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	05/30/2025

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

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, record review, and interviews during the recertification survey conducted 5/27/2025-5/30/2025, the facility did not ensure residents received services with reasonable accommodation of needs for one (1) of one (1) resident (Resident #94) reviewed. Specifically, Resident #94 did not have their call bell in reach. Findings include: The facility policy Call Bell, last reviewed 3/1/2024, documented each resident needed a call bell at their bedside and the call bell should be within reach of the resident. Resident #94 had diagnoses including muscle weakness, compression fracture of thoracic vertebra (mid-spine), and dementia. The 5/1/2025 Minimum Data Set assessment documented the resident was cognitively intact, required supervision or touching assistance with activities of daily living. The 4/29/2025 Comprehensive Care Plan documented the resident was at risk for falls due to muscle weakness. Interventions included the call bell should be in reach. The following observations were made of Resident #94: - on 5/27/2025 at 11:44 AM the call bell was on the floor between the bed and the wall. The resident was lying in bed and stated they were not able to locate the call bell. At 3:21 PM in bed with the call bell between the bed and the wall towards their feet. The resident stated if they needed assistance, they would use their call bell but that they could not locate it. They stated they would just yell out for help if needed. - on 5/28/2025 at 8:10 AM, lying in bed with the call bell on the floor between the bed and the wall at the foot of the bed. The resident stated if they needed something they would use their call bell. The resident stated they were unable to locate their call bell. At 12:00 PM in bed with the call bell between the wall and the bed on the floor at the foot of their bed. They stated they tried not to call unless they really needed something to eat and drink, as they could get to the bathroom independently. At 10:50 AM, the resident was lying in bed, the call bell was on the floor between the wall and the bed. During an interview on 5/28/2025 at 9:39 AM, Certified Nurse Aide #4 stated if residents needed something or required assistance, they should use their call bell. Call bells should be kept within reach of the resident. If a call bell was out of reach of a resident, it should be placed back within reach. Resident #94 was able to use their call bell. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 10:34 AM, Licensed Practical Nurse #6 stated residents should use their call bell if they needed help. Call bells should be in reach and usually clipped to their bed. Resident #94 could use their call bell. 10NYCRR 415.5(e)(1)

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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 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. Based on observations, record review, and interviews during the recertification survey conducted 5/27/2025-5/30/2025, the facility did not ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan one (1) of four (4) residents (Resident #76) reviewed. Specifically, Resident #76 had an unwitnessed fall and was not assessed timely by a qualified professional; their call bell was observed out of reach; and they were not assisted with toileting by Licensed Practical Nurse #9 as planned. Findings include: The facility policy Fall Prevention Program, revised 2/2025, documented remind the resident to call for assistance with transfers or ambulation; do not leave unattended in the bathroom until ability/compliance with call cord use was verified and adequate sitting balance and postural stability were established; and call bell within resident's reach at all times. High risk falls interventions included ensure toileting needs were care planned for and call bell was within reach. If a resident sustained a fall or was found on the floor, staff were not to move the resident. They were to call for assistance, the charge nurse would complete an initial evaluation. The Registered Nurse would do a secondary and more thorough assessment. If there was no Registered Nurse in the facility, emergency medical services (EMS) would to be contacted immediately to assess the resident. Resident #76 had diagnoses including dementia, brain tumor, and osteoporosis (weak bones). The 4/7/2025 Minimum Data Set assessment documented the resident had severely impaired cognition, did not reject care, used a walker and wheelchair, was independent with sitting to lying and lying to sitting on side of bed, sitting to standing, and chair/bed-to-chair transfers, required supervision or touching assistance with toileting hygiene, refused toileting transfers, was frequently incontinent of bladder and bowel, and had a fall in the last 2-6 months prior to admission/entry or reentry. The Comprehensive Care Plan documented: - on 4/1/25 the resident was at risk for falls related to recent illness and decline in activities of daily living. Interventions included to complete fall risk assessments, ensure proper lighting, clear pathway, low position bed, ensure resident was comfortably positioned in bed with the head of the bed elevated as appropriate, remind to call for assistance as needed, post visual prompt to remind resident to call for assistance, staff to round frequently while resident slept, encourage to stay in common areas when awake, and staff to help position back to bed. - on 4/2/2025 documented the resident was dependent with toileting and was incontinent of bladder and bowel. The 4/1/2025, 4/12/2025, and 4/22/2025 fall risk assessments documented the resident was at high risk for falls. The 5/8/2025 Registered Nurse #22 progress note documented they responded to the unit for a call that Resident #78 had an unwitnessed fall at 11:26 AM. The resident was assessed, and medical and family were notified of the fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5/8/2025 Registered Nurse #22 late entry progress note documented while they responding to the fall that occurred at 11:30 AM, a certified nurse aide (unidentified) reported the resident had another fall at 6:45 AM and was found on the ground in their room. There were no reported symptoms or concerns from the initial incident. The resident was at their baseline. The 5/8/2025 staffing schedule documented there was no Registered Nurse in the building from 6:00 AM - 7:00 AM and Licensed Practical Nurse #20 worked 6:00 AM - 2:00 PM. The 5/8/2025 Incident/ Accident form completed at 11:30 AM, by Registered Nurse #22 documented at 11:30 AM, Resident # 78 had an unwitnessed fall from their bed and was discovered lying on the floor by Licensed Practical Nurse #20. A certified nurse aide (unidentified) reported to Registered Nurse #22 at 11:30 AM the resident had another fall that occurred around 6:45 AM, the resident was found out of bed on the ground and was in no distress. There were no reported concerns or symptoms. Licensed Practical Nurse #20 statement completed at 11:00 AM on 5/8/2025, documented they entered the resident's room at 6:45 AM, and the resident was on the floor. The resident was last seen at 6:15 AM, lying in their bed. At the time of the incident the resident's call bell was in reach, call bell was not on, and the resident was soiled. They took the resident's vital signs and helped to clean up the resident and sit them in their chair. Licensed Practical Nurse #20's statement did not document if they notified anyone of the resident's unwitnessed fall. There was no documented evidence the resident was assessed by a registered nurse, a medical provider was notified, or emergency medical services was contacted after the resident was found on the floor at 6:45 AM. The following observations of Resident #76 were made on 5/28/2025: - from 9:47 AM-11:16 AM, lying in bed, their call bell was clipped to the privacy curtain and was not within reach. - at 11:58 AM, standing next to the right side of their bed holding onto the foot of the bed with their wheelchair behind them, their wheelchair was not locked, and they sat down in the wheelchair. Their call bell was clipped to the privacy curtain. - at 12:01 PM, seated in their wheelchair rocking back and forth attempting to scoot closer to the foot of the bed. At 12:03 PM, they pulled themself up from their wheelchair to a standing position holding onto the foot of the bed with their left hand and their right hand was placed on the mattress. At 12:05 PM, they sat back down in their wheelchair. Their call bell was clipped to the privacy curtain. - at 2:06 PM, in their room seated in their wheelchair eating a cookie. Their call bell was clipped to the privacy curtain. The following observations of Resident #76 were made on 5/29/2025 - at 8:57 AM, sitting in the dining room. The call bell in their room was clipped to the privacy curtain and there was a sign on their dresser to call help. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- at 9:13 AM, wheeling themself into their room from the dining room. The call bell was clipped to the privacy curtain - at 9:37 AM seated in their wheelchair in their room. The call bell was clipped to the privacy curtain. - at 10:50 AM, the resident lying in bed. The call bell was clipped to the privacy curtain - at 11:36 AM, standing up at the side of their bed and sat down in their wheelchair. They brought themself to the bathroom unsupervised by staff. - at 11:39 AM, Licensed Practical Nurse #9 knocked on the resident's door and looked into the resident's bathroom and exited the room without assisting the resident in the bathroom. - at 11:42 AM, Licensed Practical Nurse #9 looked in the resident's room and did not enter the room. After the nurse walked away the toilet seat was heard closing with a loud bang. - at 11:44 AM, Licensed Practical Nurse #9 entered the resident's room, looked in the bathroom and walked out without assisting the resident in the bathroom. - at 11:47 AM, the resident wheeled themself out of the bathroom and was not wearing pants. During an interview on 5/29/2025 at 12:34 PM, Certified Nurse Aide #26 stated Resident #76 was on their assignment, had a lot of falls and could use their call bell, but did not use it. When residents were in their room their call bell should be within reach. They stated after getting the resident up for the day they clipped the call bell to the privacy curtain while they made the resident's bed. If the call bell was attached to the privacy curtain the resident could not access it while lying in bed. It was important for the residents to have access to the call bell to call for assistance. During an interview on 5/29/2025 at 1:01 PM, Licensed Practical Nurse #20 stated Resident #76 was known to be noncompliant with asking for assistance when getting up. They worked on the unit as an agency nurse on 5/8/2025 and recalled the resident had two falls that day. The first fall occurred early in the morning and the resident was last seen at change of shift lying in their bed. A certified nurse aide alerted them the resident was on the floor. They notified a registered nurse (could not identify) who came to assess the resident, and the resident was then assisted up from the floor. The registered nurse started the investigation. They stated the resident was able to use their call bell, but did not use it. It was important for residents who could use their call bells to have them in reach for safety reasons. During an interview on 5/29/2025 at 1:35 PM, Licensed Practical Nurse #9 stated Resident #76 had falls and could use their call bell, and it was important for the call bell to be within reach so they could use it. They stated on 5/29/2025 they observed the resident alone in the bathroom when they attempted to administer the resident's medications. They left the resident's room without assisting them in the bathroom and did not tell anyone the resident was in the bathroom by themself. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/2025 at 2:20 PM, Licensed Practical Nurse Unit Manager #21 stated they were unsure if Resident #76 could use their call bell but had a sign in their room to remind them to call for help. Call bells should be accessible to the resident. Resident #76 was a fall risk and had multiple falls. They stated if a resident had a fall a registered nurse and the medical provider should be notified. There was a procedure in place if a registered nurse was not in the building at the time of a fall. During an interview on 5/29/2025 at 3:57 PM, Registered Nurse #22 stated any nurse in the building could respond to falls. A registered nurse should assess the resident and notify medical and the family. They should also start the investigation, obtain witness statements, and document in the resident's medical chart. All falls were reviewed with the interdisciplinary team. They stated they responded to a call Resident #76 had fallen on 5/8/2025 around 11:30 AM. While responding to that fall a certified nurse aide told them the resident had another fall earlier in the day around 6:45 AM. They stated they were not in the building at the time of the first fall and was unsure which registered nurse was notified of the fall. Licensed practical nurses could not assess a resident and the resident should not be moved until they were assessed. During an interview on 5/29/2025 at 6:01 PM, the Director of Nursing stated the facility had at least 12 hours of registered nurse coverage a day. It was the policy of the facility if a resident fell and there was no registered nurse in the building emergency services would be called to assess the resident and assist with moving the resident. Staff should start the incident report and obtain statements. Resident #76 was impulsive and had multiple falls. They stated on 5/8/2025 at 6:45 AM, there was no registered nurse in the building. They were unaware the resident fell at 6:45 AM on 5/8/2025 and was just notified of the incident earlier today. They reviewed the incident report and there was no documentation a registered nurse assessed the resident. The resident was moved from the floor without being assessed, and staff should not move a resident until they were assessed for injuries. They stated medical and nursing were not notified until the resident had a second fall later that day when Registered Nurse #22 was notified about the incident by a certified nurse aide. Additionally, the resident's call bell should be within reach while in their room for safety reason. 10NYCRR 415.12

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews during the recertification survey conducted [DATE]-[DATE], the facility did not ensure drugs and biologicals were stored in accordance with professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable to include proper labeling of medication with resident information and expiration date for 3 (three) of 3 (three) medication carts (Maplewood Unit Cart 1, Parkside Unit Cart 2, and Whispering Pines) reviewed. Specifically, Maplewood Unit Cart 1 contained opened, unlabeled insulin pens and inhalers; Parkside Unit Cart 2 contained eye drops without a resident identifier, and opened, unlabeled insulin pens, eye drops, and inhalers; and Whispering Pines contained opened, unlabeled eye drops. Findings include: The facility policy Storage in the Facility-Medications, revised 2/2025, documented medications were stored safely, securely, and properly following manufacturer's recommendation or those of the supplier. All over the counter medications, inhalers, eye drops, nasal sprays, and insulin pens were dated when opened. The facility policy Insulin Injection Pen, revised 2/2025, documented injection pens may be stored at room temperature in the medication cart once opened. Any un-opened pens were stored in the refrigerator until opened. The policy did not include dating of opened insulin pens. During a medication cart observation and interview on [DATE] at 10:47 AM the Maplewood Unit Cart 1 had undated, opened insulin pens for Residents #34, #426, #415, #421, and #51, and for a discharged resident. Inhalers (breathing medicine) for Residents #424, #49, #51, and #415 were open and undated. Licensed Practical Nurse #7 stated insulin pens should be labeled with the open date and expiration date by the nurse who used the pen first. They were not sure when the pens were opened, and insulin pens were good for 28 days after opening. They used the pens earlier in the morning and did not notice they were not labeled. They stated they should not have used them because they might not be as effective if they were opened more than 28 days ago. Licensed Practical Nurse #7 stated inhalers were not required to be labeled when opened and were used until all the medication contained in the inhaler was administered. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication cart observation and interview on [DATE] at 11:05 AM, Parkside Unit Cart 2 had artificial tears eyedrops in boxes for Residents #55, #65, #70, and #86. The eyedrops inside the boxes did not have an open date or pharmacy label for resident identification. There were undated insulin pens for Residents #86 and #1. Licensed Practical Nurse #8 stated whoever opened the eyedrop boxes was responsible for labeling the bottle with the resident's name and expiration date. They were not sure when the bottles were opened or why they were not labeled. If the medications fell out of the box, they could not be sure which resident it belonged to. Licensed Practical Nurse #8 stated the insulin pens were used that morning, and they did not notice they were not labeled and should have been. They could not be sure if the insulin was expired because it did not have an open date and insulin expired 30 days after opening. They should not have used the insulin pens. The Inhalers for Resident # 7, Resident #23, Resident #52, and Resident #65 were not labeled when they were first used. Licensed Practical Nurse # 8 said they used the inhalers this morning and did not notice they were not labeled with the date opened or the expiration date. They were not effective when used after 30 days. During a medication cart observation and interview on [DATE] at 11:44 AM, the Whispering Pines cart contained Resident #11's eye drops labeled as opened on [DATE]; Resident #28's timolol 0.5% eye drops were opened on [DATE] and latanoprost 0.005% eye drops were opened and not labeled with an open date; and Resident #41's Dopzol eye drops were labeled as opened on [DATE] and lantanoprost 0.005% eye drops were not labeled when opened. Licensed Practical Nurse #9 stated medications were good for different times frames, some were good for 30 days and others 90 days which was confusing to them. They stated when they returned from a recent vacation the medication cart was not in order and they were trying to get it back in order. Medications were not labeled with open dates or expiration dates, and they should have been labeled. During an interview on [DATE] at 2:31 PM, Assistant Director of Nursing #18 stated they expected medication carts to be clean, locked, and organized. Stock medications were labeled when opened and the expiration date used was the manufacturers expiration date on the bottle. Eye drops were patient specific, should be labeled and placed in a zip lock bag, and could not be shared between residents. They were not sure if the actual bottle of eye drops had to be labeled with the resident's name or just the zip lock bag and would defer to the policy. Inhalers were dated when they were used for the first time and the expiration date should be written on the inhaler. They were not sure when eye drops or inhalers expired and would defer to policy but believed it was 30 days. Insulin pens should be labeled with the date opened and they deferred to the policy for expiration date time frames but believed insulin was good for 30 days. If a resident received medication that was expired, it might not be as potent and could be an infection control issue. 10 NYCRR 483.45 (g)(h)