STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335396	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Nursing and Rehabilitation Center	2817 Albany Post Road Montgomery, NY 12549

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview conducted during the recertification survey from [DATE] to [DATE], the facility did not ensure a medication error rate of no more than 5%, 2 of 35 opportunities (5.71%) for 2 of 4 residents (Resident #34 and Resident #31) reviewed for Medication Administration. Specifically, 1) Resident #34 was administered one Tums 200 mg/ Calcium 500 mg chewable tablet instead of two as per physician order, and 2) Resident #31 did not receive Vitamin C as per physician order. The findings include: The Policy titled Medication Administration dated [DATE] documented medications would be administered to residents in a timely and accurate manner by a licensed nurse or physician. Resident #34 was admitted to the facility with diagnoses including but not limited to Atrial Fibrillation, Dysphagia and Hypertension. The [DATE] Physician Order documented Tums 200 mg/Calcium 500 mg chewable tablet, give 2 by oral route for heartburn. During the [DATE] at 9:40 AM medication administration observation Licensed Practical Nurse #21 removed one tablet of Tums 200 mg/Calcium 500 mg chewable tablet from the bottle and administered it to Resident #35. During an interview on [DATE] at 12;49 PM Licensed Practical Nurse #21 stated they did not realize they needed to administer two Tums 200 mg/Calcium 500 mg chewable tablets, and should have read the order more closely. Resident # 31 was admitted with diagnoses including but not limited to Atrial Fibrillation, Congestive Heart Failure and Pleural Effusion. The [DATE] Physician Order documented Vitamin C 500 mg tab, two tablets every day. During the [DATE] at 10:00 AM medication administration observation Vitamin C was not administered. The Medication Administration Record documented Vitamin C was signed off by the Licensed Practical Nurse #20 on [DATE] as administered at 9:00 AM. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 11:15 AM Licensed Practical Nurse #20 stated they gave the Vitamin C during the medication pass. Licensed Practical Nurse #20 then stated the Vitamin C bottle was expired, they needed to get a new bottle. When asked why they signed for the Vitamin C before they administered the Vitamin C, they stated they accidentally signed off. During an interview on [DATE] at 11:56 AM the Director of Nursing stated medications needed to be given as prescribed by the physician. They stated the nurses needed to do better. 10NYCRR 415.12(m)(1)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the recertification and abbreviated surveys (NY00360214) conducted from 1/7/25 to 1/14/25, the facility did not ensure residents were free from significant medication errors for one of one resident (Resident #70) reviewed for Neglect. Specifically, staff administered medications to Resident #70 including Doxycycline 100 mg (antibiotic), Metformin 500 mg (diabetes pill), [NAME] 95-100 mg (heart pill), Torsemide 20 mg (water pill), Metoprolol ER 75 mg (blood pressure pill), and Farxiga 10 mg (kidney pill), which were not physician prescribed for Resident #70 resulting in Resident #70 developing chest pain and being transferred to an acute care hospital for evaluation. The findings include: The facility policy Medication Incident Errors dated 12/28/2020 and revised on 11/12/2024, documented medication incidents to include wrong resident, wrong dose, wrong medication, wrong time, wrong day, wrong route. To determine if the incident is significant include, resident condition and medical history, drug category, frequency, and dosing. Resident #70 had diagnoses including Cerebral Vascular Accident, Type 2 Diabetes, and Peripheral Vascular Disease. The Quarterly Minimum Data Set (assessment tool) dated 11/21/24 documented Resident #70 had severe cognitive impairment. The Investigation Report dated 11/20/24 documented occurrence date 11/10/24 at 8:40 AM, the Licensed Practical Nurse self-reported they gave the wrong medication to the resident. The resident received Doxycycline 100 mg, Metformin 500 mg, Entresto 95-100 mg, Torsemide 250mg, Metoprolol 75 mg, and Farxigia 10 mg. The Medical Provider was notified immediately and ordered monitoring of vital signs and blood sugar. The Investigation Report documented Licensed Practical Nurse #16 was suspended pending investigation, interviewing other alert residents on Licensed Practical Nurse #16's assignment for any other potential issues. The facility policy and procedure for medication error and medication administration was reviewed and revised. Statements were obtained from all parties. Education and in-service was conducted with nurses, completed on 12/2/24, and random medication pass observations were conducted. The nurse involved resigned on 11/14/24. The Progress Note dated 11/11/24 documented vital signs 173/67, 59, 16 96% blood glucose 148. Monitoring and Vital Signs 10 AM, 164/56, 60, 21 96% blood glucose 168, 11 AM 181/76, 60, 16 96% blood glucose 186, 12:15 PM 135/68, 62, 20 98%. At 12:45 PM resident complained of chest pain and was sent to the Emergency Room. The emergency room records documented the resident was brought in by Emergency Medical Services following the resident receiving another resident's medication in the Skilled Nursing Facility. The resident had an episode of feeling faint and complained of chest pain at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/10/25 at 1:01 PM the Administrator stated they were made aware right away of the error, the family was at the bedside at the time. The physician was notified at the time and felt they could manage the resident's monitoring in the facility. When the resident complained of chest pain they sent the resident to the Emergency Room. During an interview on 1/13/25 at 12:14 PM the Physician stated they were called when the medication error occurred. The resident later complained of chest pain and was sent to the emergency room and was subsequently admitted for an unrelated issue. Since the resident received medication not prescribed including a diuretic (torsemide-water pill), they felt it should be considered a significant medication error. During an interview on 1/13/25 at 12:25 PM the Director of Nursing stated they did the investigation right away; they were grateful the nurse self-reported. Because the resident received another resident's medication, they considered it a significant medication error. They started an investigation, the nurse was suspended, and the event was reported to the State Agency. During an interview on 1/13/25 at 1:09 PM Licensed Practical Nurse Supervisor #21 stated they were the supervisor when the medication nurse let them know they had given Resident #70 someone else's medication. They stated they had a Registered Nurse assess the resident and called the Medical Doctor. They continued to monitor the resident until Resident #70 complained of chest pain. They notified the Medical Doctor and sent the resident to the Emergency Room. The Director of Nursing was notified of the medication error. 10 NYCRR 415.12 (m)(2)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the recertification and abbreviated surveys (NY00359070) from 1/7/2025 to 1/14/2024, the facility did not ensure that an effective pest control program was maintained so that the facility was free of rodents on 1 of 2 units (South) and the physical therapy department. Specifically, there was no documented evidence of facility follow up/monitoring to assess ongoing need and/or effectiveness of interventions put in place by the pest control company to eradicate and/or contain mice. The findings are: The policy and procedure effective 3/2019 last reviewed 3/2024 titled Pest Control documented this facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents. The Pest Control Logbook dated 2/7/24 to 1/8/25 documented mice were observed in room [ROOM NUMBER] and #106 on 4/16/24, a mole was observed in room [ROOM NUMBER], and maintenance shop on 10/15/24, a mouse was in room [ROOM NUMBER] on 10/15/24, and a mouse was in the therapy room on 11/3/24. The 4/17/24 Service Inspection Report documented mice were in room [ROOM NUMBER] and room [ROOM NUMBER]. Ready to use glue boards were placed in each room. No other reports. Inspected and treated all nursing stations, common areas and kitchen. The 10/16/24 Service Inspection Report documented treated all nursing stations in common areas and kitchen for general pest prevention. Check all ready to use monitors and tincats. One mouse caught on the glueboard near the exit door under ventilation. Replenished all monitors. The 11/13/24 Service Inspection Report documented light activity in the therapy department. Inspected and treated the entire interior and exterior for all pest and rodent activity including all common areas, nursing stations and kitchen. Replenished all bait stations throughout the facility interior and exterior. During observation on 1/07/25 at 11:17 AM, room # 131/Resident #54 was observed to have a mouse trap behind the dresser and located under the radiator. It was also observed that Resident #54 had an open box of donuts on the dresser and extra food items in the room. During interview on 1/13/25 at 3:53 PM, the Director of Rehabilitation stated they did not actually see mice, but they saw mice droppings in the physical therapy department. They stated they alerted the head of maintenance and they called the pest control company who sprayed all along the baseboards and put a mouse trap in the room.They stated the mouse trap was no longer in place. During interview on 1/14/25 at 9:13 AM, Licensed Practical Nurse #14 stated they did not recall seeing or hearing about mice in April of 2024. Licensed Practical Nurse #14 stated if a Certified Nurse Aide saw a mouse they would verbally report it to maintenance. Licensed Practical Nurse #14 stated they did not have maintenance repair/housekeeping logs on the units where they would report concerns for maintenance/housekeeping such as mice. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During interview on 1/14/25 at 9:47 AM, the Director of Maintenance/Housekeeping stated when there were reports of mice, they had pest control company place mouse traps. The Director of Maintenance/Housekeeping stated they knew traps were placed but, a review of reports to determine if the traps were working/rounds to check for mice was not done. The Director of Maintenance/Housekeeping stated they had no documentation of their follow regarding the issue. The Director of Maintenance/Housekeeping stated they felt it was being taken care of by having the mouse traps. The Director of Maintenance/Housekeeping stated the pest control company checked the traps to see if there were mice in them. The Director of Maintenance/Housekeeping stated they were not informed of any mice being found in the mouse traps. 10 NYCRR 415.29(j)(5)