STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335218	A. Building B. Wing	10/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cortland Park Rehabilitation and Nursing Center	193 Clinton Avenue Cortland, NY 13045

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 46276 Based on observation, record review, and interview during the recertification and abbreviated (NY00324417) surveys conducted 10/16/23-10/20/23, the facility did not ensure residents had the right to a safe, clean, comfortable, and homelike environment for 2 of 3 resident units (Parkside and Whispering Pines Units including resident rooms 201, 202A, 203, 206, 318A and 320A, and Residents #31, #47, and #64). Specifically, there were unclean wheelchairs, medical equipment, common areas, and damaged walls. Findings include: The undated facility policy Complete Room Cleaning documented the procedure for daily room cleaning and bathroom cleaning which included emptying wastebaskets, dusting, and mopping. The daily complete room cleanings will be inspected by the Director of Housekeeping to ensure necessary cleanliness and sanitation levels have been achieved. In the event a complete room cleaning is unsatisfactory, the housekeeper responsible is expected to return to the area immediately and remedy the situation. The following observations were made on Parkside Unit: - on 10/16/2023 at 10:25 AM, the wall behind the recliner in room [ROOM NUMBER]A was scraped along the length of the wall behind the bed. - on 10/19/23 at 7:56 AM, the wall across from the nurse's station had scraped paint. - on 10/16/2023 at 11:08 AM, the wall behind the handrail next to the kitchen entrance was in disrepair. The following observations were made on Whispering Pines Unit on 10/16/2023: - at 9:49 AM there were visible crumbs in room [ROOM NUMBER] on bed B and a green lettuce leaf stuck to the floor next to the bed. Resident #31 had a piece of bread in their wheelchair footrest. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 10:13 AM, room [ROOM NUMBER] had brownish-black matter smeared on the floor by the wheel of bed A and on the left side at the head of the bed. The tube feeding pump had dried brownish fluid on the face of the machine. The continuous positive airway pressure (CPAP) machine in the room was dusty. - at 10:28 AM, Resident #47's wheelchair arm was dirty with dusty brown matter and had dirty wheels. - at 10:42 AM, room [ROOM NUMBER] had food matter on the floor near bed C and by the door, and the bottom of the quarter wall by the sink had cracked and jagged edges. - at 10:44 AM Resident #64's wheelchair was dirty with dried matter on the seat, left arm, leg rest, and wheel well. - at 12:29 PM, the main dining room wall was scuffed, the entryway door was scuffed, and the rubber base was separated from the wall. The following observations were made on Whispering Pines Unit on 10/17/2023: - at 8:31 AM, room [ROOM NUMBER] had partially wiped, medium sized food matter on the floor. - at 09:16 AM, room [ROOM NUMBER] had brownish-black matter smeared on the floor under the wheel of the bed near the head of bed A; the bottom of the tube feeding pump pole was dirty with a dried light brown substance and the CPAP machine was dusty. - at 9:33 AM, the floor between rooms [ROOM NUMBERS] was dirty with dried liquid drip spots and dirt, dried food, and crumbs. - at 10:38 AM, the sink in room [ROOM NUMBER] was loose and the caulking was coming off the wall on the back of the sink. - at 2:03 PM, room [ROOM NUMBER] had a blood sugar monitoring strip on the floor, blackish-brown matter smeared on the left side of bed A, the floor under the bed was dirty, dried brownish fluid was on the face of the feeding pump, and the CPAP machine was dusty. - at 2:06 PM, the inside of Resident #31's wheelchair foot cradle was dirty with skin flakes, crumbs, and dried liquid spills. The following observations were made on Whispering Pines Unit on 10/18/2023: - at 08:36 AM, room [ROOM NUMBER] had quarter sized spots of food matter in the middle of the floor and near the bed. - at 1:59 PM, Resident #31's wheelchair foot cradle was dirty with dried liquids, food debris, and a fork. The following observations were made on Whispering Pines Unit on 10/19/2023: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- at 8:00 AM, Resident #31's wheelchair arm rest, wheel well, and brake were unclean. - at 8:03 AM, the floor between resident room [ROOM NUMBER] and resident room [ROOM NUMBER] had dried liquid drip spots and dirt. The floor in front of the TV across from the nurse's station had dried liquid spots and dried food matter. - at 8:04 AM, the floor along the front of the nurse's station had dried liquid and matter. The following observations were made on Whispering Pines Unit on 10/20/2023: - at 8:47 AM, Resident #31's wheelchair foot cradle had food crumbs and skin flakes. - at 8:49 AM, the floor along the front of the nurse's station had dried dirt, dark spots, and liquid spills. The floor in front of the TV across from the nurses' station had dried white spot and dark matter stains. - at 8:53 AM, room [ROOM NUMBER] had dried food matter and liquid spill stains next to bed A. - at 8:56 AM, Resident #47 had dried spilled liquid on the right arm rest of their wheelchair. - at 9:09 AM the quarter wall by the sink in room [ROOM NUMBER] had cracked and jagged edges and there was food debris on the floor between beds A and B. - at 9:11 AM, Resident #31's wheelchair wheels and connecting metal were dirty with dried food and dried liquid matter. During an interview on 10/19/2023 at 8:05 AM, certified nursing assistant (CNA) # 44 stated housekeeping was responsible for cleaning resident rooms, emptying trash and washing floors. If a CNA or other staff noticed walls that needed repair, then a work order was placed into the computer. CNA #44 stated any staff could enter a work order and they were unsure if one had been placed for Resident #3's wall. During an interview on 10/19/2023 at 9:19 AM, housekeeper #42 stated they were on the unit Whispering Pines every day. Housekeeper #42 stated they were responsible for the daily cleaning of resident rooms which included dry and wet mopping floors and under beds. Housekeeper #42 stated all staff were responsible for common area spills. They stated there was a floor technician but on days the technician was not there, and they were responsible for floors in common area. Housekeeper #42 stated they tried to get all rooms on one hall done before lunch, and all rooms were completed prior to them leaving the facility. They stated that the spot in room [ROOM NUMBER] by bed A was an oil mark from the bed after a strip and wax of the room. There were plans to strip and wax the room again and fix the wall. Housekeeper #42 stated the CNAs were responsible for wheelchair cleaning. During an interview on 10/19/2023 at 10:23 AM, CNA #34 stated everyone was responsible for cleaning wheelchairs. Overnight nursing staff were primarily responsible, but all staff should ensure they were cleaned. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/19/2023 at 2:22 PM, licensed practical nurse (LPN) Unit Manager #28 stated that nightshift nursing staff was responsible for cleaning wheelchairs. LPN Unit Manager #28 stated there was no log or formal schedule for cleaning wheelchairs but should be cleaned weekly. If a wheelchair was visibly dirty, it should be cleaned by any staff who saw it. During an interview on 10/20/2023 at 8:24 AM the Director of Maintenance stated the walls in the facility were looked at every week to try and match up paint if painting needed to be done. They stated it was not homelike for walls to be scraped up and in need of paint. The Director of Maintenance stated they had new staff working on repairing walls every week and if staff would report them, they would follow up as soon as they were aware. The Director of Maintenance stated all the issues were not homelike and should be repaired. During an interview on 10/20/2023 at 9:00 AM with the Regional Director of Housekeeping, they stated dirty wheelchairs and medical equipment were supposed to be cleaned by nursing. If there were substances spilled on the floor nursing staff knew how to clean them up. They stated dirty floors and walls should be cleaned daily by housekeeping. Housekeeping had a list of areas to clean daily that included washing and mopping floors, emptying trash, cleaning windowsills, cleaning sinks, and washing the rubber baseboards. They stated some of the rubber baseboards needed to be replaced, they were pulling away from the walls and no amount of cleaning would make them appear clean. During an interview on 10/20/2023 at 9:32 AM, LPN #37 stated the overnight shift should clean medical equipment and tube feeding poles. LPN #37 stated that if a nurse used the machine/pole, they should have cleaned it. During an interview on 10/20/2023 at 9:36 AM, LPN Unit Manager #28 stated housekeeping was responsible for cleaning feeding poles and machines. 10NYCRR 415.29 (j)(1) 48052

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46276 48511 48632 Based on observation, record review, and interviews conducted during the recertification and abbreviated (NY00324417) surveys the facility did not ensure residents were free of significant medication errors for 2 of 5 residents (Residents #59 and #68) reviewed. Specifically, Resident #59 had an order to hold their insulin if their finger stick blood glucose (FSBG) level was less than 120 milligrams/deciliter (mg/dl) and the resident received insulin when their FSBG was 77 mg/dl; Resident #68 did not receive nebulizer treatments as ordered. Findings include: The facility policy, Medication Administration revised June 2023, documented that medications would be administered as prescribed and nursing staff would strongly adhere to the five rights of medication administration (right resident, medication, dose, route, and time) to ensure safety. 1) Resident #59 was admitted to the facility with diagnoses including diabetes and dementia. The Minimum Data Set (MDS) dated [DATE], documented that the resident had moderately impaired cognition, and received insulin injections 7 of 7 days. Physician orders documented: - on 5/4/2023 by physician #1 check finger stick blood glucose (FSBG) level before meals and at bedtime on Wednesdays at 8:00 AM, 12:00 PM, 4:30 PM, and 9:00 PM, call the physician or nurse practitioner (NP) if FSBG was less than 60 (milligrams/deciliter, mg/dl) or greater than 450 mg/dl. - on 5/8/2023 by physician assistant (PA) #35 Humalog (fast acting insulin) pen subcutaneous injection 5 units before meals at 8:00 AM, 12:30 PM, and 4:30 PM, hold if BG (blood glucose) is less than 120 mg/dl. There was no corresponding order for daily FSBGs before meals. During a medication administration observation and interview on 10/18/2023 at 11:34 AM with licensed practical nurse (LPN) # 20, Resident #59 was wheeled into their room from the dining room where they were eating a dessert food item. LPN # 20 obtained the FSBG blood sugar and stated the results were 77 and would administer the insulin unless the resident's glucose was below 40. LPN #20 administered Humalog insulin 5 units subcutaneously into the resident's left lower abdomen. At 11:38 AM, while documenting for the administered medication, LPN #20 stated that the insulin should not have been given as the resident's blood glucose result was 77 which was less than 120 as documented on the physician order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 10/1/2023-10/20/2023 Medication Administration Record (MAR) documented Humalog insulin 5 units subcutaneously hold if BG is less than 120. On 10/3/2023 at 4:30 PM the resident's BG was documented as 112 mg/dl and was administered 5 units of insulin in the left arm by LPN #47. On 10/16/2023 at 8:00 AM the resident's BG was documented as 105 mg/dl and was administered 5 units of insulin in the left lower quadrant (LLQ) by LPN #6. On 10/16/2023 at 12:20 PM the resident's BG was documented as 105 mg/dl and was administered 5 units of insulin in the LLQ by LPN #6. On 10/18/2023 at 12:30 PM the resident's BG was documented as 77 mg/dl and was administered 5 units of insulin in the LLQ by LPN #20. During an interview on 10/18/2023 at 12:03 PM, LPN UM #21 stated additional orders had been obtained to monitor residents blood glucose levels and Resident #59's blood glucose was now 85 and they had finished their dessert. During an interview on 10/20/2023 at 1:44 PM, the DON stated that the provider should be called with any medication error or omission. The facility had a hypoglycemic policy and staff could access the policies on their computers. 2) Resident #68 was admitted to the facility with diagnoses including Parkinson's disease (a progressive neurological disorder), chronic obstructive pulmonary disease (COPD, lung disease), and wheezing. The 9/27/2023 Minimum Data Set (MDS) assessment documented the resident was cognitively intact. During an interview and observation on 10/16/2023 at 12:07 PM, Resident #68 had a deep, congested, productive cough with white/yellowish sputum. The resident stated they had difficulty lying flat in bed and sleeping due to the increased cough. They stated the symptoms were present for 3 days and were getting worse. They stated they told a nurse (no identifier) on 10/15/2023. A 10/17/2023 at 9:51 AM, registered nurse (RN) #4 progress note documented the resident was assessed for complaint of increased cough and congestion. The resident reported they had the cough for a couple of days. The resident's lung sounds were diminished throughout all fields. The left lower lobe of the lung was noted to have fine crackle sounds. The plan was for the licensed practical nurse (LPN) Unit Manager (LPN/UM) #2 to contact the medical team. A 10/17/2023 at 12:10 PM LPN/UM #2 progress note documented a phone call was made to the on-call medical provider. The LPN/Unit Manager #2 received orders for a STAT (immediate) chest Xray, and additional blood work was to be performed. A 10/17/2023 at 12:45 PM nurse practitioner (NP) #7 progress note documented they assessed the resident after they received a phone call from staff that the resident had a cough and congestion. The resident's vital signs were stable, and the oxygen saturation (percentage of oxygen in the blood) was 93%. On physical exam, they documented the resident's lung sounds were diminished, and no rhonchi (abnormal lung sounds), wheezes or cough were heard. The plan was to wait for the results of the chest Xray, and blood work ordered for definitive diagnosis. NP #7 ordered DuoNeb (a combination medication) nebulized (an aerosol treatment) every 6 hours. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 10/17/2023 at 7:59 PM RN #5 progress note documented they received a call from the on-call medical provider. The resident's chest Xray was positive for a left lower lung pneumonia. RN #5 received verbal orders from NP #38 for doxycycline (an antibiotic) and DuoNeb inhalation treatment every 6 hours for treatment of pneumonia. RN #5 completed entry of new orders electronically on the medication administration record (MAR). A 10/17/2023 at 10:02 PM LPN# 6 progress note documented they gave the resident the first dose of doxycycline 100 (milligram) mg. There was no entry on the medication administration record (MAR) documenting doxycycline was given. The October MAR documented DuoNeb nebulizer treatment every 6 hours ordered on 10/17/2023. The 10/17/2023 doses due at 12:00 PM and 6:00 PM were documented by LPN #6 as not administered, the reason was discontinued. The 10/18/2023 dose due at 12:00 AM was documented by LPN #8 as not administered, the reason was documented as discontinued. The 10/18/2023 6:00 AM dose was documented by LPN #8 as given. The original DuoNeb order was discontinued by NP #7 on 10/18/2023 at 11:19 AM. NP #7 wrote a new order on 10/18/2023 at 11:19 AM for ipratropium-albuterol nebulized every 6 hours During an interview on 10/18/2023 at 9:07 AM, the resident stated they were told by the nurse that the chest Xray performed on 10/17/2023 showed they had pneumonia. The resident stated the nurse gave them an antibiotic last night to treat the pneumonia. They stated they received the first nebulizer treatment that morning around 5:30 AM. During an interview on 10/18/2023 at 10:02AM, NP #7 stated the resident had left lower lobe pneumonia. The resident was prescribed doxycycline 100 mg two times a day for 7 days and DuoNeb nebulized every 6 hours for one week. They stated no follow up care was required if the resident continued to improve. During a follow up telephone interview on 10/18/2023 at 4:02 PM NP #7 stated they discontinued the orders for DuoNeb and placed new orders for the same medications today to reflect accuracy in medication name, dose, and duration. NP #7 stated LPN/Unit Manager #2 entered an erroneous verbal medication order for ipratropium on 10/17/2023 and that order was also discontinued. NP #7 stated the original verbal order was for DuoNeb. During an interview on 10/18/2023 at 4:10 PM, LPN/Unit Manager #2 stated they made a medication error by placing a verbal order for ipratropium nebulized on 10/17/2023. They stated they thought DuoNeb was ipratropium. They stated that the medication error could have caused the resident to have difficulty breathing. During a telephone interview on 10/18/2023 at 4:46 PM, LPN #8 stated they received in nurse to nurse report at the start of the shift on 10/17/2023 at 7:00 PM that the resident was being treated for pneumonia with doxycycline. They stated they were told by the off going LPN that the DuoNeb nebulizer treatment was discontinued. They stated they documented the treatment was discontinued at the 12:00 AM. They stated that the pharmacy delivered DuoNeb for the resident on 10/18/2023 at 4:35 AM and when the delivery was received, they checked the order and realized it was an active order. They stated they gave the resident the DuoNeb nebulizer treatment on 10/18/2023 at 5:30 AM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/20/2023 at 1:00 PM, the Director of Nursing (DON) stated a provider (physician, NP, or PA) must order all medications for the residents. They stated verbal medication orders could be obtained by a registered nurse (RN) only. When a RN received a verbal order, the order must be placed in the electronic medical record (EMR) immediately. The verbal order must be verified by another RN to be certain the order was entered correctly. They stated if a verbal order was entered incorrectly, it was considered a medication error. They stated there should be no delay in administering a DuoNeb nebulized treatment after the order was entered in the EMR as DuoNeb medication was kept in the facility pyxis (a locked cabinet where medication is stored). 10NYCRR 415.12(m)(2)