| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335764 | A. Building<br>B. Wing | 01/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Iroquois Nursing Home Inc | 4600 Southwood Heights Drive<br>Jamesville, NY 13078 |

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) |
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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident’s drug regimen must be free from unnecessary drugs.<br><br>Based on record review and interviews during the abbreviated survey (#2649782) conducted 01/30/2026, the facility did not ensure each resident's drug regimen was free from unnecessary drugs for one (1) of three (3) residents (Resident #2). Specifically, Resident #2 was administered an as needed antipsychotic medication for agitation without a documented medical rationale. There was no documented evidence that the medication was medically necessary, nor that non-pharmacological interventions were attempted prior to administering the medication. Additionally, the resident did not have a care plan to address their behaviors or personalized interventions for their behaviors.Findings include:The undated facility policy, Psychotropic Medication Use, documented a psychotropic drug was any medication that affected brain activities associated with mental processes and behavior which included anti-psychotics. The facility would not use psychotropic medications to address behaviors without first determining if there was a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors. Facility staff should take a holistic approach to behavior management that involved a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. Residents who exhibited new or worsening behavioral or psychological symptoms of dementia were to be evaluated by a health care professional and the care team to identify contributing factors such as treatable medical conditions, physical problems, emotional stressors, psychiatric or psychological factors, social issues or environmental factors. The physician order for an as needed psychotropic would indicate that the medication was only to be administered if non-drug approaches were ineffective, the specific symptoms that are to be exhibited for the as needed medication to be administered, and that the post-medication effects are to be documented by the nurse. Resident #2 had diagnoses including unspecified dementia with unspecified severity with other behavioral disturbance and age-related osteoporosis with current pathological fracture of the right femur. The 09/11/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, had continuously present inattention and disorganized thinking, rarely felt lonely or isolated, had no behaviors, and required partial to moderate assistance most activities of daily living.The 09/05/2025 Comprehensive Care Plan documented the resident had the potential for adverse effects from daily use of an antipsychotic with no associated diagnosis listed. Interventions included: provide the anti-psychotic per the provider's order; assess for the effectiveness of the antipsychotic medication to relieve symptoms of aggression/combativeness; document the onset, duration and characteristics of all symptoms of aggression/combativeness; inform the physician of any increase symptoms or possibility of adverse effects of the drug; monitor for the side-effects of the anti-psychotic medications; utilize gradual dose reduction to maintain the lowest effective dose; and utilize non-pharmacological interventions.There was no documented care plan for the resident's behaviors or personalized interventions for the resident's behaviors.The undated Resident Care Record (care instructions) did not include any information related to behavioral symptoms or interventions.The 09/05/2025 hospital<br><br>(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 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | discharge medication list documented 0.5 tablet of quetiapine (antipsychotic) 25 milligrams by mouth nightly as needed for agitation, unable to be redirected, with harm to self and others.The 09/05/2025 physician's order documented the resident was to receive 0.5 tablet (12.5 milligrams) of a quetiapine 25 milligram tablet by oral route once daily as needed, in the evening for 14 days.The 09/05/2025 History and Physical, completed by Nurse Practitioner #19, documented the resident had a diagnosis of dementia with behavior disturbances, hypertension, recurrent falls, recurrent urinary tract infections, and osteoporosis. The plan was to give quetiapine 12.5 milligrams once daily in the evening as needed for agitation. There were no documented behaviors or related diagnosis for the quetiapine.The September 2025 Medication Administration Record documented the resident received 12.5 milligrams of quetiapine on 09/05/2025 at 8:18 PM, 09/06/2025 at 7:35 PM, 09/08/2025 at 7:53 PM, and 09/11/2025 at 12:05 AM.There were no documented behaviors or evidence of non-pharmacological interventions attempted prior to the administration of the as needed quetiapine on 09/05/2025, 09/06/2025, and 09/08/2025 and there were no assessments of the effectiveness of the medication post-administration.The 09/11/2025 progress note completed by Registered Nurse #18 documented the resident exhibited restlessness and irritability and was reported to have had aggression during the 3 PM to 11 PM shift. The writer offered some snacks, but the resident refused. Redirection and incontinence care were also done. The nursing supervisor was notified, and the resident was given their as needed quetiapine 12.5 milligrams. There were no documented specific behaviors of aggression noted or outcome after redirection, incontinence care, or medication administration was completed.The 09/11/2025 progress note completed by Registered Nurse Unit Manager #15 documented the resident's health care proxy was requesting to have the resident's melatonin scheduled as they thought the as needed quetiapine was making the resident groggy during the day. Nurse Practitioner #19 was updated, and the orders were to schedule the resident's melatonin and continue with the as needed quetiapine.During an interview on 10/29/2025 at 8:56 AM, Resident #2's health care proxy stated the resident was admitted to the facility after surgery for their broken hip. They stated after the resident was admitted they had a hard time keeping the resident awake and could not coordinate getting the utensil to their mouth during meals. They had a hard time finding out what medication the resident was being given. One of the nurses had informed them the resident had received quetiapine at midnight, there was no note as to why it was given, and it was only to be given for agitation or aggression which the resident never really exhibited. They expressed concerns regarding the resident's medication, but nothing was done. The next day the resident was asleep in their chair, and they asked the nurse if the resident was given quetiapine and was told it was given at 7:45 PM and there was no note as to why. They stated the resident was trying to get out of bed at midnight, was given the medication, and the resident was sleepy for the rest of the day. They asked why the resident had not received melatonin and were told they could not give it because it was an as needed medication. They asked for the melatonin to be changed to scheduled.During an interview on 10/30/2025 at 11:31 AM, Social Worker #17 stated they were responsible for the meetings for baseline care plans, assessed for changes with mood, cognition, and behaviors, and care plan meetings with families. Resident #2 did not have behaviors to their knowledge. If Resident #2 was having behaviors, it was to be reported to themselves and Registered Nurse Unit Manager #15 so they could update their care plan to include the behaviors and update their risk tool. The risk tool assessed the potential to be an aggressor or victim, and Resident #2 was assessed to be low risk. They were unaware the resident had received their as needed quetiapine four times prior to it being discontinued.During a phone interview on 10/30/2025 at 1:21 PM, Licensed Practical Nurse #25 stated an as needed antipsychotic medication was given, if the nurse deemed the resident needed<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | it or if the resident was alert enough to ask for it. The reason for administering the medication needed to be documented as well as what led up to using it, the results of using the medication, and what happened after the medication was administered in a progress note. They recalled giving Resident #2 their as needed antipsychotic on 09/05/2025 and 09/08/2025. The medication was given due to the way the resident was acting. The resident was aggressive, hitting, getting up, and trying to leave the facility. It was always after their family or someone they were familiar with left. The resident thought they were trying to harm them because they did not know the staff. They believed they put in a note on 09/08/2025, because they did not put in a note on 09/05/2025, and was spoken to about it. They were told they had to document what interventions were attempted prior to giving the medication. The nurse stated the resident calmed down after the quetiapine and the medication does make people sleepy but that was not the main reason it was given to the resident.During an interview on 10/30/2025 at 3:08 PM, Licensed Practical Nurse #24 stated a resident could be given an as needed antipsychotic medication if the resident was agitated after redirection, having them go to an activity, or trying to calm them down and that was not working. The medication order documented the reason the medication was given. The nurses had to document the reason the medication was given in the comment section of the medication administration record, sometimes a progress note was put into the electronic medical record. They did not remember Resident #2 or why they gave the resident the as needed antipsychotic medication on 09/06/2025. They would have documented the reason in the notes or the medication administration record.During a phone interview on 10/31/2025 at 2:22 PM, Registered Nurse Manager #15 stated the staff knew what interventions to utilize with a resident when they were having behaviors by the care plan. Behaviors, what interventions were tried, and if the interventions were effective were recorded in a progress note. Psychotropic medications and behavior care plans were usually done upon admission but if not, they were put in by the Unit Manager or the Director of Nursing. If a resident was admitted with an as needed antipsychotic medication, they should have a care plan at admission. An as needed antipsychotic was only used if a resident was harmful to themselves or others and the staff felt the resident needed it. The nursing staff did not have to document the reason for the as needed antipsychotic use, but it was good practice to do it in a progress note. Resident #2 had some behaviors while at the facility which included restlessness, irritability, and some aggression. They had a care plan for their antipsychotic use but not one for their behaviors. They stated they saw in the resident's record, Resident #2 had received their as needed antipsychotic medication on four occasions and there was no note documented for three of the four occasions as to why the resident received the medication. There should have been a note with the administration of the medication because by the third administration, they would have put in a behavior care plan to address the resident's behaviors.During a phone interview on 11/03/2025 at 10:12 AM, Nurse Practitioner #19 stated they did the history and physicals for new admissions. During the history and physical, they reviewed the resident's medication and ensured indications for use matched the medication. If a resident was admitted on as needed quetiapine, the indication for use was either for dementia with psychosis, a mood disorder, anxiety, or delirium (short-term confusion). Agitation was not an indication for as needed quetiapine, there had to be a cause of the agitation. The medical providers or the Unit Manager were responsible for finding out the background for an as needed antipsychotic and it was typically documented in a note. Non-pharmacological interventions should be tried prior to an as needed antipsychotic being utilized and they should be documented as well as if they were effective or ineffective and what happened to reach the level of medications. Resident #2 should only receive the as needed antipsychotic medication for restlessness, if they were a danger to themselves or<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | others.During a phone interview on 11/04/2025 at 1:58 PM, Medical Director #20 stated when the Nurse Practitioner and nursing staff reconcile the medications at admission, they ensured the medications have a corresponding diagnosis or indication for use. They did not usually make changes to the medications of residents who come in for short-term rehabilitation. Resident #2 was admitted with the as needed antipsychotic medication. The hospital record stated it was for agitation, so they did not need to ask any more questions as to the reason for use. In the facility, the antipsychotic medication was used for agitation, sleep, psychosis, or behavioral problems that came with dementia which Resident #2 had as a diagnosis. Resident #2 was on the medication for agitation as needed specifically at nighttime when the resident could not sleep. Even if the resident did not have a diagnosis of insomnia, the medication was used routinely for sleep in the facility. In the evening, residents that were Resident #2's age sundown (a pattern of increased behavior late afternoon to nighttime), they are irritable, agitated, and cannot sleep. If the resident could not sleep at night, the resident could get the quetiapine, and there was nothing wrong with that. Other interventions should be utilized first such as redirection or addressing the resident's needs. However, Resident #2 was older and could not say what they needed out loud. The idea behind an as needed antipsychotic was for comfort for the patient so they could rest and sleep. The reason for the medication was given should be documented by the nurse, as needed medication should not be given without a documented reason.During an interview on 01/29/2026 at 11:37 AM, the Director of Nursing stated interventions for individual resident behaviors were in their care plans. Staff were also trained to reapproach, reattempt, and redirect for dementia residents. Specific resident behaviors were recorded in the resident's care plan, if they were known. If a resident was actively having behaviors, it should be documented in a behavior note. The Unit Managers were responsible for the behavior care plans with Social Work's assistance. If a resident had known behaviors, there should be a care plan with personalized interventions. The indication for use for an as needed antipsychotic was if the resident was a danger to themselves or others. Other interventions should be utilized prior to the resident receiving an as needed antipsychotic. It was expected that if an as needed antipsychotic was administered, there should be a corresponding nurse's note as to why. 10 New York Codes, Rules and Regulations, 415.12(l)(1) |