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	02/25/2026

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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations and interviews during the survey, the facility failed to ensure residents maintained acceptable parameters of nutritional status for three (3) of three (3) Residents (Residents #6, #43, and #74) reviewed. Specifically, Residents #6, #43, and #74 had severe weight loss, which was not addressed by the medical provider and their nutritional needs were not reassessed by the registered dietitian. Additionally, the registered dietitian recommended the addition of Liquacel (liquid protein supplement) for Resident #6 and there was no documented evidence the supplement was ordered. Failure to assess and address nutritional status resulted in immediate jeopardy to Residents #6, #43, and #74 and placed all residents with altered nutritional status at risk for serious harm, serious injury, serious impairment or death. Findings include:The facility policy Admission, Nutrition Assessment and Care Plan, revised 01/23/2026, documented nutritional problems, goals, and plan were documented in the interdisciplinary care plan. The Nutrition Assessment and interdisciplinary care plan was reviewed and adjusted at least quarterly according to the residents' needs. Additional progress notes were written at any time as the residents' conditions dictated, this included weight changes. The facility policy Weights, revised 01/06/2026, documented the facility monitored, recorded, and evaluated each resident's weights routinely as an indicator of overall health status and take corrective action as necessary. The nursing staff obtained weights unless there was a medical order for No Weights. If a resident had a weight change of five (5) pounds nursing staff obtained a re-weight within 24 hours. Nursing staff notified Dietary services of weight changes of five (5) pounds. Dietary Services addressed weight changes. Any refusals were documented in the resident's medical record. The undated facility policy Standards of Care, documented the registered dietitian used their clinical judgment and the following guidelines to determine estimated nutritional needs. The Standards of Care documented estimated calorie needs for females with unintended weights loss/weight maintenance for healthy older adults was 25-35 calories per kilogram of body weight and 30-20 calories per kilogram of body weight for males. 1) Resident #43 had diagnoses including heart failure, chronic kidney disease, and anxiety. The 11/20/2025 Minimum Data Set (a resident assessment tool) documented that the resident had moderate cognitive impairment, did not reject care, required set up or clean up assistance with eating, was 65 inches tall, weighed 111 pounds, and had unplanned weight loss of 5% or more at one (1) month or 10% or more in the past six (6) months. The 08/21/2025 Comprehensive Care Plan initiated, revised 12/02/2025, documented the resident required optimal nutrient and fluid intakes related to weight management. Interventions included interventions per nutrition standards of care, provide diet as ordered, assistance as needed, and snacks and supplements as accepting. (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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 08/21/2025 physician orders documented a regular diet. Resident #43's weight record documented the following weights: -07/02/2025, 144.5 pounds; 08/21/2025, 130.4 pounds; and 09/01/2025, 134.1 pounds. The weight record documented that the resident had a 10.4 pound weight loss from 07/02/2025 to 09/01/2025 (7.2%). The 09/02/2025 at 12:18 PM Registered Dietitian #10 progress note documented the resident had a 10.2% weight change (14.7 pounds) since 07/02/2025. The plan was to trial Ensure Plus High Protein (nutritional supplement) twice daily and continue to monitor. Resident #43's weight record documented the following weights on 10/01/2025, 120.8 pounds (9.9%/13.3-pound loss in one (1) month); and on 10/03/2025, 114.7 pounds; and 10/06/2025, 117.7 pounds. The resident had a 10% severe weight loss from 09/01/2025-10/01/2025. The 10/05/2025 at 6:38 PM Registered Nurse #3 progress note documented they spoke to the resident's family who voiced concerns about the resident possibly having issues with swallowing food and drink. The family reported the resident had lost quite a bit of weight. There was no documented evidence that the registered dietitian reassessed the resident's nutritional needs following the severe weight loss of 9.9%/13.3-pounds in 10/2025. The 10/29/2025, Physician #6 progress note documented the resident was seen for a 60 day follow up visit. They weighed 116.6 pounds, their weights were stable, and they had significant muscle wasting. There was no documented evidence that the physician was aware of the resident's severe weight loss. Resident #43's weight record documented the following weight on 11/05/2025, 117.4 pounds, re-weight 117.4 (severe 9.9%/13-pound loss in three (3) months). The 11/17/2025, Nurse Practitioner #5 progress note documented the resident was seen for a comprehensive assessment. The resident had bilateral lower extremity edema and was at risk for malnutrition. The resident had a condition or chronic disease that may result in a life expectancy of less than six (6) months. There was no documented evidence that the resident's severe weight loss was addressed. The 11/20/2025 Nutrition Assessment completed by Registered Dietitian #4 documented the resident weighed 111 pounds on 11/19/2025, their body mass index was 22, had a weight loss of 5% in one (1) month or a loss of 10% in six (6) months and was not on prescribed physician weight loss regimen. The resident was at risk for malnutrition related to limited mobility, history of depression, and psychological stress or acute disease in the past three (3) months. The resident did not accept supplements, and they would continue to monitor intakes and weights. The resident had no noted edema, their skin was intact, appeared well nourished. Their estimated daily nutritional needs were 1000-1250 calories (20-25 calories/ kilogram of body weight), 50 grams of protein (1 gram of protein (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	per kilogram of body weight), and 1000-1250 milliliters of fluids (1 milliliter of fluids per kilogram of body weight). Resident's #43 weight record documented the following weights 12/01/2025, 105.8 pounds, (severe 9.8%/11.6-pound loss in two (2) months and 21.1% /28.3-pound loss at three (3) months); 12/03/2025, 110 pounds; 01/02/2026, 96.8 pounds, re-weight 96.7 pounds (severe 12%/13.3-pound loss at one (1) month, severe 17.5%/20.6-pound loss at three (3) months and 33%/47.7-pound loss at six (6) months); 01/07/2026, 91.2 pounds, re-weight 91.2 pounds (severe 5.7%/5.6-pound loss in five (5) days). There was no documented evidence that Registered Dietitian #4 reassessed the resident's nutritional needs after the November 2025 nutritional assessment and the resident continued to have severe weight loss. The 12/31/2025 Physician #6 progress note documented the resident was seen for a 60 day follow up visit. Their weight was 96.7 pounds, their weight was stable, and they had significant muscle wasting. There was no documented evidence that the resident's severe weight loss was addressed. The 01/25/2026, Nurse Practitioner #5 progress note documented the resident was seen for a comprehensive assessment, the resident had minimal bilateral lower extremity edema and was at risk for malnutrition. The resident had a condition or chronic disease that may result in a life expectancy of less than six months. There was no documented evidence that the resident's severe weight loss was addressed. During an interview on 02/10/2026 at 10:25 AM, Registered Nurse Unit Manager #9 stated significant weight changes were discussed during the monthly weight meetings attended by Registered Dietitians #4 and #10, Nurse Practitioner #5, the Director of Nursing, Minimum Data Set Registered Nurse, and the registered nurse unit managers. The team discussed significant weight changes and anything that could impact the resident's weight status. The registered nurse managers also notified Nurse Practitioner #5 about significant weight changes via electronic communication. Resident #43 had lost weight and their intakes wavered. Staff encouraged the resident to eat at meals, and their significant other would also come in to provide encouragement. Staff offered snacks or alternatives if their intakes were not good at meals. The resident was discussed frequently at the monthly weight meeting, and they thought the registered dietitian and medical providers were addressing the significant weight loss. During an interview on 02/10/2026 at 02:35 PM, Registered Dietitian #4 stated a resident triggered for a significant weight change if they lost or gained 5% in one (1) month, 7.5% in three (3) months, and 10% in six (6) months. The facility had a monthly weight meeting and all residents with significant weight changes were discussed. The nurse practitioner, Director of Nursing, and unit managers attended the meeting. They stated if a resident triggered for a significant weight change, they documented in a progress note and discussed any interventions. They did not always reassess the resident's nutritional needs right away if there was a significant weight change as they looked at the whole picture. They talked to the resident or family, updated menus, and asked if the resident was willing to try supplements. If a resident triggered a significant weight change, the facility completed a significant change assessment. They would complete a full comprehensive nutritional assessment at that time. They stated Resident #43 did have a significant weight loss in October 2025 and they did (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	not document a note addressing the resident's significant weight loss and did not reassess their nutritional needs at that time. They stated they should have documented and were unsure why they did not. They also did not document a note about the residents' significant weight losses in December 2025 and January 2026. They were unsure why they did not address the weight loss and did not reassess the residents' needs. The resident was discussed in the monthly weight meeting and medical stated they had a poor prognosis. 2) Resident #74 had diagnoses including Parkinson's disease (a progressive neurological disease), dysphagia (difficulty swallowing), and dementia. The 12/05/2025 Minimum Data Set documented the resident had severely impaired cognition; did not reject care; required supervision or touching assistance with meals; was 60 inches tall; weighed 105 pounds; and did not have any significant weight changes in the last one (1) or six (6) months. The 10/25/2025 physician order documented a mechanical soft (ground diet). The Comprehensive Care Plan, revised 12/18/2025, documented the resident was at risk for malnutrition related to decreased intakes, history of weight loss, and dementia. Interventions included to monitor for swallowing difficulties, notify medical of refusals of meals, report significant weight changes to medical, provide diet as ordered, and offer snacks and supplements as accepted. The resident required supervision or touching assistance intermittently throughout meal. Resident #74's weight record documented a weight of 115.2 pounds on 10/01/2025. The 10/01/2025 Nutrition Assessment completed by Registered Dietitian #10 documented the resident weighed 112.9 pounds, their body mass index was 22, and they had a significant weight loss of 5% at one (1) month or 10% at six (6) months. The resident refused oral nutritional supplements and chocolate ice cream was added to their lunch and dinner meals. Their estimated daily nutritional needs were 1530-1785 calories (30–35 calories per kilogram of body weight), 51-61 grams of protein (1-1.2 grams of protein per kilogram of body weight), and 1785-2040 milliliters of fluid (35-40 milliliters of fluid per kilogram of body weight). The resident's average meal intakes were 31% and 636 milliliters of fluid. The plan was to continue with diet as ordered, monitor weights and labs as available, and update preferences as needed. Resident #74's weight record documented the following weights; on 11/03/2025, 106.0 pounds (severe 7.9%/9.2 pound loss at one (1) month and severe 8.6%/10 pound loss at three (3) months); 11/17/2025, 107.7 pounds; 11/19/2025, 106.6 pounds; There was no documented evidence that the registered dietitian reassessed the residents' nutritional needs following the severe weight loss of 7.9%/9.2-pounds in November of 2025. The 11/29/2025, Nurse Practitioner #5 progress note documented the resident was seen for a comprehensive assessment. The resident was frail and had Parkinson's disease and dementia, received a mechanical soft diet, and had severe protein/calorie malnutrition. The resident had a life expectancy of less than six (6) months related to a condition or chronic disease. There was no documented evidence the resident's severe weight loss was addressed. Resident #74's weight record documented on 12/01/2025, 104.9 pounds. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 12/10/2025 Nutrition Assessment completed by Registered Dietitian #10 documented the resident weighed 104.9 pounds, their body mass index was 21, and they had an 8.9%/10.3 pound weight loss since 10/01/2025. Their estimated daily nutritional needs were 1440-1680 calories (30–35 calories per kilogram of body weight), 48-58 grams of protein (1-1.2 grams of protein per kilogram of body weight), and 1680-1920 milliliters of fluid (35-40 milliliters of fluid per kilogram of body weight). The resident's average meal intakes were 25% and 603 milliliters of fluid. The plan was to continue with diet as ordered, monitor weights and labs as available, and update preferences as needed. Resident #74's weight record documented 01/07/2026, 102 pounds (severe 11.4%/13.2 pound loss at three (3) months). There was no documented evidence that Registered Dietitian #10 reassessed the resident's nutritional needs following the severe weight loss of 11.4%/13.2-pounds in January of 2026. The 01/19/2026, Nurse Practitioner #5 progress note documented the resident was seen for a comprehensive assessment, continued on a mechanical soft diet and had severe protein/calorie malnutrition. The resident had a life expectancy of less than six (6) months related to a condition or chronic disease. There was no documented evidence the resident's severe weight loss was addressed. During an interview on 02/10/2026 at 12:16 PM, Registered Nurse Unit Manager #12 stated the dietitians, Director of Nursing, nurse managers, and nurse practitioner met monthly to review significant weight changes. The team reviewed significant weight changes and discussed them. Medical and the registered dietitians documented significant weight changes. Resident #74 refused supplements and liked chocolate. The resident lost weight, and they were unsure of the etiology of the weight loss. The team had discussed the resident's weight loss in the monthly weight meetings. During an interview on 02/10/2026 at 1:34 PM, Registered Dietitian #10 stated nursing staff obtained resident weights and if there was five (5) pound weight change since the previous documented weight, a reweight was obtained. Significant weight changes were 5% or more in one (1) month, 7.5% or more in three (3) months, and 10% or more in six (6) months. If a resident triggered for a significant weight change, the team discussed the weight change in the monthly weight meeting with the interdisciplinary team, including medical. Resident #74 had a significant weight change in November of 2025. They did not document the resident's significant weight change but did complete a nutritional assessment in December of 2025. There were no new nutritional interventions to the resident's plan of care. They did not document the resident's significant weight loss in January 2026 and there were no nutritional interventions to the resident's plan of care. They did not always document significant weight changes because they were discussed in the monthly meeting. During an interview on 02/10/2026 at 4:43 PM, Nurse Practitioner #5 stated they were made aware of significant weight changes in the monthly weight meeting. They assessed the residents as needed. During the meeting, the team reviewed intakes and looked at possible causes of weight changes. They did not routinely document significant weight changes in their notes due to time constraints. They had not told anyone at the facility they were not documenting significant weight changes and were aware they should be documenting significant weight changes. Resident #43 was fading away, had heart failure and was on comfort care, but weights were still being obtained. The resident had a life expectancy of less than six (6) months. The resident was discussed at the monthly weight (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	meeting, and they were aware of their significant weight loss and did not document on their significant weight loss. They thought their weight loss could be attributed to their disease process. If weights were not being followed, it could impact a resident's skin and nutritional status. They were not aware the registered dietitians were not documenting significant weight changes. 3) Resident #6 had diagnoses including kidney disease, dialysis (filtration of blood when kidneys do not function properly), diabetes, colostomy (artificial opening in abdomen to collect stool), and urostomy (artificial opening in the abdomen that collects urine). The 01/16/2026 Minimum Data Set documented the resident was cognitively intact, required set up or clean up assistance with eating, was 72 inches in height, weighed 175 pounds, and had weight loss of 5% or more at one (1) month or 10% or more in the past six (6) months. The Comprehensive Care Plan initiated 11/26/2025 and revised 01/16/2026 documented the resident qualified for malnutrition related to weight loss, limited mobility, psychological stress or acute disease in the past three (3) months, history of depression, and multiple pressure injuries. Interventions included monitor intake, weights, labs, bowels, skin, and other nutrition related parameters were monitored. Resident #6's weight record documented the following weights: on 11/11/2025 193.6 pounds; 11/25/2025 186 pounds (a 3.9%/7.6 pound weight loss in 2 weeks); and 11/26/2025 188.5 pounds. The 11/26/2025 Nutrition Assessment completed by Registered Dietitian #10 documented the resident weighed 186 pounds, had a body mass index of 25 (normal), had weight loss of 5% in one (1) month or a loss of 10% in (6) six months and was not on prescribed physician weight loss regimen. The resident qualified for malnutrition related to weight loss, limited mobility, psychological stress or acute disease the past three months, and history of depression. They would continue the resident on Liquacel (nutritional supplement) three (3) times a day from previous admission and would continue to communicate with the dialysis registered dietitian for any further recommendations or requests. Intakes were monitored and improved consistency of weights. The resident had no noted edema, had an unstageable pressure injury on coccyx (improving), right third and fourth toe (improving), and appeared well nourished. Their estimated daily nutritional needs were 1700-2125 calories (20-25 calories/kilogram of body weight), 127-170 grams of protein (1.5-2 gram of protein per kilogram of body weight), and 1800 milliliters of fluid restriction per medical doctor. There was no documented evidence of a physician order for Liquacel. There was no documented evidence of Liquacel included on the 12/2025, 01/2026, and 02/2026, Medication Administration Record and Treatment Administration Records. Resident #6's weight record documented the following weights: 11/28/2025 186.3 pounds; 12/01/2025 183 pounds; 12/03/2025 176.4 pounds and reweigh 176.5 pounds (a weight loss of 3.6%/ 6.6 pounds in two (2) days and 8.9%/ 16.6 pounds in three (3) weeks); and 12/23/2025 175 pounds (a severe 9.6%/18.6-pound weight loss in six (6) weeks). The 12/28/2025 Nutrition Assessment completed by Registered Dietitian #10 documented the resident weighed 175 pounds, their body mass index was 24, they had weight loss of 5% in one (1) month or a loss of 10% in six (6) months and was not on prescribed physician weight loss regimen. The resident qualified for malnutrition related to weight loss, limited mobility, psychological stress or acute disease in the past three (3) months, and history of depression. They would continue the resident on Liquacel three (3) times a day from previous admission and would continue to (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	communicate with the dialysis registered dietitian for any further recommendations or requests. Intakes were monitored and improved consistency of weights. The resident had no noted edema, had pressure injuries to left knee, coccyx, right third and fourth toes and appeared well nourished. Their estimated daily nutritional needs were 1580-1975 calories (20-25 calories/kilogram of body weight), 119-158 grams of protein (1.5-2 grams per kilogram of body weight), and 1800 milliliters of fluid restriction per medical doctor. Physician orders documented: -On 01/13/2026 the resident was on a renal and a fluid restricted diet with a total volume of 3000 milliliters a day. -On 01/16/2026 the resident was malnourished. Resident #6's weight record documented the following weights: 01/14/2026 183 pounds; and 01/16/2026 178.3 pounds (a 2.6%/4.7 pound weight loss in two (2) days). The 01/19/2026 Nutrition Assessment completed by Registered Dietitian #10 documented the resident weighed 178.3 pounds, their body mass index was 24, they had weight loss of 5% in one (1) month or a loss of 10% in six (6) months and was not on prescribed physician weight loss regimen. The resident qualified for malnutrition related to weight loss, limited mobility, psychological stress or acute disease in the past three (3) months, and history of depression, and multiple pressure injuries. They would continue the resident on Liquacel three (3) times a day from previous admission and would continue to communicate with the dialysis registered dietitian for any further recommendations or requests. Intakes were monitored and improved consistency of weights. The resident had no noted edema, had pressure injuries to left knee, coccyx, right third and fourth toes and appeared well nourished. Their estimated daily nutritional needs were 1620-2025 calories (20-25 calories/ kilogram of body weight), 122-162 grams of protein (1.5-2 gram of protein per kilogram of body weight), and 1800 milliliters of fluid restriction per medical doctor. Resident #6's weight record documented the following weights: 02/04/2026 163.5 pounds (a 10.6%/19.5 pound weight loss in three (3) weeks); 02/06/2026 164.4 pounds (a severe 15.1%/29.2 pound weight loss in three (3) months). The 02/04/2026 Physician #6 progress note documented the resident's chart was reviewed and they had a discussion of care goals and treatment plan with the resident's spouse. A review of systems was not performed as they did not see the resident. The spouse requested the physician speak with the resident about the possibility of trying mirtazapine (medication) for appetite stimulation. The plan was to discuss with the resident when they saw them next week. There was no documented evidence Physician #6 was aware of the resident's severe weight loss. During an observation and interview on 02/02/2026 at 12:44 PM, the resident was lying in bed dressed and had just returned from dialysis. Their lunch was untouched on the over-the-bed table. They stated they did not want the sandwich, and they were going to ask staff for a salad. During an interview on 02/10/2026 at 10:09 AM, Resident #6 stated they lost weight. The dietitian at dialysis spoke with them often about their phosphorus and potassium intake. They did not recall any specific conversations with the facility's dietitian. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 02/10/2026 at 10:59 AM, Registered Nurse Manager #12 stated there were monthly weight meetings. Resident #6 had weight loss. They stated they used the weights from dialysis and those were entered into the electronic medical record by the registered dietitian. During an interview on 02/10/2026 at 1:34 PM, Registered Dietitian #10 stated there was a monthly weight meeting. If there was a 5% loss in a month, 7.5% in three (3) months, or 10% in six (6) months it was considered a significant change. If this significant change was identified the resident was put on weekly weights. For Resident #6, it was a team effort between dialysis and the facility. They were working on better communication with the registered dietitian at the dialysis center. The dietitian at dialysis emailed the resident's weights to them every two (2)- three (3) weeks. Weights were obtained at dialysis because weights were inconsistent with the facility staff and there were large changes that they could not verify if they were accurate. The resident had a decline in the past few weeks. The resident did not like the food and often refused meals, but they were on a supplement. They followed the direct recommendations from dialysis. Upon review of their standards of care document, they were not meeting the resident's nutritional needs. They had not reassessed the resident since their readmission in January 2026. During an interview on 02/10/2026 at 4:05 PM, Nurse Practitioner #5 stated they attended the monthly weight meetings and anyone with significant weight loss was discussed. They did not recall being notified of any significant weight loss for Resident #6. If they had, they would have contacted dialysis and talked to their nephrologist (kidney doctor) as they should oversee the resident's care. They had not seen the resident. If they had, they would have documented a note. They were one person and relied a lot on the nurses. 10 New York Codes, Rules and Regulations 415.12(i)(1) Immediate Jeopardy was identified, and the Administrator was notified on 02/24/2026 at 10:59 AM. Immediate Jeopardy was removed on 02/25/2026 at 12:38 PM based on the following corrective actions: -Policies and Procedures were revised to include reweight parameters, registered dietitian assessments for significant weight changes, provider notifications, and nutritional supplement orders. -100% of in-house staff were educated on the updated policies and procedures with a plan to educate all staff prior to their next scheduled shift. -All residents' weights were reviewed and residents with weight loss were assessed by the registered dietitian and the medical provider was notified. All nutritional supplements were included in physician orders. -Staff were interviewed and were able to accurately report the educational content.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews during the recertification survey, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices for one (1) of one (1) resident (Resident #6) reviewed. Specifically, -Resident #6 required a colostomy (a surgical opening in the abdomen that allows stool to pass out of the body) and did not have orders for changing the appliance and was not provided with appropriate colostomy supplies.-Resident #6 required use of a urostomy (surgical opening in the abdomen that allows urine to pass out of the body) and there were no orders to change the appliance. -the person-centered comprehensive care plan did not include the diagnoses of diabetes mellitus and insulin use, use of an anticoagulant (blood thinner), or the use of opiates (narcotic pain medication). -the physician was not notified when the resident had low blood pressure. Findings include: The facility policy Colostomy and Ileostomy Appliance Care, Long-Term Care, revised 12/15/2025, documented a resident with a colostomy wore an external pouch to collect emerging fecal matter. The pouching system that a resident used depended on which type provided the best adhesive seal and skin protection. Documentation associated with colostomy appliance care included the date and time the pouching system was applied or changed, the drainage characteristics, the appearance of the stoma and surrounding skin, and type of appliance applied. The facility policy Urostomy Care, Home Care, revised 12/15/2025 documented the resident was required to wear a urine collection appliance or pouching system. Nursing care included the stoma and surrounding skin was assessed, and the pouching system was emptied and replaced. Documentation included the date and time of urostomy care, the amount and characteristics of urine in the pouch, as well as stoma and surrounding skin assessment.The facility policy [Minimum Data Set] Assessment and Care Plans, revised 06/02/2025, documented care plans reflected the residents' medical and nursing assessment. The facility policy Notification of Changes to Provider, effective 01/23/2026, documented any unusual change in vital signs was reported to a physician/ nurse practitioner in a timely manner with documented evidence noted in the clinical electronic medical record by the licensed nurse. Resident #6 had diagnoses including diabetes, colostomy and urostomy status, and long term use of insulin, anticoagulants, and opiates. The 01/16/2026 Minimum Data Set assessment (a health status assessment tool) documented the resident was cognitively intact, had diagnoses of high blood pressure, low blood pressure with position changes, and diabetes, had a colostomy and a urostomy, and received insulin, anticoagulants, and opiates. The Comprehensive Care Plan initiated 11/25/2025 documented the resident had a colostomy bowel appliance. Interventions included the appliance was changed weekly with shower and emptied every shift and as needed and the drainage bag was emptied as needed. The care plan did not include the specific type of appliance. The resident had a urostomy appliance. Interventions included intake and output were monitored per facility policy, and signs and symptoms of discomfort on urination and frequency were monitored. The care plan did not include the specific type of appliance or frequency the drainage bag was emptied or changed. The person-centered care plan did not address the diagnosis of diabetes, or the use of insulin, anticoagulants, and opiates. Physician orders documented:-On 01/13/2026 colostomy and urostomy care every shift.-On 01/13/2026 hydromorphone hydrochloride (opiate) oral tablet 4 milligrams every 12 hours as needed for moderate/ severe pain-On 01/14/2026 apixaban (anticoagulant) oral tablet 5 milligrams, give a half tablet by mouth twice daily for a history of deep vein thrombosis (blood clot).-On 01/14/2026 Humalog mix 50/50 subcutaneous suspension (short acting insulin) as per sliding scale (amount of insulin is based on blood sugar results) subcutaneously with meals for diabetes mellitus. There was no documented evidence of physician orders to change the colostomy or urostomy appliances.On 01/28/2026 at 12:00 AM the Vitals Summary by Registered Nurse #27 documented a blood pressure of 82/58 (low).There was no documented evidence that the physician (continued on next page)

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	335768	A. Building B. Wing	02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Guthrie Cortland Medical Center	134 Homer Avenue Cortland, NY 13045

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was notified of the low blood pressure. During an observation and interview on 02/02/2026 at 12:44 PM, Resident #6 was lying in bed. They stated they had a urostomy and colostomy and they could care for them themself but had to ask for supplies. The facility was out of colostomy supplies, so their spouse ordered some off the internet, but they had not come in yet. They had to change the colostomy bags more often than the urostomy bags. Staff had to help clean them up today after dialysis because their bag burst. They were using urostomy bags for their colostomy because the facility was out of colostomy bags. They lifted their shirt and the urostomy and colostomy appliances were identical; they were [NAME] bags with a twist drainage port. They stated they had used a urostomy bag for the colostomy site last night as well. During a follow up interview on 02/05/2026 at 9:43 AM, the resident stated the supplies their spouse ordered on the internet came in yesterday. When they had to use the urostomy appliance instead of the colostomy appliance they had to change it more often because the drain port was not equipped to drain any chunks and the seal was not equipped for the acidity. The facility did provide them with more urostomy supplies and the facility still did not have any colostomy supplies for them.During an observation on 02/05/2026 at 2:52 PM of the clean utility room, there were no ostomy supplies. During an observation on 02/05/2026 at 3:02 PM of the medication room, there were no ostomy supplies. During an interview on 02/06/2026 at 2:20 PM, Certified Nurse Aide #15 stated the resident's spouse ordered colostomy supplies on the internet last weekend. They thought the hospital supplied them but last weekend they ran out of supplies because they were going through three bags a shift. The resident had to use urostomy bags last weekend because they did not have colostomy bags. The bags were different, the colostomy bags rolled up with Velcro or a clip, the urostomy bag had a twist cap. The urostomy bag was smaller and did not hold as much. The resident taped the urostomy bag because it was not staying on the colostomy site. They thought the medication room was where extra supplies were kept but the resident kept their supplies in their closet. During a follow up interview on 02/09/2026 at 1:59 PM, Certified Nurse Aide #15 stated the care plan told them what the resident needed. They referenced it every day because it changed. If a resident was diabetic, they could not cut their toenails. They were not sure if Resident #6 was diabetic or what medications they were on.During a telephone interview on 02/10/2026 at 8:41 AM, Registered Nurse #27 stated when a resident's blood pressure was really off, they contacted the on-call provider. If they called the on-call provider, they would chart a nursing note. Resident #6's blood pressure was normally in the 130's. They did not recall the blood pressure of 82/58 on 01/28/2026 and it was a concerning blood pressure. Resident #6 was very sick and that blood pressure could indicate sepsis. They often took residents' blood pressures on the night shift, but they usually had a workload of 35 patients and that was a lot.During an interview on 02/10/2026 at 10:09 AM, Resident #6 stated the facility still had not provided them with colostomy supplies and they were on their last urostomy bag. During an interview on 02/10/2026 at 10:25 AM, Licensed Practical Nurse #19 stated they told Registered Nurse Manager #12 if they needed more colostomy or urostomy supplies during the week. Over the previous weekend, they asked the resident's spouse to order more colostomy supplies because they did not know how to order them on the weekends. Because the residents had liquid stools, they could use urostomy bags. They asked Registered Nurse Manager #12 to order more urostomy supplies today. There was no documentation when the bag was changed. Blood pressures lower than 100/60 were considered low and they should tell Registered Nurse Manager #12 if the resident had low blood pressure. Care plans were completed by Registered Nurse Manager #12. They referred to the care plans for a resident's transfer status. They were not sure if there should be diabetic or high-risk medication care plans. They relied on the registered nurses for that. During an interview on 02/10/2026 at 10:59 AM, Registered Nurse Manager #12 stated ostomy supplies were ordered from central supply. There was a new process and not everyone knew how to do it. Nurse managers, unit secretaries and charge nurses have been trained so far. There was no trouble getting ostomy supplies. They ordered supplies from home before if staff reached out to them on the weekend. Resident #6 was going through a lot of colostomy supplies. They did not know (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was using urostomy supplies for their colostomy. They ordered colostomy supplies on 02/03/2026 and ordered 5 bags and 5 wafers of all 3 sizes because they did not know which size was needed. This last shipment they asked nursing staff to keep in the medication room so they could keep a better eye on it and order more supplies when they were down to 1-2. Ostomy appliances should be changed weekly on shower days. They referenced the resident's orders and did not see an order to change their urostomy and colostomy appliances on shower days. If there was no documentation, there was no proof it was done. The provider was notified for a blood pressure that was lower than 90. Diabetic residents had a care plan for that diagnosis. There were also care plans for high-risk medications, like insulin, anticoagulants, and opiates. Care plan would alert the staff what side effects to monitor for. In reviewing Resident #6's care plan, they did not have a diabetic care plan, or a care plan for their high-risk medications of insulin, anticoagulant, and opiates. The resident had been back and forth so much from the hospital, and they must have missed it. 10 New York Codes, Rules, and Regulations 415.12

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interviews during the recertification survey, the facility failed to ensure residents were provided food and drink that was palatable, flavorful, and at an appetizing temperature for one (1) of one (1) meal reviewed (the 02/09/2026 lunch meal) and 10 of 10 anonymous residents during a resident council meeting. Specifically, food was not served at palatable and appetizing temperatures during the lunch meal on 02/09/2026 and 10 anonymous residents during a resident council meeting stated the food was cold. Findings include:The facility policy Food Safety and Infection Control, last revised 07/02/2025, documented food and sauces were held at a temperature of 135 degrees Fahrenheit.The 11/24/2025 Test Tray Audit form documented entrees, soups and hot beverages should be 135 degrees Fahrenheit or above.During a meal observation on 02/09/2026 at 12:26 PM, Resident #46 was served their lunch tray. A replacement tray was ordered, and Resident #46's original meal tray was tested. At 12:26 PM, Registered Nurse #14 verified the measured food temperatures. The chicken tenders measured 114 degrees Fahrenheit and were chewy.During an interview on 02/02/2026 at 12:44 PM Resident #46 stated food was cold, there was no variety and the quality was poor. During an interview on 02/10/2026 at 03:30 PM, the Food Service Director stated they had a monthly food council where residents talked about flavors and textures of food. They had never heard of cold food complaints. They completed food temperature checks at the start of the meal services. Hot food should be served at 135 degrees Fahrenheit and should be palatable. If the temperature was not in the danger zone it was ok. The chicken tenders should be hotter than 114 degrees Fahrenheit and not chewy. The food might be getting soft in transit to the floors. They stated when they placed the lid on it the steam could make the product chewy.10 New York Codes, Rules and Regulations 415.14(d)(1)(2)

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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. Based on observations, record review, and interviews during the recertification survey, the facility failed to consult with the physician when there was a significant change in the resident's physical status for one (1) of one (1) resident (Resident #6) reviewed. Specifically, Resident #6 returned from the emergency department on 01/30/2026 with a diagnosis of clostridioides difficile (a highly contagious bacteria causing diarrhea) and instructions to start vancomycin (an antibiotic) 125 milligram capsule every six (6) hours for ten (10) days and the physician was not notified. Subsequently, the antibiotic was not ordered until five days later on 02/04/2026. Findings include:The facility policy, Admission/ readmission Process of a New Resident, revised 01/23/2026, documented if a resident was admitted to the facility without discharge orders, nursing staff would contact the discharging facility. The nurse manager/ designee would discuss the resident's condition, status, and orders with the medical provider. The facility policy, Notification of Changes to Provider, effective 01/23/2026 documented that physician/ provider was notified of any changes in physical or mental status or any unusual occurrences of the residents by the charge nurse. Notification was documented in the progress notes of the residents' chart. Consult/ emergency department recommendations were reported to the physician/ nurse practitioner in a timely manner with documented evidence noted in the clinical electronic medical record by the licensed nurse. Resident #6 had diagnoses including kidney disease with dialysis (filtration of blood when kidneys do not function properly), diabetes, and colostomy (surgical opening from intestine that redirects stool into a collection bag). The 01/16/2026 Minimum Data Set assessment documented the resident had intact cognition, required set up/clean up assistance with toileting, and had an ostomy appliance. The Comprehensive Care Plan initiated 11/25/2025 documented the resident had a colostomy appliance. Interventions included emptying the drainage bag as needed, changing the appliance weekly with shower, emptying every shift and as needed, and gastroenterology consult as ordered. The 01/30/2026 hospital after visit summary documented diagnoses including clostridioides difficile diarrhea. Instructions included to start vancomycin 125 mg capsule every 6 hours for 10 days. The 01/30/2026 at 10:47 PM Licensed Practical Nurse #20 progress note documented the resident returned from the emergency department around 6:00 PM. No new orders were found with the resident. There was a new diagnosis of clostridioides difficile, and all precautions were in place.The 02/04/2026 physician orders documented vancomycin 125 mg capsule every 6 hours for 14 days for clostridioides difficile and contact/gastrointestinal precautions maintained. During an observation and interview on 02/02/2026 at 12:44 PM, there was a gastrointestinal precaution sign on the resident's door. The resident was lying in bed and stated they were on precautions and antibiotics for a diagnosis of clostridioides difficile. During an interview on 02/06/2026 at 2:20 PM, Certified Nurse Aide #15 stated Resident #6 was on precautions because they had clostridioides difficile.During an interview on 02/10/2026 at 10:09 AM, Resident #6 stated the emergency department told them they were going to start an antibiotic. The hospital did not provide discharge paperwork and said they would send the paperwork over to the facility. During a telephone interview on 02/10/2026 at 11:43 AM, Licensed Practical Nurse #20 stated they were assigned Resident #6 when they returned to the facility with a clostridioides difficile diagnosis. The resident did not return with paperwork, and they stated they should have called the emergency department, but they did not. They should have also called the provider on call and let them know, but they did not. The resident's spouse told them the resident had clostridioides difficile. Residents were usually on vancomycin for clostridioides difficile, but they were not sure if Resident #6 had an order for that antibiotic. Antibiotics should be given as soon as possible after an infection was identified.During an interview on 02/10/2026 at 10:59 AM, Registered Nurse Manager #12 stated if a resident returned without discharge paperwork, the nurse assigned was responsible to call the emergency department and request the paperwork. The nurse assigned to (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident was also responsible for notifying the provider. They stated in report the following Monday morning (02/02/2026) they were informed Resident #6 had clostridioides difficile. They did not look at the paperwork or see if the resident was ordered an antibiotic. During an interview on 02/10/2026 at 4:05 PM, Nurse Practitioner #5 stated when residents went to the hospital or returned to the hospital, it was discussed in morning report. They were not made aware of Resident #6's 1/30/2026 emergency department visit until 02/04/2026 and that is when they ordered the antibiotic for their diagnoses of clostridioides difficile. They were not on call when the resident returned to the facility. They were upset that this was missed. They were one person and relied a lot on the nurses. 10 New York Codes, Rules, and Regulations 415.3(2)(ii)(a)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, record review, and interviews during the recertification survey, the facility failed to ensure that residents who required dialysis services (filtration of blood when the kidneys do not work efficiently) received such services consistent with professional standards of practice for one (1) of one (1) resident (Resident #6) reviewed. Specifically, Resident #6 received hemodialysis treatments at a community-based dialysis center and did not have on-going assessments and oversight before and after dialysis treatments, there was no documented evidence the resident's dialysis access site (Permacath, a central catheter) was routinely assessed, and there were no physician orders for dialysis, pre or post dialysis assessments, or dialysis vascular site monitoring.Findings include:The facility policy, Offsite Hemodialysis Care and Coordination, revised 12/31/2025, documented a continuous 24-hour communication process was maintained between the facility and the dialysis center. Before each treatment a licensed nurse monitored the resident's vital signs, weight, and general condition as ordered by the physician. The facility checked and monitored the resident's vascular access site. Upon the resident's return, the nursing staff performed an immediate assessment, including vital signs and an examination of the vascular access site for bleeding or other complications. Staff monitored post-dialysis symptoms such as dizziness, nausea, vomiting, or fatigue. Resident #6 had diagnoses including end stage kidney disease, dependence on renal dialysis, and diabetes. The 01/16/2026 Minimum Data Set assessment documented the resident was cognitively intact, was medically complex, had end stage kidney disease, and required dialysis treatments.The Comprehensive Care Plan initiated 11/25/2025 documented the resident received dialysis on Monday, Wednesday, and Friday. Interventions included the vascular access site was checked daily and as needed. The care plan did not specify the location, type of access site, or what specifically the site was checked for.There was no documented evidence of a physician order for dialysis, pre or post dialysis assessments, or dialysis vascular site monitoring. The dialysis and nursing home handoff communication tool documented the resident attended dialysis on 01/16/2026, 01/19/2026, 01/21/2026, 01/23/2026, 01/26/2026, 01/28/2026, 01/30/2026, 02/02/2026, 02/04/2026, and 02/06/2026. There was no documented evidence of a pre-dialysis evaluation on 01/23/2026.There was no documented evidence of a post-dialysis evaluation on 01/16/2026, 01/28/2026, and 02/02/2026.During an interview on 02/09/2026 at 1:59 PM, Certified Nurse Aide #15 stated Resident #6 left for dialysis at the time they started their shift. There was a binder that went with them. When the resident returned from dialysis, they got back in bed and had lunch. They stated they were careful with helping to take the resident's shirt off and pulling it down because they had a port. During an observation and interview on 02/10/2026 at 10:09 AM, Resident #5 was seated in their wheelchair in their room. The resident lifted their shirt for the surveyor, and they had a dual lumen right chest Permacath for dialysis, covered with a white dressing that was clean, dry, and intact. The lumens were also wrapped with a white dressing that was clean, dry and intact. The resident stated staff at the facility did not look at their access site and the dressing was changed at dialysis. During an interview on 02/10/2026 at 10:25 AM, Licensed Practical Nurse #19 stated when Resident #6 came back from dialysis they took their vital signs and documented them on the paper sheet. The resident had a right chest port, but they were not sure what it was called. They stated it was checked by the nurse every shift. They were not sure if this was documented anywhere. During an interview on 02/10/2026 at 10:59 AM, Registered Nurse Manager #12 stated there was a communication sheet for Resident #6 that was completed by the nurse before and after dialysis. If the communication sheet was not completed, there should be a nurse's note. The dialysis site was only checked on dialysis days. 10 New York Codes, Rules, and Regulations 415.12(k)