STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335392	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Park Rehabilitation and Nursing Center	28 Kellogg Road 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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Actual harm Residents Affected - Few	Based on record review and interview during the abbreviated survey (NY00370972, iQIES# 452008), the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for one (1) of three (3) residents (Resident #2) reviewed. Specifically, Resident #2 was discharged from the hospital to the facility with atrial fibrillation (irregular heartbeat) and a mechanical heart valve replacement and was ordered weekly Prothrombin Time/International Normalized Ratio's (blood test that checks how long it takes for blood to clot) and anticoagulant (blood thinner) therapy. There was no documentation in the resident's electronic record of a diagnosis of a mechanical heart valve replacement and no documented evidence of a provider rationale for the reason International Normalized Ratios were not maintained at the recommended levels for mechanical heart valves (2.5-3-5). Additionally, there was no documented evidence the resident's Prothrombin Time/International Normalized Ratio was obtained as ordered on 10/22/2024 and no documented evidence the provider was notified that it was not obtained. Three (3) days after the missed Prothrombin Time/International Normalized Ratio, the resident presented with impaired speech, was more confused and sent to the hospital where they were found with a subtherapeutic (blood level below desired treatment range) International Normalized Ratio (1.16) and they were diagnosed with an acute stroke. This resulted in actual harm that was not Immediate Jeopardy for Resident #2. Findings include: Findings include: The facility policy Coumadin (warfarin) Therapy and Monitoring, dated 10/2024 documented:-Anticoagulation was needed for stroke, atrial fibrillation, pulmonary embolism and mechanical heart valve replacements. Dosage: to achieve target International Normalized Ratio was usually 1.5 to 2.5 times control. Mechanical heart valve target International Normalized Ratio was usually higher at 2.5 -3.5. Care planning for residents on anticoagulant medication including reporting lab values as soon as they were received, monitoring side effects- International Normalized Ratio testing, observation, prevention of side effects-falls, identifying procedures where medication should be held, education and certified nurse aide plan. Nursing documented in the nursing progress notes and 24-hour report. -Residents on anticoagulant therapy i.e., Coumadin (generic name: warfarin), would be tracked using a red binder located on each unit, utilizing the Anticoagulant Therapy Flow Sheet to ensure appropriate care and treatment, as well as monitoring for side effects. Procedure: the licensed nurse (day/evening shift) initiated the Anticoagulant therapy flow sheet and placed Prothrombin Time/ International Normalized Ratio lab order on the laboratory log for the date ordered. The licensed nurse (night shift) reviewed laboratory log and completed the lab requisition form. The licensed nurse received and reviewed the laboratory report and called the physician to report lab results and obtain orders for Coumadin therapy. Resident #2 had diagnoses including atrial fibrillation and Parkinson's Disease. The 09/05/2024 Minimum Data Set assessment documented the resident's cognition was intact, they were dependent with most activities of daily living, and the resident took anticoagulant medications during the assessment period. The resident's Diagnosis Sheet and 09/05/2024 Minimum Data Set assessment did not document the resident had a mechanical heart valve replacement. The 08/30/2024 hospital discharge summary documented Resident #2 was admitted with syncope (temporary loss of consciousness), collapse, and urinary tract infection. The resident had history of atrial fibrillation (irregular heartbeat that could increase risk of stroke), mechanical aortic valve replacement (surgical procedure where aortic valve is replaced with an artificial valve, higher risk of blood clots) and supratherapeutic (blood level higher than desired treatment range) International Normalized Ratio (blood test that checks how long it takes for blood to clot). Discharge medications included warfarin (anticoagulant) 2 milligrams, alternating 1 milligram and 2 milligrams every night. The 09/03/2024 Physician Assistant #4 progress note documented the resident was seen following hospitalization for falls and a urinary tract infection. The resident's diagnoses and assessment included atrial fibrillation, continue on warfarin, and they would order International Normalized Ratio to assess further. The 09/19/2024 History and Physical completed by the Medical Director documented the resident was admitted following hospitalization. The resident's diagnoses included atrial fibrillation. The History and Physical did not address a mechanical heart valve. The 10/02/2024 former Physician Assistant #4 note documented a follow up for atrial fibrillation. The recent International Normalized Ratio was 3.3 and supratherapeutic. The plan was to reduce the dose and repeat International Normalized Ratio in one (1) week. There was no documentation related to the resident's mechanical heart valve. The 10/02/2024 physician order documented warfarin 1 milligram every other day. The 10/07/2024 Comprehensive Care Plan did not document the resident had atrial fibrillation or a