STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335226	A. Building B. Wing	10/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vestal Park Rehabilitation and Nursing Center	1501 Route 26 South, Vestal, NY 13850

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46276 Based on record review and interview during the abbreviated (NY00329596) survey the facility did not consult with the resident's physician and notify the resident representative when there was a need to alter treatment significantly for 1 of 1 resident (Resident #1) reviewed. Specially, Resident #1 was not administered twenty doses of their physician ordered antipsychotic medication and there was no documented evidence the physician or the resident representative was notified. Findings include: The facility policy, Notifying the Provider, revised 10/2013, documented the resident's physician would be updated with any changes in a resident that may affect significant change status. The facility policy, Unavailable Medications revised 8/2020 documented the facility must make every effort to ensure medications are available to meet the needs of each resident. Nursing staff should notify the attending physician (or on-call if applicable) of the situation, explain the circumstances, expected availability, and alternative therapies available. If the facility nurse was unable to reach the attending physician or the on-call physician, then the nurse should notify the Nursing Supervisor and contact the Facility Medical Director for orders and/or direction. Resident #1 had diagnoses including orthopedic care following open reduction with internal fixation (surgical repair of a fracture) of the right ankle, anxiety, and schizo-affective disorder. The 10/23/2023 Minimum Data Set assessment documented the resident had intact cognition, had no behaviors, and felt socially isolated at times. The Comprehensive Care Plan initiated 10/30/2023 documented the resident was prescribed an anti-psychotic medication for schizoaffective disorder. Interventions included discuss with physician/family/resident the need for continued use of the medication; review behaviors/interventions and alternate therapies attempted and their effectiveness; licensed nurse to administer medication per physician's order; monitor for side effects and adverse reactions to medication and report to medical provider. The 10/17/2023 physician order documented olanzapine (an anti-psychotic medication) 10 milligram tablets, one tablet by oral route once daily between 6:00 PM and 10:00 PM for schizo-affective disorder. (continued on next page)

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 11/2023 Medication Administration Record documented olanzapine was not given/unavailable from 11/18/2023-11/26/2023, 11/28/2023, and 11/30/2023. The 11/13/2023 pharmacy received manifest documented Resident #1's 30-day supply of olanzapine 10 milligrams tablets was delivered and signed for by Licensed Practical Nurse #7. The 11/17/2023 progress note by Nurse Practitioner #5 documented the resident was seen for a routine visit and their medications were reviewed and updated. The resident's mood was stable per the resident. The plan was to continue their anti-psychotic medications. There was no documentation Nurse Practitioner #5 was aware the resident's anti-psychotic medication was unavailable. The 12/2023 Medication Administration Record documented olanzapine was not given/unavailable from 12/1/2023-12/9/2023. The 12/1/2023 Pharmacy returned medications log documented Resident #1 had a blister pack of 30 olanzapine 10 milligrams tablets returned to the pharmacy. The 12/7/2023 Physician #8 progress note documented Resident #1 was seen for an acute visit for a headache. Physician #8 documented the resident's review of systems included schizoaffective disorder and olanzapine was in their medication list on 10/23/2023. There was no documentation the resident's anti-psychotic medication was unavailable. There were no documented nursing notes referencing Resident #1's missed doses of olanzapine or that the provider and resident representative were notified of the missed doses. There was no documentation why the resident's olanzapine was returned to the pharmacy. During an interview on 10/17/2024 at 10:55 AM, Nurse Practitioner #5 stated Resident #1 was admitted to the facility on olanzapine. They stated they were not notified when the resident's olanzapine became unavailable. They expected the nursing staff to notify them, and they would have seen the resident if they were notified. During an interview on 10/17/2024 at 12:45 PM, the resident's representative stated they were Resident #1's health care proxy and visited the resident almost daily when the resident was at the facility. They stated they were not notified the resident had missed doses of their medicine. They stated the resident had previous episodes of being hospitalized when their olanzapine was missed at home. The only notification they received was the resident complaining to them that they were having trouble sleeping. Approximately a week later, the resident phoned them to tell them they were not receiving their medication and thought that was the reason for their insomnia. During an interview on 10/18/2024 at 9:03 AM the Director of Nursing stated they were not aware of the missing medication; it was unacceptable, and nursing should have notified the nursing supervisor or the provider. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/18/2024 at 11:10 AM, Physician #8 stated Resident #1 had diagnoses of schizophrenia and schizoaffective disorder. They reviewed their medical notes and were not aware Resident #8 had missed their anti-psychotic medications for 20 doses. Physician #8 stated they expected nursing to notify them, and it would have changed their treatment plan if they had been notified. They would have visited the resident and prescribed them an alternate medication if olanzapine was not available. 10 NYCRR 415.3(2)(ii)(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 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. 46276 Based on record review and interview during the abbreviated survey (NY00329596) 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 1 resident (Resident #1) reviewed. Specially, Resident #1 was not administered twenty doses of their physician ordered anti-psychotic medication. Findings include: The facility policy, Notifying the Provider, revised 10/2013 documented the resident's physician would be updated with any changes in a resident that may affect significant change status. The facility policy, Unavailable Medications, revised 8/2020, documented the facility must make every effort to ensure medications were available to meet the needs of each resident. Nursing staff should notify the attending physician (or on-call if applicable) of the situation, explain the circumstances, expected availability, and alternative therapies available. If the facility nurse was unable to reach the attending physician or the on-call physician, then the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. The facility policy, Returning Medications to the Pharmacy, revised 8/2020, documented medications other than controlled substances may be returned to the pharmacy if the medication was in a sealed package or container; a copy of the medication disposition form was kept with the medications to be returned until pharmacy picked them up; completed disposition forms were kept by the facility for two years or according to applicable law and regulation. Resident #1 had diagnoses including orthopedic care following open reduction with internal fixation (surgical repair of a fracture) of the right ankle, anxiety, and schizo-affective disorder. The 10/23/2023 Minimum Data Set assessment documented the resident had intact cognition, had no behaviors, and felt socially isolated at times. The Comprehensive Care Plan initiated 10/30/2023 documented the resident was prescribed anti-psychotic medication for schizoaffective disorder. Interventions included discuss with physician/family/resident the need for continued use of medication; review behaviors/interventions and alternate therapies attempted and their effectiveness; licensed nurse to administer medication per physician's order; monitor for side effects and adverse reactions to medication and report to medical provider. The 10/17/2023 physician order documented olanzapine (an anti-psychotic medication) 10 milligram tablets, one tablet by oral route once daily between 6:00 PM and 10:00 PM for schizo-affective disorder. The 11/13/2023 pharmacy received manifest documented Resident #1's 30-day supply of olanzapine 10 milligram tablets was delivered and signed for by Licensed Practical Nurse #7. The 11/2023 Medication Administration Record documented olanzapine was not given/unavailable from 11/18/2023-11/26/2023, 11/28/2023, and 11/30/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were no nursing notes documenting Resident #1's missing medication or that a provider was notified. The 11/17/2023 progress note by Nurse Practitioner #5 documented the resident was seen for a routine visit and their medications were reviewed and updated. The resident's mood was stable per the resident and the plan was to continue their anti-psychotic medications. There was no documentation the resident's anti-psychotic medication was unavailable. The 12/1/2023 Pharmacy returned medications log documented Resident #1 had a blister pack of 30 Olanzapine 10 milligram tablets returned to the pharmacy. There were no nursing progress notes documenting why the olanzapine was returned to the pharmacy. The 12/2023 Medication Administration Record documented olanzapine was not given/unavailable from 12/1/2023-12/9/2023. The 12/7/2023 Physician #8 progress note documented Resident #1 was seen for an acute visit for a headache. Physician #8 documented the resident's review of systems included schizoaffective disorder and olanzapine was in their medication list on 10/23/2023. There was no documentation the resident's anti-psychotic medication was unavailable. During an interview on 10/15/2024 at 9:00AM, Licensed Pharmacist #5 stated olanzapine was an anti-psychotic medication administered for residents with schizophrenia, schizoaffective disorders, and depressive disorders and should not be stopped abruptly. They stated the pharmacy received Resident #1's olanzapine 10 milligrams tablets, quantity of 30, as a return and processed it on 12/1/2023. They could not determine who sent the medication back or the reason why it was returned. During an interview on 10/17/2024 at 10:55 AM, Nurse Practitioner #5 stated Resident #1 was admitted to the facility on olanzapine. Their role was to review all the resident's medications upon admission and approve them. They stated they were not notified when the resident's olanzapine became unavailable. They expected the nursing staff to notify them, and they would have visited the resident. During an interview on 10/17/2023 at 11:54 AM, Registered Nurse #4 stated they no longer worked for the facility and could not recall Resident #1 or any missing medications. They stated when they worked at the facility, they passed medications and if a medication was unavailable, they would notify the nursing supervisor and document a note in the resident's electronic medical record. They thought the supervisor was responsible for ordering medications if they were not available in the emergency medication dispensing machine. On 10/17/2024 at 1:05 PM, a phone call was placed to Licensed Practical Nurse #7 and they did not return the call for an interview. During an interview on 10/17/2024 at 1:44 PM Physician #8 stated olanzapine was prescribed for residents with schizophrenia, hallucinations, and psychosis. The purpose of the medication was to suppress the symptoms. If a resident missed doses, those symptoms could return. If a resident received a small dose of 2-2.5 milligrams, the medication could be stopped abruptly but larger doses of 10-20 milligrams should be tapered down over 2-4 days. (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 10/18/2024 at 9:03 AM, the Director of Nursing stated the facility's medication order policy started with the admission nurse and provider. All medications would be reviewed and then ordered from the pharmacy. Most medications were packaged in blister packs with 30 pills except for stock medications that come in bottles. They stated when a resident only had one weeks' worth of medication left, they expected nurses to order it. The Director of Nursing reviewed Resident #1's Medication Administration Record and stated the resident did not receive olanzapine from 11/18/2023-11/26/2023,11/28/2023, 11/20/2023 and 12/1/2023-12/9/2023. They stated they were not aware of the missing medication; it was unacceptable, and nursing should have notified the nursing supervisor or the provider. The Director of Nursing stated the resident's medication was returned to the pharmacy, but the facility had no system to track who sent it back or why. They stated the pharmacy logged return medications in for the facility, but they did not keep records. During a follow-up interview on 10/18/2024 at 11:10 AM, Physician #8 stated Resident #1 had diagnoses of schizophrenia/schizoaffective disorder. They reviewed their medical notes and was not aware Resident #8 had missed their anti-psychotic medications for 20 doses. Physician #8 stated they expected nursing to notify them, and they would have changed their treatment plan if they had been notified. They would have visited the resident and prescribed an alternate medication if olanzapine was not available. Physician #8 stated the resident could have had symptoms of hallucination or psychosis return from not taking the medications. 10 NYCRR 415.12