STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335768	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guthrie Cortland Medical Center	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)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 40803 Based on observation and interview during the recertification survey conducted 3/11/2024-3/15/2024, the facility did not ensure the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction were posted in a place readily accessible to residents, family members, and legal representatives. Specifically, the survey results and plan of correction were in a pink binder on a shelf behind the nursing station on Cedar Run (second floor) and in a black binder on a shelf in the dining room on Misty Glen (third floor). Additionally, there were no notices of the availability of such reports posted in areas that were prominent and accessible to the public. Findings include: The facility policy Resident Rights revised 2/2024 documented the facility allowed residents to examine the results of the most recent survey of the facility conducted by Federal or State surveyors including any statements of deficiencies, any plan of correction in effect with respect to the facility and any enforcement actions taken by the Department of Health. The results would be made available for examination. They would be in a place readily accessible to residents and designated representatives without staff assistance. A copy of the most recent survey reports (statement of deficiencies) is available for inspection in the Cedar Run (second floor) dining room. Inquiries concerning the examination of survey results would be referred to the Administrator and/or the Director of Nursing. During an anonymous resident group meeting on 3/12/2024 at 10:03 AM, two residents stated they did not know where the previous survey results were posted. During an observation on 3/12/2024 at 10:37 AM, the Department of Health survey results were not located on Cedar Run (second floor), Misty Glen (third floor), or the main lobby. During an observation on 3/13/2024 at 11:51 AM, the Department of Health survey results were not located on Cedar Run (second floor), Misty Glen (third floor), or the main lobby. During an observation on 3/14/2024 at 11:51 AM, the Department of Health survey results were not located on Cedar Run (second floor), Misty Glen (third floor), or the main lobby. (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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an observation and interview on 3/14/2024 at 11:37 AM Staffing Coordinator #11 was seated at their desk located at the main entrance. They stated part of their duties included allowing visitors into the facility. They had never observed the Department of Health survey results in the main lobby area. During an interview on 3/14/2024 at 11:42 AM unit clerk #10 stated the Department of Health survey results were in a pink binder on a shelf bind the Cedar Run nursing station. They stated the Department of Health survey results had been there for a while and they were unsure who placed them there. Only staff was able to go behind the desk, and non-employees would have to ask for staff assistance to view the survey results. During an interview on 3/14/2024 at 2:51 PM registered nurse Unit Manager #2 stated the Department of Health survey results were kept in a binder on a shelf in the dining room next to the audio equipment. They stated there was no signage to alert residents or visitors of the location of the survey results and they were unsure how they would know where the survey results were located without asking for staff assistance. During an interview on 3/14/2024 at 3:05 PM the Director of Nursing/ Acting Administrator stated a copy of the Department of Health survey results were in a binder behind the nursing station on Cedar Run (second floor) and in the dining room on Misty Glen (third floor). There was no signage to alert residents and visitors of the location of the survey results and the survey results were not readily accessible to view without staff assistance. They were aware that Department of Health survey results needed to be in a place readily accessible to view without staff assistance, but they thought the previous Administrator had ensured the survey results were in visible locations. 10NYCRR 415.3(1)(c)(1)(v)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48675 Based on observation, record review, and interview during the recertification survey conducted 3/11/2024-3/15/2024, the facility did not ensure nursing staff had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for 1 of 1 resident (Resident #45) reviewed. Specifically, Resident #45 used an external catheter device (a soft flexible wick that draws urine away from the body into a sealed canister using suction) to manage urinary incontinence and there was no documented evidence nursing possessed the competencies and skill sets to manage the device. Additionally, there was no medical order for use of the device. Findings include: The facility policy Compliance Training and Education revised 1/25/2023 documented employees were to be provided with ongoing training and education to mitigate noncompliance. Training/education were completed upon hire, annually, and as needed. The facility policy External urine collection device use, assigned female at birth revised 12/11/2023 documented external urine collection devices serve as an alternative to indwelling urinary catheters. The device reduces the risk of urinary tract infection, prevents incontinence associated dermatitis (irritated skin due to urine or feces), and promotes comfort. After securing the device properly, turn on the continuous suction to at least 40 millimeter of mercury, assess the patient's skin, empty the urine collection canister as needed, and replace the device every 8 to 12 hours or whenever it becomes soiled. Documentation associated with the device included: date and time of application/replacement, assessment findings, tolerance to the procedure, provider notification (if applicable), and teaching provided to the patient/family as needed. Resident #45 had diagnoses including acute kidney failure and difficulty walking. The 1/25/2023 Minimum Data Set assessment documented the resident was cognitively intact, was frequently incontinent of urine, had an external catheter, moisture associated skin damage, and was dependent on staff for toileting, personal hygiene, and bed mobility. The comprehensive care plan initiated 3/7/2024 documented the resident had alteration in skin integrity related to incontinence associated dermatitis (skin inflammation). Interventions included assessment and documentation of skin integrity upon admission and per policy, thorough skin care after episodes of incontinence with barrier cream application, and treatment for any areas of breakdown upon admission. The care plan did not include use of an external urinary catheter device. The resident Kardex (care instructions) with a print date of 3/15/2024 documented the resident was frequently incontinent and had an external catheter. The 3/14/2024 order summary report did not include a medical order for an external catheter. Nursing progress notes dated 2/22/2024-3/9/2024 did not include the use of an external catheter. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documented evidence the March 2024 treatment administration record included external catheter care and maintenance from 3/1/2024-3/14/2024. During an observation and interview on 3/13/2024 at 10:40 AM, Resident #45 was lying in bed. There was a urine collection canister on the wall, half full of clear yellow urine. Resident #45 stated they had been using an external urinary catheter device for a few months due to increased skin breakdown from incontinence. They stated it was usually changed daily by a nurse or a certified nurse aide, and some of the nurses had never worked with one before so they would need to find assistance and have someone else change it. They stated they could feel when the catheter fell off and they would have to remind staff it needed to be changed. During an interview on 3/14/2023 at 1:54 PM, certified nurse aide #7 stated they looked at the resident's care plan (Kardex) to know how to care for them. It included if they had a catheter, and what kind of assistance they needed. Resident #45 used an external urinary catheter device, but they were not sure if it was on the care plan. They thought the nurse was responsible for changing the external urinary catheter device and thought it should be changed daily. It was usually changed every shift when it became soiled. They stated they were notified by one of the nurses when resident #45 started to use the external urinary catheter device. The nurse showed them how to change it, and they did not recall if they received formal education on the device. Resident #45 notified them if it fell off and they notified the nurse. They stated it was important to know how to change the external urinary catheter device because if it was not changed properly the resident could get an infection or their skin could get worse and breakdown. During an interview on 3/14/2024 at 2:20 PM, licensed practical nurse #9 stated Resident #45 had an external urinary catheter device. They were not sure who was responsible for changing the external urinary catheter device and they had not taken care of Resident #45 since they started to use it. They stated they received education from the Nurse Manager, but they were not sure how often it had to be changed. They stated it was important to know how often it needed changed so it did not put Resident #45 at risk for infection or more skin breakdown. During an interview on 3/14/2024 at 2:31 PM, registered nurse Unit Manager #8 stated each resident had their care instructions in their room and the care instructions were generated from the care plan. The resident used an external urinary catheter device that needed to be changed every 12 hours and as needed. The nurses were responsible for changing the device. Resident #45 let the nurses know when it needed to be changed and staff knew to change it when providing care if it was soiled. They were not sure if staff needed to document in the electronic medical record when it was changed, and they did not think instructions for changing the external urinary catheter device were on the treatment administration record. They stated all the nurses on the unit watched an educational video on how to manage the external urinary catheter device, and they signed their names after receiving the education. They stated if it was not changed, or staff did not know the resident had an external urinary catheter device Resident #45 would be at increased risk for infection or skin breakdown. There was no documented evidence staff received education on the use and care of an external wick catheter device. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2024 at 3:17 PM, Director of Nursing/interim Administrator #3 stated nursing staff looked at the resident's care instructions to know how to care for them and the care instructions were generated from the care plan. The external urinary catheter device should be listed on Resident #45's care plan, so staff knew they had one and how to care for it. They stated the certified nurse aide, or the nurse could change the external urinary catheter device, but they were not sure how often it had to be changed. Registered nurse Unit Manager #8 had instructions for use and provided education to the staff on the unit. They thought nursing staff should have been documenting when the external urinary catheter device was changed, and it was important to change it as needed to prevent infections and skin breakdown. During an interview on 3/15/2024 at 8:37 AM, interim Director of Nursing #12 stated registered nurse Unit Manager #8 had nursing staff watch a video on managing the external urinary catheter device but did not have an attendance record of who received the education. 10 NYCRR 415.26(c)(1)(iv)

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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** 49448 Based on observation, record review, and interview during the recertification and abbreviated (NY00294915) surveys conducted 3/11/2024-3/15/2024, the facility did not ensure residents were free of any significant medication errors for 1 of 5 residents (Resident #34) reviewed. Specifically, Resident #34's prepared medications were left in a cup unattended on their bedside table for over 2 hours and licensed practical nurse #1 documented the medications were administered at 8:00 AM when they were not. Additionally, licensed practical nurse #1 crushed extended release medications (potassium chloride extended release and pantoprazole delayed release). Findings include: The facility policy Medication Administration revised 12/1/2020 documented the nurse should stay with the resident until the medication was swallowed and should not leave medications at the bedside. All medications were signed for at the time of administration after the resident had taken the medications. Medications could be administered an hour before or an hour after the scheduled administration time. A facility Pharmacist's Letter titled Meds that Should Not be Crushed updated February 2023 documented crushing extended-release medications could result in administration of a large dose all at once. Crushing delayed release medications could alter the mechanism designed to protect the drug from gastric (stomach) acids or prevent gastric mucosal (lining of the stomach) irritation. Pantoprazole delayed release and potassium chloride extended-release medications were included in the list of common medications that should not be crushed. The facility policy Medication Administration Standardization Schedule and Terminology revised 2/5/2024 documented all residents received their medications in a manner that optimized therapeutic effect. The standardized time schedule met the resident's needs in accordance with accepted medical and pharmaceutical practice. Medications ordered daily were given at either 8:00 AM or 9:00 AM and medications ordered twice daily were given at either 8:00 AM and 4:00 PM or 9:00 AM and 5:00 PM. Resident #34 was admitted to the facility with diagnoses including hypertension (high blood pressure), hypokalemia (low blood potassium), and gastro-esophageal reflux disease (stomach acid flows up). The Minimum Data Set assessment dated [DATE] documented the resident had moderate cognitive impairment, was independent with eating, and did not reject care. The comprehensive care plan initiated 4/27/2023 and revised 3/8/2024 documented the resident had coronary artery disease (blockage of heart arteries), hypertension, congestive heart failure (the heart does not pump efficiently), and gastro-esophageal reflux disease. Interventions included administer medications as ordered. The 4/28/2023 physician orders documented the resident was to receive the following oral medications: - amlodipine besylate (treats high blood pressure) 10 milligram oral tablet, one tablet by mouth one time a day for hypertension; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- aspirin 81 milligram chewable tablet, one tablet by mouth one time a day for coronary artery disease; - clopidogrel bisulfate (blood thinner) 75 milligram tablet, one tablet by mouth one time a day for coronary artery disease; - furosemide (diuretic) 20 milligram tablet, one tablet by mouth one time a day for edema (swelling). - lisinopril (treats high blood pressure) 20 milligram tablet, one tablet by mouth one time a day for hypertension; - potassium chloride (mineral) extended release 10 milliequivalent tablet, one tablet by mouth one time a day for hypokalemia (included on do not crush list); - pantoprazole sodium (acid reducer) delayed release 40 milligram tablet, one tablet by mouth before meals two times a day for gastro-esophageal reflux disease (included on do not crush list). There was no documented evidence of a physician order to self-administer medications or an evaluation for self-administration of medication. During an observation and interview on 3/11/2024 at 10:25 AM, Resident #34 was lying in their bed. There was a plastic medication cup on their bedside table that contained a spoon and applesauce with colorful flecks. There was no staff present in the room. The resident stated the plastic medication cup contained their morning medications for that day. The Medication Administration Record documented the following medications were administered by licensed practical nurse #1 on 3/11/2024 during the scheduled 8:00 AM medication pass. - amlodipine besylate 10 milligram oral tablet, one tablet by mouth one time a day - aspirin 81 milligram chewable tablet, one tablet by mouth one time a day - clopidogrel bisulfate 75 milligram tablet, one tablet by mouth one time a day - furosemide 20 milligram tablet, one tablet by mouth one time a day - lisinopril 20 milligram tablet, one tablet by mouth one time a day - potassium chloride extended release 10 milliequivalent tablet, one tablet by mouth one time a day - pantoprazole sodium delayed release 40 milligram tablet, one tablet by mouth before meals. (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 3/11/2024 at 11:59 AM Resident #63 stated the nurses frequently left medications on their bedside table and did not watch them take their medications. They stated the nurses knew they would take their medications. The resident stated they were concerned because someone else could take a medication from their cup. They stated licensed practical nurse #1 left a syringe on their bedside table that morning because they were not ready for their injection at that time, and they did not think that was safe. During an interview on 3/14/2024 at 2:07 PM, licensed practical nurse #1 stated they administered medications scheduled for 8:00 AM to Resident #34 on 3/11/2024. They had an hour before and an hour after the scheduled time to administer the medication. They stated they crushed the resident's medications on 3/11/2024 and put them in applesauce and it was sometimes time consuming to watch the resident take their medications. If they did not watch the resident take their medications, then they had no way of knowing they took them. There were certain medications that should not be crushed such as extended-release medications. If they were uncertain there was a document in the medication room that referenced medications that could not be crushed. If a medication was documented as administered on the medication administration record it meant they witnessed the medication taken. It was not appropriate to leave medications at the bedside because there were residents that wandered who could take medications that were not intended for them. It was not appropriate for medications to be documented as given if the medication cup was left untouched at the bedside. Syringes should not be left on bedside tables because there could be an accidental needle stick and it was also an infection control issue. During an interview on 3/14/2024 at 2:33 PM registered nurse Unit Manager #2 stated Resident #34 sometimes took medications whole one at a time and sometimes crushed. They stated some medications could not be crushed such as extended-release medications. They expected nurses to watch residents take their medications to ensure they were taken without difficulty. If it was documented as given in the medication administration record, it meant the nurse watched the resident swallow the medication. Nurses had an hour before and after scheduled administration time to give the medications. If a resident did not take the medications, they expected it to be documented as refused. It was not appropriate to leave medications at the bedside for safety reasons because anyone could take the medications. It was important residents took medications because they were ordered to address medical conditions and there could be a negative effect if they did not take them. It was also not appropriate to leave syringes on bedside tables because residents or staff could get injured. They stated they sometimes did the medication pass and many residents had told them that other nurses left medications in their room and did not watch them take them. (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 3/14/2024 at 2:54 PM the Director of Nursing stated there were medications that could not be crushed, and that information was posted in the medication room. Residents needed to be watched when given their medications to ensure they were taken. It was acceptable to give medications up to an hour before and after the scheduled administration time. If a medication was documented as given, they expected the nurse had witnessed ingestion of the medications. If a nurse did not watch the resident take the medications, they could not be certain they were taken. If a resident refused a medication, it should be documented as a refusal. It was not appropriate for medications to be left unattended at the bedside because there were residents that wandered who could take the medications. It would only be appropriate for medications to be left at bedside if there was an order and an assessment that determined a resident could safely self-administer medications. Resident #34 was not cognitively appropriate to self-administer medications and medications should not be left at their bedside. If the registered nurse Unit Manager #2 was aware that nurses were leaving medications at the bedside, they expected them to educate the nurses and write it up as a medication error. 10NYCRR 415.11(c)(3)(i)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44838 Based on observation, interview, and record review during the recertification survey conducted 3/11/2024-3/15/2024, the facility did not ensure drugs and biologicals were labelled and stored in accordance with currently accepted professional principles and included the appropriate accessory and cautionary instructions when applicable for 1 of 3 medication carts (3rd floor Team1 cart) reviewed. Specifically, the 3rd floor Team 1 medication cart contained 1 insulin pen and 1 insulin vial without an opened date, and 1 insulin pen that was expired. Findings include: The facility policy Medication Storage in the Facility dated May 2018 documented medications and biologicals were stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. When the original seal of a manufacturer's container or vial was initially broken, the container or vial was dated. The nurse placed a date opened sticker on the medication and entered the new date of expiration. The expiration date of the vial or container was 30 days unless the manufacturer recommended another date or regulations/guidelines required different dating. The facility policy, Residential Care Facility FlexPen revised 3/1/2019 documented FlexPens (prefilled insulin pens) were stored in the refrigerator until needed. Once a FlexPen was opened, it was labeled with the resident's name and date. The FlexPen no longer required refrigeration and was stored in the medication cart. The manufacturer's recommendations for expiration date were used. Manufacturer's instructions for lispro insulin (rapid acting insulin) documented once opened insulin lispro vials, prefilled pens, and cartridges were to be thrown away after 28 days. During an observation of the 3rd floor Team 1 medication cart with licensed practical nurse #1 on 3/13/2024 at 12:00 PM there was an insulin lispro pen with no opened date, an insulin lispro pen with an opened date of 2/10/2024, and an opened vial of insulin lispro with no documented opened date on the vial or box. Licensed practical nurse #1 stated all 3 insulins were currently being used for residents on the unit. The nurse stated when insulin was opened, it should be dated as a safety precaution. They could not tell when 2 of the insulins were opened because there was no date on the pen or vial. They stated they could tell the undated pen was not expired by the amount of insulin in the pen because the pens were usually used up quite quickly. Expired medications should not be used, they may not be as effective and blood sugar could stay too high. When giving insulin, they should always check expiration dates. They stated the insulin lispro pen with pen date opened of 2/10/2024, may be expired. They were not sure how long it was good for after opening. The nurse that opened the insulin was responsible for dating it so the expiration date could be determined. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/13/2024 at 12:45 PM, registered nurse Unit Manager #2 stated expired medication's potency may decrease or increase and could change the desired effect of the medication. The nurses should be checking expiration dates daily when administering medications. Pharmacy technicians came periodically to check the medication carts. The Unit Manager stated they did spot checks periodically and was not sure when they last checked the Team 1 medication cart. Insulin expired 28 days from opening and the nurse that opened the insulin should have dated it when opened. The nurse administering the insulin should check to make sure it was dated and not expired. They stated insulin may not be as effective if expired. During an interview on 3/15/2024 at 9:35 AM, the Director of Nursing stated nurses were responsible for making sure medications in the cart were not expired. During administration they should check for proper labeling and expiration dates. Expired meds may not have the expected potency and may not have the desired effect. Insulin was stored in the refrigerator until opened and should be dated when opened because insulin was only good for a specific number of days after opening. Insulin should always be checked when administered for an opened date to ensure it was not expired. 10 NYCRR 415.18(d)

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43754 44838 Based on observation, record review, and interview during the recertification survey conducted 3/11/2024 - 3/15/2024, the facility did not ensure food was stored in accordance with professional standards for food service safety in the main kitchen. Specifically, walk-in freezer #3 within the main kitchen had ice dripping from the compressor onto food that was stored below. Findings include: The facility policy Food Safety Operations and Infection Control revised 8/20/2023 documented all walk-in refrigerators and freezers have temperature dials and thermometers inside. The temperature of the thermometers and condition of the food is monitored daily. The following observations were made: - on 3/11/2024 at 9:58 AM, walk-in freezer #3 had ice dripping from the compressor onto cases of food product stored below. - on 3/12/2024 at 12:14 PM, walk-in freezer #3 had ice dripping from the compressor onto a case of bread, a gallon jug of chocolate milk, and a sheet pan of cake partially covered with plastic wrap. The ice was in contact with the cake. During an interview on 3/12/2024 at 3:22 PM, the Food Service Director stated the coolers were cleaned weekly. They stated the source of the ice was a leak from the compressor condensation. The Executive Chef periodically used a golf club to knock down the ice which had been an issue for at least a year. They believed maintenance had been informed of the problem via a work order. The Food Service Director stated it was important for food to be stored unadulterated to protect the residents from the possibility of unsafe food. The ice that dripped from the compressor onto the food below was unacceptable. During an interview on 3/15/2024 at 10:00 AM, the Executive Chef stated the freezer was cleaned and deiced monthly by the kitchen cleaner. They checked it themself at least every other week and had not removed ice from the compressor. [NAME] freezer #3 has been looked at by maintenance and an outside contractor. The seals were worn and could not be fixed. They were aware of the condensation on the walls forming ice and falling on food boxes below. It was not appropriate for ice to be on the food. They tried to keep all stored items away from the back of the cooler where they saw the ice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335768	A. Building B. Wing	03/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guthrie Cortland Medical Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/15/2024 at 11:06 AM, Facilities Supervisor stated that work orders were to be entered into the electronic system. The work was then assigned to maintenance for completion. If there was an emergency, maintenance should be called. Walk-in freezer #3 had preventive maintenance performed every 3 months and staff should notify the maintenance department if there was ice buildup in the freezer. They had not been notified that ice buildup was present in walk-in freezer #3. If ice was falling onto food products or the freezer floor, that would not be safe. They had an app on their phone that notified them of any freezer temperatures out of range and they had not received any such notifications. The Preventative Maintenance Work Orders documented walk-in freezer #3 had the evaporator cleaned, condenser cleaned, and the door gasket checked on 12/14/2023, 2/4/2023, 11/21/2022, and 3/21/2022. On 12/14/2023 and 11/21/2022 the Facilities Supervisor documented under comments, Preventative maintenance completed to manufacturer's specification. Additional documentation had an entry on 3/9/2022, Old Walk in Freezer #3, and on 8/17/2023, Freezer 3 door not closing tight. There was no documented evidence the dripping ice was addressed. 10NYCRR 415.14(h)