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

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615 Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labelled and stored in accordance with professional standards of practice. Specifically, (a.) opened medications had no open and/or expiration dates; (b.) controlled substances were not kept secured in a double locked cabinet; (c.) expired medications were present; and (d.) medications were left on top of medication cart unattended. This was evident for 3 out of 10 medication carts reviewed, and for 2 out of 5 medication storage rooms reviewed. This is evidenced by: The facility's Medication Administration Policy and Procedure, effective 12/2019 documented, the expiration date on the medication label must be checked prior to administering. When opening a multi-dose container, the date should be recorded on the container. During administration of medications, the medication cart would be kept closed and locked when out of sight of the medication nurse or aide. No medications were to be kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by. During an observation on 4/24/2024 at 11:50 AM, Medication Cart on [NAME] unit, right side, contained the following medications with no open or expiration dates: 3 glargine insulin kwik pens; 1 vial of Humulin insulin; 1 latanoprost eye drop solution and 1 dorzol eye drop solution. The Left side of the medication cart contained the following medications with no open or expiration dates: 1 glargine insulin kwik pen; 1 vial of lispro insulin. During an observation on 4/24/2024 at 12:05 PM, a list of medications with shortened expiration dates was posted in the [NAME] Medication Room. (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/24/2024 at 11:59 AM, Licensed Practical Nurse #6 was observed administering Oxycodone 10milligrams by mouth to Resident #116. Licensed Practical Nurse #6 stated the narcotic book was left in the medication room, and they sign out all narcotics given for the day at the end of their shift. There were 13 oxycodone 10 milligram tablets left in blister pack on the medication cart. The narcotic book locked in the medication room indicated there were 15 oxycodone 10milligram tablets still in blister pack. Licensed Practical Nurse #6 stated they gave Resident #116 one pill earlier in the day in addition to the dose just given. Licensed Practical Nurse #6 stated they did not know the facility's policy off hand for narcotic medication administration, but this system worked for them. During an observation on 4/24/2024 at 12:05 PM, the [NAME] unit Medication Room narcotic lock box on right side had only one functioning lock. The narcotic lock box was observed to have a broken lock inside while it contained multiple narcotics. Licensed Practical Nurse #6 stated they called maintenance. However, they could not recall what date maintenance was called. The medication room refrigerator contained a tuberculin purified protein derivative bottle opened on 3/01/2024. The manufacturer's label documented discard 30 days after opening. Licensed Practical Nurse #6 discarded the bottle. During an observation on 4/24/2024 at 12:20 PM, Medication Cart on [NAME] unit left side contained a narcotic book for left side assignment. The left side cart also contained a list of medications with shortened expiration dates. During an observation on 04/29/2024 at 11:50AM, Medication Storage Room on Mountain Ridge unit, right lock box had an Epinephrine pen with expiration date of 12/2023, no resident name was on the pen or bag. During an observation on 4/30/2024 at 09:42 AM, medication cart on Mountain Ridge unit was observed to have an insulin pen and a blister pack of medication laying on the top of the medication cart, unattended. Licensed Practical Nurse #3 was observed walking out of a resident's room down the hall to the medication cart. Licensed Practical Nurse #3 put away medication on the cart mumbling as they did so. During an interview on 4/24/2024 at 12:25 PM, Licensed Practical Nurse #7 stated they kept narcotic book on medication cart and each time a narcotic was given, the narcotic book was updated and reconciled. During an interview on 4/29/2024 at 11:50 AM, Licensed Practical Nurse #3 stated they were unsure what to do with the medication and did not want to just leave it out for anyone to grab before the pharmacy pick up was done. Licensed Practical Nurse #3 stated they did not know why the expired pen had not been returned to pharmacy. They stated that pharmacy pick-ups were Monday through Friday, two times per day at 2:00 PM and 10:30 PM; Saturday and Sunday, one time daily around 6:00 PM. Licensed Practical Nurse #3 removed the epinephrine pen from the lock box and placed it in the return to pharmacy bin for pharmacy pick up. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/01/24 at 09:25 AM, Licensed Practical Nurse #3 stated they would not normally leave medication on top of the cart unattended. They gave medication to a resident that was going out to an appointment and their catheter was leaking. They had to run and get another catheter and accidently left the medications on the cart. Licensed Practical Nurse #3 stated that the insulin pen was empty, but the blister pack was not. They stated it was wrong and that was not their typical practice. During an interview on 4/24/2024 at 12:50 PM, Director of Nursing #1 stated the facility completed a full staff medication administration training the previous month. In addition, each nurse completed competencies for medication administration upon hire and annually. During an interview on 4/26/24 at 14:00PM, Director of Nursing #1 stated the narcotic box on right side of Medication Room on [NAME] Unit had been replaced and both inside and outside locks were functioning. 10 New York Codes, Rules and Regulations 415.18(d) 48744

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 21414 Based on observation, record review, and staff interviews during the recertification survey, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety in the main kitchen and 7 of 10 kitchenettes. Specifically, food contact equipment was not being sanitized, thermometers were not calibrated, and surfaces were not clean. This is evidenced by: During observations in the main kitchen on 4/22/2024 at 6:48 PM: The concentration of quaternary ammonium compound used in the final, sanitizing rinse sink of the 3-compartment sink was 0 parts per million when measured at 70 degrees Fahrenheit, in accordance with the testing kit directions; food contact equipment was being washed during this observation. The label directions on the quaternary ammonium compound concentrate instruct that the dilution range is to be between 200 and 400 parts per million. Two food temperature thermometers were found not in calibration at 24 degrees Fahrenheit and 52 degrees Fahrenheit when tested in a standard ice-bath method. The serving line reach-down refrigerator, housekeeping room door, door to the loading dock, K-rated fire extinguisher, fire alarm pull station were soiled with food residue. Two utensil drawers by the preparation sink were broken and did not ride on their rails. During observations on 4/22/2024 at 7:37 PM: The Hollyhock Way kitchenette freezer door gasket was split and uncleanable, and the floor under refrigerator was soiled with food particles. The Gardenia Way kitchenette cabinets were soiled with food particles. The Whispering Way kitchenette floor under refrigerator was soiled with food particles. The Star Haven kitchenette bottom shelf in the refrigerator was soiled with food particles. The Emerald Way kitchenette cabinets were soiled with food particles. The [NAME] Glen kitchenette cabinets were soiled with food particles. The [NAME] Creek kitchenette freezer door gasket was split and uncleanable, and the floor under refrigerator was soiled with food particles. The Oak Creek kitchenette cabinets were soiled with food particles. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/2024 at 7:28 PM, Food Service Director #1 stated that the person washing equipment at the 3-bay sink had likely diluted the solution during their shift but would be re-educated on checking the solution to ensure it remained at the proper concentration. During an interview on 5/01/2024 at 1:17 PM, Administrator #1 stated that Food Service Director #1 had started staff education on the correct concentration of the sanitizing solution and on thermometer calibration. Administrator #1 stated that the low-boy cooler had been cleaned; one utensil drawer was repaired and the other was removed. 10 New York Codes, Rules, and Regulations 415.14(h) Chapter 1 State Sanitary Code Subpart 14