STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335364	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuba Memorial Hospital Inc Snf	140 West Main Street Cuba, NY 14727

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on interview and record review conducted during a Standard survey completed on 5/17/24, the facility did not ensure that a resident has the right to refuse treatment for one (Resident #10) of five residents reviewed for immunizations. Specifically, Resident #10 was administered the pneumococcal vaccine (used to prevent pneumonia) by facility staff without consent. The finding is: The policy and procedure titled Resident Rights dated 10/22 documented the facility will protect and promote the rights of the resident. The policy and procedure documented the resident had the right to accept or refuse care and treatment. Residents have a right to be provided a statement that should they be unable to make their own decisions and be adjudicated incompetent and not be restored to legal capacity, or if a conservator should be appointed for you, these rights and responsibilities shall be exercised by the appointed committee or conservator in a representative capacity. The policy and procedure titled Vaccinations - Patient/Elder revised 9/22 documented residents [AGE] years or older are assessed for pneumococcal status at time of admission and immunization consent/declination received at that time. The policy and procedure documented prior to vaccination, double check the chart for physician's order, normal baseline temperature, serious reaction to applicable vaccine, and signed consent form. Resident #10 was admitted with diagnoses that included dementia, diabetes mellitus (high blood sugar), and anxiety. The Minimum Data Set (MDS- a resident assessment tool) dated 4/17/24 documented Resident #10 was always understood, always understands, and had moderate cognitive impairment. The Minimum Data Set documented Resident #10 received the pneumococcal vaccine. The Health Care Proxy form dated 9/26/23 documented Resident #10's responsible party was their Health Care Proxy. The Health Care Proxy documented the responsible party would make decisions for Resident #10 when Resident #10 was unable to make their own health care decisions. The Employee/Resident/Inpatient Vaccine Administration Consent/Waiver Form dated 1/26/24 documented verbal declination was obtained via phone with the Health Care Proxy for Influenza (flu), Pneumococcal, Respiratory Syncytial Virus (RSV- a common respiratory virus), Hepatitis B and Covid-19 Vaccines. The form further documented Resident #10 received the Pneumococcal Vaccine on 2/28/24. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The History and Physical dated 11/10/23 documented Resident #10 had baseline Alzheimer dementia and was definitely confused. The Physician General Clinic Note dated 2/8/24 documented Resident #10 was pleasantly confused. Review of the Medication Administration History Report dated 2/1/24-2/29/24 documented Resident #10 received the Prevnar 20 (pneumococcal) vaccination on 2/28/24. Review of the Care Plan edited on 4/24/24 documented Resident #10 had advance directives. The Care Plan documented Resident #10's wishes would be honored and the Health Care Proxy was in the chart. During an interview on 5/15/24 at 2:56 PM, Registered Nurse #3 stated they had helped to obtain vaccination consents and declinations from the residents or the residents' responsible party. Registered Nurse #3 stated based on Resident #10's Brief Interview for Mental Status score, they would not be able to make the decision to consent to or decline a vaccination. Registered Nurse #3 stated a verbal declination was obtained from Resident #10's Health Care Proxy by Registered Nurse #2 and cosigned by Registered Nurse #3. Registered Nurse #3 stated Resident #10 received the pneumococcal vaccination after the declination was obtained. Registered Nurse #3 stated Resident #10 should not have received the pneumococcal vaccination because they had the right to refuse the vaccination. During an interview on 5/15/24 at 3:13 PM, the Social Worker stated Resident #10's Health Care Proxy was very involved in their care and made health care decisions for Resident #10. During an interview on 5/15/24 at 3:22 PM, Registered Nurse #2 stated Resident #10 was unable to make their own decisions and that was why they contacted Resident #10's Health Care Proxy. Registered Nurse #2 stated, based on the electronic medication administration record, the Director of Nursing gave the pneumococcal vaccination on 2/28/24. During an interview on 5/15/24 at 3:30 PM, the Director of Nursing stated the consent and declination form was filled out incorrectly. The Director of Nursing stated Resident #10 should not have received the vaccination because the family did not want them to have it. The Director of Nursing stated they signed in two places that Resident #10 received the vaccination. removed. During an interview on 5/16/24 at 9:52 AM, the Medical Director stated it was expected for nurses to follow Resident #10's wishes. During an interview on 5/17/24 at 10:00 AM, the Administrator stated it was expected for nursing to administer or not administer a vaccination based on the consent and declination form. The Administrator stated it was the Director of Nursing's responsibility to make sure consent forms and administering immunizations were done accurately. 10 NYCRR 415.3f(1)(ii)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on interview and record review conducted during a Standard survey completed on 5/17/24 the facility did not immediately inform resident's representatives of a change in their physical and/or mental status for two (Resident #39 and Resident #28) of three residents reviewed for notification of change. Specifically, Resident #39 was given an intramuscularly injection (IM) of Haldol (antipsychotic medication) 5 milligrams and the family was not notified until after the resident had an adverse reaction to the medication. Additionally, the facility did not notify Resident #28's representative of a reddened area on their coccyx until 6 days later, and there was no documented evidence Resident #28's representative was notified of a stage II pressure area. The findings are: The policy titled Change in Condition dated 2/2021 documented that it was the responsibility of the Registered Nurse or Registered Nurse Supervisor to notify the resident, the physician, and the resident's responsible party, of changes in the resident's medical or mental condition, and document the notification in the medical record. The form titled Your Rights as a Nursing Home Resident in New York State dated 2022, documented that residents had the right to refuse medications, treatments, and chemical restraints. It also documented that the resident's representative had those rights in the instance that the resident was unable to make their own decisions. 1. Resident #39 had diagnoses including unspecified dementia, macular degeneration (loss of the central field of vision), and lung cancer. The Minimum Data Set (a resident assessment tool) dated 2/22/24, documented Resident #39 was severely cognitively impaired and displayed no behaviors. Resident #39's care plan dated 3/6/24, documented the resident was at risk for pain and receiving palliative care (comfort care). Interventions included to monitor for changes in behavior that may be contributed to pain and to monitor. The care plan also documented interventions to maintain family contacts. Resident #39's progress note dated 2/28/24 at 3:00 PM revealed the Director of Nursing documented they were made aware that Resident #39 had become very agitated, restless, and physically aggressive with staff during routine care and rounds. They contacted Nurse Practitioner #1, and a new order was received for Haldol 5 milligrams intramuscularly X 1 dose and every 4 hours as needed. There was no documented evidence the family was notified of the resident's behaviors, or that they were notified of the new order for Haldol prior to its administration. The Prescription Order dated 2/28/24 at 3:13 PM, documented an order for haloperidol lactate (Haldol) 5 milligrams intramuscularly injection, one time and as needed every 4 hours. The order was written for vascular dementia with other behavioral disturbance by the Director of Nursing. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration History dated 2/1/24- 2/29/24, revealed Licensed Practical Nurse #4 administered the haloperidol lactate 5 milligrams intramuscularly injection on 2/28/24 at 9:07 PM. Review of Resident #39's progress note dated 2/29/24 at 2:00 PM (documented as late entry on 3/1/24 at 7:27 AM) revealed the Unit Manager Registered Nurse #1 documented they communicated with Nurse Practitioner #1 about the resident's reaction to the Haldol and that the family was aware. During an interview on 5/13/24 at 12:43 PM, Resident #39's representative stated they had not been notified of the resident's behaviors or that Haldol was administered until they came to visit (2/29/24). The representative stated they noticed Resident #39 was not behaving as they normally did; their arms and legs were flailing around, and they were unable to respond or communicate. At that time, the unit manager told them the resident's change was a reaction to the Haldol they had received the night before. During an interview on 5/15/24 at 10:39 AM, Registered Nurse Unit Manager #1 stated when the resident had a change in condition and a new order was received from the provider the receiving nurse (Director of Nursing) should have notified the resident's representative and documented the notifications in the progress notes. During an interview on 5/15/24 at 11:46 AM, the Director of Nursing stated that nursing staff should notify the family before a new medication was given. The Director of Nursing stated that it was important because the family could be aware that the resident had an adverse reaction to the medication in the past, and they have the right to refuse the medication. During an interview on 5/15/24 at 1:21 PM, Nurse Practitioner #1 stated they expected the nursing staff to notify the resident's family or representative prior to giving any new medication. Especially with a medication like Haldol because it was considered a form of chemical restraint. 2. Resident #28 had diagnoses including Alzheimer's disease, stroke, and type II diabetes mellitus. The Minimum Data Set, dated dated dated [DATE], documented the resident was severely cognitively impaired, and was at risk for developing pressure areas. Resident #28's care plan dated 9/12/22, documented the resident was at risk for altered skin integrity related to a history of pressure areas, incontinence of bowel and bladder, and dementia. Review of Resident #28's progress note dated 8/24/23 revealed the Director of Nursing documented that a Stage 2 open ulcer (shallow ulcer cause by pressure) was noted on the resident's left buttock that measured 0.5 centimeters by 0.3 centimeters. The ulcer was cleansed with wound wash skin prep applied (a liquid film forming a protective barrier on a patient's skin to help reduce friction from removing adhesive dressings), and covered with a foam border dressing. There was no documented evidence the resident representative was notified of the development of the stage 2 pressure ulcer. Review of Resident #28's progress note dated 8/30/23 revealed Registered Nurse Unit Manager #1 documented they assessed resident's left buttock, and the area was resolved. They also assessed the coccyx and found no open area; skin was peeling; apply [NAME] (Calmoseptine- a moisture barrier cream to prevent skin irritation from urine and feces) three times a day and as needed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #28's progress notes dated 9/7/23 revealed Licensed Practical Nurse #2 documented that patient had redness in coccyx area, cleaned area, and foam border dressing applied. There was no documented evidence the resident representative was made aware of the redness and the need to start a treatment. Review of Resident #28's progress notes dated 12/19/23 revealed Licensed Practical Nurse #1 documented that resident continues with open area on coccyx; Calmoseptine applied, unit manager aware and will continue to monitor. There was no documented evidence the resident representative was made aware of the skin concerns. Review of the Physician Order Report - Treatments flow sheet dated 9/12/22 to 2/28/24 documented the following: 9/12/22 - skin checks weekly on shower days. 7/28/23 - remove lidocaine patch from back. 8/11/23 - Calmoseptine to buttocks as needed per shift. 12/20/23 - oxygen to at 2 liters via nasal canula as needed. 2/28/24 - apply Calmoseptine to right and left buttock, cover with foam border dressing once a day. Review of the View Care Conference - Care Conference Information dated 9/13/23 revealed no evidence the family was notified of the reddened area. During an interview on 5/16/24 at 10:09 AM, the Medical Director stated they would expect the nurses to contact them to notify them of any open area. During an interview on 5/16/24 at 10:45 AM, Licensed Practical Nurse #1 stated they do not recall being told about the reddened area on the resident's coccyx by Licensed Practical Nurse #2 who worked the night shift before them. They stated they would document they contacted the family or the physician about the reddened area. During an interview on 5/16/24 at 11:08 AM, Registered Nurse Unit Manager #1 stated they expect the Licensed Practical Nurses to tell them about any skin conditions. They stated they would have documented in progress notes about contacting the family and the Medical Director for any skin issues. During an interview on 5/16/24 at 12:02 PM, the Director of Nursing stated the physician should be notified about any open area on the resident, because Resident #28's coccyx was a chronic pressure area, they would not have notified the family. They stated family should be notified about any change in condition within 24 hours. They also stated that it should be documented in progress notes that family was notified. The Director of Nursing reviewed the medical record and stated the family attended the care conference meeting on 9/13/23, and may have been notified at that time of skin concerns. (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 5/17/24 at 9:05 AM, Licensed Practical Nurse #2 stated they should have contacted a Registered Nurse to assess the reddened area. They stated if the area wasn't followed up on by the morning shift nurse, they should have contacted the Registered Nurse on their next shift. During an interview on 5/17/24 at 9:19 AM, Registered Nurse Unit Manager #2 stated if there was not a registered nurse available in long term care, they expected the Licensed Practical Nurses to call the Medical Care Unit to get a Registered Nurse to assess any skin areas. They stated they expect their nurses to document in progress notes they contacted the Registered Nurse or Supervisor to assess a skin area. During an interview on 5/17/24 at 10:05 AM, the Administrator stated they expected nursing staff to notify family, and the physician of any change in condition, or any new treatment or medication. 415.3 (e)(2)(ii)(c)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on interview and record review conducted during a Complaint (NY00325631) investigation conducted during a Standard Survey completed on 5/17/24, the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice for two (Resident #28 and #39) of fifteen residents reviewed for quality of care. Specifically, there was no Registered Nurse assessment for a resident with a reddened area on their coccyx, and there was no order obtained from the physician for treatment of a Stage 2 (a shallow wound that affects the skin and the tissue below it) pressure ulcer (#28). Additionally, there was no evidence of a Registered Nurse assessment for a resident who experienced a change in their behavior, received an antipsychotic medication and after the resident had an adverse reaction to the medication (Resident #39). The findings are: The policy titled Skin - Pressure Ulcer/Injury Treatment dated 10/05, documented that an assessment by a Registered Nurse included: the date assessed, measurements including length, width, and depth, stage of ulcer if appropriate, the location and type of wound. The policy titled Standard Physician Orders dated 6/23/11, documented that telephone or verbal orders for Long Term Care residents may be accepted by a licensed nurse and must be countersigned by a physician within 48 hours. The undated facility job description for a Licensed Practical Nurse, documented that the Licensed Practical Nurse was to provide nursing care under the guidance of a Registered Nurse, must be able to document in the patient's records, and identify appropriate nursing interventions. The undated facility job description for a Registered Nurse, it documented that the Registered Nurse assures the delivery of safe, comprehensive, effective, appropriate nursing care including resident assessments, documentation, and medication administration. 1. Resident #28 was admitted to the facility with Alzheimer's disease, stroke, and type 2 diabetes mellitus. Review of the Minimum Data Set (a resident assessment tool) dated 9/3/23 documented the resident was severely cognitively impaired. Further review of the Minimum Data Set documented the resident was at risk for developing pressure areas. The resident's Care Plan dated 9/12/22, documented the resident was at risk for altered skin integrity related to a history of pressure areas, incontinent bowel and bladder, and dementia. Review of the chronological nursing progress notes dated 8/1/23 to 12/27/23 documented the following: 8/24/23 - The Director of Nursing wrote that a Stage 2 open area was noted on the resident's left buttock measuring 0.5 centimeters by 0.3 centimeters, area was cleansed with wound wash with skin prep (protective barrier) and covered with a foam border dressing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/30/23 - Registered Nurse Unit Manager #1 wrote that assessed resident's left buttock and area resolved; also assessed the coccyx and found no open area; skin is peeling; apply [NAME] (calmoseptine- a moisture barrier cream to prevent skin irritation from urine and feces) three times a day and as needed. 9/7/23 - Licensed Practical Nurse #2 wrote that patient has redness in coccyx area, cleaned area, and foam border dressing applied. 12/19/23 - Licensed Practical Nurse #1 wrote that resident continues with open area on coccyx; Calmoseptine applied, unit manager aware and will continue to monitor. There was no documented evidence that there was a registered nurse assessment regarding the reddened area to the resident's coccyx 9/7/23, and there was evidence of a registered nurse assessment on 12/19/23 of the open area on the resident's coccyx. Review of the chronological Physician Order Report - Treatments flow sheet dated 9/12/22 to 2/28/24 documented the following: 9/12/22 - skin checks weekly on shower days. 7/28/23 - remove lidocaine patch from back. 8/11/23 - Calmoseptine to buttocks as needed per shift. 12/20/23 - oxygen to at 2 liters via nasal canula as needed. 2/28/24 - apply Calmoseptine to right and left buttock, cover with foam border dressing once a day. There was no evidence a physician's order was obtained on 8/24/23 for the Stage 2 pressure ulcer on the resident's left buttocks to include the use of skin prep and dry foam dressing; the discontinuation and the initiation of applying Calmoseptine three times daily and as needed on 8/30/23; and there was no evidence there was a physician's order on 9/7/23 to add the foam dressing. During an interview on 5/16/24 at 10:09 AM, the Medical Director, they stated they expected the nurses to contact them to obtain an order for a foam border dressing and any treatment for any open area on a resident. They stated they expected the registered nurses to assess any open area on a resident. During an interview on 5/16/24 at 10:45 AM, Licensed Practical Nurse #1 stated an order from the physician's was needed for any dressing and treatment. (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 5/16/24 at 11:08 AM, Registered Nurse Unit Manager #1 stated they expected the Licensed Practical Nurses to get a registered nurse to assess all skin issues. They stated that if it was after the day shift ended and there were no Registered Nurses in the skilled nursing facility, the Licensed Practical Nurses were to go to the Medical Care Unit or call the Medical Care Unit to find a Registered Nurse to assess any skin concerns. hey stated they would expect the Licensed Practical Nurses to write a progress note and document they contacted a Registered Nurse to complete the assessment. They stated that a foam border dressing and any skin treatment needed an order from a physician. During an interview on 5/16/24 at 12:02 PM, the Director of Nursing stated the physician should be notified about any open areas on a resident. The Director of Nursing stated that any foam border dressing for an open area required an order from the physician. They stated they thought they obtained an order for the Stage 2 on 8/24/23, then verified that the order was not on the Physician Order Report - Treatment flow sheet. During an interview on 5/17/24 at 9:05 AM, Licensed Practical Nurse #2, they stated that they should have contacted a Registered Nurse to assess the reddened area on the resident. They stated if the area wasn't followed up on by the morning shift nurse, they should have contacted the Registered Nurse on their next shift. During an interview on 5/17/24 at 9:19 AM, Registered Nurse Unit Manager #2, they expected any of the Licensed Practical Nurses to call the Medical Care Unit to get a Registered Nurse to assess any skin concerns. They stated they expect their nurses to document in progress notes that they contacted the Registered Nurse or Supervisor to assess a skin area. 2. Resident #39 had diagnoses including unspecified dementia, macular degeneration (loss of the central field of vision), and lung cancer. The Minimum Data Set, dated dated dated [DATE], documented Resident #39 was severely cognitively impaired, and displayed no behaviors. Resident #39's Care Plan dated 3/6/24, documented resident was at risk for pain due to diagnosis of cancer and admitted on palliative care (comfort care). Further review of the Care Plan documented monitor for changes in behavior that may be contributed to pain and monitor for verbal and non-verbal signs of pain. Review of Resident #39's progress note dated 2/28/24 at 3:00 PM revealed the Director of Nursing documented they were made aware that Resident #39 was becoming very agitated, restless, and physically aggressive with staff during routine care and rounds. They contacted Nurse Practitioner #1, and a new order was received for Haldol 5 milligrams intramuscular X 1. There was no evidence a Registered Nurse or the Director of Nursing completed a comprehensive resident assessment of the resident's condition/status when the resident experienced a change in their behavior. The Prescription Order dated 2/28/24 at 3:13 PM, documented an order for haloperidol lactate (Haldol) 5 milligrams intramuscularly injection, one time and as needed every 4 hours. The order was written for vascular dementia with other behavioral disturbance by the Director of Nursing. Review of the Medication Administration History dated 2/1/24- 2/29/24, revealed Licensed Practical Nurse #4 administered the haloperidol lactate 5 milligrams intramuscularly injection on 2/28/24 at 9:07 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #39's progress note dated 2/29/24 at 2:00 PM (late entry on 3/1/24 at 7:27 AM) revealed the Unit Manager Registered Nurse #1 documented they communicated with Nurse Practitioner #1 about the resident's reaction to the Haldol. There was no evidence a comprehensive resident assessment was completed by a Registered Nurse when the resident experienced an adverse reaction to the Haldol. During an interview on 5/16/24 at 9:40 AM, the Medical Director stated if a resident was having a change in condition or a reaction to a medication, they would expect the Registered Nurse to document a complete assessment. The provider might not be able to come into the facility so they would trust the nurse's assessment, make recommendations, or give orders. During an interview on 5/16/24 at 11:40 AM, the Director of Nursing stated when a resident has a change in condition or a reaction to a medication, a thorough physical assessment should be documented in the resident's progress note by the Registered Nurse. They stated that the progress note dated 2/28/24 at 3:00 PM did not contain a thorough physical assessment of Resident #39. The Director of Nursing also stated that the progress note dated 2/29/24 at 2:00 PM did not contain a thorough physical assessment of Resident #39. During an interview on 5/17/24 at 10:05 AM, the Administrator stated that as a standard of practice a thorough registered nurse assessment should be completed and documented for any change in a resident's condition. 10 NYCRR 415.12

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34587 Based on record and interview review conducted during a Standard survey completed on 5/17/24, the facility did not maintain complete and accurately documented medical records for six (Resident #3, #10, #25, #36, #39, and #41) of 16 residents. Specifically, medical orders were not accurately entered under the prescribing providers name in the medical record. The findings are but not limited to: The policy and procedure titled Medication - Verbal and Written Physician Orders reviewed 2/21 documented verbal orders will be written by the person receiving the order as soon as it is received, noting the date and time received, the name of the physician/PA (physician assistant)/NP (nurse practitioner) and the receiver's name and title. The prescriber shall co-sign the order within 48 hours. The policy and procedure titled Standard Physician Orders reviewed 2/21 documented telephone or verbal orders for Long Term Care elders may be accepted by a licensed nurse only and must be countersigned by the physician within 48 hours of receiving the orders. 1. Resident #39 had diagnoses including dementia, macular degeneration (loss of the central field of vision), and lung cancer. The Minimum Data Set (MDS-a resident assessment tool) dated 2/22/24, documented Resident #39 was severely cognitively impaired. Resident #39's progress note dated 2/28/24 at 3:00 PM documented the Director of Nursing contacted Nurse Practitioner #1 and obtained a new order for Haloperidol (Haldol-an antipsychotic medication) five milligrams (mg- a unit of measurement) intramuscularly (an injection into a muscle) for one dose and an order for Haloperidol five milligrams intramuscularly every four hours as needed. Review of the prescription order report for Resident #39, revealed an order, for Haloperidol lactate five milligrams for one dose and as needed every four hours, was created on 2/28/24 at 3:13 PM by the Director of Nursing. It was entered as a written order by the Medical Director. The order was signed electronically by the Medical Director on 3/19/24. Resident #39's progress note dated 2/29/24 at 2:00 PM revealed the Registered Nurse Unit Manager #1 documented they communicated with Nurse Practitioner #1 about Resident 39's reaction to the Haldol and obtained an order to discontinue the Haloperidol and to increase the Ativan (an antianxiety medication). Review of the prescription order report for Resident #39, revealed an order, to increase Ativan to one milligram every four hours as needed, was created on 2/29/24 at 1:50 PM by Registered Nurse Unit Manager #1. It was entered as a written order by the Medical Director. The order was signed electronically by the Medical Director on 3/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335364	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuba Memorial Hospital Inc Snf	140 West Main Street Cuba, NY 14727

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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the prescription order report for Resident #39, revealed an order, to discontinue Haloperidol, was created on 3/1/24 at 1:02 PM by Unit Manager Registered Nurse #1. It was entered as a written order by the Medical Director. The order was signed electronically by the Medical Director on 3/19/24. During an interview on 5/15/24 at 1:21 PM, Nurse Practitioner #1 stated the orders for Resident #39 should have been entered under their name, if they gave the orders. During an interview on 5/17/24 at 9:36 AM, Licensed Practical Nurse #3 stated that if the order was written, there would have been a handwritten order in the paper chart. Licensed Practical Nurse #3 stated that they would then choose which provider gave them the order and complete the entry. After completing the order entry process, the nurse should have documented in a progress note. 2. Resident #3 had diagnoses including osteoarthritis (a type of arthritis), neuropathy (a disorder effecting the nervous system), and cellulitis (inflammation of tissue under the skin) of the toe. The Minimum Data Set, dated dated dated [DATE] documented Resident #3 had moderate cognitive impairment. The progress note dated 3/8/24, documented Resident #3's left great toe was red, swollen, and warm with scant yellow/white drainage. The progress note documented the On-Call Physician was notified and a new order was written for Keflex (an antibiotic) 500 milligrams by mouth three times a day for 10 days, for an infection. The prescription order report dated 3/8/24 documented an order for Keflex 500 milligrams three times a day by mouth. The order was created by Registered Nurse Unit Manager #2 as a written order and signed by the Medical Director on 3/19/24. During an interview on 5/16/24 at 2:42 PM, Registered Nurse Unit Manager #2 stated the On-Call Physician was not an available option in the computer system when creating new orders. Nurse Practitioner #1 and the Medical Director were the only options. 3. Resident #41 was admitted to the facility with diagnoses of aphasia (a communication and comprehension disorder resulting from a traumatic brain injury), stroke, and hemiparesis (paralyzed on one side). Review of the Minimum Data Set, dated dated dated [DATE] documented that the resident was severely cognitively impaired, sometimes understands others, and sometimes was understood by others. The progress note dated 3/6/24 documented Resident #41 was seen for a 60-day assessment by the On-Call Physician and documented there were new orders for the resident including to obtain labs (blood work), Lasix 20 milligrams (a medication that reduces extra fluid in the body), and potassium (supplement) 10 milliequivalent. Review of Resident #41's Physician orders - medications flow sheet dated 3/6/24 documented the resident was ordered Lasix 20 milligrams by mouth once a day and potassium 10 milliequivalent tablet once a day every other day. Further review of the medication orders documented the orders were signed by the Medical Director on 3/19/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335364	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cuba Memorial Hospital Inc Snf	140 West Main Street Cuba, NY 14727

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident #41's Physician Orders - labs flow sheet dated 3/7/24 documented the resident was ordered a complete metabolic panel and complete blood count with differential. Further review of the laboratory orders documented the orders were signed by the Medical Director on 3/19/24. During an interview on 5/16/24 at 9:40 AM, the Medical Director stated Nurse Practitioner #1, and the On-Call Physician were covering the facility from 2/22/24 through 3/18/24. The Medical Director stated the orders should have been entered under the name of the provider that gave the order. The Medical Director stated there have been times staff put the Medical Director's name on the orders when they were not the prescriber. The Medical Director stated they have told staff to pick the correct prescriber, but they end up signing the orders anyway. During a telephone interview on 5/16/24 at 9:58 AM, the On-Call Physician stated they expected the staff to choose the correct prescriber- either physician or nurse practitioner, when creating new orders. During an interview on 5/17/24 at 9:48 AM, Registered Nurse Unit Manager #1, stated that they should have had the orders signed by the attending physician. During an interview on 5/16/24 at 11:40 AM, the Director of Nursing stated orders should have been entered under the provider that gave the order. They stated that if it was a written order there should have been a paper order in the resident's chart. During a telephone interview 5/16/24 at 3:19 PM, the Computer Tech for the electronic medical record stated there have been no requests for updating a providers list submitted. They stated the nursing staff had to call the help desk number or put in an electronic ticket (request) on the hospital internet system to add a provider. During an interview on 5/17/24 at 10:00 AM, the Administrator somebody should have brought it to their attention the On- Call Physician's name was not on the list of providers in the electronic medical record system. 10 NYCRR 415.22(a)(1)(2)