STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335233	A. Building B. Wing	11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Park Rehabilitation and Nursing Center	950 Floyd Avenue Rome, NY 13440

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34465 Based on record review and interviews during the abbreviated survey (NY00334012), the facility did not ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for 1 of 3 residents (Resident #2) reviewed. Specifically, Resident #2 did not receive medications as ordered on multiple occasions. Findings include: The facility policy, Medication Administration, revised 1/2024, documented the nurse should document all medications administered to each resident on the resident's medication administration record. Documentation must include name and strength of the drug, dosage, method of administration, date and time, and reason(s) why a medication was withheld, not administered, or refused. In the event a medication pass time had passed, the nurse would inform the medical professional and obtain orders to either give the medication, hold, or discontinue. The nurse must inform the Nursing Supervisor of the medication administration event. Resident #2 had diagnoses including depression, diabetes, chronic obstructive pulmonary disease (lung disorder), and Parkinson's Disease (a progressive neurological disease). The 2/24/2024 Minimum Data Set assessment documented the resident had intact cognition. The 2/18/2024 Comprehensive Care Plan documented the resident had an alteration in respiratory system, had insulin dependent diabetes, was prescribed psychotropic medication related to depression/anxiety and was at risk for functional decline in mobility and self-care related to Parkinson's disease. Interventions included to administer treatments (nebulizers) and medications per physician orders. The 2/18/2024 Physician #9 progress note documented the resident was recently discharged from the hospital. They had Parkinson's Disease, and they were to continue their Parkinson's medication. The 2/18/2024 physician orders included: -Novolog (rapid acting insulin-reduces blood sugar) Injection Solution, inject per sliding scale before meals and at bedtime. If blood sugar was 70-120 (milligrams/deciliter), give 1 unit; 121-170, give 2 units; 171-220, give 2 units; 221-270, give 3 units; 271-320, give 3 units; 321-370, give 3 units; 371-400, give 4 units. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Pulmicort (respiratory medication, reduces inflammation) Suspension 0.5 milligrams/2 milliliters, 0.5 milligrams inhaled orally twice daily for chronic obstructive pulmonary disease (restrictive lung disease). -Rytary (treats symptoms of Parkinson's disease) 48.75-195 milligrams, 3 capsules four times daily. -vilazodone (antidepressant) 20 milligrams tablet in the afternoon. On 2/18/2024, Medication Administration Notes completed by Licensed Practical Nurse #1 documented the following medications were not available: - at 7:55 AM, Rytary, and Pulmicort; - at 10:10 AM, Rytary and vilazodone; and - at 2:39 PM and 6:52 PM, Rytary. On 2/19/2024, the Medication Administration Record and Medication Administration Notes completed by Licensed Practical Nurse #2 documented the following medications were on order/not available: - at 7:30 AM, Novolog. The resident's blood sugar was 181 (2 units of insulin was required per physician ordered sliding scale); and - at 2:35 PM, vilazodone, Pulmicort, and Novolog. The resident's blood sugar was 218 (2 units of insulin was required per physician ordered sliding scale). On 2/20/2024, Medication Administration Notes completed by Licensed Practical Nurse #2 documented the following medications were not available: - at 7:00 AM, Pulmicort; - at 11:53 AM, Novolog. The resident's blood sugar was 170 milligrams/deciliter (2 units of insulin was required per physician ordered sliding scale); and - at 12:00 PM, vilazodone. There was no documented evidence a provider was notified that medications were not available. The 2/20/2024 at 2:19 PM Physician Assistant #10 progress note documented they were notified the resident was having more dysarthria (slurred speech), they complained of chest pain, and they had some nausea the previous night. The resident was sent to hospital. Not sure if need but was hoping to correlate to missing meds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 2/20/2024 hospital report documented the resident complained of chest pain and anxiety that started last night and was still present. The resident stated they vomited yesterday and did not take their medications today. The resident reported they were experiencing distress regarding their current living situation. Labs were essentially normal, and the resident was discharged back to the facility. The 2/23/2024 Physician #9 progress note documented the resident's Parkinson's was unstable and the disease was progressing. The resident was to continue their Parkinson's medication and was to follow up with neurology. The Medication Administration Record documented Rytary was not available on: - 2/23/2024 at 3:00 PM and 7:00 PM by Licensed Practical Nurse #3; - 2/24/2024 at 7:00 AM, 11:00 AM, and 3:00 PM by Licensed Practical Nurse #1; - 2/29/2024 at 3:00 PM and 7:00 PM by Licensed Practical Nurse #3; - 3/1/2024 at 7:00 AM and 11:00 AM by Licensed Practical Nurse #4 and at 3:00 PM and 7:00 PM by Licensed Practical Nurse #5; - 3/2/2024 at 7:00 AM and 11:00 AM by Licensed Practical Nurse #4 and at 3:00 PM and 7:00 PM by Licensed Practical Nurse #6; - 3/3/2024 at 7:00 AM and 11:00 AM by Licensed Practical Nurse #4 and at 3:00 PM and 7:00 PM by Licensed Practical Nurse #6; - 3/4/2024 at 7:00 AM and 11:00 AM by Licensed Practical Nurse #7 and at 3:00 PM and 7:00 PM by Licensed Practical Nurse #5; - 3/5/2024 at 7:00 AM and 11:00 AM by Licensed Practical Nurse #4 and at 3:00 PM and 7:00 PM by Licensed Practical Nurse #8; and - 3/6/2024 at 7:00 AM, 11:00 AM, 3:00 PM and 7:00 PM by Licensed Practical Nurse #4. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/31/2024 at 10:43 AM, Pharmacist #11 stated medications were typically delivered to the facility the same day they were ordered. Most resident's entering the facility as a new admission were on Medicare and the facility was responsible for paying for their medications. The facility practice was any medication costing over 50 dollars required corporate approval before the medication could be filled and sent to the facility. Additionally, if a resident was admitted after 5:00 PM, it could take until the next day or the following day for medications to be filled due to corporate needing to approve medications first. Rytary was a Parkinson's disease medication, was very expensive and should be given on time. If not given on time, residents were at risk of adverse reactions including having their Parkinson's symptoms recurring such as tremors. On 2/17/2024, the order for the resident's Rytary was received at the pharmacy and the facility Corporate Pharmacy Liaison #12 did not approve the medication until 2/19/2024. On 2/24/2024, they received corporate approval again and sent 4.5 days' worth of medication to the facility. On 3/4/2024, the facility requested a refill, corporate approved it on 3/5/2024 and the medication was sent that day. Vilazodone, Novolog and Pulmicort also were expensive and needed corporate approval before they could be sent to the facility. On 2/18/2024, the order for Novolog was received at the pharmacy and was not approved by corporate until 2/20/2024. The facility could have used a short acting insulin from the Cubex (on-site medication dispensing machine) but would need a physician order to do so. During a telephone interview on 10/31/2024 at 12:25 PM, Licensed Practical Nurse #4 stated medications not being available had been an issue and they had seen some medications not available for up to 2 weeks. When a medication was not available, they notified their supervisor. They were not sure if a provider was notified. They did not recall the resident or why they documented Rytary was not available from 3/1/2024 through 3/3/2024 and from 3/5/2024 to 3/6/2024. During a telephone interview on 10/31/2024 at 12:40 PM, Licensed Practical Nurse #2 stated when a medication ran out, they ordered it directly through the electronic medication administration record or called the pharmacy directly to refill the medication. If a medication could not be obtained in time for administration, they should notify their Unit Manager who would notify a provider. On 2/19/2024 and 2/20/2024, medications were not yet available from the pharmacy. Sometimes medications were not sent immediately after admission because the medications required prior authorization, however, they were not sure this was the case for the resident. Medications were also available through the Cubex however if they were given, they would have signed for the medications. They did not recall noticing any side effects and the resident did not complain of side effects from missing medications. During a telephone interview on 11/1/2024 at 11:29 AM, facility Corporate Pharmacy Liaison #12 stated when a medication was not covered and needed prior authorization, the pharmacy notified them, and they relayed what covered alternative medication could be used to the Director of Nursing and the clinical team including the physician. If the team agreed, they or the clinical team notified the pharmacy. This was all done in the same day. If the clinical team did not agree with the covered alternative, the team had them work with the pharmacy to get prior authorization for the original medication. There was no waste of time and the medication should be available the same day depending on the pharmacy delivery. There were also medications available in the Cubex. They did not recall the resident and would have to look through the resident's medical information. The stated they did not think it was acceptable when the resident went 2 days without Novolog, Pulmicort, vilazodone and Rytary. They stated staff could have accessed the Cubex for medications. When the resident went without Rytary from 2/23 to 2/24/2024 and 2/29 to 3/6/2024, they stated they were not sure why and would have to look into it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 11/1/2024 at 1:51 PM, the Director of Nursing stated the facility wanted to provide the best care for all residents, and they followed what the physician ordered for a resident's specific needs. The facility had a For Your Information email that was sent by the pharmacy whenever a medication was over 50 dollars. They stated they did not have to approve the cost prior to the pharmacy sending the medication and they were not sure if anyone else needed to approve the cost. The Director of Nursing stated they had spoken to Corporate Pharmacy Liaison #12 a few times when they called and had questions about different medications and wanted to know if there was an alternative that could be used. When staff documented medications were not available from 2/18/2024-2/20/2024, they expected the pharmacy to be called to find out where the medication was, and the physician should have been notified. The resident should not have gone 3 days without ordered medications. The resident should not have missed their Rytary dose for 2 days on 2/23/2024 and 2/24/2024 and should not have gone 7 days without ordered Rytary from 2/29/2024-3/6/2024. Nobody notified them of the missing medications and staff should have notified them. During a telephone interview on 11/5/2024 at 9:30 AM, the Medical Director stated physician orders were for needed medications. If a medication was not available, they expected staff to notify the Director of Nursing or the Administrator. If staff were not able to obtain the medication, they expected to be notified. They were not aware of a facility process requiring approval of medications over 50 dollars. Rytary was used to treat the symptoms of Parkinson's Disease. If a resident went several days without the medication the symptoms of Parkinson's could return. They stated when the resident went multiple days without Rytary, it was not acceptable. If a particular brand was not available, another brand could have been substituted. Staff should have notified the Director of Nursing and/or the Administrator when the resident's medications could not have been obtained. A week without Rytary was too long and patient care was number one. 10NYCRR 415.12