

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335876	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/13/2026
NAME OF PROVIDER OR SUPPLIER Delhi Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 41861 State Route 10 Delhi, NY 13753	
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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review conducted during survey, the facility failed to report reasonable suspicion of a crime committed in the facility to the State Survey Agency and one or more law enforcement entities, within required timeframes for Resident #4 and Resident #5. Specifically, on 03/23/2026, through staff reporting and an investigation, the facility discovered that Licensed Practical Nurse #2 falsely entered medication orders for Resident #4 without provider authorization, discontinued the orders, and diverted (removed) the medication for personal use in December 2025 and attempted to do so again in March 2026 for Resident #5. There was no documented evidence the facility reported the incidents to the Department of Health or local law enforcement, as required. Failure to report suspicion of a crime committed in the facility resulted in Immediate Jeopardy and placed all residents at risk for serious harm, serious impairment, serious injury, or death. Findings Include: Cross reference to F-602 and F-865. The facility's policy and procedure dated 07/02/2026 titled Seven Components of a Systematic Approach to Abuse Prohibition documented the facility must submit reports that are accurate, to the best of its knowledge at the time of submission. In the initial report, facility must provide sufficient information to describe the alleged violation and indicate how residents are being protected. A report to the Department of Health must be made immediately, but no later than two hours if the alleged violation involves abuse or has resulted in serious bodily injury; and no later than 24 hours if the alleged violation involves neglect, exploitation, mistreatment or misappropriation of resident property; and does not result in serious bodily harm. Record review revealed Licensed Practical Nurse #2 entered a medication order for fluoxetine in Resident #5's chart on 03/18/2026 at 8:33 AM for provider approval and the order was discontinued later that day at 7:19 PM by Nurse Practitioner #1. Facility investigation records included a written statement from Licensed Practical Nurse #2 dated 03/24/2026 acknowledging that in December 2025 they entered an order under Resident #4 for fluoxetine 10 milligrams, discontinued it, and took the medication when it arrived. The statement further documented that in March 2026, Licensed Practical Nurse #2 entered an order under Resident #5 for fluoxetine 20 milligrams, discontinued it, and intended to take the medication, but the medication had been removed from the medication cart. On a written statement in the Facility Investigation Report dated 03/24/2026, Licensed Practical Nurse #3 stated Licensed Practical Nurse #2 came over to the medication cart looking for medication. Licensed Practical Nurse #2 did not respond when Licensed Practical Nurse #3 asked what medication they were looking for. Licensed Practical Nurse #2 stated the medication they ordered did not come in. Shortly after Licensed Practical Nurse #2 walked away, Licensed Practical Nurse #3 recalled fluoxetine was delivered during the overnight shift and Licensed Practical Nurse #3 had moved it to the bottom drawer so they could put it in the pile of medications to return to the pharmacy due to Resident #5 not having an order for it. When Licensed Practical Nurse #3 went back to the orders page, they saw a (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 335876	Facility ID: 335876 If continuation sheet Page 1 of 6

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	medication order placed for fluoxetine the morning of 03/18/2026 and discontinued in the afternoon on 03/18/2026. In the written statement, Licensed Practical Nurse #3 recalled a couple months ago Licensed Practical Nurse #2 mentioning they were helping their current partner get a medication (fluoxetine) which raised suspicion that the medication was ordered for Licensed Practical Nurse #2's partner. Licensed Practical Nurse #3 then reported the suspicion to Registered Nurse #1 who was supervising at the time. On a written statement in the Facility Investigation Report, Registered Nurse #1 stated they did confront Licensed Practical Nurse #2, and Licensed Practical Nurse #2 admitted to ordering, discontinuing and giving the medication to her significant other because they were having withdrawals and they were trying to help them. Licensed Practical Nurse #2 admitted they knew they were wrong and that they needed to tell the Director of Nursing and the Administrator. Facility investigation report dated 03/24/2026 concluded that Licensed Practical Nurse #2 took the remaining medication for personal use in December 2025 instead of returning it to the pharmacy for credit. There was no documented evidence in the facility investigation report conclusion that Licensed Practical Nurse #2 falsified orders on Resident #4 and #5 with attempt to (and success for one of two instances) divert medication. During an interview on 07/02/2026 at 10:41 AM, Nurse Practitioner #1 stated resident orders are typically communicated verbally to nursing staff during rounds. Licensed Practical Nurses and Registered Nurses enter the orders into the electronic medical record, and the provider later reviews and signs them. If nursing staff are unavailable, the provider may enter the orders directly. Nurse Practitioner #1 stated that once entered and before signing off, orders become active and are transmitted to the pharmacy for dispensing. Controlled substance orders require provider authentication before being sent to the pharmacy. Orders are reviewed twice daily, and the facility's Nurse Practitioners and Medical Providers are authorized to initiate and discontinue orders. Regarding Resident #4, Nurse Practitioner #1 stated a gradual dose reduction of fluoxetine had been requested but was not appropriate due to the resident's obsessive-compulsive disorder and previous unsuccessful reduction attempts. Regarding Resident #5, Nurse Practitioner #1 stated the resident had been successfully weaned off fluoxetine through a gradual dose reduction. Nurse Practitioner #1 stated they were informed that Licensed Practical Nurse #2 had entered fluoxetine orders under their name on two occasions. They were unaware a different dose had been entered and stated that, due to multiple providers managing residents, nurses may enter routine refill orders under a different provider's name. Nurse Practitioner #1 stated they cannot sign orders entered under another provider's name. To verify verbal orders, providers review orders, resident records, and progress notes and communicate with one another when questions arise. Nurse Practitioner #1 stated the orders involved in this incident were routine fluoxetine renewal orders. They further stated that discontinued medications should be returned to the pharmacy and should not remain available for use within the facility by staff. During an interview on 07/02/2026 at 2:42 PM, Licensed Practical Nurse #2 stated that sometime in December 2025, they created and entered a fraudulent order for Resident #4 for fluoxetine (a medication for depression) and successfully diverted the medication. They explained that after a gradual dose reduction decreased Resident #4's fluoxetine medication from 20 milligrams to 10 milligrams, Licensed Practical Nurse #2 entered an order for the discontinued 10 milligram dose, discontinued the order the same day so it would not appear on the Medication Administration Record, and took the medication home. Licensed Practical Nurse #2 stated that in March 2026, they again entered a fraudulent order for Resident #5 for fluoxetine 20 milligrams and discontinued it the same day with the intent to divert the medication. They stated they knew Resident #5 had stopped taking fluoxetine due to concerns about adverse effects and a gradual dose reduction had been initiated. They intended to take the medication home but could not find it, and another nurse (continued on next page)		

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	observed them looking for the medication. Licensed Practical Nurse #2 stated they informed the nurse they wanted to speak with Director of Nursing #1 and Administrator #1 to confess what they had done. Licensed Practical Nurse #2 stated they were suspended for several days. During an interview on 07/02/2026 at 1:52 PM, Director of Nursing #1 stated that on 03/24/2026, they were made aware by Registered Nurse #1 there was a situation involving the possible diversion of medication. Registered Nurse #1 reported this to both Director of Nursing #1 and Administrator #1. Director of Nursing #1 stated Licensed Practical Nurse #2 went into the Director of Nursing office on 03/24/2026 and confessed to both Director of Nursing #1 and Administrator #1 that they had entered a medication order into the electronic health record and then discontinued it, with the intention of diverting the medication for personal use. Licensed Practical Nurse #2 stated to Director of Nursing #1 that they had a loved one who was going through issues and remembered that Resident #4 was on fluoxetine and created the order and then discontinued the medication. In addition, Licensed Practical Nurse #2 created an order on 03/18/2026 under Resident #5's electronic medical record for 10 milligrams of fluoxetine and then discontinued the medication the same day. Director of Nursing #1 stated that both incidents were not reported to the Department of Health or Law Enforcement because they did not feel the incident rose to the level of a crime. During an interview on 07/02/2026 at 3:33 PM, Administrator #1 stated they were first made aware of the incident on 03/23/2026 by Registered Nurse #1, and the facility initiated an investigation that same day. Registered Nurse #1 began reviewing medication records and medication supplies for discrepancies involving fluoxetine. Administrator #1 stated Licensed Practical Nurse #2 met with Director of Nursing #1 and #1 and admitted entering an order and diverting the medication for Resident #4 in December 2025 and entered a medication order without provider approval with intention of diverting medication for personal use for Resident #5 in March 2026 but did not get ahold of the medication. Licensed Practical Nurse #2 was immediately suspended pending investigation. Administrator #1 stated they consulted with corporate leadership and determined the incident appeared to be isolated. Administrator #1 stated Nurse Practitioner #1 and Director of Nursing #1 were interviewed on 03/23/2026; however, no documentation of the interview was maintained. Administrator #1 stated the incident was not reported because they did not believe the definition of gross negligence applied. Administrator #1 further stated the incident was not a crime, as the facility determined the medications were taken from facility stock and residents were not billed. Administrator #1 also stated the incident was not brought to the Quality Assurance and Performance Improvement committee due to concerns regarding employee rights and personnel matters. 10 New York Codes, Rules and Regulations 415.4(b)(2) Immediate Jeopardy was issued to the Administrator on 07/02/2026. Facility Immediacy Removal Plan submitted on 07/03/2026 was approved. Immediate Jeopardy was lifted effective 07/03/2026. The facility's immediacy removal actions included the following: On 07/02/2026 at 6:38 PM, Administrator #1 called law enforcement and reported stolen medication and falsification of medical orders. On 07/02/2026 at 9:43 PM, facility submitted a report to New York State Department of Education Office of the Professions, detailing theft of the 30-day supply of fluoxetine and falsification of medical orders for fluoxetine. On 07/02/2026, facility indefinitely suspended Licensed Practical Nurse #2. During an interview on 7/07/2026 at 11:15 AM, Administrator #1 stated Licensed Practical Nurse #2 is on indefinite suspension pending legal review. As of 07/03/2026 at 11:59 PM, 159 of 164 staff received education on reporting suspected crimes under the Federal Elder Justice Act, with remaining employees to be educated upon arrival to their next shift.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during survey, the facility failed to ensure Resident #s 4 and 5 were free from misappropriation and exploitation in being taken advantage of for personal gain. Specifically, in December 2025, Licensed Practical Nurse #2 entered medication orders using Resident #4's information and without provider authorization, discontinued the orders, and diverted medication for personal use. In March 2026, Licensed Practical Nurse #2 entered and discontinued a medication order for Resident #5 with the intent to obtain the medication for personal use. The residents' personal health information including their name, diagnoses and identifying information, were fraudulently used to facilitate the medication orders. Findings include: Cross reference to F-609, F-865. The facility's policy and procedure titled Abuse-Investigation, Protection and Reporting - Components #5, 6, 7 dated 05/23/2023 under the Procedures Section listed 1. The facility will notify the Department of Health when the reasonable cause threshold has been established; meaning that there is sufficient evidence for a prudent person to believe that abuse, misappropriation of property, involuntary seclusion, neglect and/or exploitation has occurred and 2. The facility will notify the local Law Enforcement Agency if the abuse/occurrence investigation concludes a crime has occurred. Resident #4 was admitted to the facility with diagnoses of depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities), adjustment disorder with mixed anxiety and depressed mood (a short-term mental health condition triggered by a stressful life event), and anxiety (an emotion characterized by apprehension, tension, and worry about future events). The Minimum Data Set (a resident assessment tool) dated 01/13/2026 documented the resident could be understood and could understand others. Resident #5 was admitted to the facility with diagnoses of bipolar disorder (a lifelong mental health condition characterized by dramatic shifts in mood, energy, and activity levels), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest) and schizoaffective disorder (mental health condition that is marked by a mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression, mania and a milder form of mania called hypomania). The Minimum Data Set, dated [DATE] documented the resident could be understood and could understand others. Facility investigation records included a written statement from Licensed Practical Nurse #2 dated 03/24/2026 acknowledging that in December 2025 they entered an order for Resident #4 for fluoxetine 10 milligrams, discontinued it, and took the medication when it arrived. The statement further documented that in March 2026, Licensed Practical Nurse #2 entered an order under Resident #5 for fluoxetine 20 milligrams, discontinued it, and intended to take the medication, but the medication had been removed from the medication cart. In a written statement in the Facility Investigation Report dated 03/24/2026, Licensed Practical Nurse #3 stated Licensed Practical Nurse #2 came over to the medication cart looking for medication. Licensed Practical Nurse #2 did not respond when Licensed Practical Nurse #3 asked what medication they were looking for. Licensed Practical Nurse #2 stated the medication they ordered did not come in. Shortly after Licensed Practical Nurse #2 walked away, Licensed Practical Nurse #3 recalled fluoxetine was delivered during the overnight shift and they had moved it to the bottom drawer so they could put it in the pile of medications to return to the pharmacy because Resident #5 did not have an order for it. When Licensed Practical Nurse #3 went back to the orders page, they saw a medication order placed for fluoxetine the morning of 03/18/2026 and discontinued in the afternoon on 03/18/2026. Licensed Practical Nurse #3 recalled a couple months prior (was unsure of date) Licensed Practical Nurse #2 (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mentioning they were helping their current partner get a medication (fluoxetine) which raised suspicion that the medication was ordered for Licensed Practical Nurse #2's partner. Licensed Practical Nurse #3 then reported the suspicion to Registered Nurse #1. During an interview on 07/02/2026 at 2:42 PM, Licensed Practical Nurse #2 stated that sometime in December 2025, they created and entered a fake order for Resident #4 for fluoxetine (a medication for depression) and successfully diverted the medication. They gave it to someone they cared about because the other person was struggling with depression. They explained that after a gradual dose reduction decreased Resident #4's fluoxetine medication from 20 milligrams to 10 milligrams, Licensed Practical Nurse #2 entered an order for the discontinued 10 milligram dose, discontinued the order the same day so it would not appear on the Medication Administration Record, and took the medication home. During an interview on 07/02/2026 at 2:43 PM, Licensed Practical Nurse #2 stated that in March 2026, they entered a fake order for Resident #5 for fluoxetine and discontinued it the same day with the intent to divert the medication. They stated they knew Resident #5 had stopped taking fluoxetine due to concerns about adverse effects and a gradual dose reduction had been initiated. They intended to take the medication home but could not find it, and Licensed Practical Nurse #3 observed them looking for the medication who then reported it to Registered Nurse #1 who was the supervisor at the time. Licensed Practical Nurse #2 stated they informed Registered Nurse #1 they wanted to speak with Director of Nursing #1 and Administrator #1 to confess what they had done. Licensed Practical Nurse #2 stated they were suspended for several days. During an interview on 07/02/2026 at 1:52 PM, Director of Nursing #1 stated Licensed Practical Nurse #2 told them that they had a loved one who was going through issues and remembered that Resident #4 was on fluoxetine and created the order and then discontinued the medication. On 03/18/2026, Licensed Practical Nurse #2 created an order for 10 milligrams of fluoxetine and then later that day, discontinued the medication. Director of Nursing #1 stated Licensed Practical Nurse #2 was suspended immediately and a facility investigation was started on 03/24/2026. Director of Nursing #1 stated residents' insurances were not billed and neither resident was affected. During an interview on 07/02/2026 at 3:33 PM, Administrator #1 stated they did not believe gross negligence applied, facility determined the medications were taken from facility stock and residents were not billed. 10 New York Codes, Rules and Regulations 415.4(b)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record review and interview during survey, the facility failed to implement its Quality Assurance and Performance Improvement (QAPI) program to address a medication diversion event involving unauthorized medication orders and misappropriation of resident medications. Specifically, the facility failed to present the incident to the Quality Assurance and Performance Improvement Committee for review, identify system failures, develop corrective actions, and monitor the effectiveness of interventions to prevent recurrence. Findings include: Cross reference to F-602, F-609. The facility's policy and procedure titled Quality Assurance and Performance Improvement (QAPI) Program dated 01/13/2026 documented the facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI Program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the Quality Assurance and Performance Improvement (QAPI) Program are to: 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. Through staff reporting and subsequent investigation, the facility became aware on 03/23/2026 that Licensed Practical Nurse #2 admitted to entering unauthorized medication orders into the electronic medical record under Resident #4's record, discontinuing those orders, and taking the medication for personal use in December 2025. Licensed Practical Nurse #2 also admitted to entering another unauthorized medication order for Resident #5 on 03/18/2026 with the intent to obtain that medication, although the medication was removed from the medication cart before they could take it. There was no documented evidence the facility brought the matter to the Quality Assurance and Performance Improvement committee after the incident. During an interview on 07/02/2026 at 3:33 PM, Administrator #1 stated they consulted with Corporate Administrator #1 and Corporate Regional Registered Nurse #1 regarding the incident. Licensed Practical Nurse #2 was placed on a probationary period, including weekly audits of medication orders and medication cart practices. Administrator #1 stated the incident was not brought to the Quality Assurance and Performance Improvement Committee due to concerns regarding employee rights and personnel matters. 10 New York Codes, Rules and Regulations 415.27		