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	11/20/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. (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 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews conducted during an abbreviated survey (2620167), the facility did not ensure the Medical Director fulfilled their responsibility for the implementation of resident care when the resident died. This was evident for 1 of 3 residents reviewed for death. Specifically, Resident # 1 died on [DATE] and the Medical Director signed the death certificate electronically on [DATE]. In accordance with State Public Health Law 4041, this was required within 72 hours of death.Resident #1's diagnoses include, but not limited to, Dementia, repeated falls, chronic kidney disease stage 3, and basal cell carcinoma of skin of nose. A significant change Minimum Data Set, dated [DATE] documented Resident #1 had a brief interview for mental status score of 09; indicating the resident has moderate cognitive impairment with no behaviors present. Resident had no impairments to upper and lower extremities and used a wheelchair for locomotion. A Nursing progress note dated [DATE] at 1:31am documented the called by unit licensed practical nurse # 1for assessment of Resident #1. Resident was absent of respirations, no apical pulse noted. Time of death 1:31am. Post-mortem care provided by Certified Nurse Aide. Family made aware. Funeral home called. Provider made aware. During a telephone interview on [DATE] at 8:45 am with Resident # 1's Representative they stated Resident #1 died at approximately 2 am on 8/15 and they were notified by the facility. After they were notified of Resident # 1's death they went to the funeral home to discuss everything. Resident # 1's Representative stated on [DATE] they made the decision to cremate the resident. Funeral home called the family and stated they could not proceed forward because the death certificate was not signed and then the death certificate was signed and received on [DATE]. They believe it is typically a business day. The delay in the death certificate put extra stress because services were delayed until [DATE] because the death certificate was not signed on time. During a telephone interview on [DATE] at 1:19 pm with the Funeral Director they stated they worked in the funeral home over 20 years. The Funeral Director stated the Care Center at Sunset Lake is typically good about signing the death certificates. The provider has 48 hours by law to sign the death certificate. This does not include weekends. They have two (2) business days to sign the death certificate. Once the provider has signed the death certificate it is sent to the township of Liberty and then a permit is issued. Surveyor requested for the director to review the death certificate of Resident #1. Funeral Director stated they should have signed it on the 18th, but it was signed on the 19th and the resident had the burial on [DATE]. During a telephone interview on [DATE] at 10:22 am with the Medical Director, they stated the process for signing a death certificate involves the nurse contacting the provider on call to make them aware. The Director of Nursing will start the death certificate in the Health Commerce System to start the process, or sometimes they will complete it their self. They have 72 hours to sign the death certificate, but they are not sure if the other providers are credentialed to sign them. A lot of times when the other providers are on call the nurses will make them aware, but they are not aware of this communication until later. Medical Provider stated they usually sign the death certificate within 24 hours because they do not want to wait because you can forget with everything going on. If they are not aware that the death certificate needs to be signed, then they cannot sign it. They go to the facility once a week, but they are available 24 hours. They signed the Resident #1's death certificate once they were made aware. The facility investigated and spoke with the nursing staff, but the facility had no documentation that anyone called them to sign. That is why they signed it late because they were not informed. The nurses are aware they need to call the provider otherwise how would they know to sign the certificate. Surveyor reviewed the expiration note with the provider, and the Medical Director stated they spoke with the nurse who put the expiration note in the system and the nurse acknowledged that they put the note in but never followed up with a phone call to inform me. This is rare and typically does not happen. 10NYCRR 415.15(a)