

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335768	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/31/2026
NAME OF PROVIDER OR SUPPLIER Guthrie Cortland Medical Center		STREET ADDRESS, CITY, STATE, ZIP CODE 134 Homer Avenue 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Based on record review and interviews during the survey, the facility failed to ensure that each resident received adequate supervision to prevent accidents for one (1) of five (5) residents (Resident #1) reviewed. Specifically, on 07/14/2024 at 3:36 PM, Resident #1, who had a history of exit seeking behaviors, was at risk for elopement, and had a wander alert device, exited the facility through the 3rd floor North Hall stairwell door. The resident was found outside by a visitor approximately 15-30 minutes later and brought back into the facility by nursing and security. This resulted in Immediate Jeopardy, past non-compliance, to Resident #1, and placed them at risk for serious harm serious injury, serious impairment, and death. Findings include: The facility policy Wandering Residents/Risk for Elopement and Recovery of Missing Resident, dated 06/01/2021, documented all residents will be assessed upon admission and on an on-going basis (quarterly, significant change, annually) to determine if wandering and elopement issues are present. The use of assigned staff to monitor a resident at times when wandering behavior may intensify (i.e. early morning, late evening, change of shift) may be necessary. Remote areas such as basements, loading docks, unsupervised stairways, non-resident areas including corridors and offices will be routinely monitored by staff or if appropriate, locked to prevent resident access. Resident #1 had diagnoses of Parkinson's Disease (progressive neurological disorder) and dementia with behavioral disturbances and anxiety. The 04/27/2024 Minimum Data Set (a resident assessment tool) documented the resident had moderately impaired cognition, used a manual wheelchair, had exit-seeking behaviors and used a wandering/elopement alarm daily. The Comprehensive Care Plan, initiated 08/16/2023 and revised 04/08/2024, documented the resident was an elopement risk/wanderer related to disorientation to place. Interventions included wandering device to left ankle. The 02/05/2024 physician order documented wandering device to right ankle and check for placement every shift. The 07/02/2024 facility maintenance work order documented maintenance disabled the 3rd floor alarm activation and placed a barricade at the door to prevent access. Nursing was made aware. Security Officer #6 documented they were called by security for assistance with resetting the wandering system alarm near the North stairwell door. The alarm would not turn off; they removed a screw from the bottom of the alarm box to lift up the alarm and it stopped alarming. A barricade was placed near the door to prevent access. Nursing and the nursing supervisor were notified. The 07/14/2024 facility video footage of the 3rd floor was reviewed and revealed:-at 1:40 PM, Resident #1 was exit-seeking at the North stairwell door. The resident opened the yellow plastic barrier (an accordion plastic barrier), wheeled themselves around the barrier and closed the barrier behind them.-at 1:41 PM, two unidentified staff members looked at Resident #1, pushed the yellow plastic accordion-style barrier back open and walked away. Resident #1 was not redirected away from the door.-at 1:45 PM, Resident #1 attempted to remove their wander alert bracelet from their right ankle with a hairbrush and left the stairwell door area.-from 1:46 PM - 2:36 PM, the North Stairwell exit was empty.-at 2:36 PM, Resident #1 returned to the stairwell door and attempted to exit. The resident was redirected away from the door by an unidentified staff and returned to the door at 2:37 PM.-from 2:59 PM - 3:05 PM, Resident #1 was at the North stairwell door and attempted to exit. The resident pushed on the crash bar handle (delayed (continued on next page)</p>

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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The door was closed, and the resident was no longer visible.-At 3:46 PM an unidentified staff member approached the door, looked through the window of the door and approached the hallway and was pointing at the door. They exited using their badge and an empty wheelchair was seen at the top of the stairwell. The door closed. Another unidentified staff member came to the door, exited with their badge, and proceeded down the stairs. Several staff approached the door, and the wheelchair was brought back onto the unit. On 07/14/2024 at 1:00 AM, Registered Nurse #5 documented Resident #1 was missing from the unit at 3:30 PM. Staff initiated a search and discovered the resident's wheelchair in the 3rd floor North stairwell. Resident #1 exited through the 3rd floor North Stairwell door onto the loading dock and was found out in front of the building on the sidewalk by a visitor. The visitor alerted security and staff, and security retrieved the resident and brought them inside. An assessment was completed, and no injuries were noted.On 07/14/2024, the untimed Investigation summary completed by the Director of Nursing documented the root cause of Resident #1's elopement was the result of the 3rd floor North stairwell door alarm being disabled by maintenance. The door was broken and the resident exited through the stairwell door to the outside of the building.On 07/17/2024 at 9:00 AM, the vendor service receipt documented all door alarms were activated and tested on the 2nd and 3rd floor.During an interview on 02/05/2026 at 9:07 AM Registered Nurse #5 stated on 07/14/2024 during the 3:00 PM to 11:00 PM shift, they noticed the 3rd floor high side stairwell door had a yellow rectangular barricade across the door. They were told by staff on the unit that the door was broken. They did not know how long it was broken. Resident #1 was at the nursing station, and 15-20 minutes later, they noticed the resident was no longer at the nursing station. They alerted staff and looked for the resident. Resident #1 was found outside in front of the building and was brought back to the unit. They notified the Director of Nursing immediately and was told to place stretchers in front of the North end doors on both the 2nd and 3rd floors as the alarm systems were linked for both floors and the doors were broken. Registered Nurse #5 stated they questioned the action due to fire hazards but placed them per the Director of Nursing's orders. They did not recall when the door alarms were fixed.During an interview on 02/05/2026 at 2:14 PM Certified Nurse Aide #11 stated Resident #1 was exit-seeking all day on 07/14/2024. The resident normally wandered near the doors and tried to exit the facility, and staff re-directed the resident. On 07/14/2024, the resident went missing. The resident was found outside near the front of the building. After the incident, they placed a stretcher in front of the broken door to keep the resident from exiting again and they had to monitor the resident closely so they would not climb over the stretcher.During an interview on 02/05/2026 at 10:00 AM, Security Officer #6 stated they recalled an issue with the 3rd floor North stairwell door alarm not working, they went to the unit and assisted maintenance. The alarm was disabled, and they placed a yellow hard plastic, construction-like barrier against the door and notified nursing. They did not recall when the door was repaired. If maintenance could not repair an issue, then an outside vendor was notified.During an interview on 02/05/2026 at 11:17 AM, the Security Supervisor stated maintenance covered general hardware work orders and the security team covered door and wandering system concerns. On 07/14/2024, Resident #1 eloped due to the 3rd floor North stairwell door not being alarmed. The door was broken days prior to the event. Maintenance disabled the door alarm mistakenly due to a wandering system alarm issue and thought the door alarms were on the same alarm system. There was a yellow barrier in front of the door to prevent residents from exiting. Door checks were conducted by staff. On 07/08/2024, a wandering system vendor came in and checked (continued on next page)</p>		

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