STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335441	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cortlandt Healthcare	110 Oregon Road Cortlandt Manor, NY 10567

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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44673 Based on record reviews and interviews conducted during an abbreviated survey (NY00351622), the facility did not ensure timely removal of discontinued medications from the narcotic cabinet. This was evident for 1 (Resident #1) out of 3 Residents reviewed for medications. Specifically, Resident #1's Oxycodone-Acetaminophen (Percocet) tablet 5-325 mg-controlled medication was discontinued as per prescriber's order on 07/11/2024. The controlled medication remained in the medication cabinet/room and narcotic records were still available from 7/11/2024 to 8/18/2024. On 8/18/2024 Licensed Practical Nurse #10 accessed and administered the discontinued controlled medication to Resident #1 without a prescriber's order. The findings are: The facility policy titled Controlled Substances dated 08/06/2024 documented that controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed. Resident #1 had diagnoses that included Malignant Neoplasm of the Colon, Emphysema (a lung condition that causes shortness of breath), and Cardiomegaly (enlarged heart). The Quarterly Minimum Data Set (resident assessment tool) dated 07/23/2024 documented resident had intact cognition and residents' pain should be assessed. Resident had no indicators of pain or possible pain in the last 5 days. The Physician Order dated 06/11/2024 documented Oxycodone - Acetaminophen tablet 5-325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain scale 6-10 for 30 days with start date on 06/11/2024 and end date 07/11/2024. There was no documented evidence that the order was renewed. The 30-tablet blister pack of Oxycodone-Acetaminophen (Percocet) tablet 5-325 mg-remained in the medication cabinet/room on the unit with the narcotic record from 07/11/2024 to 08/18/2024. (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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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the incident report dated 08/18/2024 documented that a Narcotic Drug - Oxycodone -Acetaminophen tablet 5-325 mg 1 tablet was administered to Resident #1 on 08/18/2024 without an order. The Conclusion of the Investigation revealed that Licensed Practical Nurse #10 took the medication and administered to Resident #1 without following the policy of checking the order before getting and administering the medication. A drug diversion investigation was conducted and was unsubstantiated. Resident #1 was assessed and there was no harm to the resident. Licensed Practical Nurse #10 was suspended pending investigation. During an interview on 10/7/2024 at 1:30PM Licensed Practical Nurse #11 stated when a narcotic is discontinued it is removed from the narcotic cabinet and the sheet is removed and it is taken down to the director of nursing's office. During a follow up interview on 10/10/2024 at 9:24 AM, the Director of Nursing stated the medication should have not been in the medication room after it was stopped (discontinued). The Director of Nursing stated the procedure is that the medication nurse should have removed from the unit, the medication, and the narcotic sheet within 24 hours from discontinuation (07/11/2024). If the discontinuation occurs on a weekend the expectation is for the medication to be in their office by Monday. The Director of Nursing stated they don't know why the process was not followed and the medication was kept on the unit until 8/18/2024. 10 NYCRR 415.18(a)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44673 Based on record reviews and interviews conducted during an abbreviated survey (NY00351622), it was determined that the facility did not ensure residents were free from medication errors. This was evident for 1 (Residents #1) out of 3 residents reviewed for medication administration. Specifically, Licensed Practical Nurse #10 administered a Narcotic Drug Oxycodone-Acetaminophen (Percocet) tablet 5-325 mg 1 tablet to Resident #1 without an order on 08/18/2024. The findings are: The facility policy titled Administering Medications dated 4/2019 documented the individual administering medications checks the physician order/label three times to verify the right resident right medications, right dosage, right time, and right method (route) of administration before giving medication. Resident #1 had diagnoses that included Malignant Neoplasm of the Colon, Emphysema (a lung condition that causes shortness of breath), and Cardiomegaly (enlarged heart). The Quarterly Minimum Data Set (resident assessment tool) dated 07/23/2024 documented resident had intact cognition and residents' pain should be assessed. Resident had no indicators of pain or possible pain in the last 5 days. The Comprehensive Care Plan for Pain dated 04/15/2024 documented administer medication as ordered by Physician and to monitor and document for probable cause of each pain episode. The Physician Order dated 06/11/2024 documented Oxycodone - Acetaminophen tablet 5-325 mg give 1 tablet by mouth every 6 hours as needed for moderate to severe pain scale 6-10 for 30 days with start date on 06/11/2024 and end date 07/11/2024. There was no documented evidence that the order was renewed. Review of the incident report dated 08/18/2024 documented that a Narcotic Drug - Oxycodone -Acetaminophen tablet 5-325 mg 1 tablet was administered to Resident #1 on 08/18/2024 without an order. The Conclusion of Investigation revealed that Licensed Practical Nurse #10 took the medicine to Resident #1 and administered it but didn't follow the policy of checking the order before getting and administering the medication. A drug diversion investigation was conducted and was unsubstantiated. Resident #1 was assessed and there was no harm to the resident. Licensed Practical Nurse #10 was suspended pending investigation. Review of the Social Worker Progress Note dated 08/23/2024 documented that the nurse reported to the supervisor that resident was complaining of pain and without reading the order Licensed Practical Nurse #10 administered pain medication that was discontinued to Resident #1. Review of the Medication Treatment Error Report dated 08/18/2024 documented an error happened but didn't cause harm or potential for harm to the resident. Education done regarding medication administration narcotic policy. (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 10/08/2024 at 8:39AM, Licensed Practical Nurse # 10 stated they were passing medications, and a Certified Nurse Aide reported to them that Resident #1 was in pain. They immediately administered Resident #1 1 tablet of Percocet without checking the order. Licensed Practical Nurse # 10 stated when they went to sign off on the Percocet in the Medication Administration Record, they realized that the medication was discontinued. They immediately reported the incident to the supervisor. During an interview on 10/08/2024 at 9:00 AM, the Director of Nursing stated Licensed Practical Nurse #10 did not follow the protocol. They were supposed to check the order before administering the medication. The medication should not have been in the medication room after it was stopped (discontinued). The procedure is to take the medication and the narcotic sheet from the unit to their office. All the nurses were in serviced after the incident. During a follow up interview on 10/10/2024 at 9:24 AM, the Director of Nursing stated the medication should not have been in the medication room, after it was stopped. The procedure is the medication nurse should remove the medication and the narcotic sheet and bring them to their office within 24 hours, and if it is the weekend the expectation is the medication should be in the office of the director of nursing by Monday. The Director of Nursing stated they don't know why the process was not followed and the medication was kept on the unit for seven days. All discontinued medications are bagged and given to the driver to bring to the pharmacy. Narcotics are kept in a lock box for destruction. 10 NYCRR 415.18(a)