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	05/29/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observations, record review, and interviews conducted during a Survey, the facility did not ensure a resident's right to be free from abuse for one (1) Resident #1 of four (4) residents reviewed for abuse. Specifically, on 05/11/2026, Certified Nurse Aide #1 reported observing Certified Nurse Aide #2 forcibly grab Resident #1, and push the resident against a wheelchair, using the dinning room table as a barrier preventing Resident #1 from getting out of the wheelchair and repeatedly used profanities towards Resident #1. Certified Nurse Aide #1 reported the allegation of verbal and physical abuse involving Resident #1 and Certified Nurse Aide #2 to Registered Nurse Supervisor #1 and Licensed Practical Nurse #1. Certified Nurse Aide #2 was not removed from the unit and continued to be assigned to care for Resident #1 from the date of the allegation until 05/21/2026 during the onsite visit when Certified Nurse Aide #2 was reassigned.The Findings include: The facility policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Residents' Property, revised 02/2026, documented the facility will investigate all incidents, grievances/complaints. The investigation process will include: statements from staff, witnesses, residents, interviews with staff witnesses, resident medical record review if applicable, and review of employee record. All findings of investigation will be documented. Investigative reports will summarize the findings and outcome as well as note any corrective action or follow-up. The policy further documented the facility will protect all residents during any investigation by reassigning staff and/or providing counseling to residents. The policy further documented that in the event suspicion of abuse is being investigated, the staff member will be suspended or reassigned until the investigation is complete. Resident #1 was admitted with diagnoses including, but not limited to, dementia, depression, and anemia. The 04/11/2026 admission Minimum Data Set documented Resident #1 had moderately impaired cognition. During an observation on 05/21/2026 at 02:50 PM, Resident #1 was observed seated at a table in the dayroom on Unit 2 with peers. Resident #1 appeared pleasant and in no apparent distress. Surveyor attempted to speak with Resident #1 regarding the alleged incident; however, Resident #1 was unable to recall the incident. Review of the psychosocial well-being care plan initiated 04/09/2026 documented Resident #1 had the potential for Abuse related to resistance to care, verbal aggression and physical aggression. Interventions included allowing Resident #1 to express feelings of being fearful, anxious, as necessary; developing a trusting, therapeutic relationship; encouraging Resident #1 to report any form of abuse from peers or staff members; and following facility protocol for reporting Abuse, Mistreatment or Neglect. Review of the behavior care plan revised 04/24/2026 documented Resident #1 had the potential to be verbally aggressive toward staff when frustrated or confused related to difficulty understanding situations, unmet needs, or communication breakdowns. Interventions included analyzing key times, places, circumstances, triggers, and what de-escalates behavior and documenting findings. Review of Resident #1's Electronic Medical Record revealed staff statements were obtained regarding the allegations of abuse on 05/11/2026. Review of a statement dated 05/11/2026 from Certified Nurse Aide #3 documented they overheard yelling while providing care in the shower room. Review of a statement dated 05/11/2026 from Licensed Practical Nurse #1 documented Certified Nurse Aide #1 approached them regarding inappropriate language toward (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1 and requested to speak to the Registered Nurse Supervisor. Review of a statement dated 05/11/2026 from Registered Nurse Supervisor #1 documented Certified Nurse Aide #1 requested to speak regarding accusations of abuse and inappropriate language toward Resident #1 involving Certified Nurse Aide #2. Review of staffing assignments showed Certified Nurse Aide #2 was not assigned to Resident #1 on 05/11/2026. However, Resident #1 remained routinely assigned to Certified Nurse Aide #2 following 05/11/2026 through 05/21/2026. There was no documented evidence of a resident assessment, physician notification, psychiatric/psychology consult, accident and incident report, an investigation summary, law enforcement notification, care plan review/update, or abuse investigation related to the allegations involving Resident #1 on 05/11/2026. During an interview on 05/21/2026 at 02:08 PM, Certified Nurse Aide #1 stated Resident #1 was near the nurses' station yelling profanities and asking to be toileted with pants down. Certified Nurse Aide #1 stated Certified Nurse Aide #2 was yelled the same profanities back to Resident #1, aggressively pushed Resident #1 back into the wheelchair, and later placed Resident #1 in the dining/dayroom area with the wheelchair against the wall and the dining room table positioned against Resident #1, preventing Resident #1 from getting out of the wheelchair. Certified Nurse Aide #1 stated observations were reported to Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 on 05/11/2026. During an interview on 05/21/2026 at 03:18 PM, Certified Nurse Aide #3 stated no yelling heard involving Resident #1 and Certified Nurse Aide #2 because they were in the shower room providing care. Certified Nurse Aide #3 stated Certified Nurse Aide #1 approached them regarding the incident and asked whether any yelling had been heard. Certified Nurse Aide #3 stated Registered Nurse Supervisor #1 came to the unit and asked if any yelling was heard or verbal/ physical abuse of Resident #1 by Certified Nurse Aide #2 was observed. Certified Nurse Aide #3 stated Certified Nurse Aide #2 was not removed from the unit. During an interview on 05/21/2026 at 03:50 PM, Licensed Practical Nurse #1 stated there was an incident on 05/11/2026. An agency Certified Nurse Aide reported that Certified Nurse Aide #2 was verbally abusive to Resident #1. Licensed Practical Nurse #1 stated the allegation was reported to them and they immediately reported it to Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated a statement was requested and completed on 05/11/2026. Licensed Practical Nurse #1 stated Certified Nurse Aide #2 was not removed from the unit. During an interview on 05/21/2026 at 04:58 PM, Certified Nurse Aide #2 stated Resident #1 was sitting in the dining/dayroom area yelling and cursing and they were attempting to redirect Resident #1 regarding the language being used. Certified Nurse Aide #2 stated Certified Nurse Aide #1 accused Certified Nurse Aide #2 of cursing at and being abusive toward Resident #1. Certified Nurse Aide #2 stated Resident #1 was yelling and cursing, which was normal behavior for Resident #1but they did not pin Resident #1 against the wall or blocked in by a table. Certified Nurse Aide #2 stated the incident was reported to the supervisor and the supervisor came to the unit to speak with staff separately regarding what transpired. Certified Nurse Aide #2 stated although Resident #1 was not assigned to them the night of the incident, but they have been working on Resident #1's unit and Resident #1 has been routinely assigned to them since the incident until 05/21/2026. Certified Nurse Aide #2 stated they were reassigned to another unit on 05/21/2026. During an interview on 05/21/2026 at 05:10 PM, Registered Nurse Supervisor #1 stated Certified Nurse Aide #1 reported the allegations of verbal/ physical abuse involving Resident #1 and Certified Nurse Aide #2 to them on 05/11/2026. Registered Nurse Supervisor #1 stated Certified Nurse Aide #1 alleged Certified Nurse Aide #2 was yelling profanities at Resident #1, getting in Resident #1's face, and pushed Resident #1 into the corner/dayroom area. Certified Nurse Aide #1 stated Certified Nurse Aide #2 was not dealing with Resident #1 appropriately. Registered Nurse Supervisor #1 stated the Director of Nursing was notified and staff statements were collected. Certified Nurse Aide #2 remained on the unit following the allegations but according to facility policy, they should have been sent home. During an interview on 05/21/2026 at 05:31 PM, the Director of Nursing stated Registered Nurse Supervisor #1 called on 05/11/2026 to inform them that Certified Nurse Aide #1 was yelling at Certified Nurse Aide #2 about (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	allegations that Certified Nurse Aide #2 yelled at Resident #1. The Director of Nursing stated while on the phone, Registered Nurse Supervisor #1 was instructed to obtain staff statements. No investigation or Accident and Incident report was initiated because it was believed Certified Nurse Aide #1 was fabricating the allegations. During a follow-up interview on 05/22/2026 at 03:18 PM, the Director of Nursing stated Registered Nurse Supervisor #1 was given direction on 05/11/2026 to initiate an investigation regarding the allegations involving Resident #1 and Certified Nurse Aide #2. The Director of Nursing stated Certified Nurse Aide #2 should have been removed from assignments pending the investigation. When they returned to the facility the following day, only staff statements were left under their office door. The Director of Nursing stated psychiatric recommendations, body assessments, and nursing assessments are supposed to be completed for allegations of abuse and acknowledged they were not documented as done. During an interview on 05/22/2026 at 04:13 PM, the Administrator stated they were not made aware of the allegations of abuse verbal/physical abuse by Certified Nurse Aide #2 against Resident #1 until they were contacted by the Attorney General's office on 05/21/2026. The Administrator stated statements were collected on 05/11/2026 to address Certified Nurse Aide #1 becoming upset and leaving their shift. The Administrator stated Certified Nurse Aide #2 continued working in the facility following the allegations and was reassigned to another unit on 05/21/2026. During a follow-up interview on 05/22/2026 at 03:25 PM, the Administrator stated the alleged incident involving Resident #1 should have been investigated and an Accident and Incident report should have been initiated. Registered Nurse Supervisor #1 should have completed a body assessment, written a nursing assessment, and initiated an investigation. Psychiatric/ psychological services should have been made aware of the allegations involving Resident #1. Staff should not use foul language toward residents as a means of redirection. During an interview on 05/26/2026 at 02:58 PM, Psychiatrist #1 stated Psychiatrist #1 saw Resident #1 on 05/26/2026 due to the allegations of abuse. Psychiatrist #1 stated this was the first time they were made aware of the incident. Psychiatrist #1 stated Resident #1 was very confused and disoriented and was unable to communicate. Psychiatrist #1 stated they expect to be notified of allegations of abuse so that residents can be evaluated timely. During an interview on 05/27/2026 at 02:28 PM, the Medical Director stated the Medical Director was made aware of the allegations on 05/21/2026. The Medical Director stated they expect to be notified right away about incidents of abuse so that the resident can be evaluated timely for harm. The Medical Director stated when Resident #1 was seen there were no injuries, however, Resident #1 was confused and could not recall the incident. Resident #1 has advanced dementia. The Medical Director stated arguing in front of residents can cause psychological harm and if that happens, residents should be evaluated. 10 NYCRR 415.4(b)(1)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on observations, record review, and interviews conducted during the Abbreviated Survey, the facility failed to ensure that alleged violations involving abuse were reported to the Department of Health immediately, but not later than 2 hours after the allegation if the events that caused the allegation result in serious bodily injury, or not later than 24 hours if the events that caused the allegation do not result in serious bodily injury, and report the results of the investigation to the Department of Health within 5 working days. This was evident for one (1) Resident #1 of four (4) residents reviewed for abuse. Specifically, on 05/11/2026, Certified Nurse Aide #1 reported an alleged physical/verbal abuse of Resident #1 by Certified Nurse Aide #2 to Licensed Practical Nurse #1 and Registered Nurse Supervisor #1. Certified Nurse Aide #1 reported observing Certified Nurse Aide #2 forcibly grab Resident #1, force Resident #1 into a wheelchair, place a dining room table in front of Resident #1 to prevent movement, and repeatedly use profanities toward Resident #1. The facility did not report the allegation to the New York State Department of Health until 05/21/2026.The Findings include:The facility policy titled Abuse, Neglect, Exploitation, Mistreatment, and Misappropriation of Residents' Property, revised 02/2026, documented, The facility will report any Incident and/or violation where Abuse, Neglect, mistreatment, or misappropriation of property is suspected to the New York State Department of Health according to protocol. The policy further documented, If the crime involves serious bodily injury, it must be reported immediately, but no later than 2 hours after forming the suspicion or if the crime does not appear to cause serious bodily injury you must report it within 24 hours of forming the suspicion. The policy further documented, Investigation Summary Report must be submitted to NYDOH within 5 business days.Resident #1 was admitted to the facility with diagnoses including, but not limited to, dementia, depression, and anemia.The admission Minimum Data Set (a resident assessment tool) dated 04/11/2026 documented Resident #1 had moderately impaired cognition.During an interview on 05/21/2026 at 02:08 PM, Certified Nurse Aide #1 stated Resident #1 was near the nurses' station yelling profanities and asking to be toileted while pants were down. Certified Nurse Aide #1 stated Certified Nurse Aide #2 was yelling the same profanities back to Resident #1, aggressively pushed Resident #1 back into the wheelchair, and later placed Resident #1 in the dining/dayroom area with the wheelchair against the wall and the dining room table positioned against Resident #1, preventing Resident #1 from getting out of the wheelchair. Certified Nurse Aide #1 stated observations were reported to Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 on 05/11/2026.Review of facility documentation revealed the allegation involving Resident #1, reported on 05/11/2026, was not reported to the New York State Department of Health until 05/21/2026.During an interview on 05/21/2026 at 04:13 PM and on 05/22/2026 at 03:25 PM, the Administrator stated they were not made aware of the incident involving allegations of abuse involving Certified Nurse Aide #2 allegedly being verbally and physically abusive toward Resident #1 until contacted by the Attorney General's office on 05/21/2026. The Administrator stated the facility process for reporting is that when the supervisor gets a report, they will call the Director of Nursing and Administrator to inform them and the Administrator or the Director of Nursing will report to the New York State Department of Health. The Administrator stated the alleged incident of abuse should have been investigated and reported.During an interview on 05/21/2026 at 05:10 PM, Registered Nurse Supervisor #1 stated Certified Nurse Aide #1 reported allegations of verbal and physical abuse to them on 05/11/2026. Registered Nurse Supervisor #1 stated the Director of Nursing was notified on 05/11/2026.During an interview on 05/21/2026 at 05:31 PM, the Director of Nursing stated office staff who are mandated reporters know they are required to report allegations of abuse and staff are left with instructions regarding reporting requirements. The Director of Nursing stated the allegations were not reported to the New York State Department of Health because it was not believed that abuse had occurred. 10 NYCRR 415.4(b)(2)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. Based on observations, record review, and interviews conducted, the facility failed to investigate an allegation of abuse and implement appropriate corrective actions to protect a resident from further abuse. This was evident for one resident (Resident #1) of four residents reviewed for abuse. Specifically, on 05/11/2026, Certified Nurse Aide #1 reported to Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 that they observed Certified Nurse Aide #2 forcibly grab Resident #1 and push the resident into a wheelchair, then use the dining room table as a barrier preventing Resident #1 from getting out of the wheelchair. Certified Nurse Aide #1 also reported that they heard Certified Nurse Aide #2 repeatedly use profanities toward Resident #1. After receiving the report of the allegations, Registered Nurse Supervisor #1 did not initiate an immediate investigation, including assessing Resident #1 for physical injuries or psychosocial harm and they did not remove Certified Nurse Aide #2 from direct access to Resident #1 or other residents. The facility's failure to investigate the allegation of abuse, assess the resident and remove Certified Nurse Aide #2 from assignment posed the likelihood of harm to Resident #1 which was Immediate Jeopardy and the potential for harm to other residents in the facility. The findings Include:The facility policy titled Accidents and Incidents - Investigating and Reporting Policy, revised February 2026, documented that all accidents and incidents involving residents shall be immediately assessed, investigated, documented, and reported in accordance with federal and state regulations. Immediate actions included ensuring resident safety and providing a medical assessment, obtaining vital signs and neurological checks if indicated, notifying the Attending Physician and resident representative, and initiating an incident report immediately. The policy documented the Nurse Supervisor/Charge Nurse shall initiate investigation at the time of discovery. Investigation must include the date and time of incident, nature and extent of injury, witness statements, resident statement (if able), corrective actions taken, and follow-up documentation. The policy further documented that if the incident involves suspected abuse, neglect, exploitation, serious bodily injury, or injury of unknown origin, reporting shall occur in accordance with the Abuse, Neglect, and Injury of Unknown Origin Reporting Policy. Resident #1 was admitted to the facility with diagnoses including, but not limited to, dementia, depression, and anemia (a condition characterized by a deficiency of healthy red blood cells leading to insufficient oxygen delivery to the body tissues). The admission Minimum Data Set (a resident assessment tool) dated 04/11/2026 documented Resident #1 had moderately impaired cognition. Review of the psychosocial wellbeing Care Plan initiated 04/09/2026 documented Resident #1 had potential for abuse related to resistance of care, verbal aggression, and physical aggression. Interventions included encouragement to report any form of abuse from peers or staff members, follow facility protocol for reporting of abuse, allow to express feelings as necessary, develop a trusting therapeutic relationshipOn 05/19/2026, Certified Nurse Aide #1 submitted a report to the Department of Health complaint unit that they observed alleged verbal and physical abuse involving Resident #1 and Certified Nurse Aide #2 in the dining/dayroom area of the locked memory care unit. Certified Nurse Aide #1 alleged Certified Nurse Aide #2 forcefully grabbed Resident #1, pushed Resident #1 against the chair, used the dining room table as a restraint/barrier to prevent Resident #1 from getting out of the wheelchair, and repeatedly called Resident #1 a motherf***er. The alleged incident was reported to Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 on 05/11/2026.The Facility provided a statement from Certified Nurse Aide #3 dated 05/11/2026 which documented yelling was overheard while they were providing care in the shower room to another resident.The facility provided a statement from Licensed Practical Nurse #1 dated 05/11/2026 which documented Certified Nurse Aide #1 approached them regarding inappropriate language used by Certified Nurse Aide #2 towards Resident #1 and requested to speak to Registered Nurse Supervisor #1.The facility provided a statement from Registered Nurse Supervisor #1 dated 05/11/2026 which documented Certified Nurse Aide #1 requested to speak to them regarding accusations of abuse and (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	inappropriate language used by Certified Nurse Aide #2 toward Resident #1.The facility provided a written statement from Certified Nurse Aide #2 dated 05/11/2026 which documented Resident #1 was yelling profanities, repeatedly pulling pants down, attempting to place self on the toilet, and banging head on the table. Certified Nurse Aide #2 documented Resident #1 was brought to the dining/dayroom area for observation and redirection. Certified Nurse Aide #2 documented attempts were made to redirect Resident #1 regarding the language being used. Certified Nurse Aide #2 documented Certified Nurse Aide #1 entered the dining/dayroom area and accused Certified Nurse Aide #2 of screaming in Resident #1's face. Certified Nurse Aide #2 documented a table was positioned between Certified Nurse Aide #2 and Resident #1 and they were seated on opposite sides of the table. Certified Nurse Aide #2 documented Resident #1 was hard of hearing, and they were speaking louder so Resident #1 could hear. Certified Nurse Aide #2 documented Certified Nurse Aide #1 began yelling at Licensed Practical Nurse #1 and later at Registered Nurse Supervisor #1. Certified Nurse Aide #2 documented Registered Nurse Supervisor #1 directed staff to continue the conversation in the office. Certified Nurse Aide #2 documented while walking to the office, Certified Nurse Aide #1 shouted, So, I'm psycho? Certified Nurse Aide #2 documented a written statement was requested from them and that it was completed. Review of Resident #1's electronic medical record revealed that there was no documented evidence for the incident or report of allegations made by Certified Nurse Aide #1; that Resident #1 was assessed for physical injuries or psychosocial harm; the medical provider was notified of the allegations; or a psychiatric consultation was made. Resident #1's representative was not contacted until 05/21/2026.Review of staffing assignments showed Certified Nurse Aide #2 was not assigned to Resident #1 on 05/11/2026. However, Resident #1 was routinely assigned to Certified Nurse Aide #2 from 05/12/2026 through 05/21/2026. During an interview on 05/21/26 at 2:08 PM, Certified Nurse Aide #1 stated Resident #1 was near the nurses' station yelling profanities and asking to be toileted while their pants were down. Certified Nurse Aide #1 stated Certified Nurse Aide #2 was yelling the same profanities back to Resident #1 and aggressively pushed Resident #1 back into their wheelchair. They reported that Certified Nurse Aide #2 later placed Resident #1 in the dining/dayroom area with the wheelchair against the wall and the dining room table positioned against Resident #1, preventing the resident from getting out of the wheelchair. Certified Nurse Aide #1 stated observations were reported to Licensed Practical Nurse #1 and Registered Nurse Supervisor #1 on 05/11/2026.During an interview on 05/21/2026 at 3:18 PM, Certified Nurse Aide #3 stated they were in the shower room providing care to another resident and did not hear yelling between Certified Nurse Aide #2 and Resident #1. Certified Nurse Aide #3 stated Registered Nurse Supervisor #1 came to the unit and asked if they heard any yelling, verbal abuse, or observed physical abuse involving Resident #1 and Certified Nurse Aide #2. Certified Nurse Aide #3 stated they did not hear any yelling because they were in the shower room and Certified Nurse Aide #2 was not removed from the unit.During an interview on 05/21/2026 at 3:50 PM, Licensed Practical Nurse #1 stated that on 05/11/2026, Certified Nurse Aide #1 reported to them that they heard Certified Nurse Aide #2 verbally abuse Resident #1. They reported it to Registered Nurse Supervisor #1. Licensed Practical Nurse #1 stated a statement was requested by Registered Nurse Supervisor #1 and completed on 05/11/2026. Licensed Practical Nurse #1 stated Certified Nurse Aide #2 was not removed from the unit. Licensed Practical Nurse #1 stated they were not interviewed by Registered Nurse #1 or anyone else from the facility. During an interview on 05/21/2026 at 4:58 PM, Certified Nurse Aide #2 stated Resident #1 was sitting in the dining/dayroom area yelling and cursing and they were attempting to redirect Resident #1 regarding the language being used. Certified Nurse Aide #2 stated Certified Nurse Aide #1 accused them of cursing at and being abusive toward Resident #1. Certified Nurse Aide #2 stated Resident #1 was yelling and cursing, which was normal behavior for Resident #1. Certified Nurse Aide #2 stated Resident #1 was never pinned against the wall or blocked in by a table. Certified Nurse Aide #2 stated the incident was reported to the supervisor and the supervisor came to the unit to speak to staff separately regarding what transpired. Certified Nurse (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Aide #2 stated the supervisor asked whether Resident #1 was yelled at or pinned against the wall and they requested a written statement about the incident. Certified Nurse Aide #2 stated although Resident #1 was not assigned to them the night of the incident, Resident #1 was routinely on their assignment and remained on their assignment until 05/21/26 when they were reassigned to another unit.During an interview on 05/21/2026 at 5:10 PM, Registered Nurse Supervisor #1 stated Certified Nurse Aide #1 reported allegations of verbal and physical abuse involving Resident #1 and Certified Nurse Aide #2 on 05/11/2026. Registered Nurse Supervisor #1 stated Certified Nurse Aide #1 alleged Certified Nurse Aide #2 was yelling profanities at Resident #1, getting in Resident #1's face, and pushed Resident #1 into the corner of the dayroom, stating Certified Nurse Aide #2 was not dealing with Resident #1 appropriately. Registered Nurse Supervisor #1 stated the Director of Nursing was notified and staff statements were collected. Registered Nurse Supervisor #1 stated Certified Nurse Aide #2 remained on the unit following the allegations and, according to their facility policy, Certified Nurse #2 should have been sent home. Registered Nurse Supervisor #1 stated no Accident and Incident report, investigative summary, body assessment, resident assessment, or abuse investigation was completed on 05/11/2026 and law enforcement was not notified. Registered Nurse #1 stated they were overwhelmed and she dropped the ball. During an interview on 05/21/2026 at 5:31 PM, the Director of Nursing stated Registered Nurse Supervisor #1 called them on 05/11/2026 to inform them that Certified Nurse Aide #1 was yelling at Certified Nurse Aide #2 about allegations that Certified Nurse Aide #2 yelled at Resident #1. The Director of Nursing stated while on the phone, Registered Nurse Supervisor #1 was instructed to obtain staff statements. The Director of Nursing stated no investigation or Accident and Incident report was initiated because it was believed Certified Nurse Aide #1 was fabricating the allegations. The Director of Nursing stated all allegations of abuse are required to be reported to the New York State Department of Health within two hours. The Director of Nursing stated the Administrator was not notified on 05/11/2026 and that they dropped the ball.During a follow-up interview on 05/22/2026 at 3:18 PM, the Director of Nursing stated Registered Nurse Supervisor #1 was given direction on 05/11/2026 to initiate an investigation regarding the allegations involving Resident #1 and Certified Nurse Aide #2. The Director of Nursing stated Certified Nurse Aide #2 should have been removed from assignments pending the investigation. They stated when returning to the facility the following day, only staff statements were left under their office door. The Director of Nursing stated psychiatric recommendations, body assessments, and nursing assessments are supposed to be completed for allegations of abuse and acknowledged they were not documented as done. The Director of Nursing stated an assessment note should have been written and the allegations were not reported to the New York State Department of Health because it was not believed that abuse had occurred.During an interview on 05/22/26 at 4:13 PM, the Administrator stated they were not made aware of the allegations of physical/verbal abuse by Certified Nurse Aide #2 toward Resident #1 until they were contacted by the Attorney General's office. The Administrator stated while on vacation, staff communicated with them throughout the day and no concerns regarding the incident were reported. The Administrator stated statements collected on 05/11/2026 were addressing Certified Nurse Aide #1 becoming upset and leaving the shift. The Administrator stated Certified Nurse Aide #2 continued working in the facility following the allegations and was reassigned to another unit on 05/21/2026. The Administrator stated staff are trained in abuse prevention and reporting requirements.During a follow-up interview on 05/22/26 at 3:25 PM, the Administrator stated when allegations of abuse are reported, Registered Nurse Supervisor #1 is responsible for notifying the Director of Nursing and/or Administrator about the allegations. The Administrator stated allegations of abuse are required to be reported to the New York State Department of Health within two hours. The Administrator stated the alleged incident involving Resident #1 should have been investigated and an Accident and Incident report initiated. The Administrator stated statements should have been collected as part of the investigation process, and Registered Nurse Supervisor #1 should have completed a body assessment, nursing assessment, and (continued on next page)

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	335628	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sullivan County Adult Care Center	256 Sunset Lake Road Liberty, NY 12754

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	initiated the investigation. In addition, psychiatric and/or psychological services should have been notified of the allegations involving Resident #1. The Administrator stated staff should not use foul language toward residents as a means of redirection. 10 NYCRR 415.4(b)(3) Immediate Jeopardy was called on 05/26/2026. The Facility submitted a removal plan to remove the immediacy on 05/11/2026. The facility implemented the following to remove immediacyAn investigation was initiated and reported to New York State Department of HealthResident #1 was assessed, and nursing/physician/social service documentations were completed.Staff statements and follow-up interviews were conducted. Facility provided in-service attendance and lesson plan provided to facility staff at 99%.The facility will implement a tracking system for abuse/neglect/allegation/investigation to audit all accident/incident reports Interviews were conducted with registered nurses, the Assistant Director of Nursing, the Director of Nursing, the Director of Rehab, licensed practical nurses who confirmed receiving inservice on initiating investigation and abuse. The facility's policy and procedure titled Abuse, Identification and Reporting were reviewed and no changes were made.IJ was removed on 05/28/2026 at 4:57 PM.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews conducted during the Abbreviated Survey, the facility failed to ensure Resident #1's Comprehensive Care Plan was reviewed and revised following assessment and as necessary to reflect changes in the resident's needs for one (1) (Resident #1) of four (4) residents reviewed for care planning. Specifically, following allegations of verbal and physical abuse of Resident #1 by Certified Nurse Aide #2, the resident's psychosocial well-being, risk to be victimized/aggressor, and behavior care plans were not reviewed or revised. Review of the psychosocial well-being and risk to be victimized/aggressor care plans revealed they were last revised on 04/09/2026. Review of the behavior care plan revealed it was last revised on 04/24/2026.The Findings Include: The facility's Comprehensive Care Planning Policy, revised 02/2026 and reviewed on 05/26/2026, documented, Comprehensive care plans shall be reviewed and updated with significant change in condition and when desired outcomes are not achieved. The policy further documented, Care plans shall be current, accurate, and reflective of the resident's present condition. All updates shall be documented in the medical record. Resident #1 was admitted to the facility with diagnoses including, but not limited to, dementia, depression, and anemia. The admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #1 had moderately impaired cognition.Review of the care plan for risk to be victimized or aggressor revised 04/09/2026 documented Resident #1 was at risk to be victimized, or aggressor related to impaired judgment and confusion. Interventions included, but were not limited to, encouraging Resident #1 to utilize positive outlets, keeping Resident #1 within viewing distance for observation as much as possible in activities, the day room, and nursing station, monitoring changes in mood or behavior triggered by environmental factors including noise, crowds, or other residents with behavioral symptoms, and monitoring well-being without environmental restrictions. The care plan was not reviewed or revised following the allegations of verbal and physical abuse of Resident #1 by Certified Nurse Aide #2 reported on 05/11/2026. Review of the care plan on 05/29/2026 revealed no documented evidence the care plan had been reviewed or revised. Review of the psychosocial well-being care plan revised 04/09/2026 documented Resident #1 had the potential for abuse related to resistance to care, verbal aggression, and physical aggression. Interventions included, but were not limited to, allowing Resident #1 to express feelings of being fearful or anxious as necessary, developing a trusting therapeutic relationship, encouraging Resident #1 to report any form of abuse from peers or staff members, and following facility protocol for reporting abuse, mistreatment, or neglect. The care plan was not reviewed or revised following the allegations of verbal and physical abuse of Resident #1 by Certified Nurse Aide #2 reported on 05/11/2026. Review of the care plan on 05/29/2026 revealed no documented evidence the care plan had been reviewed or revised. Review of the behavior care plan revised 04/24/2026 documented Resident #1 had the potential to be verbally aggressive toward staff when frustrated or confused related to difficulty understanding situations, unmet needs, or communication breakdowns. Interventions included analyzing key times, places, circumstances, triggers, and what de-escalates behavior and documenting findings. The care plan was not reviewed or revised following the allegations of verbal and physical abuse of Resident #1 by Certified Nurse Aide #2 reported on 05/11/2026. Review of the care plan on 05/29/2026 revealed no documented evidence the care plan had been reviewed or revised. During an interview on 05/21/2026 at 02:08 PM, Certified Nurse Aide #1 stated Resident #1 was near the nurses' station yelling profanities and asking to be toileted while pants were down. Certified Nurse Aide #1 stated Certified Nurse Aide #2 was yelling the same profanities back to Resident #1, aggressively pushed Resident #1 back into the wheelchair, and later placed Resident #1 in the dining/dayroom area with the wheelchair against the wall and a dining room table positioned in front of Resident #1, preventing Resident #1 from getting (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of the wheelchair. During an interview on 05/29/2026 at 02:00 PM, the Infection Control/Quality Assurance Nurse stated they assisted with the Accident/Incident report completion process related to the 05/11/2026 allegations of verbal and physical abuse involving Resident #1 after becoming aware of the allegations on 05/21/2026. The Infection Control/Quality Assurance Nurse stated care plans should be reviewed and updated to reflect Accident and Incident investigations and the resident's current plan of care. The Infection Control/Quality Assurance Nurse acknowledged Resident #1's behavior, psychosocial well-being, and risk of being victimized or aggressor care plans were not reviewed or revised following the 05/11/2026 allegations of verbal and physical abuse involving Resident #1 and stated the care plans should have been updated to reflect the allegations and resident-specific interventions should have been added. During an interview on 05/29/2026 at 02:57 PM, Registered Nurse #3 stated they were the Unit Manager on Unit 2 and assisted on Units 3 and 4 as needed. Registered Nurse #3 stated they were not aware of the 05/11/2026 allegations of verbal and physical abuse involving Resident #1 and were not made aware of the allegations until staff received education regarding abuse and reporting requirements. Registered Nurse #3 stated they were not aware of the specific details of the allegations. Registered nurses review, update, and revise resident care plans. Care plans are updated to reflect residents' current needs, changes in condition, and new incidents, including Accident and Incident reports. Part of the Accident and Incident process includes reviewing and updating the resident's care plan and notifying the resident's family. Registered Nurse #3 stated care plans are reviewed and revised to ensure they accurately reflect the resident's current needs and plan of care. 10 NYCRR 415.11(c)(1)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interviews conducted during the Abbreviated Survey, the facility failed to ensure nursing staff possessed the competencies and skill sets necessary to provide nursing and related services to residents for one (1) (Certified Nurse Aide #1) of nine (9) facility staff records reviewed for mandatory training requirements. Specifically, Certified Nurse Aide #1 was assigned resident care duties and worked on 05/11/2026; however, the facility was unable to provide documentation verifying completion of required orientation and mandatory training, which included, but was not limited to, Abuse/Neglect/Exploitation Prohibition, Behavioral Care Services/Cognitive Impairment/Dementia Training, and Trauma Informed Care.The Findings Include: The facility's Education and Training of Nursing Personnel Policy documented, The facility uses a competency-based approach to nurse and nurse aide staffing and will conduct regular competency reviews to ensure that nursing personnel are adequately trained. The policy further documented, New employees of the facility will attend Orientation and receive necessary mandatory training and on-the-job training as needed. On 05/22/2026 at 12:58 PM, the facility's mandatory orientation and in-service training documentation for Certified Nurse Aide #1 was requested from the Assistant Director of Nursing/Staff Educator. Review of the documentation provided revealed no documented evidence that Certified Nurse Aide #1 completed the facility's required orientation and mandatory training. The facility was unable to provide documentation verifying completion of training which included, but was not limited to, Abuse/Neglect/Exploitation Prohibition, Behavioral Health Training: Dementia Care, Trauma Informed Care and Managing Difficult Behaviors, Communication Training, and other mandatory orientation and in-service training requirements. During an interview on 05/21/2026 at 02:08 PM, Certified Nurse Aide #1 stated 05/11/2026 was their first day working at the facility as agency staff. Certified Nurse Aide #1 stated they did not receive orientation, a training packet, or sign any orientation documents. Certified Nurse Aide #1 stated they did not receive training related to abuse and neglect, dementia care, behavioral health, trauma-informed care, or managing difficult behaviors prior to being assigned resident care duties. Certified Nurse Aide #1 stated they were assigned to provide resident care on Units 2 and 3 on 05/11/2026. During an interview on 05/22/2026 at 12:58 PM, the Assistant Director of Nursing/Staff Educator stated agency staff are required to complete the same mandatory orientation and in-service training as facility staff, which includes, but is not limited to, Abuse/Neglect/Exploitation Prohibition, Behavioral Health Training: Dementia Care, Trauma Informed Care and Managing Difficult Behaviors, and other mandatory orientation and in-service training requirements. The Assistant Director of Nursing/Staff Educator stated staff are required to complete training modules, sign training documentation, and complete post-tests which are maintained in employee files. The Assistant Director of Nursing/Staff Educator stated they were unable to locate documentation verifying Certified Nurse Aide #1 completed the facility's required orientation and mandatory training. The Assistant Director of Nursing/Staff Educator stated they recalled introducing Certified Nurse Aide #1 to staff and providing an orientation to the facility; however, they were unable to locate documentation verifying completion of the required orientation packet and mandatory training. During an interview on 05/27/2026 at 03:50 PM, the Administrator stated all staff who perform employment duties within the facility are required to complete mandatory orientation and in-service training. The Administrator stated staff are provided the facility's mandatory orientation and in-service training by the Staff Educator prior to working independently. The Administrator stated Certified Nurse Aide #1 should have received the facility's mandatory orientation and in-service training prior to providing resident care and documentation of completion should have been maintained in the employee file. The Administrator stated they were unsure why the documentation could not be located and stated if the training had been completed, the documentation should have been available in Certified Nurse Aide #1's employee file. During an interview on (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/27/2026 at 04:02 PM, the Director of Nursing stated they were responsible for overseeing the Staff Educator and ensuring staff received required training. The Director of Nursing stated staff are required to complete mandatory orientation and in-service training prior to providing resident care. The Director of Nursing stated Certified Nurse Aide #1 should have completed the facility's mandatory orientation and training before caring for residents. The Director of Nursing stated staff who have not completed required orientation and training should not be assigned resident care duties because the training provides staff with the knowledge and skills necessary to care for residents. 10 NYCRR 415.13(c)