STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335543	A. Building B. Wing	05/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Capstone Center for Rehabilitation and Nursing	302 Swart Hill Road Amsterdam, NY 12010

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 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. 47140 Based on record review and interviews during an abbreviated survey (Case # NY00295962 and NY00319632), the facility did not ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source were reported immediately, but not later than two (2) hours after the allegation was made to the State Survey Agency for 2 of 2 qualifying reportable incident and accident investigations. Specifically, when Resident #2 and Resident #3 were observed with injuries of an unknown origin, the facility conducted investigations into the incidents, however, never reported them to the New York State Department of Health. The findings include: The Policy and Procedure titled Abuse, last revised February April 2023, read in pertinent part, that each resident had the right to be free from abuse, corporal punishment, and involuntary seclusion as well as mistreatment, neglect and misappropriation of property. Residents must not be subjected to abuse by anyone including but not limited to facility staff, other residents, consultant, volunteers, staff or other agencies serving the resident, family member or legal guardians, friends or others such as visitors. All employees, volunteers and consultants had an obligation to report resident abuse, mistreatment, or neglect (including misappropriation of property) when they had reasonable cause to believe that such incident had occurred. Allegations of abuse, mistreatment, and neglect from other sources such as family member or other visitors also required further inquiry. Staff were reminded in the policy that they were mandated reporters of abuse, neglect, mistreatment, and misappropriation of property to the New York State Department of Health hotline of any potential concerns. The facility policy informed all employees and volunteers that it was their legal obligation to report actual or suspected instances of resident abuse, mistreatment, or neglect, including injuries of unknown etiology/origin and misappropriation of property. The facility also informed all other personnel providing care in the facility of their obligation to report actual or suspected instances of resident abuse, mistreatment, or neglect, including injuries of unknown cause. Resident #2 Resident #2 was admitted to the facility with diagnoses of unspecified dementia with behavioral disturbance, muscle weakness and age-related osteoporosis with current pathological fracture (fracture caused by weakness of the bone structure that leads to decrease mechanical resistance). The Minimum Data Set (an assessment tool) dated 5/05/2022, documented the resident had severe cognitive impairment, could sometimes be understood and could sometimes understand others. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing Progress Note dated 5/10/2022 documented that Director of Nursing was called to the resident's room by Certified Nurse Aide and Licensed Practical Nurse after it noted by other nursing staff that the resident had bruising to their chest/ shoulder area. The resident was documented to otherwise appeared to be themself. The Nurse Practitioner was to assess the resident and contact the resident's family to discuss the bruising/treatment. Review of the facility's investigation revealed Certified Nurse Aide #2 was interviewed on 5/13/2022 (three days after the injuries were observed). Review of the facility's investigation revealed Certified Nurse Aide #3 was interviewed on 5/19/2022 (nine days after the injuries were observed). The Facility Investigation, initiated 5/10/2022, concluded that the resident did not have any falls that would have contributed to the bruising that was found. Staff statements and notes indicated that the resident's baseline was to be combative when care was being performed. It was also documented, that at times the resident's breasts could get caught in the gait belt due to being care planned not to wear a bra. Progress notes just prior to the observed bruising had also documented that the resident was observed pushing their tray table into themself. The facility determined that bruising was the result of behaviors. The facility investigation documented that the investigation showed no signs/symptoms of abuse, neglect or injury of unknown origin and the timeline of the resident's behaviors being in direct correlation of when the bruises had presented; the interdisciplinary team determined to not report the incident to the New York State Department of Health. Resident #3 Resident #3 was admitted to the facility with diagnoses of unspecified dementia with behavioral disturbance, difficulty walking and retention of urine (when the bladder does not empty completely or at all). The Minimum Data Set (an assessment tool) dated 12/21/2022, documented the resident had severe cognitive impairment, could usually be understood and could sometimes understand others. A Nursing Progress Note, dated 12/24/2022, documented that the resident was observed to have discoloration around their left eye which was of unknown origin. The resident's son was documented to be in visiting in the resident and wanted answers about the injury. A Nursing Progress Note dated 12/24/2022 documented that the resident's son insisted that an X-ray be performed on the resident's eye. The Facility Investigation, undated, documented on 12/24/2024 Resident #3's son had insisted on sending the resident out to the hospital for an X-ray, after the resident was identified to have discoloration around their left eye. The resident was sent out via ambulance as requested and the results indicated no abnormal findings. The investigation documented the resident was observed during an activity in the dining room on 12/22/2022 with the behavior of repeatedly picking up their head and dropping it down onto the table they were seated at. The investigation concluded that after review, it was indicated that less than forty-eight (48) hours prior to the identification of the discoloration around the resident's left eye, that the resident was noted with behaviors that could have caused the injury. The resident was also noted to be prescribed a blood thinning medication (Eliquis). Due to the investigation showing no indications of abuse having occurred, the interdisciplinary team determined to not report the incident to the New York State Department of Health. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/14/2024 at 11:05 AM, Registered Nurse #4 stated that if a resident was found to have an injury of an unknown origin; they would assess the resident and alert the physician, supervisors, and facility administration. They stated the facility would initiate an investigation to determine the cause of injury and rule out possible abuse. They stated that they would assist and participate in conducting interviews of staff on various shifts to determine when and how the injury may have occurred. They stated injuries of unknown origin should be reported to the New York State Department of Health within two hours from the time they were observed. During an interview on 3/14/2024 at 12:20 PM, Registered Nurse #5 stated if a resident was observed with an injury of unknown origin, an investigation would be initiated and interviews of all staff on various shifts who interacted with the resident would be conducted. They stated the resident would be assessed and their physician, emergency contact and facility administration would be notified right away. They stated the incident should be reported right away but no later than two (2) hours from the time the injury was observed to New York State Department of Health or within twenty-four (24) hours if there was no serious injury occurred. They stated facility administration would make the report to the New York State Department of Health. During an interview on 3/14/2024 at 12:26 PM, Director of Nursing #1 stated that if a resident was observed with an injury of unknown origin, an investigation would be initiated immediately to rule out abuse and try to determine how the resident was injured to treat and prevent recurrence. They stated they would complete the investigation and then determine if the facility needed to report the incident to the New York State Department of Health. They stated since they had become the Director of Nursing at the facility, there had not been any incidents of injuries of unknown origin that were determined to be reportable incidents. During an interview on 3/14/2024 at 1:36 PM, Nursing Home Administrator #1 stated if a resident was observed to have an injury of unknown origin; first the resident would be assessed, and staff would ensure the resident was safe and then a statement would be taken from the person reported the injury. They stated they would notify the police if any harm had been caused. They stated they would conduct an investigation to rule out potential abuse. They stated that if their investigation ruled out abuse within two hours, then they would not report the incident to the New York State Department of Health. They stated their belief that injuries of unknown origin could be investigated and then a determination be made on whether to report. The Nursing Home Administrator was unaware of the requirement to report all incidents of injuries of unknown origin. 10 New York Codes, Rules, and Regulations 415.4(4)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 48744 Based on record review and interviews during an abbreviated survey (Case #NY00302737), the facility did not ensure sufficient nursing staff were available to provide nursing services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Specifically, the facility did not ensure that a resident was permitted to return to an available bed in the location in which they previously resided. Specifically, Resident #10 was sent to the hospital on 9/09/2022 for evaluation, and not permitted to return after medically cleared to return back to facility. The facility stated they could not provide 1:1 care to the resident upon a readmission from the hospital until such time a safe discharge could be secured. This is evidenced by: Resident #10 was admitted with diagnoses of unspecified dementia with behavioral disturbance, post-traumatic stress disorder, and Alzheimer's Disease. The Minimum Data Set (an assessment tool) dated 9/01/2022, documented the resident had significant cognitive impairment, could be understood and could sometimes understand others. A facility Policy and Procedure titled Transfer and Discharge Right Policy and Procedure, last revised 6/02/2022, read in pertinent part, that when a resident was transferred or discharged because the resident's needs could not be met at the facility, the resident's physician must document the specific needs the facility could not meet, the facility's attempts to meet the resident's needs, and the services available at the receiving facility to meet the resident's needs. A resident and/or resident representative had the right to appeal their transfer or discharge. If the appeal was required prior to the actual discharge, the facility may not discharge the resident while the appeal was pending unless the discharge was based on imminent danger of the resident or other residents of the facility. The facility must document the danger that failure to transfer or discharge the resident would pose. If a resident, or was applicable, their representative, appealed their discharge while in the hospital, the facility must allow the resident to return pending their appeal, unless there was evident that the facility could not meet the needs to the resident or the resident's return would pose a danger to the health or safety of the resident or others in the facility. A Discharge Summary from a hospital dated 8/29/2022 at 12:30 PM, documented that Resident #10 was brought to the emergency room by the resident's family for aggressive behavior. The summary documented that the resident had been hospitalized since 8/21/2022 and had no violent outbursts while hospitalized , was up and ambulatory in no distress. The resident was documented to be stable and expected to discharge back to their nursing home on 8/29/2022. The facility's discharge notice dated September 9, 2022 with the discharge date of [DATE]. The reason cited for discharge was that the safety of others in the facility would be endangered. A nursing note dated 9/01/2022 documented that the resident had a history of violent behaviors toward family and other residents at previous facilities. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note dated 9/09/2022 documented that Resident #10 was self-ambulatory in the hall when they attempted to aggressively go toward another resident in an attempt to strike them. Staff were able to intervene and prevent the resident from reaching the other resident; however, the resident did strike staff and continued to make threats against both staff and residents. The note further documents the facility was not able to provide care for the resident as they were violent, aggressive, and unstable. Medical provider and family made aware that the resident was sent to the hospital. During an interview on 3/12/2024 at 11:45 AM, Nursing Home Administrator #1 stated Resident #10 resided at the facility for 7 days. The resident arrived the Thursday before Labor Day weekend. Administrator #1 stated they were unaware of the resident's violent history when they accepted the resident. The facility did try to medicate Resident #10, however they refused to take medications. They stated the resident was not at the facility long enough to have in the house psychiatrist see them. They stated that under normal situations, the facility would not take someone back from the hospital if the resident could not be managed medically. When asked for the process regarding transferring a resident to another facility, the Administrator stated that social work assisted in the planning for discharge, helped set up services, or helped with a lateral transfer. The facility would never just release a resident without setting them up first. In this case, the facility was unaware of the resident's history and Director of Nursing #1 and staff had reported Resident #10 was too dangerous to be at the facility. During a subsequent interview on 3/14/2024 at 1:37 PM, Nursing Home Administrator #1 stated they were not made aware of Resident #10's behaviors prior to admission to the facility. They stated there was a break-down in the system and they should have made aware of the resident's history of behaviors. They stated the admissions paperwork that was sent documented the resident's history of aggression on the last page submitted. They stated the nurse who approved the resident's admission no longer worked at the facility. They stated Resident #10 went after staff and other residents physically. They stated Resident #10 attempted to strike another resident in the face and staff were able to intervene. They stated the resident said they liked to punch and hit. They stated the facility could not have a staff member with the resident 24 hours per day and did not feel they could continue to intervene and protect other residents. They stated the resident was moved to a private room. They received an order from the physician to administer haldol (an antipsychotic medication) but were unable to administer. They stated the resident continued with physically aggressive behaviors and was sent to hospital. They stated that they would not accept the resident back at the facility because they did not feel it was safe for others if they were to be readmitted . 10 New York Codes, Rules, and Regulations 415.3(h)(4)(iii)