STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335412	A. Building B. Wing	05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cooperstown Center for Rehabilitation and Nursing	128 Phoenix Mills Cross Road Cooperstown, NY 13326

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48413 Based on record review and interviews during the recertification and abbreviated survey (Case #NY00324855), the facility did not ensure the resident's right to be free from neglect for 1 (Resident #45) of 6 residents reviewed for abuse and neglect. Specifically, on 9/19/2023, Certified Nurse Aide #4 did not use two staff for bed mobility as documented in Resident #45's Comprehensive Care Plan while providing care to the resident. Resident #45 rolled out of bed onto the floor. This is evidenced by: Resident #45 was admitted to the facility with diagnoses of hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure), chronic obstructive pulmonary disorder (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and morbid (severe) obesity. The Minimum Data Set (an assessment tool) dated 4/01/2024, documented the resident had moderately impaired cognition, could usually understand others and be understood. The Policy and Procedure titled, Abuse, with a review date of 12/2022, documented neglect was defined as the failure of the facility, employees, or service providers to provide goods and services to a resident that were necessary to avoid physical harm, pain, mental anguish, or emotional distress. Additionally, the policy defined neglect as the failure to provide a resident with personal safety. The Comprehensive Care Plan titled, Assistance in Activities of Daily Living, dated September 2023, documented the resident was dependent on two staff members for bed mobility. The Certified Nursing Aide Kardex (resident care card followed by Certified Nurse Aides to provide care), for September 2023, documented the resident was dependent and required two staff members for bed mobility. Record review of the nursing progress note dated 9/19/2023 at 5:28 PM documented the nursing staff was called to the resident's room for observations after the resident fell off the bed during care. The resident was found on the floor complaining of head pain and pain all over. The resident was sent to the hospital for further evaluation. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Accident and Incident report, dated 9/19/2023 at 05:28 PM, documented Resident #45 fell out of bed and was lying on their back complaining of head and body pain. Certified Nurse Aide #4 was the only documented witness to the event. The statement by Certified Nurse Aide #4 on 9/19/2023 documented that they did not look at the resident's care Kardex before providing care. They stated that while they attempted to place new sheets under the resident, the resident rolled over too far to be held and fell off the bed. During an interview on 4/30/2024 at 10:09 AM, Certified Nurse Aide #5 stated each resident's bed mobility status was documented on the Kardex. If a resident was documented as requiring two staff members for bed mobility, they would have to get another staff member to assist in caring for the resident in bed; they would not attempt to perform care with need for mobility by themselves. During an interview on 5/01/2024 at 12:09 PM, Registered Nurse #1 stated that Certified Nurse Aide #4 had rolled the resident, who was in bed, and the resident fell . Certified Nurse Aide #4 did not realize at the time that the resident required two staff members to provide care moving the resident, but a second staff member should have been there to help. They stated that all Certified Nurse Aides should have reviewed the residents' Kardex every day and before providing care. Certified Nurse Aide #4 was unable to be reached for an interview. 10 New York Codes, Rules and Regulations 415.4(b)(1)(i)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 48413 Based on record review and interviews during a recertification and abbreviated survey (Case # NY00324855), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for 1 resident (Resident #45) of 6 residents reviewed for abuse, neglect, and mistreatment. Specifically, for Resident #45, Certified Nurse Aide #4 did not use two staff for bed mobility as documented in Resident #45's Comprehensive Care Plan while providing care to the resident on 9/19/2023. This resulted in Resident #45 rolling out of bed onto the floor and was not reported to the New York State Department of Health. This is evidenced by: Resident #45 was admitted to the facility with diagnoses of hypertensive heart disease (a long-term condition that develops over many years in people who have high blood pressure), chronic obstructive pulmonary disorder (a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and morbid (severe) obesity. The Minimum Data Set (an assessment tool) dated 4/01/2024, documented the resident had moderately impaired cognition, could usually understand others and be understood. The facility's policy and procedure titled Accidents and Incidents, last revised in July 2020, documented abuse allegations were reported per Federal and State Law. The facility would ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, were reported immediately, but not later than 2 hours after the allegation was made. An interdisciplinary team would review all cases and the Administrator and Director of Nursing would determine whether the incident required reporting to outside agencies such as the Department of Health. The Comprehensive Care Plan titled, Assistance in Activities of Daily Living, dated September 2023, documented the resident was dependent on two staff members for bed mobility. The Certified Nurse Aide Kardex (Resident care card followed by Certified Nurse Aides to provide care), for September 2023, documented the resident was dependent and required two staff members for bed mobility. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Accident and Incident report, dated 9/19/2023 at 05:28 PM, documented Resident #45 fell out of bed and was lying on their back complaining of head and body pain. Certified Nurse Aide #4 was the only documented witness to the event. The statement by Certified Nurse Aide #4 on 9/19/2023, documented that they did not look at the resident's care Kardex before providing care. They stated that while attempting to place new sheets under the resident, the resident rolled over too far to be held and fell off the bed. During an interview on 5/01/2024 at 11:15 AM, Director of Nursing #1 stated that they and the Administrator along with the interdisciplinary team were responsible for reporting incidents to the Department of Health. They stated that all cases of abuse, whether physical or verbal, injuries, failure to follow resident care plans, and neglect, should be reported to the Department of Health. They stated that Certified Nurse Aide #4 did not follow the resident's care plan and caused the resident to fall. They stated that they did not report the incident as the resident did not have any injury from the fall. During an interview on 5/01/2023 at 12:09 PM, Registered Nurse #1 stated that Certified Nurse Aide #4 had rolled the resident in bed, and they fell . They stated Certified Nurse Aide #4 did not realize at the time that the resident required the total assistance of two staff members for bed mobility. They stated a second person should have been there to help. Registered Nurse #1 stated that all Certified Nurse Aides should review the resident's Kardex every day and before providing care. They stated that this was reported to the Director of Nursing after the resident was evaluated and sent to the emergency room . They stated that they were unsure if it was reported to the Department of Health but probably should have since Certified Nurse Aide #4 did not follow the care plan. 10 New York Codes, Rules and Regulations 483.12(c)(1)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. 43805 Based on record review and interviews during a recertification and abbreviated survey (Case # NY00324038), the facility did not ensure residents who were hospitalized or on therapeutic leave were allowed to return to the facility for skilled nursing or nursing facility care or services for 1 of 2 residents reviewed (Resident #165). Specifically, Resident #165 was sent to the hospital on 9/12/2023 for evaluation for behaviors. The resident was medically cleared and discharged from the emergency department. The facility refused to accept the transfer back to the facility. This is evidenced by: The facility policy and procedure titled, Discharge-Transfer/Discharge Process, dated 12/2019, documented if a resident was transferred to the hospital because the facility was unable to safely manage the resident's care at the time of transfer, the facility was expected to readmit the resident once the hospital had determined it was safe for them to return to the facility. Resident #165 was admitted with diagnoses of dementia, diffuse traumatic brain injury, and depression. There was no documented evidence of comprehensive assessment on the resident. The discharge summary dated 9/08/2023 from discharging hospital did not document any behaviors from the resident toward self or others. The Social Services progress note dated 9/11/2023 at 10:25 AM documented the resident was physically aggressive toward staff and a danger to self and others. The progress note documented the resident was to return to the hospital as they were unsafe to remain in the facility. The Physician progress note dated 9/12/2023 documented the resident was seen for aggressive behaviors. The progress note indicated the hospitalization records documented aggressive behavior in the hospital as well prior to transfer to the facility. The physician documented the resident was a danger to themselves and others due to aggressive behaviors and would be sent to the hospital. A nursing progress note dated 9/12/2023 documented the resident was exhibiting aggressive behaviors. De-escalation attempts and distraction attempts were documented as unsuccessful. The progress note documented the interdisciplinary team agreed that the resident's needs could not be met in the facility and the resident would be transferred to the hospital that discharged them. A document submitted to the New York State Health Department dated 9/19/2023 documented emergency services was called and law enforcement came to the facility. Emergency services reportedly refused to transfer the resident as there was no medically emergent need. The facility then transferred the resident to the hospital in the facility transportation vehicle with additional staff. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/30/2024 at 10:51 AM, Complainant #1 stated Resident #165 was not brought to the closest hospital but instead was transported to a hospital one hour away in a private vehicle. Complainant #1 stated if Resident #165 was exhibiting severe behaviors that were a threat to self or others, transporting in a private vehicle would not be appropriate. Complainant #1 stated Resident #165 did not exhibit any behaviors of that nature in the emergency room of the hospital and the medical doctor did not feel the resident was a danger to self or others. They stated the resident was medically cleared for discharge from the emergency department but when transfer to the facility was attempted, the facility refused to take the resident back. During an interview on 5/01/2024 at 10:15 AM, Director of Nursing #1 stated the facility was not aware of Resident #165's prior behaviors before they were admitted to the facility. When the resident was admitted to the facility, they began exhibiting dangerous behaviors toward staff and other residents. Director of Nursing #1 stated the resident believed they were being discharged to home and was expected to be transferred to another facility. They stated the medical provider also determined the resident was a danger to self and others, and the facility did not have the ability to have one-on-one supervision of the resident to ensure safety. Director of Nursing #1 confirmed emergency medical services would not transport the resident. They stated Resident #165 was calm when they were informed that they were leaving the facility. Director of Nursing #1 stated when the facility was informed the resident was medically cleared to be discharged from the emergency department on 9/12/2024, the facility refused to readmit the resident because they feared the resident would become agitated and dangerous if they came back to the facility. 10 New York Codes, Rules, and Regulations 415.3(h)(4)(iii)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observations, record reviews, and interviews during the recertification and abbreviated survey (Case # NY00318691), the facility did not ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for all residents in the facility. Specifically, call lights were not answered timely to meet the needs of residents, with multiple residents stating there were long waits for call lights, and there were 34 falls documented for the month of April 2024. This is evidenced by: The Facility Assessment, last updated 3/01/2024, documented the facility capacity was 174 residents with an average daily census range of 163-170 residents. The following two units were designated for extra staffing: [NAME]: 30 designated short term rehab beds, and Serenity Place: 35 designated beds for the dementia population on a secure unit. Staffing was based on acuity and resident needs. Record review revealed the following from 6/13/2023- 6/20/2023: On 06/13/2023 the facility census was 150: On 7:00 AM-3 PM shift, 18 Certified Nurse Aides were required but 11 Certified Nurse Aide were present. On 11:00 PM- 7:00 AM 9 Certified Nurse Aides were required but 7 Certified Nurse Aide were present. On 06/20/2023 the facility census was 155: On 7:00 AM-3 PM shift, 19 Certified Nurse Aides were required but 17 Certified Nurse Aide were present. On 7:00 AM- 3:00 PM shift, 9 Medication Nurse (Licensed Practical Nurse/Registered Nurse) were required but 8 nurses were present. On 11:00 PM- 7:00 AM 9 Certified Nurse Aides were required but 8 Certified Nurse Aide were present. Record review revealed actual staffing for 4/29/2024 - 5/02/2024 documented the following: On 4/29/2024 the facility census was 163: On 7:00 AM-3 PM shift, 20 Certified Nurse Aides were required but 18 Certified Nurse Aide were present. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 Medication Nurse (Licensed Practical Nurse/Registered Nurse) were required but 6.6 nurses were present. On 4/30/2024 the facility census was 166: On 7:00 AM-3 PM shift, 20 Certified Nurse Aides were required but 19 Certified Nurse Aide were present. On 7:00 AM- 3:00 PM shift, 10 Medication Nurses (Licensed Practical Nurse/Registered Nurse) were required but 6 nurses were present. On 5/01/2024 the facility census was 166: On 7:00 AM-3 PM shift, 20 Certified Nurse Aides were required but 18 Certified Nurse Aide were present. On 7:00 AM- 3:00 PM shift, 10 Medication Nurses (Licensed Practical Nurse/Registered Nurse), were required but 6 nurses were present. On 3:00 PM-11:00 PM shift, 16 Certified Nurse Aides were required but 14 Certified Nurse Aide were present. On 11:00 PM- 7:00 AM shift, 10 Certified Nurse Aides were required but 9 Certified Nurse Aide were present. On 5/02/2024 the facility census was 168: On 7:00 AM-3 PM shift, 20 Certified Nurse Aides were required but 19 Certified Nurse Aide were present. On 7:00 AM- 3:00 PM shift, Medication Nurse (Licensed Practical Nurse/Registered Nurse), 10 nurses were required but 5 nurses were present. On 3:00 PM-11:00 PM shift, 20 Certified Nurse Aides were required but 16 Certified Nurse Aide were present. During an observation on 4/22/2024 at 6:50 PM on [NAME] unit, there were no staff members visible for over 20 minutes, and all residents on the floor were in bed. Residents # 116 and #132 were awake awaiting assistance. During an interview on 4/23/2024 at 9:30 AM, Resident #76 stated they waited for long periods before call light was answered. Resident #76 stated they had been waiting for over an hour for oxygen concentrator to be changed. They stated that the existing concentrator was not working properly. During an interview on 4/23/2024 at 10:30 AM, Resident #138 stated they waited a long time for staff to answer lights, especially over the weekend. However, they eventually come to assist. Resident #138 stated they were fortunate as they could do some things for themself. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/30/2024 at 10:46 AM, Certified Nurse Aide #7 stated they worked 16 hours a day and 6 days per week. At times there was only 1 Certified Nurse Aide overnight and only 2 Certified Nurse Aides on day shift. During an interview on 5/01/2024 at 10:00 AM, Registered Nurse #2 stated they had been assigned to the medication cart for the second day in a row. Instead of being assigned to the Serenity Place medication cart, they were assigned to [NAME] Book medication cart. Registered Nurse #2 stated Licensed Practical Nurse #8 usually worked both sides of the [NAME] unit. However, today Licensed Practical Nurse #8 refused to work alone. During an interview on 5/01/2024 at 2:50 PM, Registered Nurse #2 stated they were assigned to work a medication cart on Serenity Place. Registered Nurse #2 stated an admission had arrived and they were unable to take report for the new admission. Registered Nurse #2 was not aware Resident #146 had been discharged , and a new resident was awaiting admission. During an interview on 4/30/2024 at 10:15 AM, Licensed Practical Nurse #8 stated they were often asked to stay late and picked up shifts. Additionally, they stated they generally work a 16-hour shift. 45 percent of the time they worked alone on the rehabilitation floor. When working alone and short staffed they have to manage their time so that if a task is not completed during the day, it can be completed on the evening shift. When working short staffed, they would tell certified nurse aides to shorten resident rounds to get work done. During an interview on 5/02/2024 at 11:47 AM, Licensed Practical Nurse #9 stated they were the only nurse for both sides of one unit working on the day shift. They stated they worked alone the previous day as well. Licensed Practical Nurse #9 stated they often came in an hour early and stayed late to complete assignments. During an interview on 5/02/2024 at 12:10 PM, Registered Nurse #3 stated they usually were the only nurse for both sides on whatever unit they were assigned to. It was very busy, but since they were familiar with the residents, they were able to complete assignment if they stayed late. Registered Nurse #3 stated each Wednesday, the wound care team rounded on the residents as well as completing wound and skin assessments, and was a help because it lessened the workload for the usual floor staff. During review of facility Incident and Accident reports for April 2024, there were 34 falls documented. During an interview on 4/30/2024 at 11:02 AM, Director of Nursing #1 stated when there were staff call outs or short-staffed days, leadership came in and helped. They reached out to agency staff and ask existing staff to pick up extra shifts. They also made changes to the schedule to balance short staffed days when possible. 10 New York Codes, Rules and Regulations 415.13(a)(1)(i-iii)