 documented that resident needs assistance with Activity of Daily Living due to limited mobility and dementia. The documented intervention for chair/bed to chair transfer is that Resident was dependent on two-person assistance. The 10/24/2024 annual Minimum Data Set (a resident assessment tool) documented that Resident #1 was moderately cognitively impaired. They had a wheelchair as their mobility device, they required substantial maximal assistance for rolling left and right, they were dependent for chair to bed transfer (meaning the resident does none of the effort to complete the activity and helper does all of the activity). The 11/01/2024 Accident and Incident report for the incident with Resident #1 is numbered as 1355 and is titled as a witnessed fall, and it is documented under nursing description: called to resident's room. Resident lying in bed on their back. Open area to left side of forehead above left eye 4 centimeters x 3 centimeters x 0.3 centimeter. Wheelchair next to bed. Bedside table next to nightstand. Complaint of pain to left shoulder. Resident stated I don't know what happened, I fell. The statement from Certified Nurse Assistant #2 on 11/01/2024 documented while transferring resident into their wheelchair for lunch, resident's one leg twisted and the resident fell onto the floor. Resident #1 hit their head on the bedside table, and the garbage can and landed on their left side. The statement from Certified Nurse Assistant #2 documents that they were unable to stop the fall from happening. Resident #1 had nonskid socks on at the time of fall. Call bell on bed. The Interdisciplinary Team review done on 11/04/2024 documented that based on hospital records, medical chart review, and staff statements/interviews, resident had a fall which resulted in a laceration to the resident's forehead. Per the resident's care plan, they are a 2-person assist with transfers, and Certified Nurse Assistant #2 did not follow this, and they stated during the interview that they were not aware of the resident being a 2-person assist for transfer because they did not look. The Plan of Care per the (continued on next page)

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	02/02/2026

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.

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Interdisciplinary Team meeting documented that the resident received sutures to their forehead that would be removed by the facility Nurse Practitioner or medical provider, the resident was put on the case load for physical therapy and at that time, it was recommended that the resident was downgraded to a 2-person assist with the use of a mechanical lift. The review of a Health Status note with an effective date of 11/01/2024 documented that Resident #1 received seven (7) stitches, was given morphine in the emergency room for pain, and all scans came back negative for fracture.During an interview on 01/22/2026 at 3:35 PM with the Infection Control Nurse, they stated that they were the Director of Nursing at the time of the 11/01/2024 incident with Resident #3. The Infection Control Nurse stated that when they interviewed Certified Nurse Assistant #2, they had stated they were not aware that Resident #1 was a two-person stand pivot. In their Incident/Accident interview, Certified Nurse Assistant #2 stated that they did not check the Kardex (guide used by staff to provide care). The Infection Control Nurse stated should the staff talk to each other? Yes, but at the end of the day you are supposed to check your Kardex and had Certified Nurse Assistant #2 checked the Kardex, which was accurate at the time, this would not have happened. The Infection Control Nurse stated that Certified Nurse Assistant #2 also said that they had seen other people transferring Resident #1 alone. The Infection Control Nurse stated that Certified Nurse Assistant #2 was re-educated on safe patient handling, but they did not recall if Certified Nurse Assistant #2 was reprimanded. The Infection Control Nurse stated that the Kardex is how you know what to do and that the certified nurse assistants all get the Kardex point of care training at orientation. They stated that they recall their interview with Certified Nurse Assistant #2, and they had stated to them, Why didn't you check the Kardex? How did you know something didn't change? They recalled asking Certified Nurse Assistant #2 if they knew how to check the Kardex and Certified Nurse Assistant #2 said that they did know. The Infection Control Nurse stated that after completing the training program, the certified nurse assistants should be able to verbalize their resident assignments and demonstrate where to obtain current information on care delivery tasks. The Infection Control Nurse stated that Resident #1's record indicated that they were a two-person transfer. Resident #2Resident #2 was originally admitted with diagnoses including, but not limited to, muscle weakness, insomnia, and glaucoma secondary to eye inflammation, bilateral. The 11/15/2025 Quarterly Review Minimum Data Set documented that Resident #2 was severely cognitively impaired. They had no need indicated for a mobility device, they required supervision or touching for most of their functional abilities like upper and lower body dressing, they were independent for rolling left and right, they required set up or clean-up for chair to bed transfer meaning they completed the activity on their own; the helper only assisted with set up prior to or following the activity.The Health Status note dated 12/22/2025 documented the resident returned from an eye doctor appointment with orders for urgent trab (trabeculectomy - a glaucoma surgery that creates a tiny drainage pathway to lower eye pressure) os (left eye) without mitomycin (the surgeon does not use the anti-scaring medication called mitomycin) surgery NPO (nothing by mouth) after midnight, and needs to be at the hospital by 3:00 PM for surgery. Daughter in agreement. Director of Nursing notified. The Transfer to Hospital Summary dated 12/23/2025 documented the diagnosis was eye surgery procedure, resident was discharged from nursing home facility on 12/23/2025, resident was admitted to hospital for an eye surgery procedure, was kept overnight for observation, and was anticipated to return once medical issues were resolved. The Health Status note dated 12/24/2025 documented the resident returned home (meaning the facility) via stretcher. Eye patch over left eye in place and remain in place until follow up appointment on 12/29/2025 at 9:45 AM. No complaints of pain or discomfort. Alarm placed on bed, Resident #2 is not to ambulate without assistance, they cannot bend, or lift, warm compresses four (4) times a day. Bruising noted right hand. The 12/25/2025 Accident and Incident report for the incident with Resident #2 is report number 1931 and provides the following description: Certified Nurse Assistant called nurse to room as bruise of light to dark purple in color, size of a 50-cent piece was found on right hip. Resident unable to give description. Immediate action taken includes x-ray order placed, provider (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	aware, Director of Nursing aware, family aware, resident recently out for eye surgery alone. Resident sent to emergency department per family request. Resident taken to hospital. Note entered at end of incident report dated 12/29/2025 documented with very limited medical history, as per family resident declined to promote health and wellness for the majority of their life and has a long-standing history of tobacco product usage. Provider reviewed medical history and notes resident with osteoporosis. No evidence of abuse, neglect or mistreatment indicated. Resident was recently at the hospital alone without family support for eye surgery. There are no statements on this incident report. Review of the x-ray image results dated 12/28/2025 documented the findings as follows: A displaced acute fracture of the right femoral neck (upper part of thigh bone). No aggressive osseous lesion (an area of abnormal growth, damage, or tissue change within a bone, effectively replacing healthy bone with abnormal tissue) is present. No erosions (localized destruction or breakdown of bone tissue) were seen. Impression displaced acute traumatic fracture (occurs when a bone breaks into two or more pieces that shift out of normal alignment, often caused by severe trauma or falls) of the right femoral neck.During an interview with the Medical Director on 01/29/2026 at 3:42 PM, they stated in this case they would think there would be more of an investigation to see what happened, maybe everyone got into the holiday mood, maybe people were on vacation. They would expect a look back of staff that provided care. They had no idea what caused the incident. It is possible that Resident #2 could have fallen and then put themself back in bed. When reviewing the x-ray result, the Medical Director stated that Resident #2 had a fracture based on the resident's history and that this is a fracture of the hip, they would not assume it is trauma related. The Medical Director stated they think the person that read the x-ray made a mistake. The Medical Director stated that it was a Type 3 fracture which means partially displaced. The Medical Director stated that it may have been from trauma and maybe the resident did fall, but a resident could also have a fracture like this just because of osteoporosis.During an interview with Certified Nurse Assistant #1 on 02/03/2026 at 1:40 PM, they stated that they found a bruise on Resident #2's right hip, they had no idea what occurred, they had just come in that Friday and found it. Certified Nurse Assistant #1 stated that Resident #2 was fine before that time. Certified Nurse Assistant #1 stated Resident #2 could not stand and stated it hurt, and normally they could stand. Certified Nurse Assistant #1 stated that the resident walked out for their surgery that Tuesday the 23rd and on the 24th they were back at the facility with an eye patch on and could still get up and move. Certified Nurse Assistant #1 stated that they did not work on Christmas and did not know what occurred. Certified Nurse Assistant #1 stated that on Friday the 26th, they did not ask Resident #2 what happened, they just asked what was wrong. Certified Nurse Assistant #1 stated that Resident #2 was just telling them that it hurt and they could not get up and could not walk. Resident #3Resident #3 was originally admitted with diagnoses including, but not limited to, Alzheimer's disease, intermittent explosive disorder (a chronic mental health condition characterized by recurrent sudden episodes of impulsive, aggressive, or violent behavior disproportionate to the situation), and generalized anxiety disorder. The Quarterly Minimum Data Set, dated [DATE] documented that Resident #3 was severely cognitively impaired, they did not have any behaviors, they were incontinent of bowel and bladder, they had a wheelchair for mobility, unable to self-transfer and needed partial moderate assistance to roll left and right in bed meaning the helper lifts, holds or supports the trunk or limbs but provides less than half the effort.The Accident Incident report prepared by the Infection Control Nurse dated 12/15/2025 at 8:58 AM is numbered as 1912 and is titled As bruises documented that staff alerted registered nurse that Resident #3 had a large bruise to the left lower extremity. On inspection, the resident had a large purple bruise noted to their left lower leg. Resident #3 laughed when asked what occurred. Documented under the subtitle Immediate Action Taken Description: the resident shows mild discomfort when area palpated, left lower extremity is noted with mild swelling, no redness or warmth to the area. Resident seen by Nurse Practitioner with no further orders. After investigation, root cause analysis determined bruise to be the result of bumping the Hoyer during transfer. The pain level was assessed at two (2) facial (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	grimacing. Under subheading Statements: there are no statements found. The Nurse Practitioner medical visit note written on 12/15/2025 at 3:39 PM documented that resident was seen to evaluate ecchymosis (bruise) on the left lower extremity. Resident #3 was seen sitting up in bed in no acute distress, and no signs or symptoms of pain. The plan for the contusion (bruise) was to monitor area, assess for signs or symptoms of pain.The Medical Director medical visit note dated 12/17/2025 at 11:52 AM documented Subjective: Patient is calm today, Patient noted with a large bruise to the left lower leg, no nausea, vomiting or diarrhea. Objective: vital signs all listed as stable. Assessment: lists all the diagnoses Order an x-ray to the lower left extremity at this time. Plan: continue present medications. The Health Status note written by the Infection Control Nurse dated 12/19/2025 at 11:22 AM documented x-ray unable to be completed today, resident has pain on palpitation [sic]. Resident to be sent to Emergency Department at this time. Sister made aware and in agreement.The Health Status note dated 12/19/2025 at 3:29 PM documented that a call was received from the Emergency Department stating that resident had a fracture of left tibia and fibula (bones of the leg) and would be transported back to the facility with a knee immobilizer, family made aware. During an interview on 01/21/2026 at 1:18 PM with Certified Nurse Assistant #3, they stated they found the bruise on 12/15/2025 and they told the infection control nurse and the overnight supervisor. They looked at it and they let the Nurse Practitioner know. Resident #3 finally got x-rays on Friday 12/19/2025. The x-ray people never came to the facility, so that Friday, the resident was sent out. Resident #3 had been complaining of pain from the moment staff found the bruise. Certified Nurse Assistant #3 stated that Resident #3 is not a very vocal person, but they said, Ow, ow, that hurts. Certified Nurse Assistant #3 stated they do not know how the bruise happened; Resident #3 gets up before they come in, and they are transferred using a Hoyer. They were last trained on a Hoyer way before Christmas time. Certified Nurse Assistant #3 counted out the number of residents that need a Hoyer for transfer and stated it was 15 to 16 residents on that unit. Certified Nurse Assistant #3 stated that no one knows how it happened. Certified Nurse Assistant #3 stated they were not sure how no one noticed, it was a huge bruise that wrapped around the leg, was swollen, and was green and purple. Certified Nurse Assistant #3 stated that it had been a while since Resident #3 had fallen. Certified Nurse Assistant #3 stated that Resident #3 has a history of sometimes resisting care, making noise and raising their hand up. During an interview with the Director of Nursing on 01/21/2026 at 12:00 PM, they stated they do not know how the Infection Control Nurse concluded that the bruise on Resident #3's leg was from a bump on the Hoyer as there are no statements in the Accident and Incident report. They further stated they do not know why they were not made aware earlier. The Director of Nursing stated that an injury of unknown origin was reported to the Infection Control Nurse on 12/15/2025 and a report was submitted by Director of Nursing to New York State Department of Health on 12/19/2025. 10 New York Codes, Rules and Regulations 415.12(h)(2)