

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335243	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Chestnut Park Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 330 Chestnut Street Oneonta, NY 13820	
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 - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, record reviews and interviews during a recertification survey, the facility did not ensure it established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and that it determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. Specifically, the facility did not document nursing unit narcotics were counted by two (2) licensed staff members and signed as appropriately done on the facility provided narcotic record sheets. This is evidenced by: The Policy and Procedure titled, Medications - Controlled Substance/Narcotic Management Protocol, effective 2/2021 and last revised 1/2025, documented it was the facility's policy to it is the policy of the facility to prescribe, administer, store and destroy all controlled substances within the accepted regulations of the responsible governing body. All narcotics will be counted and reconciled at the beginning of every shift with the outgoing and oncoming nurse. Both must sign the controlled substance log attesting to the presence of the narcotic as stated from the previous shift. Any discrepancies in the count, must be reported to the unit manager, nursing supervisor immediately. Any suspected tampering of blister packs, packages or documentation of controlled substances must be reported immediately to the unit manager / supervisor. Staff responsible for narcotic administration will not leave the shift until the narcotic count is reconciled. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, North side, dated 7/14/2025 through 7/17/2025, did not consistently document signatures by the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, North side, dated 7/21/2025 through 7/25/2025, did not consistently document signatures by the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, North side, dated 8/30/2025 through 9/04/2025, did not consistently document signatures by the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, North side, dated 9/05/2025 through 9/09/2025, did not consistently document signatures by the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, North side, dated 9/15/2025 through 9/19/2025, did not consistently document signatures by the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, North side, dated 9/21/2025 through 9/24/2025, did not consistently document signatures by the off-going and oncoming nurse. Review of Narcotic and Controlled Substance Shift Count Sheet for the first-floor nursing unit, South side, dated 9/16/2025 through 9/20/2025, did not consistently document signatures by the off-going and oncoming nurse. During an interview on 9/24/2025 at 8:40 AM, Licensed Practical Nurse #2 stated that narcotic sheets were supposed to be signed by two licensed nurses. Licensed Practical Nurse #2 then went and asked Licensed Practical Nurse #3 to sign the narcotic sheets from previous shifts. Licensed Practical Nurse #3 stated that they would have to figure out if they were working the shifts in question, then stated they were in training on the days Licensed Practical Nurse #2 asked them to sign and refused to do so. During an interview on 9/24/2025 at 9:58 AM, Licensed Practical Nurse #1 stated that when (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	narcotic counts were done, the outgoing nurse did the counting, the oncoming nurse did the writing of the count, and then they would both sign the sheets together. During an interview on 9/25/2025 at 8:33 AM, Licensed Practical Nurse #4 stated that white out was not able to be used on narcotic count sheet. [NAME] out was noted on one of the lines for Tramadol on 9/14/2025. A copy of the narcotic sheet was provided. During an interview on 9/26/2025 at 10:37 AM, Director of Nursing #1 stated that both oncoming and off going nurses needed to sign the narcotic sheets to ensure the count was complete and accurate. When asked if they were reviewing the narcotic sheets for signatures, would Director of Nursing #1 ask the missing staff members to sign for past sheets, Director of Nursing #1 stated they would not ask someone to back sign narcotic sheets. They would ensure the count was correct and educate the staff member. If there was an issue with the narcotic sheets, they would immediately bring it to the Administrator's attention. 10 New York Code Rules and Regulations 415.18(a)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, record reviews, and interviews during a recertification survey, the facility did not maintain an infection control program in accordance with professional standards of care. Specifically, a) for Resident #7, the licensed practical nurse removed a dressing without wearing gloves and b) the facility did not ensure signage and supplies for transmission-based precautions were readily available and visible. Resident #7 The Policy and Procedure titled Wound Care dated 1/2025 stated hands should be washed and dried before and after a dressing change, and gloves should be worn. Resident #7 was admitted to the facility with the diagnoses of iron deficiency anemia (when there aren't enough healthy red blood cells to carry oxygen throughout the body), pressure ulcer of left buttock (damage to the skin and underlying tissue caused by prolonged pressure, friction, or shear force, most commonly forming on bony areas like the tailbone, hips, heels, and back), and peripheral vascular disease (a circulation disorder where blood flow to the limbs and organs is reduced due to narrowed, blocked, or inflamed blood vessels). The Minimum Data Set (an assessment tool) dated 8/19/2025 documented the resident was understood, could understand others, and was moderately cognitively impaired. During an observation on 9/25/2025 at 1:43 PM, Licensed Practical Nurse #2 removed a dressing from right lateral ankle and replaced the dressing without wearing gloves. Licensed Practical Nurse #2 did not wash hands during observation. A wound care progress note dated 9/18/2025 documented the resident had wounds on their left ischium, left heel, right lateral ankle, left lateral ankle, and left lateral heel. During an interview on 9/25/2-25 at 1:43 PM, Licensed Practical Nurse #2 verbalized the steps to changing a wound dressing and did not include washing hands as a step in the process. Facility During an observation on 9/25/2025 at 9:25 AM, a room was observed with a personal protection equipment cart outside the door without signage. During an observation on 9/26/2025 from 9:30 AM through 10:10 AM on both units, two different rooms were observed with signage on the door indicating enhanced barrier precautions but neither room had readily available carts containing personal protective equipment. During an interview on 9/25/2025 at 9:25 AM, Licensed Practical Nurse #1 stated the resident was on enhanced barrier precautions for a pressure wound and that when rooms were changed, sometimes the sign wouldn't follow the resident immediately. When informed the resident had been in that room since March 2025, Licensed Practical Nurse #1 stated the sign must have fallen off the door. Licensed Practical Nurse #1 stated they should be walking the floor to make sure signage was in place and supplies were available. During an interview on 9/25/2025 at 12:10 PM, Registered Nurse #2 stated that all precautions should have the signage in place to instruct the proper personal protection equipment to be used. Each room on transmission-based precautions should have a cart with personal protection equipment readily available. During an interview on 9/26/2025 at 10:05 AM, Certified Nurse Aide #1 stated they expected clear signage on a room where a resident was on transmission-based precautions and would expect a cart with the right equipment available to staff. During an interview on 9/26/2025 at 10:30 AM, Director of Nursing #1 stated appropriate signage should always be posted to be visible on each room that was under transmission-based precautions and supplies should be available. They stated that extra carts and supplies were stored in the conference room and was readily available to staff through unit managers and supervisors. 10 New York Codes, Rules, and Regulations 415.19(a)(1-3)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on record review and interview during the recertification survey, the facility did not ensure development of policies and procedures for the monthly drug regimen review that included, but was not limited to, time frames for the different steps in the process. Specifically, the facility policy, titled Medication Therapy, did not identify time frames for the steps in the process. This is evidenced by: The facility policy titled, Medication Therapy, reviewed 01/2025, stated the Consultant Pharmacist would review each resident's medication regimen monthly, as requested by the staff or practitioner, or when a clinically significant adverse consequence is confirmed or suspected, and the Medical Director and Consultant Pharmacist would collaborate to address issues of medication prescribing and monitoring with the practitioners and staff. The policy did not include time frames for each step in the process. During an interview on 09/25/2025 at 12:05 PM, Director of Nursing #1 agreed there should be time frames for each step of the medication review process and did not know why the policy did not include time frames. 10 New York Code Rules and Regulations 415.18(c)(2)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and staff interview during the recertification survey, the facility did not store, prepare, distribute or serve food in accordance with professional standards for food service safety. Specifically, the automatic dishwashing machine was not operating within the manufacturer's instructions, sanitizing solution concentration could not be verified, and surfaces, equipment, and floors required cleaning or repair. This is evidenced by: During observations on 09/21/2025 at 10:56 AM: The automatic dishwashing machine final rinse was 197 degrees Fahrenheit at 7 (seven) pounds per square inch of water pressure; the dishwashing machine data plate states that the water pressure is to be between 15 and 25 pounds per square inch. The facility did not have a chemical test kit with graduations above 400 parts per million; the label on the bottle of sanitizer concentrate stated that when sanitizing food contact surfaces the dilution is to be between 200 and 400 parts per million. A wooden block-style knife-rack that cannot be disassembled was being used for knife storage. The drainpipe below the three (3)-compartment sink was leaking. The following items were soiled with food particles, grime, or dirt: can opener holder, fire extinguishers, floor under dishwashing machine, floor right of the stove, dry storage area floor, mop bucket & wringer. The North Wing kitchenette cabinets and South Wing kitchenette cabinets were soiled with food particles. During an interview on 09/21/2025 at 11:49 AM, Assistant Food Service Manager #1 stated that they would speak with the maintenance department about the dishwashing machine & drain leak, talk with the vendor about getting the right test papers, discard the wooden knife rack, and address the cleaning items. New York Codes, Rules, and Regulations Title 10 S415.14(h)		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation and interview during the recertification survey, the facility did not ensure garbage and refuse was disposed properly. Specifically, the garbage dumpster was heavily soiled below the side door and was not rodent proof. This is evidenced by: During observations on 09/21/2025 at 12:02 PM, the right dumpster was heavily soiled below the side door and was missing a drain hole plug and was not rodent proof. During an interview on 09/21/2025 at 12:07 PM, Assistant Food Service Manager #1 stated that they would speak with the maintenance department about having the dumpster cleaned and a drain hole plug installed. New York Codes, Rules, and Regulations Title 10 S415.14(h)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews conducted during the recertification survey, the facility did not ensure Comprehensive Care Plans were reviewed and revised by the interdisciplinary team after each assessment based on changing goals, preferences, and needs of the resident and in response to current interventions for two (2) (Resident #'s 11 and 20) of 19 reviewed. Specifically, Resident #11's Comprehensive Care Plan for Anticoagulants was not resolved after the resident's order for Plavix was discontinued in 2023 and Resident #20's Comprehensive Care Plan was not reviewed or revised to include the resident's diagnosis of constipation and treatment/orders for constipation. This is evidenced by: The facility policy titled, Care Plans, Comprehensive Person-Centered, last revised 01/2025, documented assessments of residents were ongoing, and care plans were revised as information about the resident and the resident's condition changed. The interdisciplinary team would review and update the care plan: (a.) when there was significant change in the resident's condition; (b.) when the desired outcome was not met; (c.) when the resident was readmitted to the facility from a hospital stay; and (d.) at least quarterly, in conjunction with the required quarterly Minimum Data Set assessment. Resident #11^ Resident #11 was admitted to the facility with diagnoses of cerebral infarction (a medical condition where blood flow to the brain is interrupted, leading to brain tissue damage), chronic obstructive pulmonary disease (a group of lung diseases that block airflow and make it difficult to breathe), and peripheral vascular disease (a condition that affects the blood vessels outside of the heart, typically in the legs and arms).^ The Minimum Data Set (an assessment tool) dated 7/13/2025 documented the resident was able to be understood, was able to understand others, and was cognitively intact.^ The Comprehensive Care Plan titled, Resident is at risk for bleeding secondary to NSAIDs (Non-Steroidal Anti-Inflammatory Drugs)/anticoagulant use of Plavix (an anti-platelet medication) initiated 01/06/2023 documented the medication was discontinued in 05/2023.^ The Comprehensive Care Plan remained active with goal that Resident #11 would be free from side effects of anticoagulant.^ During an interview on 9/25/2025 at 12:05 PM, Director of Nursing #1 stated care plans should be reviewed and updated with each care conference and as needed.^ They stated they did not know why Resident #11's Comprehensive Care Plan for anticoagulants was still active and that it should not be active if the resident was no longer on the medication. Resident #20 Resident #20 was admitted to the facility with diagnoses of bilateral primary osteoarthritis of knee (a condition where the cartilage in both knees gradually wears down, leading to pain, stiffness, and reduced mobility, type 2 diabetes (an endocrine dysfunction causing unregulated blood glucose levels), and morbid obesity (a severe form of obesity characterized by a Body Mass Index (BMI) of 40 or higher). The Minimum Data Set, dated [DATE], documented that the resident was cognitively intact, could be understood and could understand others. A physician progress note dated 6/24/2025 at 11:26 AM, documented they were notified that Resident #20 complained of constipation, which appeared to be an ongoing issue for the resident. A kidney, ureter, and bladder (KUB) scan was completed and a bowel obstruction was ruled out, but there was a large amount of stool in the rectum. Resident #20 was receiving Senna and Colace for bowels at that time. Additional recommendations were made to include manual disimpaction, fleet enema, MiraLax once a day for 7 days, and to closely monitor the resident. During an observation on 9/22/2025 at 9:58 AM, Resident #20 was lying in bed, crying out. During an interview on 9/22/2024 at 9:58 AM, Resident #20 was crying and stated they were in severe pain because they had not had a bowel movement in several days. A physician order dated 6/17/2025, documented senna-time oral tablet 8.6 milligram, give 1 tablet by mouth two times a day for constipation. A physician order dated 6/17/2025, documented docusate sodium capsule 100 milligram, give 2 capsules by mouth two times a day for constipation, hold for loose stools. A physician order dated 8/03/2025, documented (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	polyethylene glycol 3350 oral powder 17 gram/scoop, give 1 scoop by mouth as needed for constipation, on scoop in the morning if patient has not passed a good stool in 2 days. A physician order dated 9/16/2025, documented bisacodyl rectal suppository 10 milligrams. Insert 1 suppository rectally one time only for constipation for 1 day. The Comprehensive Care Plan for Bowel Incontinence, dated 9/18/2025, documented the resident was incontinent of bowel related to resident choice. Resident #20 refused to use the toilet or bedpan. It was further documented that Resident #20 had anxiety related to their bowels. There was no documented evidence that Resident #20's Comprehensive Care Plan was updated to include the diagnosis of constipation and treatments/orders for constipation after their admission to the facility. During an interview on 9/26/2025, Director of Nursing #1 stated there should be some kind of focus in Resident #20's care plan related to bowels. They reviewed Resident #20's care plan during the interview and acknowledged there was no care plan related to constipation or medications used for constipation. 10 New York Codes, Rules, and Regulations 415.11(c)(2)(i-iii)		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, record review, and interview during the recertification survey, the facility did not ensure food brought for residents by family or visitors was stored safely and in a way that is either separate or easily distinguishable from facility food on one (1) of two (2) resident units. Specifically, resident food was not properly labeled, and the facility did not have a policy to assist residents in accessing food brought in to them. This is evidenced by: During observations on the North Wing kitchenette on 09/21/2025 at 11:39 AM, deli chicken salad was not labeled with a resident name, and two (2) homemade sandwiches were not labeled. During an interview on 09/21/2025 at 11:46 AM, Assistant Food Service Manager #1 stated that the homemade sandwiches were likely for a resident, and food brought to residents should be labeled with the resident name and dated. There was no documented evidence that the facility had a policy to date and label with the resident name food brought in to residents. There was no documented evidence that the facility had a policy to ensure facility staff would assist residents in accessing and consuming food if the resident were not able to do so on their own. New York Codes, Rules, and Regulations Title 10 S415.14(h)		