STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0755 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46526 Based on observations, interviews and record review conducted during the Recertification Survey, it was determined for two (2nd floor and 3rd floor) of two residential units reviewed, the facility did not ensure that an accurate reconciliation of all controlled substances was maintained. Specifically, the narcotic count logs which included reconciliation of narcotic medications and the signatures of staff members for each shift-to-shift count, were not consistently signed to indicate the count was complete and the correct count was verified. This was evidenced by the following: The facility policy and procedure, Medication - Narcotic Management, dated April 2019, included that narcotics and schedule two medications would be counted with two professional nurses and documentation that the count was completed and accurate would be completed at the beginning and end of each shift. Any discrepancy in a shift-to-shift count must be immediately communicated to the Director of Nursing. Review of the Narcotic Count logs for the second and third floor residential units from 1/1/24 to 2/29/24, revealed multiple missing nurse signatures to verify that the controlled substance count had been completed and was accurate for the following: a) Records labeled 2nd Even, had 76 missing signatures out of 336 opportunities. b) Records labeled 2nd Even Wrap, had 94 missing signatures out of 334 opportunities. c) Records labeled 2nd Odd, had 101 missing signatures out of 304 opportunities. d) Records labeled, 2nd Odd Wrap, had 107 missing signatures out of 312 opportunities. e) Records labeled 3rd Even, had 47 missing signatures out of 346 opportunities. f) Records labeled, 3rd Even Wrap, had 27 missing signatures out of 346 opportunities. g) Records labeled, 3rd Odd had 45 missing signatures out of 364 opportunities. h) Records labeled, 3rd Odd Wrap, had 61 missing signatures out of 374 opportunities. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0755 Level of Harm - Potential for minimal harm Residents Affected - Many	During an observation of medication storage on 2/28/24 at 12:29 PM, review of the third-floor Narcotic Count Log books labeled Odd and Odd Wrap, revealed multiple missing nurse signatures. When interviewed at that time, Licensed Practical Nurse #3 stated at the change of shift, the arriving and leaving nurses counted the narcotics and signed the log if the count was correct. During an observation of medication storage on 2/28/24 at 3:11 PM, review of the third-floor Narcotic Count Log book labeled, Even, revealed multiple missing nurse signatures. When interviewed at that time, Licensed Practical Nurse #1 stated the arriving nurse and leaving nurse sign the narcotic log at the change of shift. Licensed Practical Nurse #1 stated a blank box on the log meant a nurse did not sign. During an observation of medication storage on 2/29/24 at 9:08 AM, review of the second-floor Narcotic books labeled Even, Even Wrap, Odd, and Odd Wrap, revealed multiple missing nurse signatures. During an interview on 2/29/24 at 9:22 AM, Licensed Practical Nurse Manager #3 stated the narcotic medications were counted by the nurses arriving and leaving from shift-to-shift, who then signed the log when the count was done. Licensed Practical Nurse #3 stated the logs should not have missing signatures. During an interview on 3/1/24 at 9:41 AM, Licensed Practical Nurse Manager #1 stated when a nurse arrived for their shift, they counted the narcotics with the nurse that was leaving. All narcotics, including discontinued ones, were counted to make sure the number matched what was in the narcotic log. At the end of the narcotic book, both nurses signed that the count was correct. Licensed Practical Nurse Manager #1 stated they had identified a couple missing signatures a few days prior. They found that one nurse would sign, but the other had not. Licensed Practical Nurse Manager #1 stated the missing signatures may have been due to the nurse forgetting to sign while they were holding the narcotics during the count. During an interview on 3/1/24 at 10:35 AM, the Director of Nursing stated the nurses were supposed to count all narcotics at the beginning and end of their shift, and sign if the counts were correct. When asked what a blank box or missing signature indicated, the Director of Nursing stated if it was not signed, it was not done. Copies of the narcotic count sheets were reviewed at that time. The Director of Nursing stated some entries included one nurse's signature, but the other nurse's signature was missing. 10 NYCRR 415.18(b)(1)(2)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 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** 46526 Based on observations, interviews, and record review conducted during the Recertification Survey and complaint investigation (NY00328090), it was determined that for one (Resident #93) of two residents reviewed, the facility did not ensure that the resident was free from significant medication errors. Specifically, Resident #93 did not receive an antibiotic medication as ordered by the physician for several days. This is evidenced by the following: The facility policy and procedure, Medication Errors, dated August 2019, included that the staff and practitioner should strive to minimize adverse consequences by following relevant clinical guidelines and manufacturer's specifications for use, dose, administration, duration, and monitoring of the medication; defining appropriate indications for use; and determining that the resident receive the medication as prescribed and timely. The facility policy and procedure, Medication Administration Review, dated August 2019, included that Licensed Nurses (Registered Nurse/Licensed Practical Nurse) must ensure prior to the end of their shift that all medications or treatments that were administered, refused, held, etc., were properly documented on the Medication Administration Record. Failure to do so was considered an omission in the medical record. The facility policy, Physician Orders, dated February 2020, included when there were order changes the current order was to be discontinued prior to initiating the new order. The Licensed Nurse receiving or accepting an order was required to transcribe the order to the Medication Administration Record, containing all the required information. The facility policy and procedure, Physician Orders - Transcription, dated August 2018, included a Clinical Nurse should transcribe and review all physician orders in order to affect their implementation. A Clinical Nurse could accept a telephone order from the physician only or Physician Assistant or Nurse Practitioner (as per state stature). The order should be repeated back to the physician for their verbal confirmation. The order should be transcribed to all appropriate areas (Medication Administration Record, Treatment Administration Record, etc.). Resident #93 had diagnoses that included diabetes, chronic kidney disease, and hypertension. The Minimum Data Set assessment dated [DATE], revealed that Resident #93 was cognitively intact. Review of physician orders revealed: A. Cefepime (an antibiotic) two grams intravenously (administered into a vein) every 12 hours for five days for pneumonia ordered on 11/3/23 at 12:59 PM by Physician #1. The order was discontinued on 11/3/23 at 6:35 PM by Licensed Practical Nurse #1 (per verbal order by Physician #1) with a reason of 'changed to intramuscular' (injected into a muscle). B. Cefepime one gram intramuscularly two times a day for five days for pneumonia, reconstitute (mix) with 2.1 milliliters of 1% Lidocaine ordered on 11/3/23 at 6:56 PM by Licensed Practical Nurse #1 (per telephone order by Physician #1). The order was discontinued on 11/4/23 at 10:42 AM by Licensed Practical Nurse Supervisor #1 with a reason of 'concentration corrected by Pharmacy.' (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Cefepime one gram intramuscularly two times a day for five days for pneumonia, reconstitute with 2.4 milliliters of 1% Lidocaine ordered on 11/5/23 at 11:31 AM by Licensed Practical Nurse Manager #1 (per verbal order by Physician #1). Review of the November 2023 Medication Administration Record revealed no documented evidence that the antibiotic was administered on 11/3/23, 11/4/23, or 11/5/23. For the evening dose scheduled for 11/5/23, the code '9' (see nurse notes) was documented. Review of a Medication Administration Note dated 11/5/23 at 10:07 PM revealed the antibiotic was on order. A progress note dated 11/3/23 at 9:10 PM and documented by Licensed Practical Nurse #1 included that new orders for an intravenous (administered into a vein) antibiotic were received from Physician #1. Licensed Practical Nurse #1 spoke with the Assistant Director of Nursing and the antibiotic order was changed to an intramuscular injection. The antibiotic was administered to Resident #93's right thigh. Additional review of progress notes from 11/4/23 to 11/5/23 did not include documentation that the antibiotic was administered or that a medical provider was notified that the medication was unavailable. Review of the scanned documents section in Resident #93's electronic health record did not reveal a Medication Administration Record that included documentation that the antibiotic was administered on 11/4/23 or 11/5/23. Additionally, the facility could not provide other documentation that showed evidence the antibiotic was administered on those dates. Review of the Daily Staffing dated 11/3/23 revealed at least one Registered Nurse was scheduled for the day shift and evening shift. There were no Registered Nurses scheduled for the night shift. During an interview on 2/29/24 at 10:40 AM, Physician #1 stated they saw Resident #93 for an acute visit related to a cough, sore throat, and crackles in their right lung. Physician #1 stated they diagnosed the resident with pneumonia and ordered an intravenous antibiotic. Physician #1 stated they had been told the facility did not have a Registered Nurse on every shift to administer an intravenous antibiotic, so they were ok with changing the order to be given intramuscularly. Physician #1 stated they stopped in the facility after 11/5/23 and was informed by the nursing supervisor that the resident had not received their antibiotic over the weekend, but they were unsure why. Physician #1 saw Resident #93 at that time and the resident said they did not get their shots over the weekend. Physician #1 stated they had not discontinued the intramuscular antibiotic order and did not recall being notified that the medication was unavailable. Physician #1 stated they would consider an antibiotic a significant medication and not receiving the medication for two days could have resulted in Resident #93's condition not improving. During an interview on 2/29/24 at 12:40 PM, Licensed Practical Nurse #2 stated nurses administered medications that were ordered by a medical provider and when the medication was given to the resident, the nurse documented in the Medication Administration Record. If a medication was not available, they would document it in a progress note and notify the supervisor. Licensed Practical Nurse #2 stated Licensed Practical Nurses were not able to administer intravenous medications, only a Registered Nurse could. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/1/24 at 9:41 AM, Licensed Practical Nurse Manager #1 stated medical providers ordered antibiotics and determined how they should be administered (i.e., intravenously, intramuscularly, orally, etc.). Nurses could receive telephone, verbal, or written orders from the medical provider and could enter or discontinue orders with a medical provider's directive. Some antibiotics were stocked in the Cubex (a cabinet used for medication storage and inventory management) which could be accessed if needed. A Registered Nurse would administer all intravenous medications. Licensed Practical Nurse Manager #1 stated if a medication was not available, the nurse could call the Pharmacy to have it sent on the next delivery; there were at least two deliveries daily. Additionally, the nurses should call the provider to see if there was another medication that could be given. Licensed Practical Nurse Manager #1 stated when a medication was given, the nurse should document it on the Medication Administration Record. A blank box on the Medication Administration Record indicated the medication was not given. Licensed Practical Nurse Manager #1 stated if the medical provider had not signed off on an order, the nurse was unable to document on the electronic Medication Administration Record that a medication was given. In that case, the nurse should print the Medication Administration Record and sign that the medication was given on the paper record. The paper record was then uploaded into the resident's electronic record. Licensed Practical Nurse Manager #1 stated that not giving a medication would be considered a medication error. Licensed Practical Nurse Manager #1 said they did recall Resident #93 being diagnosed with pneumonia but could not remember specific dates. While reviewing Resident #93's electronic health record at this time, Licensed Practical Nurse Manager #1 was unable to find documented evidence that the antibiotic had been administered on 11/4/23 or 11/5/23 or that the medical provider was notified that the antibiotic was unavailable. During an interview on 3/1/24 at 10:35 AM, the Director of Nursing stated they would expect medications to be administered as they were ordered, and nurses could enter or change orders with a medical provider's direction. The Director of Nursing stated the facility had at least eight hours of Registered Nurse coverage every day but did not routinely have a Registered Nurse on every shift. The Director of Nursing stated if an order was not signed by the provider, the nurse could not document the administration of the medication on the electronic Medication Administration Record. In those cases, the nurse would print the Medication Administration Record and document on the paper record or document the medication administration in a progress note. The Director of Nursing stated a blank box on the Medication Administration Record indicated the medication was not given. They would expect the medical provider to be informed if a medication was unavailable to determine if another medication could be given. The Director of Nursing stated they did not recall Resident #93 not being administered their prescribed antibiotic and would have to investigate the concern further. The Director of Nursing stated at that time, there were new medical providers at the facility. Since Licensed Practical Nurses could not administer intravenous antibiotics and there was not always a Registered Nurse available to give it, nursing may have requested the antibiotic order be changed to intramuscular so the antibiotic could be given immediately. The Director of Nursing stated an antibiotic not being administered would be considered a medication error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/1/24 at 11:25 AM, Licensed Practical Nurse Supervisor #1 stated they vaguely remembered when Resident #93 was ordered an intravenous antibiotic and intravenous medications could not be given if a Registered Nurse was not in the facility. Licensed Practical Nurse Supervisor #1 said the covering medical provider was notified and the order was changed from intravenous to intramuscular. Licensed Practical Nurse Supervisor #1 stated they were assigned to the medication cart on 11/4/23 and would not have been able to document in the electronic Medication Administration Record that the antibiotic was administered because the order had been changed and was awaiting the medical provider's signature. Licensed Practical Nurse Supervisor #1 stated when they changed the antibiotic order on 11/4/23, they forgot to change the start time, which had defaulted to start on 11/5/23 at 8:00 PM. 10 NYCRR 415.12(m)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 49368 Based on observations, interviews and record review conducted during the Recertification Survey, it was determined that for one (Resident #84) of one resident reviewed, the facility did not assist with obtaining dental services to meet the needs of each resident. Specifically, Resident #84 reported a broken tooth to facility staff on or around 2/12/24 and the resident was not evaluated by a provider or assisted with scheduling an appointment for dental services until following surveyor intervention. This is evidenced by the following: The facility policy and procedure, Dental Services, dated 2/2019 documented that both routine and emergency dental services were available to meet the resident's oral health care needs and were provided to residents through a licensed dentist that came to the facility monthly or by referral to the resident's personal dentist, community dentist, or other health care organizations that provide dental services. Resident #84 had diagnoses including osteoporosis (a condition causing bones to become weak and brittle), atrial fibrillation (an irregular heart rate) and congestive heart failure. The Minimum Data Set Assessment, dated 1/12/24, revealed the resident was cognitively intact and had no dental concerns. Review of the Comprehensive Care Plan, dated 6/29/21, revealed Resident #84 had oral and dental health problems related to the need for a full upper denture and their own teeth on the bottom. Interventions included to monitor, document, and report signs or symptoms of dental problems; including broken teeth, to the medical provider as needed and refer to the dentist and coordinate arrangements for dental care as needed. Review of the current physician orders included a dental consult as needed. Review of Resident #84's electronic medical record from 12/1/23-2/28/24 revealed no interdisciplinary notes related to the evaluation or assessment of the broken tooth or dental evaluations. During an interview on 2/26/24 at 3:04 PM, Resident #84 stated their tooth broke approximately two weeks ago and nothing had been done about it. They reported the broken tooth to their primary aide, Certified Nursing Assistant #1, who then told a nurse. Resident #84 stated that Certified Nursing Assistant #1 confirmed with them that the nurse had been told about the broken tooth. When interviewed on 2/28/24 at 8:41 AM, Resident #84 stated their tooth had broken at the gum line while eating lunch. During an interview on 3/1/24 at 8:30 AM, Certified Nursing Assistant #1 stated Resident #84's tooth broke while they were in the room and the resident denied having pain at that time. Certified Nursing Assistant #1 stated they had notified Licensed Practical Nurse Manager #2 about the broken tooth. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335330	A. Building B. Wing	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corning Center for Rehabilitation and Healthcare	205 East First Street Corning, NY 14830

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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/1/24 at 8:44 AM, Licensed Practical Nurse Manager #2 stated they did not remember Certified Nursing Assistant #1 reporting the resident's broken tooth. Licensed Practical Nurse Manager #2 added Resident #84 to the facilities monthly dental list following surveyor intervention. During an interview on 3/1/24 at 11:26 AM, the Director of Nursing stated they would expect that if a resident was having any dental issues the resident would be placed on the facilities dental list to be seen. During an interview on 03/01/24 at 12:59 PM, the Administrator stated they were unsure why the Resident's broken tooth was an issue. Resident #84 had told a Certified Nursing Assistant but had not told any other staff member. The Administrator stated that a broken tooth with no pain or infection and that was not affecting the resident's chewing, was not emergent. If the broken tooth was causing them pain, Resident #84 would have been seen emergently. 10 NYCRR 415.17(a-d)