| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335233 | A. Building<br>B. Wing | 12/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Colonial Park Rehabilitation and Nursing Center | 950 Floyd Avenue<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>(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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during the abbreviated (iQIES reference number 2610929) survey the facility did not ensure residents were free of significant medication errors for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 had a physician order for intravenous (directly into a vein) cefepime and vancomycin (antibiotics) every 12 hours that were not administered on 04/10/2025, 04/13/2025, 04/14/2025, 04/15/2025, 04/18/2025, and 04/19/2025.Findings include:The facility policy Administering Medications, reviewed 01/2025 documented medications must be administered in accordance with the orders, including any required time frame. Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified. If a drug was withheld, refused, or given at a time other than the scheduled time, the individual administering the medication should document in the electronic Medication Administration Record for that drug and dose. The person who withheld, received the refusal, or administered medication at a different time would notify the attending /covering physician. The individual that administered the medication must sign the resident's electronic Medication Administration Record as indicated by the software after giving each medication and before administering the next ones.Resident #1 had diagnoses including osteomyelitis (bone infection) of thoracic vertebrae (upper spine) and local infection of skin and underlaying tissue. The 04/16/2025 Minimum Data Set assessment documented the resident was cognitively intact and received antibiotics. The Comprehensive Care Plan initiated 04/07/2025 and revised on 04/22/2025 documented the resident received antibacterial therapy for sepsis (systematic infection), discitis of the thoracic region (infection of the discs of the spinal bones), and osteomyelitis of the thoracic vertebrae. Interventions included monitor for side effects of the antibiotic, report all side effects to the medical provider, and monitor for efficacy of the antibiotic chosen as well as adverse reactions during antibiotic use and post completion. The 04/07/2025 Physician #1's order documented:-cefepime HCl intravenous solution 2 gram/100 milliliters, use 2 grams intravenously every 12 hours for 162 administrations.-vancomycin HCl intravenous solution, use 1 gram intravenously every 12 hours for anti-infective agent for 162 administrations. The 04/2025 Medication Administration Record documented cefepime HCl intravenous solution 2 grams/100 milliliters, use 2 grams intravenously every 12 hours for cephalosporin for 162 administrations with a start date of 04/08/2025 at 9:00 AM. The Medication Administration Record was blank/not signed on 04/14/2025 at 9:00 AM, 04/15/2025 at 9:00 PM, 04/18/2025 at 9:00 PM, and 04/19/2025 at 9:00 PM to verify the medication was administered. The 04/2025 Medication Administration Record documented vancomycin HCl intravenous solution, use 1 gram intravenously every 12 hours for anti-infective agent for 162 administrations with a start date of 04/08/2025 at 9:00 AM. The Medication Administration Record was blank/ not signed on 04/10/2025 at 9:00 AM, 04/13/2025 at 9:00 AM, 04/14/2025 at 9:00 AM, and 04/15/2025 at 9:00 AM and 9:00 PM to verify the medication was administered. There was no documented evidence in the nursing progress notes from 04/07/2025-04/22/2025 of missed doses of Cefepime or Vancomycin, or notification to the provider of the missed doses. The resident was transferred to the hospital on [DATE] at 9:20 AM for altered mental status. Physician assessments or physician progress notes were not provided when requested. During an interview on 10/16/2025 at 11:00 AM, Licensed Practical Nurse #4 stated there was not always a registered nurse in the building. The medications were normally scheduled during a time when there was a registered nurse on the schedule. If the medication was listed on the Registered Nurse Medication Administration Record, they would not be alerted for the medication administration time. If it was listed on the electronic regular Licensed Practical Nurse Medication Administration Record the medication would be highlighted yellow when it was due and turn red when it was overdue. If the medication was missed the provider should be notified. They did not always know who was covering the intravenous therapy treatments each day. The Unit Manager could do it during the day, or possibly the Director of Nursing. The Medication Administration Record should have something in each box, they were not sure why the boxes were blank. During a telephone interview on 10/16/2025 at 11:58 AM, Registered Nurse Supervisor #5 stated they were the only Registered Nurse on the weekend. They were never alerted that Resident #1 missed medications. There were two days they were given late. They always gave the medications, and they put a check mark on their paperwork. They made a to do list for themselves while on shift. If there was a blank box on the Medication Administration Record it meant the medication was not documented on. They always gave the medication with enough time for the medication to finish and be |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>(continued on next page) |

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| F 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Based on record review and interviews during the abbreviated (iQIES reference number 2610929) survey the facility did not ensure laboratory services were obtained to meet the needs of its residents for one (1) of three (3) residents (Resident #1) reviewed. Specifically, Resident #1 had physician orders for laboratory tests to check their vancomycin (antibiotic) trough level (blood test used to monitor the antibiotic's effectiveness and to minimize toxicity) and the laboratory tests were not performed timely or accurately. Findings include:The facility policy Vancomycin Management, dated 01/2025, documented renal function should be monitored at least twice weekly or more frequently based on physician orders. Trough level monitoring should be completed to ensure adequate serum levels for efficacy while avoiding toxicity. Lab draw should happen within 30 minutes prior to the fourth dose, after dose adjustments, significant changes in renal function, or during prolonged therapy. With prolonged therapy testing should be repeated every 3-5 fays or per physician orders. Nursing would initiate orders per physician ordered timing with laboratory to ensure timely blood draws. Resident #1 had diagnoses including osteomyelitis (bone infection) of thoracic vertebra and local infection of skin and underlaying tissue. The 04/16/2025 Minimum Data Set assessment documented the resident was cognitively intact and received antibiotics. The Comprehensive Care Plan initiated 04/7/2025 and revised on 04/22/2025 documented the resident received antibacterial therapy for sepsis (systematic infection of the blood), discitis of the thoracic region (infection of the spinal discs), and osteomyelitis of the thoracic vertebrae. Interventions included monitor for side effects of the antibiotic, report all side effects to the medical provider, and monitor for efficacy of the antibiotic chosen as well as adverse reactions during the course of antibiotic and post completion. The 3/28/2025 hospital Physician #15 Hospital Discharge Summary documented Resident #1 was started on cefepime and vancomycin on 04/04/2025. Infectious Disease Physician #16 recommended to continue with both antibiotics until 06/27/2025. Monitor vancomycin trough level weekly to maintain between 18 microgram/milliliter and 20 microgram/milliliter. Monitor weekly complete blood count, complete metabolic panel, and c-reactive protein while on the intravenous antibiotics. Physician orders documented: -04/07/2025 by Physician #1 vancomycin intravenous solution one (1) gram intravenously every 12 hours for anti-infective agent, on hold from 04/18/2025-04/23/2025. -04/14/2025 by Physician #1 vancomycin trough every Monday until 06/30/2025.-04/18/2025 by Physician #1 vancomycin trough one time only the last dose of vancomycin given 04/17/2025 at 8:00 PM, to start on 04/18/2025. The 04/2025 Laboratory Administration Record documented to check the vancomycin trough one time only for 1-day, last dose of vancomycin given 04/17/20205. The Laboratory Administration Record was blank/not signed on 04/18/2025 and 04/19/2025 for the completion of the labs. There was no documented evidence the resident's vancomycin trough was completed on 4/14/2025 or 4/21/2025. During a telephone interview on 10/16/2025 at 9:59 AM, Consultant Pharmacist #18 stated they expected the facility to contact them with vancomycin trough levels, and they could assist with dosing amounts and administrations times. The trough should be drawn after the fourth dose, a half hour before the next dose. The facility did not contact them about vancomycin troughs. They stated they did not recall Resident #1, and there was nothing in the computer for them to reference. The facility never contacted them about Resident #1 or their vancomycin troughs. During a telephone interview on 10/16/2025 at 10:09 AM, Pharmacist #19 (from the Medication Delivery Pharmacy) stated they supplied the facility with medications. The vancomycin trough should be drawn for weekly monitoring for a set dose, or long-time user. Upon review of the pharmacy records, Pharmacist #19 stated the resident started on vancomycin on 04/07/2025. The pharmacy contacted the facility on 04/11/2025 about the need for a vancomycin trough. The pharmacy was told the facility would draw the trough on 04/14/2025. On 04/14/2025, the pharmacy followed up and the facility stated they were going to draw the trough on 04/16/2025. On 4/18/2025, the facility stated the lab sat too long and needed to be redrawn and would be drawn again on 04/21/2025. On 4/21/2025, the facility stated the trough was high and the resident was sent to the hospital, and the vancomycin was put on hold. During a telephone interview on 10/16/2025 at 11:58 AM, Registered Nurse #5 stated the registered nurses in the facility drew the blood for the labs from the peripherally inserted central catheters (venous access). The lab order was completed, and they called the lab to come get the specimens. During an interview on 10/16/2025 at 12:57 PM, Assistant Director of Nursing #7 stated labs went out on Monday, Wednesday, and Friday. Orders were usually placed with a 3-day window so they could be drawn on one of those days. A list of who needed labs drawn was provided to the phlebotomist (person who draws blood). The phlebotomist completed a |