

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Capstone Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34630</p> <p>Based on observation, record review and interviews during the recertification survey, the facility did not ensure each resident was treated with respect and dignity and cared for in a manner that promotes maintenance or enhancement of his or her quality of life for 6 (Resident #'s 2, 12, 28, 44, 97, and 114) of 35 residents reviewed. Specifically, (a.) Resident #'s 2, 12, 28, and 114 were provided plastic flatware with their meals instead of silver flatware. (b.) Residents #44 and #97 were not talked to in a dignified manner by staff providing care.</p> <p>This is evidenced by:</p> <p>A facility policy Dignity and Quality of Life Policy, not dated, documented that each resident shall be cared for in a manner that promoted and enhanced quality of life, dignity, respect, and individuality. Under the policy section procedure/implementation it was documented that:</p> <p>Residents should be treated with dignity and respect at all times.</p> <p>Staff should promote and ensure each resident had a dignified dining experience through:</p> <ul style="list-style-type: none"> <li>- Consider resident wishes when using clothing protectors</li> <li>- Ensuring the residents receive plastic utensils/dishware when care planned or in the event of a temporary kitchen need.</li> <li>- Sit next to residents while assisting them to eat.</li> <li>- All residents at a table were served at a time</li> <li>- Wait for residents at a table to finish before clearing the table.</li> <li>- Talk with residents for whom they were providing assistance rather than conducting social conversations with other staff.</li> <li>- Allow residents adequate time to complete their meal.</li> </ul> <p>(continued on next page)</p>		

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- Speak with residents politely, respectfully, and communicate personal information in a way that maintains confidentiality.</p> <p>- Respond to residents' requests in a timely manner</p> <p>Staff shall treat cognitively impaired residents with dignity and sensitivity: for example:</p> <p>a. Addressing the underlying motives or root causes for behavior; and</p> <p>b. Not challenging or contradicting the resident's beliefs or statements.</p> <p>A facility policy Resident Rights, not dated, documented that the facility would abide by all state and federal regulations pertaining to resident rights. Under the policy section procedure, it was documented that:</p> <p>- Upon admission each resident will be provided with a Your Rights As A Nursing Home Resident booklet, see attached. This booklet could be provided again to any resident at any time during their stay.</p> <p>- Resident Rights were discussed monthly at Resident Council Meetings.</p> <p>- Ombudsman name and contact information is displayed throughout the facility.</p> <p>Resident #2:</p> <p>Resident #2 was admitted to the facility with diabetes, chronic obstructive pulmonary disease, and depression. The Minimum Data Set (an assessment tool) dated 10/09/2024, documented the resident was cognitively intact. The resident was able to make themselves understood and understand others.</p> <p>During an interview on 12/02/2024 at 1:58 PM, Resident #2 stated they received plasticware with their meals 90% of the time. They stated they did not receive an explanation from the facility.</p> <p>Resident #12:</p> <p>Resident #12 was admitted to the facility with diagnoses of diabetes, hypertension, and depression. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understand others.</p> <p>During an interview on 12/06/2024 at 10:44 AM, Resident #12 stated that sometime last week they received plasticware with their meals. They received plasticware a few times prior to that. They stated it was not as easy to use plasticware as silverware. They did not know the reason for the plasticware.</p> <p>Resident #28:</p> <p>Resident #28 was admitted to the facility with diagnoses of heart failure, generalized muscle weakness, and difficulty walking. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/06/2024 at 10:50 AM, Resident #28 had 4 plastic knives on the bedside table. Resident stated they received plasticware regularly. The stated they did not get metal utensils that often. Stated they were given a metal knife this morning and usually received silverware at breakfast and for lunch and dinner it varied between metal and plastic.</p> <p>Resident #114:</p> <p>Resident #114 was admitted to the facility with diagnoses of dysphagia (difficulty swallowing), generalized muscle weakness, and anemia. The Minimum Data Set, dated dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understand others.</p> <p>During an observation on 12/06/2024 at 10:47 AM, Resident #114 stated they were given plasticware today. A plastic spoon was noted inside of a cup of coffee. Resident #114 stated they occasionally received plasticware and stated, It's not the best. They stated they did not know why they received plasticware. They stated normally they received silverware wrapped in a napkin and when they received plasticware it was a loose spoon or fork.</p> <p>During an interview on 12/10/2024 at 10:43 AM, Registered Nurse #1 stated they were not aware Resident #s 2, 12, 28, and 114 were receiving plasticware. Stated there were couple residents who were care planned for plasticware, but these residents were not. Stated they would have to talk to someone in the kitchen.</p> <p>During an interview on 12/10/2024 at 11:00 AM, Director of Nursing #1, stated there were a couple of residents who received plasticware due to mental health issues. Stated they were not aware of any problems in the kitchen and would not necessarily be made aware of the plasticware being given to residents.</p> <p>48615</p> <p>Resident #44:</p> <p>Resident #44 was admitted to the facility with a diagnosis of dementia unspecified (loss of memory, language, problem-solving and other thinking abilities), anxiety (a type of mental health condition) and hard of hearing. The Minimum Data Set, dated dated dated [DATE], documented the resident was severely cognitively impaired, could sometimes be understood and could sometimes understand others.</p> <p>During an observation on 12/05/2024 at 10:15 AM, Certified Nurse Aide #8 was overheard yelling relax and sit back in chair to Resident #44. Resident #44 was overhead yelling back, stating no, I don't want to. Certified Nurse Aide #4 stated Resident #44 did not like to be dressed, they were upset because they just had a shower and gotten dressed.</p> <p>During an interview on 12/05/2024 at 10:15 AM, Registered Nurse #7 stated nursing staff received Oasis (a certified program) training on care of residents with dementia, as well as annual training on abuse and neglect. Registered Nurse #7 stated that abuse could be verbal, and that Resident #44 was hard of hearing. They were in the process of finding more comfortable clothing to accommodate Resident #44. Certified Nurse Assistant #8 was removed from Resident #44's care and coached on tone of voice when speaking with residents that were hearing impaired.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 12/09/2024 at 10:46 AM, Registered Nurse #7 was shouting anxiously at Resident #44. Registered Nurse #7 was aware that their shouting was observed and stated Resident #44 was very hard of hearing. When asked if they had hearing aids, Resident #44 stated I need hearing aids. Registered Nurse #7 stated Resident #44 had bilateral cochlear implants, but they were not aware of hearing aids for the resident.</p> <p>During an interview on 12/10/2024 at 10:31 AM, Director of Nursing #1 stated Resident #44 was hard of hearing, had hearing aids but refused to wear them. Resident #44 went out to have an audiology evaluation but did not cooperate with the exam. Additionally, all staff undergo Oasis (a certified program) for care of patients with dementia.</p> <p>Surveyor: [NAME], [NAME]</p> <p>Resident #97:</p> <p>Resident #97 was admitted with the diagnoses of unspecified dementia with behavioral disturbances (a degenerative neurological disease affecting memory and mood), Parkinson's disease (a progressive neurological disease causing uncontrollable muscle movement), and peripheral vascular disease (dysfunction of blood flow all extremities). The Minimum Data Set, dated dated [DATE] documented the resident could usually understand others, could usually be understood, was severely cognitively impaired and required moderate assistance with activities of daily living.</p> <p>During general floor observations on 12/03/2024 at 9:18 AM, Resident #97 was getting cleaned up with the assistance of Certified Nurse Aide #1. Resident #97 could be heard yelling at Certified Nurse Aide #1 indicating they were displeased with what Certified Nurse Aide #1 was doing in their room. Resident #97 stated they were cold multiple times. Certified Nurse Aide #1 was heard explaining what they were trying to accomplish. At 9:35 AM, Resident #97 shouted I'm leaving!, Certified Nurse Aide #1 shouted back Good! Resident #97 left the room while Certified Nurse Aide #1 continued to finish their job of changing the resident's bed linens.</p> <p>During an interview on 12/05/2024 at 10:46 AM, Certified Nurse Aide #1 stated that when they were having a difficult time with a resident while trying to provide care, they walked away and came back after the resident had calmed down. Certified Nurse Aide #1 stated that they did not believe that staff struggled to work with the residents on the floor. They knew that when residents were upset that the best approach was to back away and reapproach later. Agitated residents were given the option of a sensory room to relax as well. When asked if the Certified Nurse Aide gave a shift-to-shift report to provide the opportunity to share if certain residents had a bad day or to give heads up to oncoming staff, Certified Nurse Aide #1 stated that they were and that was what kind of information was shared.</p> <p>During an interview on 12/06/2024 at 11:21 AM, Certified Nurse Aide #2 stated that if a resident spoke inappropriately with them or refused to comply with their request, they would approach at a later time when the resident had calmed down.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/06/2024 at 12:15 PM, Social Worker #1 stated that they worked with staff to prevent burnout and off-the-cuff responses when staff members felt frustrated. When a resident had significant behavior issues, the behavior committee, which met every two weeks, would discuss different strategies to help staff manage the resident. It was not expected that staff would respond sharply to residents and if they were to have seen it, they would pull the staff member aside and tell them to take a break or report them if it was appropriate.</p> <p>During an interview on 12/10/2024 at 12:00 PM, Dietitian #1 stated the facility did use plasticware as part of their adaptive equipment for resident's who had muscle weakness, recommendations from therapy or just request to use plasticware. They stated that the plasticware was care planned for each resident under adaptive equipment in the resident's care plan. Dietitian #1 also stated that when the dishwasher was broken, plasticware was used facility wide until the dishwasher was repaired. Dietician #1 stated that they have seen more plasticware than expected on the units recently but could not attest to whether the resident's receiving the plasticware were care planned for it. Dietitian stated they did not believe plasticware should be used regularly for all residents.</p> <p>During an interview on 12/10/2024 at 12:15 PM, Dietary Director #1 stated that the residents normally received silverware unless they were care planned for plasticware. They stated they have residents who were care planned for plasticware with every meal based on the Unit Managers discretion and recommendation. They stated sometimes plasticware was recommended by speech therapy or occupational therapy and the resident would be care planned through those departments to receive plasticware. The plasticware was put on the care plan under adaptive equipment. Dietary Director #1 stated they could not print a list of residents receiving plasticware because it did not come up on the list of adaptive equipment. The resident would have plasticware identified on their meal ticket and dietary staff place the items when they prepare the tray. Dietary Director #1 stated that the plasticware would only be used facility wide if the dishwasher was not operational. Dietary Director #1 confirmed that the dishwasher was operating adequately, and they did not believe that any resident received plasticware who was not care planned to receive it. Dietary Director #1 stated that they had multiple sets of silverware and that it was used daily. Dietary Director #1 stated they were aware plasticware should not be used regularly for all residents.</p> <p>10 New York Code Rules and Regulations 415.3(c)(1)(i)</p> <p>48744</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>34630</p> <p>Based on observation, record review, and interviews during a recertification survey, the facility did not ensure residents received services in the facility with reasonable accommodation for 1(Resident #86) of 30 residents reviewed. Specifically, the facility did not ensure Resident #86 had a call device they were able to use and was accessible to the resident.</p> <p>This is evidenced by:</p> <p>Resident #86 was admitted to the facility with diagnoses of end stage renal disease, generalized muscle weakness, and need for assistance with personal care. The Minimum Data Set (an assessment tool) dated 9/16/2024, documented the resident was cognitively intact, could be understood, and understand others. The resident had upper extremity impairment on both sides.</p> <p>The Care Plan for Comfort Care/End of Life, updated 11/15/2024, documented the resident was admitted to Hospice on 11/14/2024 for end-of-life care related to end stage renal disease. Goals documented resident would have their wishes for supportive end of life care honored and the resident would be supported emotionally, physically, and palliatively through end-of-life care.</p> <p>During an observation on 12/03/2024 at 9:08 AM, Resident #86 was lying in bed on their back. A push button call bell was noted to be clipped to the resident's bedding in an area that was not accessible to the resident. Resident #86 stated they were unable to use the call bell due to their condition and said they would ask their roommate (Resident #2) to put their call light on when they needed help. Resident #86 stated the facility was supposed to be getting them a touch call bell to use.</p> <p>During an observation on 12/04/2024 at 9:15 AM, Resident #86 was lying in bed on their back. The resident stated they had not given them a different call bell. A push button call bell was clipped to the resident's bedding and was not accessible.</p> <p>During an observation on 12/09/2024 at 3:30 PM, Resident #86 was noted to have a tap call bell that was located to the side of the resident and was accessible.</p> <p>During an observation on 12/10/2024, at 9:15 AM. Resident #86's tap call bell was under the resident's blanket and was not accessible to the resident. The Hospice nurse stated they just came to check the resident and found the call bell out of reach when they arrived. The Hospice nurse adjusted the call bell and placed it on the inside of the resident's bedding, below the resident's chin.</p> <p>During an interview on 12/04/2024 at 5:36 PM, Resident #2 stated their roommate (Resident #86) had them use their call bell to get help for them. When asked how often, Resident #2 stated it usually occurred at least 5 or 6 times during the day and night hours.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/10/2024 at 9:31 AM, Registered Nurse #1 stated Resident #86 was on Hospice and was weak. They provided the resident with a tap call button. They stated the call bell should be placed where the resident could reach it. Registered Nurse #1stated they would reeducate staff if that was not being done. The expectation was for the resident to be able to call for assistance when needed. They stated the bell should not be obstructed and under blankets because that would defeat the purpose of the soft tap button. They stated they were not sure when the soft touch button was made available to the resident.</p> <p>10 New York Code of Rules and Regulations 415.5(e)(1)</p> <p>36922</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48615</p> <p>Based on record review and interview during a recertification survey, the facility did not immediately consult with and or notify resident's physician of a significant change in the resident's physical, mental, or psychosocial status for 1 (Resident #115) of 2 residents reviewed. Specially, Resident #115 had a history of chronic respiratory failure, had increased congestion and cough. Resident's health care proxy expressed concern to Registered Nurse #4. Registered Nurse #4 assessed Resident #115 and was noted with altered mental status, decrease in oxygen saturation from 98% to 94%, and abnormal lung sounds. There was no documented evidence that the physician was notified of the change in condition including change in mental status and respiratory distress. There were no new orders to manage resident symptoms. Subsequently, Resident #115 was found not breathing, a code blue was activated cardiopulmonary resuscitation was performed, and resident expired. This resulted in actual harm that was not Immediate Jeopardy.</p> <p>This is evidenced by:</p> <p>The facility's Policy and Procedure titled Resident Status Change/Physician Family Notification, revised , d+[DATE] and last reviewed: ,d+[DATE] documented, resident physician and primary family contact/resident representative or Health Care Proxy/Power of Attorney would be notified of significant change in residents' condition whether physical, mental, or emotional, improvement or deterioration and of incidents with resulting injuries. The primary family contact or Health Care Proxy/Power of Attorney would be notified of any consultation, diagnostic test x-rays, extensive blood work, etcetera, transfers or hospitalization prior to being done via telephone or during their visit. When there is a significant change in resident's condition, the Registered Nurse would assess the resident and complete a Situation, Background, Assessment, and Recommendation (SBAR) or detailed nurse note. The physician would be notified by licensed nursing personnel. Family would be informed of resident's condition and physician notification and treatment by licensed nursing personnel. Licensed nursing personnel would document the above calls and response to the resident's chart.</p> <p>Resident #115 was admitted to the facility with diagnoses of chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body), chronic kidney disease stage 4 (severe loss of kidney function), and anxiety (persistent and excessive worry that interferes with daily activities). The Minimum Data Set (an assessment tool) dated [DATE], documented resident was cognitively intact, could be understood, and understand others.</p> <p>Resident's Respiratory Comprehensive Care Plan dated [DATE] documented, resident would maintain/regain normal respiratory rate, will have no untreated signs or symptoms of respiratory distress, lethargy, decreased activity, change in sputum production, or change in color, character of sputum, and monitor breath sounds.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>The readmission Hospital Discharge Summary dated [DATE] documented patient had a past medical history of stroke with chronic left-sided weakness, presented to hospital from facility with weakness and dyspnea (shortness of breath). The patient was found to be acutely hypoxic (low oxygen levels). They were found to have bilateral (both lungs) pneumonia. Pulmonology was consulted. During the course of their stay, the patient's oxygen requirement had improved.</p> <p>Progress note dated [DATE] at 1518 written by Registered Nurse #5 documented Resident #115 was readmitted from hospital for rehabilitation. Resident was Full code, had diagnosis of respiratory failure with COVID-19 and pneumonia. Oxygen at 2 liters via nasal canula. Respirations easy with good chest movement. No cough. Head of bed elevated. Resident #115 was alert, oriented, cooperative, and able to make their needs known. Resident had limited bed mobility and able to feed themselves after setup.</p> <p>Progress note dated [DATE] untimed, written by Registered Nurse #4, documented respiratory symptoms, loose congested cough - lung sound with coarse rhonchi (low-pitched, continuous, loud lung sounds that resemble snoring or gurgling) throughout. Vital signs: Pulse Oximetry: 94%, increase edema lower extremities - on Lasix 20 milligrams daily. Blood Urea Nitrogen 75 Creatinine 2.75. Doctor aware. Appetite poor, resident alert and oriented to person and confused. Resident lethargic, confused, and did not respond to direct questions. Family Member #1 concerned regarding resident's congestion. Would continue to monitor.</p> <p>Progress note dated [DATE] untimed, written by Registered Nurse #4, documented Resident #115 had congestion, cough, rhonchi throughout the lungs. Vital signs: blood pressure: systolic: 134, diastolic: 71 Pulse: 69 beats per minute, appetite fair, and needed increase assistance with meals.</p> <p>There was no documented evidence the physician was notified of the resident's change in condition that was worsening for 2 days.</p> <p>Progress note dated [DATE] untimed, written by Registered Nurse #1, documented Resident #115 was found unresponsive while lying in bed in their room at 3:50 PM, 911 was called, cardiopulmonary resuscitation (CPR) was started by writer and nurses. Emergency Medical Technician arrived, took over cardiopulmonary resuscitation, resident was without pulse for over 60 seconds at 4:45 PM. Family and Medical Doctor made aware.</p> <p>During an interview on [DATE] at 2:44 PM, Registered Nurse #4 stated, they remember very little regarding Resident #115. They stated resident did have Covid Pneumonia. They remember talking with Family Member #1 about the congestion. They stated they sent a text to the doctor and thought the doctor may have ordered a chest Xray. They were not able to locate chest Xray.</p> <p>During an interview on [DATE] at 2:54 PM, Registered Nurse #5 stated they recalled completing the re-admission assessment for Resident #115 on [DATE]. Upon arrival, Resident #115 was alert and oriented and breathing without effort. Resident had no respiratory distress or other apparent distress were noted. Their vital signs were stable; resident had good bowel sound. Resident #115's Family Member #1 was present and had no concerns. Two days later, Resident started to have congestion, and supervisor was in with resident.</p> <p>During an interview on [DATE] at 2:55 PM, Assistant Director of Nursing #1 stated with any change in condition, the medical doctor should have been notified. They stated they would notify doctor of vital signs and oxygen saturation, and any assessment findings.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on [DATE] at 11:20 AM, Director of Nursing #1 stated the Medical Doctor should be notified with any change in condition and not sure if they documented in progress notes after on call outreach.</p> <p>During an interview on [DATE] at 12:34 PM, Medical Doctor #1 stated Resident #115 was well known to this provider. Resident #115 was stable when they returned from the hospital, and they were shocked to hear resident had coded and expired. Medical Doctor #1 stated the only communication they received about Resident #115 on [DATE] or [DATE] was the resident had ankle edema. It was never brought to their attention the resident had altered mental status, change in condition or any type of respiratory distress. Medical Doctor #1 stated since patient was already on Lasix, they ordered ace wrap with the belief resident had dependent edema. It was the expectation that the nurse calling would be the eyes of the doctor as they were not seeing the patient firsthand. They stated if they had been made aware of such symptoms of congestion and abnormal lung sounds, they would have ordered a chest Xray, additional medications, or would have sent the resident back to the hospital.</p> <p>10 New York Codes, Rules, and Regulations 415.12</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Capstone Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  302 Swart Hill Road Amsterdam, NY 12010	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>21414</p> <p>Based on observation and interviews conducted during the recertification survey, the facility did not provide effective housekeeping and maintenance services on 1 of 3 resident units and the building exterior. Specifically, the exterior of the building and walls were not clean.</p> <p>This is evidenced by:</p> <p>During observation on 12/03/2024 at 11:17 AM, the walls beneath the hand sanitizer dispensers attached to the walls outside room #s 366, 374, 337, 387, and by the elevator on unit 3 had multiple streak stains around the dispenser that descended to the baseboard.</p> <p>During observations on 12/04/2024 at 5:29 PM, the walls beneath the hand sanitizer dispensers attached to the walls outside room #s 237, 266, 274, 279, and 287 had multiple streak stains that descended to the baseboard.</p> <p>During observation on 12/09/2024 at 11:35 AM, the walls beneath the hand sanitizer dispensers attached to the walls outside room #s 366, 374, 337, and 387 had multiple streak stains around the dispenser that descended to the baseboard.</p> <p>During observations on 12/09/2024 at 8:15 AM and again on 12/10/2024 at 12:15 PM, the front of the building was soiled and stained with a black build-up and a green mold-like substance around the windows and along the bottom 10-feet of the facade.</p> <p>During an interview on 12/10/2024 at 10:26 AM, Certified Nurse Aide #5 stated the hand sanitizer don't work right, the containers were either empty or the tubing inside got clogged and the gel squirts outside ways and more runs down the wall than ends up in your hand. Housekeepers or staff can fill them if they were empty, but housekeeping should be cleaning the walls.</p> <p>During an interview on 12/10/2024 at 11:13 PM, Housekeeper #2 stated they clean the walls periodically, but they were not done every day. The gel squirts out of the hand sanitizers dispensers and gets on the walls. Housekeeper #2 was ot sure what the plan was to correct that.</p> <p>During an interview on 12/10/2024 at 1:49 PM, Director of Plant Operations #1 stated that the front of the building and walls the coving base would be repaired.</p> <p>10 New York Codes, Rules, and Regulations 415.5(h)(4)</p> <p>34630</p> <p>36922</p> <p>51131</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48615</p> <p>Based on record review and interviews during a recertification survey, the facility did not ensure that Comprehensive Care Plans were reviewed and revised to meet the needs of each resident for 2 (Residents #16 and #79) of 30 residents reviewed. Specifically, Resident #16 and Resident #79 had multiple falls and the patient centered Comprehensive Care Plans were not updated to reflect number of falls with corresponding interventions and goals to prevent falls.</p> <p>This is evidenced by:</p> <p>The facility's Policy and Procedure titled Care Planning, Minimum Data Set (is a standardized assessment tool that measures health status in nursing home residents) Assessments and Minimum Data Set Interviews effective 4/2015 and last revised 2/2024, documented PHILOSOPHY: It is the policy of the facility to provide each resident with current care plans reflecting their needs to maintain optimal ability as able and to keep current with Professional Standards. PURPOSE: To evaluate and assess each resident's status and plan of care in order to prevent deterioration/decline unless a clinical condition makes the decline unavoidable. PRINCIPLES: Care Plans to be developed based on resident's Care Area Assessment (CAA), needs, desires, problems with appropriate interventions and realistic goals. Utilize care planning guide to ensure all potential areas were addressed. Further Care Plans to be initiated when problems arise and were to be updated with each routine Minimum Data Set as set forth in the Minimum Data Set Process Protocol.</p> <p>Resident #16:</p> <p>Resident #16 was admitted to the facility with a diagnoses of dementia unspecified (loss of memory, language, problem-solving and other thinking abilities), anxiety (a type of mental health condition), and aged-related osteoporosis (bones to become weak and brittle). The Minimum Data Set (an assessment tool) dated 9/07/2024, documented the resident could be understood and understand others and was moderately cognitively impaired.</p> <p>Nurse progress notes documented falls on 6/19/2024, 10/10/2024, and 10/19/2024. The Comprehensive Care Plans for falls was updated 10/11/2024. Resident #16 had a subsequent fall on 10/16/2024, no updates to care plan were made.</p> <p>During an interview on 12/06/2024 at 9:56 AM, Assistant Director of Nursing #1 stated Care Plans were not updated after every fall if an intervention was already in place. Failure to follow a care plan was referred to the Director of Nursing. Director of Nursing #1 also stated staff should be updating care plan after each fall.</p> <p>Resident 79:</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #79 was admitted to the facility with diagnoses of unspecified dementia (loss of memory, language, problem-solving and other thinking abilities), acquired absence of right leg above knee, legally blind, and anxiety disorder (involves persistent anxiety or dread, which can interfere with daily life). The Minimum Data Set, dated dated [DATE], documented Resident #79 was severely cognitively impaired, could be understood and understand others.</p> <p>Nursing Progress notes dated 10/07/2024 and 11/16/2024 documented Resident #79 had witnessed falls with no injuries.</p> <p>The Comprehensive Care Plan for falls dated 8/08/2024 documented the resident was at risk for falls with the following interventions: Wear proper footwear/non-skid, observe for decline in strength, mobility, and transfer ability, and ensure proper lighting. Educate resident and family on mobility and transfer. Physical Therapy or Occupational Therapy evaluation and participation to build strength + endurance as needed lab tests as appropriate. Remind resident to call for assistance before attempting to get out of bed, keep bed in low position. Encourage resident to sit near nurse's station when in wheelchair 8/27/2024. There were no updates to the fall care plan after 8/27/2024.</p> <p>During an interview on 12/06/2024 at 10:33 AM, Director of Nursing #1 stated the care plans should be updated after each fall noting the fall and interventions. The previous Director of Nursing had not made the appropriate updates to care plans. Going forward Nurse Managers and the Director of Nursing will update care plan after each fall.</p> <p>10 New York Codes, Rules, and Regulations 415.11(c)(2)(ii-iii)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48615</p> <p>Based on observations, record review, and interviews during the recertification survey, the facility did not ensure a dependent resident was provided with appropriate treatment and services to maintain or improve their language and communication for 1 (Resident #367) of 1 reviewed for Activities of Daily Living. Specifically, nursing staff did not provide Resident #367 with adequate, consistent interpreter services in accordance with professional standards of care.</p> <p>This was evidenced by:</p> <p>The facility's Policy and Procedure titled Communication effective 6/19/2029 and reviewed 3/2024, documented its Purpose: To provide our residents who communicate with non-oral communication devices, sign language, or who speak a language other than the dominate language of the facility (English) the highest practicable level of quality of life and the resources to achieve just that. Social Services kept an up-to-date list of all of our residents who communicate with non-oral communication devices, sign language, or who speak a language other than the dominate language of the facility (English), English Second Language (ESL) residents. For our English Second Language residents interpreter services could be utilized: Provide translator [PHONE NUMBER] code:527633.</p> <p>The New York State Department of Health Code, Rules and Regulation, Volume C (Title 10) Section 415.3 Effective 2/24/2022, documented each resident shall have the right to: (i) adequate and appropriate medical care, and to be fully informed by a physician in a language or in a form that the resident can understand, using an interpreter when necessary, of his or her total health status including but not limited to, his or her medical condition including diagnosis, prognosis, and treatment plan. Residents shall have the right to ask questions and have them answered.</p> <p>Resident # 367 was admitted to the facility with a diagnoses of Alzheimer's Disease unspecified (a brain disorder that slowly destroys memory and thinking skills), dementia unspecified (loss of memory, language, problem-solving and other thinking abilities), and anxiety. The minimum Data Set (an assessment tool) dated 11/25/2024 documented resident could be understood and understand others in Spanish. Resident was unable to complete Brief Interview for Mental Status. Resident's primary language is Spanish, and resident observed speaking Spanish only.</p> <p>Resident #367 Comprehensive Care Plan dated 11/25/2024, documented preferred language is Spanish.</p> <p>During an observation on 12/02/2024 at 10:45 AM, Resident #367 was observed pacing up and down halls on 400 unit. Resident appeared distressed and was speaking in Spanish. Staff did not respond to resident.</p> <p>During a dining observation on 12/02/2024 at 11:54 AM, Resident #367 observed pacing in and out of dining room. Resident required much re-direction to sit at dining room table for lunch. Staff observed making gestures to resident and speaking to resident in English.</p> <p>(continued on next page)</p>

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/02/2024 at 12:35 PM, Resident #367 approached surveyor speaking in Spanish. Surveyor asked resident their name. Resident responded inappropriately in Spanish. Survey asked how are you in Spanish ([NAME] estas?) resident responded bien [NAME] with a smile.</p> <p>During an observation on 12/03/2024 at 10:30 AM, resident had a male visitor (husband). Resident observed having a fluent conversation with visitor in Spanish. Resident appeared very happy to have the visitor present. Visitor brought Latin music and resident was moving to the music happily.</p> <p>During an interview on 12/02/2024 at 12:12 PM, Social Worker #1 stated they keep translation line for English Second Language Residents in their office along with the code. If staff needed to use the interpreter line, they would contact the social worker. When Social Worker is not available, they have bilingual staff to translate.</p> <p>During an interview on 12/02/2024 at 12:15 PM, Certified Nurse Aide #3 stated they use google translator to communicate with Resident #367. They stated there was a point object sheet in the manager's office but had not used it.</p> <p>During an interview on 12/02/2024 at 12:17 PM, Certified Nurse Aide #4 stated they communicated with Resident #367 using hand movements, guide with hands, and had never used google translator.</p> <p>During an interview on 12/02/2024 at 12:33 PM, Licensed Practical Nurse #15 stated they used communication phone line if needed, but was not sure where to locate the number, and was not aware there was a code.</p> <p>During an interview on 12/03/2024 at 11:15 AM, Administrator #1 stated they had a language line for English Second Language residents, but there was no specific training on language line. Administrator #1 stated they staffed facility each shift with Spanish speaking staff that can be used as an interpreter.</p> <p>10 New York Codes, Rules, and Regulations 415.12(a)(2)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide activities to meet all resident's needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</b></p> <p>Based on observation, record review, and interviews during the recertification survey, the facility did not ensure ongoing provision of programs to support each resident and their choices of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident for 2 (Resident #49, and #367) of 4 residents reviewed. Specifically, Residents #49, and #367 did not consistently attend meaningful, accommodating activities to maintain their highest practicable quality of life.</p> <p>This is evidenced by:</p> <p>The Facility's Policy and Procedure titled Activity Assessment and Programming, undated, documented, The purpose of this policy was to establish a framework for meaningful, individualized activities that promote physical, cognitive, emotional, and social well-being of each resident. The goal was to offer activities that enhanced residents' quality of life by fostering independence, engagement, and a sense of purpose, while respecting each individual's preferences and abilities.</p> <p>Guiding Principles: 1. Person-Centered Care: Activities will be personalized to each resident's interests, cultural background, and life history. The focus will be on offering choice and autonomy, allowing residents to engage in activities that resonate with them.</p> <p>Resident #49</p> <p>Resident # 49 was admitted to the facility with a diagnoses of dementia unspecified (loss of memory, language, problem-solving and other thinking abilities), anxiety, and hard of hearing. The Minimum Data Set (an assessment tool) dated 11/25/2024, documented resident was severely cognitively impaired, could be understood, and understand others.</p> <p>During an observation and interview on 12/02/2024 at 11:19 AM, Resident #49 was in bed awake, wearing hospital gown. Resident responded to writer in Spanish when asked how are you?</p> <p>Resident #49 was observed in bed on subsequent days of 12/03/2024 at 10:00AM, 12/04/2024 at 11:40 AM, and 12/05/2024 at 9:50 AM. On all days the room lights were off, and roommate had television on.</p> <p>During an observation and interview on 12/05/2024 at 9:47 AM, several residents on the 4th floor unit were engaged in a music activity with staff. Resident #49 was noted not in attendance but was found in bed dressed in shorts and a shirt and was asleep. Activities Aide #1 stated they worked 1:1 with Resident #49. They stated on 12/03/2024 they talked with Resident #49 at the bedside about how the day was going. Activities Aide #1 stated they did not speak Spanish but had a conversation with resident with the limited knowledge of Spanish that they had. Director of Nursing #1 stated Resident #49 generally got up in the afternoon and sat in the corridor.</p> <p>During an observation on 12/05/2024 at 3:21 PM, Resident #49 was in bed asleep, difficult to arouse.</p> <p>(continued on next page)</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #49's Activity Log documented resident refused the following: 11/27/2024 sensory; 11/28/2024; educational; 11/27/2024; games; 11/28/2024; floor carts; 12/01/2024 floor carts.</p> <p>Resident #367</p> <p>Resident # 367 was admitted to the facility with a diagnoses of Alzheimer's Disease unspecified (a brain disorder that slowly destroys memory and thinking skills), dementia unspecified (loss of memory, language, problem-solving and other thinking abilities), and anxiety. Resident's primary language is Spanish, and resident observed speaking Spanish only. The documentation indicated resident could understand and be understood by others in Spanish. The Minimum Data Set, dated dated dated [DATE], documented a Brief Interview for Mental Status score of 99 suggesting resident was unable to complete the interview.</p> <p>Resident #367 Comprehensive Care Plan dated 11/25/2024, documented preferred language is Spanish.</p> <p>During an observation on 12/02/2024 at 01:07 PM, Resident #367 paced up and down 4th floor unit. Resident was anxious and required much encouragement and direction. Activities calendar for the day consisted of BINGO, resident with dementia and unable to actively participate; cooking club at 1:30 PM; and Wheel of Fortune at 3:00 PM. English is resident's Second Language. Activities Director #1 stated activities were not in Spanish.</p> <p>During an observation on 12/03/2024 at 10:30 AM, resident had a male visitor (husband). Resident observed having a fluent conversation with visitor in Spanish. Resident appeared very happy to have the visitor present. Visitor brought Latin music and resident was moving to the music happily.</p> <p>10 New York Codes, Rules, and Regulations 415.5(f)(1)h</p> <p>48744</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34630</p> <p>Based on observations, record review, and interviews during a recertification survey, the facility did not ensure a resident who was fed by enteral means received the appropriate treatment and services to prevent complications of enteral feeding for 2 (Resident #s 114 and 172) of 2 residents reviewed. Specifically, for Resident #s 114 and 172, the facility did not ensure (a.) multiuse feeding sets (syringe/bottle) were labeled with the date opened and disposed of within 24 hours; (b) opened multiuse bottles of formula were labeled with the date/time opened and discarded within 48 hours.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Tube Feeding and Tube Care, reviewed 6/2024, documented the policy was written to provide guidance and general guidelines for administration of enteral feedings by the licensed nurse. Administration of feeding documented label the outside of the container (formula) with the date, time, and initials if appropriate (i.e. multiuse bottles). Prevention of bacterial contamination documented the enteral tube feeding set and tubing along with syringe was to be changed every 24 hours and discard any unused feeding after 48 hours of being open.</p> <p>Resident #114</p> <p>Resident #114 was admitted to the facility with diagnoses of gastrostomy status (a surgical opening in the stomach used for feeding), dysphagia (difficulty swallowing), generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 11/11/2024, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. The resident had a feeding tube while a resident in the facility.</p> <p>The Care Plan for Tube Feeding, revised 11/26/2024, documented the resident received bolus tube feeds (administration of a limited volume of enteral formula over extended periods of time). Interventions documented: 5 bolus tube feeds of 237 milliliters of Jevity (enteral formula) per day and change the feeding tubing and bag every day per policy and procedure.</p> <p>The Nutrition Progress Note dated 12/02/2024, documented the resident was receiving 100% of estimated needs from bolus tube feeds and well as an oral diet.</p> <p>The Nurse's Note dated 12/02/2024 by the Registered Nurse #3, documented Jevity was given via bolus as ordered.</p> <p>During an observation on 12/02/2024 at 12:25 PM, Resident #114 was noted to have two opened multiuse bottles of Jevity in their room. One bottle was dated 11/29/2024 and one was dated 12/01/2024. The time opened was not indicated. Two multiuse feeding sets were in the room that were dated 11/29/2024 and 12/01/2024.</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 12/05/2024 at 12:10 PM, Resident #114 was noted to have a multiuse feeding set labeled 12/03/2024 8:20 AM. There was an opened multiuse bottle of Jevity dated 12/01/2024 with a line through the date and a date of 12/03/2024 written above it. The time opened was not indicated.</p> <p>Resident #172</p> <p>Resident #172 was admitted to the facility with diagnoses of gastrostomy status (surgical opening in the stomach used for feeding), dysphagia (difficulty swallowing), and prediabetes. The Minimum Data Set, dated dated [DATE], documented the resident had severe cognitive impairment. The resident sometimes made themselves understood and usually understood others. The resident had feeding tube while a resident in the facility.</p> <p>The Care Plan for Nutrition, updated 11/26/2024, documented the resident received bolus feeds. Interventions documented: 3 bolus feeds per day of 237 ml of Jevity 1.2.</p> <p>During an observation on 12/2/2024 at 12:48 PM, Resident #172 had an opened multiuse bottle of Jevity dated 11/29/2024 with no time indicated. A multiuse feeding set was in the room and was not dated.</p> <p>The Nutrition Progress Note dated 12/4/2024, documented to continue with 3 bolus feeds per day of 237 ml of Jevity 1.2.</p> <p>During an observation on 12/05/2024 at 12:12 PM, Resident #172 had a multiuse feeding set in their room that was not dated and was filled about one-half inch with water and a multiuse feeding set that was labeled 12/3/2024 9:00 AM.</p> <p>During an interview on 12/10/2024 at 10:43 AM, Registered Nurse #1, stated everything should be labeled. The Jevity bottle should be labeled with date/time when it was opened and should be discarded after 24 hours. Stated the feeding syringe and bottle should be dated/time and discarded after 24 hours. Stated Resident #s 114 and 172 both received bolus tube feeds daily by gravity.</p> <p>During an interview on 12/10/2024 at 11:00 AM, Director of Nursing #1 stated the Jevity multiuse bottle should be discarded after 24 hours. Stated the Jevity bottle should be dated and timed so that you know exactly when the 24 hours was. Stated the syringe/bottle was changed daily on the night shift and documented on the treatment administration record.</p> <p>10 New York Code of Rules and Regulations 415.12(g)(2)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>34630</p> <p>Based on observations, record review, and interviews during a recertification survey, the facility did not ensure that each resident received respiratory care consistent with professional standards of practice for 1 (Resident #86) of 3 residents reviewed. Specifically, Resident #86's oxygen tubing was not changed on 12/01/2024 as ordered by the physician.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Oxygen Therapy - Mask and Nasal Cannula, revised 5/2024, documented all oxygen must be prescribed and dispensed in accordance with federal, state, and local laws and regulations. Oxygen administration would be monitored by the licensed nurse and documented on the Treatment Administration Record and in the electronic medical record.</p> <p>Resident #86 was admitted to the facility with diagnoses of chronic respiratory failure with hypoxia (decreased perfusion of oxygen to the tissues), end stage renal disease, and generalized muscle weakness. The Minimum Data Set (an assessment tool) dated 9/16/2024, documented the resident was cognitively intact. The resident was able to make themselves understood and understand others. The resident received continuous oxygen therapy.</p> <p>The Care Plan for Risk for Compromised Respiratory Status, updated 9/11/2024, documented chronic respiratory failure with hypoxia. Interventions documented oxygen per physician order.</p> <p>The Physician Order dated 10/29/2024 for oxygen therapy, documented change oxygen nasal cannula/tubing weekly on Sunday during the night shift.</p> <p>During an observation on 12/03/2024 at 9:08 AM, Resident #86 was receiving supplemental oxygen. There was no date on the oxygen tubing.</p> <p>The Treatment Administration Record as of 12/04/2024 at 11:04 AM, documented the oxygen tubing was last changed on 11/24/2024 at 5:00 AM.</p> <p>There was no documentation on the Treatment Administration Record that the oxygen tubing was changed on 12/01/2024.</p> <p>During an interview on 12/10/2024 at 11:00 AM, Director of Nursing #1 stated oxygen tubing was changed weekly on the night shift and documented in the medical record on the Treatment Administration Record. They stated the facility did not have oxygen tubing labels. They said that although they were not sure about the facility's policy, the documentation on the Treatment Administration Record was done at the time the oxygen was changed and that was how they knew when it was last changed.</p> <p>10 New York Code of Rules and Regulations 415.12(k)(6)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Capstone Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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)		
<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51131</b></p> <p>Based on observation, record review, and interviews during the recertification survey, the facility did not ensure pain management was provided to each resident in accordance with professional standards of care for 3 (Resident #'s 22, 25, and 317) of 4 residents reviewed for pain management. Specifically over a two-month period, the facility did not evaluate their existing pain and the cause(s), and managing or preventing pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. This resulted in residents' pain symptoms not being relieved to the extent possible.</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Pain Management, dated 3/17/2018 and last updated 8/2024, documented the resident's pain level was to be checked every shift, and documented in the resident's Medication Administration Record. Pain levels should have been determined using a scale appropriate to the resident's cognitive level and pain medication given as ordered in addition to non-medication interventions. Additionally, the facility policy documented it was the philosophy of this facility that pain management would be available to all residents. Residents who experience pain would be assessed and a treatment plan will be established to allow the resident the ability to function at their highest practicable level.</p> <p>Resident #22</p> <p>Resident #22 was admitted to the facility with diagnoses which included hypertensive heart and chronic kidney disease with heart failure (a disease of the heart and kidneys causing increased blood pressure and damage to the heart muscle), lymphedema (chronic swelling of the legs caused by excess fluid) and chronic pain syndrome (constant pain). The Minimum Data Set assessment dated [DATE], documented the resident had moderately impaired cognition, could be understood, and understand others.</p> <p>The Comprehensive Care Plan for Pain, last updated on 11/15/2024, documented the resident was to have a pain assessment on admission and every 3 months. The staff were to provide medical management of underlying causes of pain, evaluate effectiveness of the pain medication, encourage family to bring in comforting objects, utilize alternative methods of pain relief such as repositioning, rehabilitation evaluation as needed including physical therapy and monitor for side effects of analgesics, administer pain medications as per orders, observe for pain including nonverbal cues of discomfort, and observe effectiveness of pain control measure if needed.</p> <p>During observations on 12/02/2024 at 10:34 AM and on 12/04/2024 at 5:50PM, Resident #22 was observed seated in their wheelchair, holding the left side of their face and moaning.</p> <p>During an observation on 12/04/2024 at 5:50PM, Resident #22 was observed sitting in their wheelchair in the dining room area of Unit Two (2). Resident #22 was noted to have bilateral leg lymphedema with edematous skin (swelling of the lower extremity)?f ?Resident #22 was observed bending over and rubbing their legs. Resident #22 was observed bending over and rubbing their legs.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/05/2024 at 5:50 PM, Resident #22 stated that they hurt, and referred to their legs. They further stated that their mouth was very painful and could not remember when they had last been given pain medication.</p> <p>A Physician order dated 9/26/2024 documented administer Oxycodone 5 milligrams by mouth three times per day and Oxycodone 5 milligrams by mouth once a day as needed for moderate to severe pain, with maximum daily dose of 4 pills per day.</p> <p>A narcotic administration record dated 10/03/2024 at 12:17 PM documented Licensed Practical Nurse #6 removed oxycodone, 5 milligrams from the narcotic pre-filled dispensing card.</p> <p>Record review of narcotic administration records for the following dates and times revealed that in each instance, a nurse removed oxycodone 5 milligrams, and the signature was illegible for:</p> <ul style="list-style-type: none"> <li>- 10/03/2024 at 8:00 PM.</li> <li>- 11/14/2024 at 8:00 AM.</li> <li>- 11/15/2024 at 8:30 PM.</li> <li>- There was another oxycodone removed on 11/15/2024; in this instance, the time listed as removed was also illegible.</li> <li>- 11/16/2024 at 8:30 AM.</li> <li>- 11/16/2024 at 11:20 AM.</li> <li>- 11/16/2024 at 1:00 PM.</li> <li>- 11/16/2024 at 8:00 PM.</li> <li>- 11/17/2024 at 11:30 AM.</li> <li>- 11/17/2024 at 1:30 PM.</li> <li>- 11/17/2024 at 8:00 PM.</li> <li>- There was an oxycodone removed on 11/17/2024; in this instance, the time listed as removed was also illegible.</li> <li>- 11/21/2024 at 6:30 AM.</li> <li>- 11/21/2024 at 10:50 AM.</li> <li>- 11/21/2024 at 1:30 PM.</li> <li>- 11/21/2024 at 8:00 PM.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 11/26/2024 at 6:00 AM, 10:40 AM, 2:00 PM, and 8:00 PM.</p> <p>- 12/01/2024 at 1:00 PM and 8:00 PM.</p> <p>There was no documented evidence provided by the facility that indicated which nurse names were attributed to the illegible signatures.</p> <p>A narcotic administration record dated 10/08/2024 at 8:30 PM documented oxycodone, 5 milligrams, was removed by Registered Nurse #3. There were no other documented removals of oxycodone from the narcotic pre-filled dispensing card for Resident #22 for 10/08/2024.</p> <p>There was no documented evidence of the narcotic removal accountability sheet for Resident #22 from 10/22/2024 through 10/30/2024.</p> <p>During an interview on 12/06/2024 at 1:00PM, Director of Nursing #1 stated they reported narcotic administration records for the dates of 10/22/2024 through 10/30/2024 missing.</p> <p>Record review of medication administration record entries for the following dates and times revealed that in each instance, Resident #22 received a dose of oxycodone, 5 milligrams; entry did not document the resident's pain level before or after administration:</p> <p>- 10/03/2024 at 8:30 AM, 1:30 PM and 8:30 PM.</p> <p>- 10/08/2024 at 8:30 AM, 1:30 PM and 8:30 PM.</p> <p>- 11/15/2024 documented that Resident #22 received oxycodone at 8:30 PM only.</p> <p>- 11/16/2024 at 8:30 AM, 1:30 PM, and 8:30 PM.</p> <p>- 11/17/2024 at 8:30 AM, 1:30 PM, and 8:30 PM.</p> <p>- 11/21/2024 at 8:30 AM, 1:30 PM, and 8:30 PM.</p> <p>- 11/26/2024 at 8:30 AM, 1:30 PM, and 8:30 PM.</p> <p>The medication administration record dated 11/14/2024 documented that there were no medications administered to Resident #22.</p> <p>The medical provider notes dated 11/25/2024 documented Resident #22's chronic pain and the order for oxycodone 3 times a day for pain control.</p> <p>Record review of nursing progress notes for Resident #22 on 10/03/2024, 11/14/2024, 11/15/2024, 11/21/2024, 11/26/2024, revealed there was no documented evidence that the resident's pain was assessed prior to or after administration of the pain medication to monitor effectiveness.</p> <p>There were no nursing notes between 11/28/2024 and 12/02/2024 indicating pain medication use.</p> <p>Resident #25</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #25 was admitted to the facility with diagnoses which included Unspecified nondisplaced fracture of a cervical vertebra (neck fracture), other chronic pain, and congestive heart failure (a condition where the heart does not pump blood as well as it should). The Minimum Data Set, dated dated [DATE], documented the resident was cognitively intact, could be understood, and be understood by others.</p> <p>The Comprehensive Care Plan for Pain, last updated on 11/25/2024, documented the resident goals for pain, were pain assessment on admission and every month, evaluate effectiveness of pain medication, encourage their family /significant other to bring in comforting objects, repositioning as needed, rehab evaluation as needed, and provide pain medications as ordered and evaluate for effectiveness.</p> <p>Physician's order dated 11/22/2024 documented oxycodone 10 milligrams should be administered every 6 hours as needed for moderate/severe pain.</p> <p>Record review of narcotic administration records for the following dates and times revealed that in each instance, a nurse removed oxycodone 10 milligrams, and the signature was illegible for:</p> <ul style="list-style-type: none"> <li>- 11/01/2024 at an illegible time in the morning, 9:30 AM, 3:30 PM, and 9:45 PM.</li> <li>- 11/02/2024 at 5:00 AM, an illegible time in the morning, 11:30 AM, an illegible time in the evening, and 9:40 PM.</li> <li>- 1/26/2024 at 6:40 AM, 1:30 PM, and 8:00 PM.</li> <li>- 11/28/2024 at 7:00 AM, 1:00 PM, and 5:19 PM.</li> <li>- 11/29/2024 at 8:00 AM, 7:25 PM, and 9:30 PM.</li> <li>- 11/30/2024 at 2:00 AM, 6:48 AM, 11:12 AM, 1:40 PM, and 6:00 PM.</li> <li>- 12/01/2024 at 7:00 AM, 12:00 PM, and 8:00 PM.</li> <li>- 12/03/2024 at 8:52 AM, 3:00 PM, and 8:30 PM.</li> <li>- 12/04/2024 at 8:00 AM, 3:00 PM, and 8:30 PM.</li> </ul> <p>The narcotic administration records dated 11/03/2024 to 11/25/2024 for Resident #25 were not available to review.</p> <p>Record review of medication administration record entries for the following dates and times revealed that in each instance, Resident #25 received a dose of oxycodone, 5 milligrams; entry did not document the resident's pain level before or after administration:</p> <ul style="list-style-type: none"> <li>- 11/01/2024 at 9:32 AM, 3:27 PM, and 9:35 PM.</li> <li>- 11/29/2024 at 7:57 AM, and 7:22 PM.</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Capstone Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  302 Swart Hill Road Amsterdam, NY 12010	
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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Additionally, the following medication administration record entries did not document the resident's pain level after administration:</p> <ul style="list-style-type: none"> <li>- 11/02/2024 at 5:23 AM.</li> <li>- 11/26/2024 at 1:12 PM, and 7:32 PM.</li> <li>- 11/28/2024 at 7:30 AM, and 5:14 PM.</li> <li>- 11/30/2024 at 4:05 PM.</li> <li>- 12/01/2024 at 1:28 PM.</li> <li>- 12/03/2024 at 8:46 AM, and 8:15 PM.</li> <li>- 12/04/2024 at 7:00 AM, and 8:24 PM.</li> </ul> <p>The nursing note dated 11/26/2024 documented that the resident did not have pain.</p> <p>The nursing note dated 12/04/2024 did not document pain.</p> <p>Resident #317</p> <p>Resident #317 was admitted to the facility with diagnoses of bilateral primary osteoarthritis of the hip (pain caused by arthritis and bone deterioration in both hip joints), Type II diabetes, and Alzheimer's Disease (a type of dementia that affects memory, thinking, and behavior). The Minimum Data Set, dated dated [DATE] documented the resident was moderately cognitively impaired, could be usually understood, and understand others.</p> <p>The Comprehensive Care Plan titled Pain dated 11/29/2024 documented Resident #317 had pain related to arthritis, bilateral osteoarthritis of the hips and other vertebral disc degeneration of the lumbar region. Interventions listed included participate in activities of daily living, continue to participate in therapy activities, maintain comfort, encourage family/significant other to bring in comforting objects, utilize alternative methods of pain relief, provide pain medications as ordered and evaluate effectiveness, and provide comfort measures as needed.</p> <p>During an observation on 12/06/2024 at 11:20AM, Resident #317 was observed seated in a wheelchair loudly moaning. Licensed Practical Nurse #2 asked Resident #317 whether they were in pain and Resident #317 stated they were having pain.</p> <p>A record review of medication administration record dated 12/06/2024 documented Resident #22 did not receive their pain medication until 12:59 PM.</p> <p>A physician order dated 11/29/2024 documented to do a pain evaluation every shift using appropriate pain scale, and as needed.</p> <p>A physician order dated 12/07/2024 documented an order for Tramadol 50 milligrams, 1 tablet, by mouth, as needed for pain every 6 hours for bilateral osteoarthritis of the hip.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/02/2024 at 10:43 AM, Resident #25 stated their biggest concern was that the nurses were not consistently giving them pain medications.</p> <p>During an interview on 12/06/2024 at 11:00AM, Licensed Practical Nurse #1 stated the process to administer narcotic medications was first to look at the order in the resident's medication administration record. Licensed Practical Nurse #1 stated they were 'old school' and always checked the resident's pain level before administering medication.</p> <p>During an interview on 12/10/2024 at 9:32AM, Licensed Practical Nurse #3 stated when they administered as-needed narcotics or other types of pain medication, they would look at the last documented administration date and time. Licensed Practical Nurse #3 stated they checked the effectiveness of the last dose of pain medication and then confirmed that the resident was within the right time frame to receive another dose. Licensed Practical Nurse #3 stated they would ask the resident their current level of pain or they would use the facial recognition pain scale to determine the pre-medication pain level. They stated they determined the type of medication to offer resident based on their level of pain. If Tylenol was ordered for the resident, they would offer that first for any pain level under five. Licensed Practical Nurse #3 stated most residents would request the narcotic pain medication be given, even if offered Tylenol first. Licensed Practical Nurse #3 stated they would administer the medication per the resident's orders and then would go back an hour later to recheck effect. They stated the electronic medical record system would send a reminder one hour after administration to document the pain level after medication. Licensed Practical Nurse #3 stated when a medication was missed or a pain level was not checked, the electronic medical record system would turn the medication order to the color red from the color green. They stated it served as a reminder to the nurse that they still needed to document the administration.</p> <p>During an interview on 12/10/2024 at 9:48 AM, Registered Nurse #1 stated when residents experienced pain, they should have been assessed with a pain scale and administered the ordered pain medication within 20-30 minutes of their first request. Registered Nurse #1 stated they were not aware that residents were not receiving medication in a timely manner from the Licensed Practical Nurses.</p> <p>During an interview on 12/10/2024 at 12:10 PM, Registered Nurse #4 stated that they usually asked all the residents that they cared for if they needed anything for pain. They stated they asked Resident #25 if they needed something for pain and gave them a pain medication. They stated not every resident was screened for pain, but staff screened</p> <p>them if they were given pain medications. They stated on a daily basis not everyone who received pain medication was screened for pain, but pain assessments were done quarterly for the Minimum Data Set assessment.</p> <p>10 New York Codes of Rules and Regulations 415.12</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48744</b></p> <p>Based on observation, record review, and interviews during an abbreviated survey (NY00353512), the facility did not ensure the provision of sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident throughout the facility. Specifically, the facility's staffing minimum staffing levels were not met each day from 12/02/2024 through 12/10/2024 per facility assessment.</p> <p>This is evidenced by:</p> <p>Upon entrance to the facility on [DATE] there were 118 residents residing on 3 units.</p> <p>The Facility assessment dated 2024 and based on a resident population profile from 7/23/2023 to 7/23/2024 documented, the facility's staffing plan for direct residential care. The assessment documented that the facility strived to have at a maximum for staff the following: Each floor was provided with 2 Licensed Practical Nurses and 5 Certified Nurse Assistants on days (6:00 AM to 2:00 PM), 2 Licensed Practical Nurses and 4 Certified Nurse Assistants on evenings (2:00 PM to 10:00 PM), and 1 Licensed Practical Nurse and 2 Certified Nurse Aides on nights (10:00 M to 6:00 AM) per floor and a Registered Nurse supervisor daily on evening and night shift. On weekends the facility strives to have a Registered Nurse supervisor on days, evenings, and nights. The facility's minimum staff requirements were the following: 1 Licensed Practical Nurse and 2 Certified Nurse Aides on days, 1 Licensed Practical Nurse and 2 Certified Nurse Assistants on evenings, and 1 Licensed Practical Nurse and 1 Certified Nurse Aide on nights per floor and Registered Nurse coverage 8 consecutive hours per day.</p> <p>A review of staffing sheets provided by the facility from 12/03/2024 through 12/10/2024 documented the following:</p> <p>On 12/03/2024 the 3rd floor unit were short 1 Licensed Practical Nurse and 1 Certified Nurse Assistant for the day shift, short 1 Licensed Practical Nurse on evenings, and had no Licensed Practical Nurses scheduled for night shift. The 4th floor was short 1 Licensed Practical Nurse on the day and evening shifts.</p> <p>On 12/04/2024 the 2nd floor unit was short 1 Licensed Practical Nurse on the evening shift. The 3rd floor was short 1 Licensed Practical Nurse on both day and evening shifts and short 1 Certified Nurse Assistant on day shift. The 4th floor was short 1 Licensed Practical Nurse on day and evening shift.</p> <p>On 12/05/2024 the 2nd floor unit was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on day shift, and 1 Certified Nurse Aide on evening shift. The 3rd floor was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on the day shift, short 1 Licensed Practical Nurse and 1 Certified Nurse Aides on evening shift and short 1 Licensed Practical Nurse on night shift. The 4th floor was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on day shift, and 1 Licensed Practical Nurse on evening shift.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 12/06/2024 the 2nd floor unit was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide for day shift, short 2 Licensed Practical Nurses, and 1 Certified Nurse Aide on evening shift and had no Licensed Practical Nurses scheduled for the night shift. The 3rd floor was short 2 Licensed Practical Nurses and 2 Certified Nurse Aides on day shift, short 1 Licensed Practical Nurse, and 1 Certified Nurse Aide on evening and night shift. The 4th floor was short 2 Licensed Practical Nurses and 1 Certified Nurse Aide for day shift, short 2 Licensed Practical Nurses and 1 Certified Nurse Aide on evening shift, and short 1 Licensed Practical Nurse on night shift.</p> <p>On 12/07/2024 the 2nd floor was short 1 Certified Nurse Aide on day, evening, and night shifts. The 3rd floor was short 1 Licensed Practical Nurse, 2 Certified Nurse Aides on day shift, short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on evening shift, and short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on night shift. The 4th floor was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on day and evening shifts, and short 1 Certified Nurse Aide on night shift.</p> <p>On 12/08/2024 the 2nd floor was short 2 Certified Nurse Aides on the day and evening shifts. The 3rd floor was short 2 Certified Nurse Aides on the day shift, short 1 Licensed Practical Nurse and 2 Certified Nurse Aide on the evening shift and short 1 Certified Nurse Aide on the night shift. The 4th floor was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on day shift, and short 1 Licensed Practical Nurse and 2 Certified Nurse Aides on the evening shift.</p> <p>On 12/09/2024 the 2nd floor was short 1 Certified Nurse Aide on the day and evening shifts. The 3rd floor was short 2 Certified Nurse Aide on day shift, short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on the evening shift, and short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on the night shift. The 4th floor was short 1 Licensed Practical Nurse on the day shift, short 1 Licensed Practical Nurse, and short 1 Certified Nurse Aide on the evening shift.</p> <p>On 12/10/2024 the 2nd floor was short 1 Certified Nurse Aide on day shift, and short 1 Licensed Practical Nurse on evening shift. The 3rd floor was short 1 Licensed Practical Nurse and 1 Certified Nurse Aide on the day shift, short 1 Licensed Practical Nurse on the evening shift, and short 1 Licensed Practical Nurse on the night shift. The 4th floor was short 1 Licensed Practical Nurse on the day shift, and short 2 Licensed Practical Nurses on the evening shift.</p> <p>During an interview on 12/02/2024 at 11:18 AM, Resident #103 stated that they have had to wait for staff for 10-20 minutes when they were short staffed, but since the resident did a lot on their own, they did not feel it affected them as much as other residents.</p> <p>During an interview on 12/02/2024 at 12:48 PM, Resident #60 stated they did not get up because they had to wait too long.</p> <p>During an interview on 12/02/2024 at 12:59 PM, a resident's family member who wished to remain anonymous stated that staff were very nice, there just were not enough of them.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Capstone Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  302 Swart Hill Road Amsterdam, NY 12010	
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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/06/2024 at 11:00 AM, Nurse Scheduler #1 stated they knew staffing was an issue but thought it was getting better for nurses. The facility had recently hired a couple of nurses. The goal was to have 2 Licensed Practical Nurses per unit on days and evening and 1 Licensed Practical Nurse on nights with 2 Certified Nurse Aides. Certified Nurse Aide numbers had gotten better. Thursday and Friday were rough days because everyone worked every other weekend, so they took the Thursday or Friday off before their weekends off which made bigger holes in staffing. Call ins have always been a problem. They stated 2nd and 4th floor were where they focused their attention because those tended to be the units with the heavier workload.</p> <p>During an interview on 12/10/24 at 9:58 AM, Nurse Scheduler #2 stated that it was the first day that they had a significant problem with staffing. Usually, every Monday the staffing sheets went to the Director of Nursing and the Administrator. The same people were also given staffing sheets whenever there was a change in the staffing. The facility did not want to put Registered Nurses on medication carts but would if the staffing holes required it. Nurse Scheduler #1 stated Director of Nursing #1 had never taken an assignment since they had been there. The unit managers have had to take an assignment when there have been staffing shortages the scheduler could not fix. There were no incentives offered to incentivize the staff to come to work. Shift swaps were done to try and make deals to get the nurses to come in. At the time of the interview, the Nurse Scheduler #1 was calling the next staff to try and get someone to come in and cover the holes for the day but had not yet heard anything. Nurse Scheduler #1 stated that they would turn to agency staff if nothing else was working.</p> <p>During an interview on 12/10/2024 at 12:11 PM, Administrator #1 stated that Unit managers were being educated that they were mini-Directors of Nursing and needed to be responsible for the staff on their units. To increase staff, retain staff already in house and entice new staff to work at the facility, there were frequent raffles. If staffed picked up extra shifts, they got extra [NAME] tickets. There were monetary bonuses for nurses that picked up extra shifts. Swapping of shifts was offered to try and fill staffing needed. Agency staff were also used to complete staffing patterns. The facility also did a lot of employee appreciation events like lunches and pies and turkeys for thanksgiving. The facility had upcoming parties for the holidays along with gifts. Additionally, the facility offered assistance with transportation for the staff for example transportation gift cards were given out. Administrator #1 stated that they try to foster a family environment within the facility and all upper leadership staff knew the floor staff and there were open door policies throughout the building. Administrator #1 stated the facility did not share staff between sister facilities and that roughly 70% of the staff had left and came back because they liked it better at their facility.</p> <p>10 New York Code Rules and Regulations 415.13(a)(1)(i-iii)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>48744</p> <p>Based on observations, record reviews, and interviews during the recertification survey, the facility did not have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Specifically, the facility nursing staff did not document unit narcotics were counted by two licensed staff members and signed as appropriately done on the facility provided narcotic record sheets.</p> <p>This is evidenced by:</p> <p>The Facility assessment dated 2024 and based on a resident population profile from 7/23/2023 to 7/23/2024 documented, Staff Training/competency/skill sets that were necessary to provide the level and types of care needed for the resident population:</p> <p>The facility had a full time Nurse Educator who maintained a list of position- based competencies for nursing staff which was position dependent. An annual education calendar was utilized and included within the supporting documentation section of this facility assessment. See job descriptions for skill sets needed under supporting documentation. See staff training policy in supporting documents.</p> <p>A facility policy titled Facility Training Policy and Procedure, not dated, documented that all new staff received a comprehensive orientation and initial training that covered the facility's policies, procedures, and resident care requirements. Nursing specific education included but was not limited to documentation and medication administration.</p> <p>A facility policy titled Medication Storage dated 3/2023, documented that all medications would be stored in a manner that maintains the integrity of the product, ensures the safety of the residents and is in accordance with Department of Health Guidelines.</p> <p>A facility policy titled Medication Administration dated 6/2024 documented the following:</p> <p>That if a resident refused a medication, re-approach twice more as appropriate. If the resident still refuses the medication/s properly dispose of the medication. Documentation should include refusal, notification of MD at the time of refusal. Notification of Unit Manager/Supervisor and place on the 24-hour report.</p> <p>Additionally, the policy documented the if the medication was dropped or integrity compromised, dispose of medication.</p> <p>Do not to administer medication prepared by someone else</p> <p>Do not prepare medication for another person to administer.</p> <p>Document all medication and treatment administration in the electronic medical record.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Narcotic medications were to be signed for in the control drug book at the time they are administered and document administration in the electric Medication Administration Record.</p> <p>Discarded Narcotics required 2 signatures of Licensed Practical Nurse or Registered Nurse staff.</p> <p>Medications were to be administered no more than one-hour before or one hour after the ordered time. If you believe you would be outside the expected time frame notify Registered Nurse Manager/Supervisor, Registered Nurse Manager/Supervisor to notify Medical Doctor of late administration and obtain any new owners if applicable. The medication cart was not to be left unattended and unlocked. Both the controlled substance drawer lock and outer lock are to be locked if cart is unattended.</p> <p>A facility policy titled Facility Training Policy and Procedure, not dated, documented the following:</p> <p>All new staff received a comprehensive orientation and initial training that covers the facility's policies, procedures, and resident care requirements.</p> <p>Nursing specific education included but was not limited to medication administration and documentation.</p> <p>During an observation of the 2nd floor unit on 12/06/2024 at 1:15 PM, the narcotic record book was observed to be on top of the medication cart in the hallway unattended and accessible to anyone in the hallway. Narcotic count sheets required to be signed by two licensed nurses at change of shift were found in the unattended book. Sheets dated throughout October, and November 2024 documented two licensed staff (one from on-coming shift and one from off-going shift) were supposed to be counting narcotic at change of shift but that was not occurring. The second narcotic book on unit 2 was in the medication room locked behind the door. It contained narcotic sheets inconsistently signed from multiple months and shifts in September and November 2024.</p> <p>During an interview on 12/06/2024 at 1:28 PM, Nurse Educator #1 stated that they were unable to explain why the shift-to-shift narcotic count sheets were unsigned or signed incorrectly. It was expected that the licensed staff would do the count together and sign the sheets together.</p> <p>During an interview on 12/06/2024 at 3:42 PM, Administrator #1 stated that they did not know the policy and would need to refer to the policy or ask the Director of Nursing regarding the requirement for counting narcotics at change of shift. Administrator #1 stated that they knew that two nurses needed to do the count, that two nurses need to sign the sheets, knew there were 2 sheets - 1 sheet for the floor count and 1 sheet for individual resident's narcotics. Administrator #1 stated that they knew 2 nurses were needed to waste medications.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/06/2024 at 3:50 PM, Director of Nursing #1 stated that the narcotic count needed to be done at change of shift before keys were handed off. 2 licensed staff members needed to do the count and sign the shift-to-shift narcotic sheet. 1 on coming staff member and 1 outgoing staff member was the expectation of the nurses that count and sign the sheets together. When wasting medication, it was expected that two nurses would sign for the wasted medication. Additionally, it was the expectation that both nurses would observe the wasting of the medication, not just sign the sheets, and let the one licensed staff member dispose of or count any narcotics on the units by themselves. When asked if the rules surrounding narcotics were taught or reviewed with new staff, or if the licensed staff were expected to know because it was part of nursing licensure, Director of Nursing #1 stated that it was reviewed when staff was newly hired and reviewed annually.</p> <p>During an interview on 12/10/2024 at 9:58 AM, Nurse Scheduler #1 stated that the staffing agency that was used to find staff for the facility had a star rating which helped the facility determine if the potential staff member had the competencies and skill required to work there. The star rating of potential staff fluctuated based on the ratings received from previous facilities. Not calling or showing up for a shift would lower a star rating as well as a bad review from previous facilities. The lower the star the less likely the facility would be to employ them through the agency.</p> <p>During an interview on 12/10/2024 at 10:42 AM, Nurse Educator #1 stated that Licensed Practical Nurses and Registered Nurses r received 3 days of orientation training. Medication competencies were part of orientation and were done annually. It was recently reviewed in April 2024. Nurse Managers did annual performance reviews of the licensed staff on the floors. Nurse Educator #1 stated they would not get the performance reviews unless they asked for them. Nurse Educator #1 stated that they went to the floor and watched the staff to make sure things were done according to policy.</p> <p>During an interview on 12/10/2024 at 12:11 PM, Administrator #1 stated that due to the extent of the issues surrounding the narcotic counts and administrations, there was someone checking the licensed staff's narcotic count sheets every shift change to make sure that the counts and sheets were done correctly. Shift supervisors were the first people to check the sheets. After that the sheets would be given to the Assistant Director of Nursing #1 to check. Then Director of Nursing #1 would check all the work to make sure it was correct. Administrator #1 stated that they had not come up with the long-term plan to ensure that staff were doing their job correctly but that the Director of Nursing was going to be very involved. The Unit Managers were being educated that they were essentially mini-Directors of Nursing and needed to be responsible for the staff on their units. Additionally, Administrator #1 stated that the corporate office was going to provide the facility a person that would travel between their facility and one other and be overseeing operations to help get them on track.</p> <p>10 New York Codes, Rules, and Regulations 415.26(c)(1)(iv)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34630</p> <p>Based on record review and interviews during a recertification survey, the facility did not ensure residents were free of any significant medication errors for 4 (Resident #s 3, 12, 22, and 25) of 30 residents reviewed. Specifically, for Resident #s 3, 12, 22 and 25, the facility did not ensure accurate medication administration and documentation of Oxycodone (narcotic pain medication).</p> <p>This is evidenced by:</p> <p>The Policy and Procedure titled, Medication Administration, revised 6/2024, documented medications would be administered by a licensed and/or registered nurse. All medications and treatments would be administered and documented using the electronic medical record. Narcotic medications were to be signed for in the control drug book (Control Substance Record) at the time they were administered, and the administration was to be documented in the electronic Medical Administration Record. Discarded Narcotics required two (2) signatures of Licensed Practical Nurse or Registered Nurse staff and Review of the electronic Medication Administration Record to ensure all medications were given at the end of the assigned shift.</p> <p>Resident #3</p> <p>Resident #3 was admitted to the facility with diagnoses of calcific tendonitis (calcium deposits form on the tendons and can cause inflammation and pain) left ankle and foot, pain in right wrist, and chronic pain syndrome. The Minimum Data Set (an assessment tool) dated 10/14/2024, documented the resident was cognitively intact. The resident was able to make themselves understood and understood others.</p> <p>The Care Plan for Pain, updated 10/10/2024, documented calcific tendonitis left ankle and foot, pain in right wrist, and chronic pain syndrome. Interventions documented provide medical management of underlying cause of pain.</p> <p>Physician Order renewed on 11/26/2024 for Oxycodone HCl 10 mg, 1 tablet by mouth PRN (as needed) for left leg pain. PRN (as needed) limit every 6 hours.</p> <p>Review of the a) Control Substance Records and b) electronic Medication Administration Records dated November and December 2024 documented:</p> <p>Control Substance Record for Oxycodone 10 mg tablet, 1 tablet by mouth every 8 hours as needed for pain. Maximum daily dose: 3 tablets.</p> <p>110/2/2024 a) Oxycodone 10 mg was administered at 8:30 PM.</p> <p>11/02/2024 b) Medication Administration Record did not document the administration.</p> <p>The Control Substance Records dated 11/03/2024 to 11/16/2024 were not available for review.</p> <p>11/17/2024 a) Oxycodone 10 mg was administered at 2:30 PM and 9:00 PM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/17/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/18/2024 a) Oxycodone 10 mg was administered at 7:30 AM.</p> <p>11/18/2024 b) Medication Administration Record did not document the administration.</p> <p>11/19/2024 a) Oxycodone 10 mg was administered at 2:30 PM and 9:30 PM.</p> <p>11/19/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/22/2024 a) Oxycodone 10 mg was administered at 8:00 PM.</p> <p>11/22/2024 b) Medication Administration Record did not document the administration.</p> <p>11/23/2024 a) Oxycodone 10 mg was administered at 7:10 AM, an illegible PM time, and 8:00 PM.</p> <p>11/23/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/24/2024 a) Oxycodone 10 mg was administered at 6:30 AM.</p> <p>11/24/2024 b) Medication Administration Record did not document the administration.</p> <p>11/25/2024 a) Oxycodone 10 mg was administered at 8:30 PM.</p> <p>11/25/2024 b) Medication Administration Record did not document the administration.</p> <p>11/28/2024 a) Oxycodone 10 mg was administered at 6:45 AM and 12:30 PM.</p> <p>11/28/2024 b) Medication Administration Record did not document the administrations.</p> <p>12/1/2024 a) Oxycodone 10 mg was administered at 8:00 AM.</p> <p>12/1/2024 b) Medication Administration Record did not document the administration.</p> <p>12/2/2024 a) Oxycodone 10 mg was administered at 3:30 PM.</p> <p>12/2/2024 b) Medication Administration Record did not document the administration.</p> <p>12/3/2024 a) Oxycodone 10 mg was administered at 8:00 PM.</p> <p>12/3/2024 b) Medication Administration Record did not document the administration.</p> <p>12/4/2024 a) Oxycodone 10 mg was administered at 7:00 AM and 1:00 PM.</p> <p>12/4/2024 b) Medication Administration Record did not document the administrations.</p> <p>12/5/2024 a) Oxycodone 10 mg was administered at 7:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>12/5/2024 b) Medication Administration Record did not document the administration.</p> <p>12/6/2024 a) Oxycodone 10 mg was administered at 7:00 AM.</p> <p>12/6/2024 b) Medication Administration Record did not document the administration.</p> <p>12/7/2024 a) Oxycodone 10 mg was administered at 7:26 AM.</p> <p>12/7/2024 b) Medication Administration Record did not document the administration.</p> <p>12/8/2024 a) Oxycodone 10 mg was administered at 2:00 PM, then at 6:34 AM, and then at 12:40 PM.</p> <p>12/8/2024 b) Medication Administration Record documented one administration at 11:32 AM.</p> <p>Resident #12</p> <p>Resident #12 was admitted to the facility with diagnoses of diabetes, arthropathies (joint disease) right shoulder, and weakness. The Minimum Data Set, dated dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others.</p> <p>The Care Plan for Pain updated 10/4/2024, documented pain in bilateral shoulders and neck. Interventions documented provide medical management of underlying cause of pain and monitor for side effects of analgesics.</p> <p>Physician Order dated 10/9/2024 for Oxycodone HCl 5 mg, 1 tablet by mouth as needed for shoulder and back pain. PRN (as needed) limit 3 times/day.</p> <p>Review of the a) Control Substance Records and b) electronic Medication Administration Records dated November and December 2024 documented:</p> <p>Control Substance Record for Oxycodone IR (immediate release) 5 mg, 1 tablet by mouth 3 times daily as needed for shoulder/back pain. Maximum daily dose: 3 tablets.</p> <p>11/5/2024 a) Oxycodone 5 mg was administered at 12:30 AM.</p> <p>11/5/2024 b) Medication Administration Record did not document the administration.</p> <p>11/7/2024 a) Oxycodone 5 mg was administered 7:00 AM, 1:00 PM, and 8:00 PM.</p> <p>11/7/2024 b) Medication Administration Record, documented Oxycodone 5 mg was administered at 7:00 AM and again at 7:00 AM. The 1:00 PM administration was not documented. The 8:00 PM administration was documented at 8:47 PM.</p> <p>11/9/2024 a) Oxycodone 5 mg was administered at 5:00 AM, 12:30 PM, 6:00 PM, 10:00 PM (4 times)</p> <p>11/9/2024 b) Medication Administration Record did not document the administrations.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/14/2024 a) Oxycodone 5 mg was administered at 12:00 PM.</p> <p>11/14/2024 b) Medication Administration Record did not document the administration.</p> <p>11/16/2024 a) Oxycodone 5 mg was administered at 7:00 AM, 1:00 PM, and 8:00 PM</p> <p>11/16/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/18/2024 a) Oxycodone 5 mg was administered at 12:00 PM.</p> <p>11/18/2024 b) Medication Administration Record did not document the administration.</p> <p>11/20/2024 a) Oxycodone 5 mg was administered at 12:00 PM and 7:30 PM.</p> <p>11/20/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/21/2024 a) Oxycodone 5 mg was administered at 1:00 PM and 8:00 PM. The 8:00 PM administration had a line through it and error was written next to the amount remaining that had changed from 30 and was 29. There was no documentation to indicate the medication was discarded.</p> <p>11/21/2024 b) Medication Administration Record did not document the 1:00 PM administration.</p> <p>11/22/2024 a) Oxycodone 5 mg was administered at 12:00 PM and 8:00 PM.</p> <p>11/22/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/23/2024 a) Oxycodone 5 mg was administered at 12:00 PM.</p> <p>11/23/2024 b) Medication Administration Record did not document the administration.</p> <p>11/25/2024 a) Oxycodone 5 mg was administered at 12:30 PM and 2:00 PM.</p> <p>11/25/2024 b) Medication Administration Record did not document the administrations.</p> <p>11/26/2024 a) Oxycodone 5 mg was administered at 12:00 PM.</p> <p>11/26/2024 b) Medication Administration Record did not document the administration.</p> <p>11/27/2024 a) Oxycodone 5 mg was administered at 1:00 PM.</p> <p>11/27/2024 b) Medication Administration Record did not document the administration.</p> <p>11/28/2024 a) Oxycodone 5 mg was administered at 12:00 PM.</p> <p>11/28/2024 b) Medication Administration Record did not document the administration.</p> <p>11/29/2024 a) Oxycodone 5 mg was administered at 7:30 PM.</p> <p>(continued on next page)</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/29/2024 b) Medication Administration Record documented the medication was administered at 4:44 PM.</p> <p>11/30/2024 a) Oxycodone 5 mg was administered at 5:00 AM, 12:00 PM, and 7:30 PM.</p> <p>11/30/2024 b) Medication Administration Record did not document the administrations.</p> <p>12/1/2024 a) Oxycodone 5 mg was administered at 12:00 PM and 8:00 PM.</p> <p>12/1/2024 b) Medication Administration Record did not document the administrations.</p> <p>12/2/2024 a) Oxycodone 5 mg was administered at 7:00 AM and 12:00 PM.</p> <p>12/2/2024 b) Medication Administration Record did not document the administrations.</p> <p>Resident #22</p> <p>Resident #22 was admitted to the facility with diagnoses of chronic pain syndrome, lymphedema (chronic swelling of the legs caused by excess lymphatic fluid), and dorsalgia (pain in the back or spine) The Minimum Data Set, dated dated dated [DATE], documented the resident had moderately impaired cognition, could understand others and be understood.</p> <p>The Care Plan for Pain updated 11/15/2024, documented dorsalgia (back) and chronic pain syndrome. Interventions documented administer pain medications as per orders.</p> <p>Physician order dated 11/15/2024 documented Oxycodone 5 milligrams by mouth three (3) times per day and one (1) as needed dose for pain.</p> <p>Review of the a) Control Substance Records and b) electronic Medication Administration Records dated November and December 2024 documented:</p> <p>Control Substance Record for Oxycodone IR (immediate release) 5 mg, 1 tablet by mouth 3 times daily and 1 tablet as needed. Maximum daily dose: 4 tablets.</p> <p>11/14/2024 a) Oxycodone 5 mg was administered at 8:00 AM</p> <p>11/14/2024 b) Medication Administration Record did not document the administration.</p> <p>11/15/2024 a) Oxycodone 5 mg was administered at 8:30 PM and was documented on the Medication Administration Record at 8:30 PM.</p> <p>- After the 8:30 PM administration, there was another administration dated 11/15/2024 with an illegible AM time.</p> <p>- b) Medication Administration Record did not document the administration.</p> <p>11/16/2024 a) Oxycodone 5 mg was administered at 11:20 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/16/2024 b) Medication Administration Record did not document the administration.</p> <p>11/17/2024 a) Oxycodone 5 mg was administered at 11:30 AM.</p> <p>11/17/2024 b) Medication Administration Record did not document the administration.</p> <p>11/21/2024 a) Oxycodone 5 mg was administered at 10:50 AM.</p> <p>11/21/2024 b) Medication Administration Record did not document the administration.</p> <p>11/26/2024 a) Oxycodone 5 mg was administered at 10:40 AM.</p> <p>11/26/2024 b) Medication Administration Record did not document the administration.</p> <p>12/1/2024 a) Oxycodone 5 mg was administered at 1:00 PM and 8:00 PM.</p> <p>12/1/2024 b) Medication Administration Record did not document the administrations.</p> <p>Resident #25</p> <p>Resident #25 was admitted to the facility with diagnoses of unspecified nondisplaced fracture of the fourth cervical vertebra (neck fracture), other chronic pain, and congestive heart failure (a condition where the heart does not pump blood as well as it should). The Minimum Data Set assessment dated [DATE], documented the resident was cognitively intact, could understand others and be understood.</p> <p>The Care Plan for Pain updated 11/27/2024. Interventions documented provide pain medications as ordered and evaluate effectiveness.</p> <p>Physician's order dated 11/22/2024 documented oxycodone 10 mg should be administered every 6 hours as needed for moderate/severe pain.</p> <p>Review of the a) Control Substance Records and b) electronic Medication Administration Records dated November and December 2024 documented:</p> <p>Control Substance Record for Oxycodone IR 10 mg tablet, 1 tablet by mouth every 6 hours as needed for pain. Maximum daily dose: 4 tablets.</p> <p>11/1/2024 a) Oxycodone 10 mg was administered at 5:00 AM.</p> <p>11/1/2024 b) Medication Administration Record did not document the administration.</p> <p>11/2/2024 a) Oxycodone 10 mg was administered 5 times: 5:00 AM, an illegible AM time, 11:30 AM, 4:30 PM, and 9:40 PM.</p> <p>11/2/2024 b) Medication Administration Record documented one administration at 5:23 AM.</p> <p>The Control Substance Records dated 11/03/2024 to 11/25/2024 were not available to review.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/26/2024 a) Oxycodone 10 mg was administered at 6:40 AM.</p> <p>11/26/2024 b) Medication Administration Record did not document the administration.</p> <p>11/28/2024 a) Oxycodone 10 mg was administered at 7:00 AM and 1:00 PM.</p> <p>11/28/2024 b) Medication Administration Record documented two administrations, both at 7:30 AM. The record did not document the 1:00 PM administration.</p> <p>11/29/2024 a) Oxycodone 10 mg was administered at 9:30 PM.</p> <p>11/29/2024 b) Medication Administration Record did not document the administration.</p> <p>11/30/2024 a) Oxycodone 10 mg was administered 5 times: 2:00 AM, 6:48 AM, 11:12 AM, 1:40 PM, and 6:00 PM.</p> <p>11/30/2024 b) Medication Administration Record documented one administration at 4:05 PM.</p> <p>12/1/2024 a) Oxycodone 10 mg was administered at 7:00 AM, 12:00 PM, and 8:00 PM.</p> <p>12/1/2024 b) Medication Administration Record documented one administration at 1:28 PM.</p> <p>12/3/2024 a) Oxycodone 10 mg was administered at 3:00 PM.</p> <p>12/3/2024 b) Medication Administration Record did not document the administration.</p> <p>12/4/2024 a) Oxycodone 10 mg was administered at 3:00 PM.</p> <p>12/4/2024 b) Medication Administration Record did not document the administration.</p> <p>During an interview on 12/06/2024 at 11:00 AM, Licensed Practical Nurse #1 stated the process to administer narcotic medications was first to look at the order in the resident's medication administration record. Licensed Practical Nurse #1 stated they determined whether the medication was as needed or a regular dose. If the medication was a scheduled dose, it would appear in green on the medication administration record as a scheduled medication for that shift. Licensed Practical Nurse #1 stated they were old school and always checked the resident's pain level before administering medication. They stated they would compare the medication administration record order of the resident to the narcotic administration record sheet in the narcotic book on their cart. They would unlock the narcotic box and remove the correct medication. They would pop the pill out of the pill pack and write down the full count of the remaining pills on the narcotic administration record. Licensed Practical Nurse #1 stated they would administer the medication to the resident and then sign the medication administration record.</p> <p>During an interview on 12/09/2024 at 9:17 AM, Registered Nurses #1 and #4 stated they were not aware of a nurse signature sheet. Registered Nurse #1 suggested asking Director of Nursing #1.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/09/24 at 9:19 AM, Director of Nursing #1 stated they did not have a nurse signature sheet. They stated the facility was currently doing signature audits so they could have an updated list. They stated PRN (as needed) Oxycodone was supposed to be documented on the Medication Administration Record. The routine medications would show up on the screen as ready to be given, whereas the PRN (as needed) would still appear on the screen as a medication that was available to be given. They stated they were not aware of any problems with documenting PRNs (as needed) on the Medication Administration Record.</p> <p>During an interview on 12/09/2024 at 12:35 PM, Licensed Practical Nurse #3 stated they never gave Resident #22 Oxycodone on their shift. They stated they worked with Licensed Practical Nurse #7 around 11/15/2024. Licensed Practical Nurse #3 stated it was not their signature on the Control Substance Record dated 11/15/2024, with a time that was illegible.</p> <p>During an interview on 12/09/2024 at 3:16 PM, Licensed Practical Nurse #7 stated it was not their signature on Resident #22's Control Substance Record dated 11/15/2024, with a time that was illegible. They stated they recognized the signature, and it was Registered Nurse #1's. they stated the time looked like 11:20 AM. They stated their process for narcotic pain medication was to do the count first and then get the keys. They check the physician order and then does the 5 checks, several times. They give the medication at the scheduled time. They stated for PRN (as needed) pain medications, they would look to see when the medication was given last and when it was documented. Stated they document on the Medication Administration Record right after they document on the Control Substance Record. Surveyor asked how any other nurse could get the keys to the narcotic box and they stated they would have to get the keys from the medication nurse.</p> <p>During an interview on 12/09/2024 at 4:14 PM, Registered Nurse #1 stated it was not their signature on the Control Substance Record dated 11/15/2024, with a time that was illegible. They stated it looked like Licensed Practical Nurse #3's signature and the time looked like 6:00 AM.</p> <p>During an interview on 12/9/2024 at 4:33 PM, Director of Nursing #1 stated Licensed Practical Nurse #20 worked on 11/15/2024. They stated Resident #22 came back from the hospital late on 11/15/2024. They stated the time on the Control Substance Record for 11/15/2024 was 11:20 PM and was written incorrectly under AM.</p> <p>Review of timecard punches for 11/15/2024, did not document any time punches for Licensed Practical Nurse #20.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/2024 at 9:32AM, Licensed Practical Nurse #3 stated when they administer as needed narcotic or other types of pain medication, they always waited for the resident to request the medication. Licensed Practical Nurse #3 stated their process was to look at the last documented administration date and time. Licensed Practical Nurse #3 stated they checked the effectiveness of the last dose of pain medication and then would confirm that the resident was within the right time frame to receive another dose. Licensed Practical Nurse #3 stated they would check the medication order on the Narcotic Administration record (Control Substance Record) located in the narcotic book and the medication order in the electronic medical record system. They would then check the dose and strength against the medication order on the pill pack from pharmacy. Licensed Practical Nurse #3 stated they would ask the resident their current level of pain or they would use the facial recognition pain scale to determine the pre-medication pain level. Licensed Practical Nurse #3 stated they determined the type of medication to offer resident based on their level of pain. If Tylenol was ordered for the resident, they would offer that first for any pain level under five (5). Licensed Practical Nurse #3 stated most residents would request the narcotic pain medication be given, even if offered Tylenol first. Licensed Practical Nurse #3 stated they would administer the medication per the residents' orders and then would go back an hour later to recheck effect. The electronic medical record system would send a reminder in one hour to document the pain level after medication. Licensed Practical Nurse #3 stated when a medication was missed or a pain level was not checked, the electronic medical record system would turn the medication order to red from the color green. They stated this indicated to the nurse they needed to document the administration. The system also allowed the nurse to review the past month of medication administrations to review whether they had any outstanding documentation. They stated the electronic medical record system allowed the nurse to complete a late entry for missed documentation. They stated if the medication administration was missed, they would go to Registered Nurse #1 and notify them of the missed dose. Resident Nurse #1 would call the physician to notify them of the missed dose and then would complete a new order based on the physician's recommendation. Licensed Practical Nurse #3 stated they had only given Resident #22 an extra as needed dose of their Oxycodone 5 milligram pain medication one time on the 11-7 shift. They stated Resident #22 normally does not request more than their scheduled three (3) times per day dose.</p> <p>During an interview on 12/10/2024 at 9:48 AM, Registered Nurse #1 stated they did not know they were responsible for checking the medication administration record for narcotics. They stated they had learned that day there were reports that could be run for when medications were administered and the responsible nurse administering the medication. Registered Nurse #1 stated they had depended on the nurses working each shift to review their medication documentation and complete a narcotic count at the end and beginning of each shift. Registered Nurse #1 stated they were aware there were medications that had not been documented by Licensed Practical Nurses administering medications. They stated these medication administrations should have been documented, and they acknowledged they were responsible to review the medication records and request corrections. They stated the residents had made formal complaints to the previous Director of Nursing they were not receiving their pain medication. Registered Nurse #1 stated they are aware they need to report any suspicious or missed narcotic administrations to the facility administration, or they would call the State Department of Health if the situation ever occurred again.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 12/10/2024 at 1:32 PM, Licensed Practical Nurse #3 was shown the timecard punches for 11/15/2024, the Controlled Drugs and Narcotics Change of Shift record for 11/15/2024, and the Control Substance Record dated 11/15/2024 for Resident #22. They stated it was not their signature on the records. They said they never gave the resident an oxycodone and stated they would go under oath and swear to it. Surveyor asked how another nurse would get the keys to the narcotic box during their shift and they stated it could have been done on a shift after theirs. They said they took their job seriously and always documented on the Medication Administration Record and on the narcotic sheets when they administered a narcotic.</p> <p>10 New York Code of Rules and Regulations 415.12(m)(2)</p> <p>48744</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48615</b></p> <p>Based on observation, record review, and interviews conducted during the recertification survey, the facility did not ensure drugs and biologicals were labeled and stored in accordance with professional standards of practice, for 2 of 2 medication rooms reviewed (200 unit and 300 unit), and 3 of 3 medication carts reviewed (200, 300, and 400 units). Specifically, (a.) opened medications had no open and/or expiration dates; (b.) opened stock eye drops were not labeled with resident's name; (c.) medication refrigerator temperature was outside of therapeutic range; (d.) non-medication items were stored in narcotic cabinet; (e) a narcotic box was not secured with double lock; and (d) open cups of food were stored in medication cart.</p> <p>This is evidenced by:</p> <p>The facility's Policy and Procedure titled Medication Storage Date Revised: ,d+[DATE] documented, Medications would be stored in an orderly, organized manner in a clean area. Expired, discontinued and/or contaminated medications would be removed from the medication storage areas and disposed of in accordance with facility policy. Medication would be stored at the appropriate temperature in accordance with the pharmacy and/or manufacturer labeling. Medications requiring refrigeration would be stored in a refrigerator that is maintained between 2 to 8 degrees Celsius (36 to 46 degrees Fahrenheit).</p> <p>The facility's Policy and Procedure titled Medication Administration date revised: ,d+[DATE], documented its purpose was to administer medications in a way that ensures resident's safety and satisfied medical and legal concerns. PROCEDURE: #3: Avoid distractions when administering medications. Ensure medication is not outdated. All medications were to be properly labeled. All labels were to be clean and clear.</p> <p>NYS Title: Part 80 - Rules And Regulations On Controlled Substances 80.50 (1) Schedule I, II, III and IV controlled substances shall be kept in stationary, locked double cabinets. Both cabinets, inner and outer, shall have key-locked doors with separate keys; spring locks or combination dial locks are not acceptable. For new construction, cabinets shall be made of steel or other approved metal.</p> <p>During an observation and interview on [DATE] at 10:05 AM, on 200-unit, Medication Cart #1 contained two Humalog Kwik pens, 1 pen was inside plastic bag labeled open date [DATE] and expiration date [DATE]. The 2nd pen was located in the back of the medication cart top drawer. Licensed Practical Nurse #1 placed the 2nd pen inside the plastic bag along with the other insulin pen. The 2nd pen did not have an open and or expiration date. Licensed Practical Nurse #1 stated the pen was opened on that morning. 1 albuterol inhaler had an open date of [DATE]. Licensed Practical Nurse #1 was unable to determined what the expiration date would or should be.</p> <p>During an observation and interview on [DATE] at 10:15 AM, on 200-unit, Medication Room, Narcotic box #1 contained a wallet and a medic alert of an expired resident. Licensed Practical Nurse #1 stated they were waiting for family to pick up the wallet.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview on [DATE] at 10:15 AM, on #200-unit, Medication Room, Narcotic Box #2 outer lock was left open. Licensed Practical Nurse #5 stated it was an oversight and the lock was left open.</p> <p>During an observation interview on [DATE] at 10:40 AM on 300 -unit, Medication Cart #2 contained 3 open bottles of artificial tears stock eye drops. Licensed Practical Nurse #14 stated each resident received their own bottle of eye drops. The eye drops were not labeled with resident name, instead illegible initials were on each of the 3 bottles. In addition, 2 unopened bottles of refresh eye drops were dated [DATE].</p> <p>During an observation and interview on [DATE] at 10:55 AM, the 300 Unit Medication Room refrigerator temperature was 50 degrees Fahrenheit. Licensed Practical Nurse #14 stated they would notify maintenance.</p> <p>During an observation interview on [DATE] at 11:00 AM, the 400-Unit Medication Room Narcotic Box side 1 contained a wedding band. Licensed Practical Nurse #15 stated it was unknown who the wedding band belonged to. The jewelry was placed there for safe keeping.</p> <p>During an observation interview on [DATE] at 11:20 AM, 400-Unit, Medication Cart #2 contained 3 open cups of applesauce and 1 unopened cup of vanilla pudding labeled refrigeration required. Licensed Practical Nurse #15 discarded the items.</p> <p>During an interview on [DATE] at 11:30 AM, Assistant Director of Nursing #1 stated all resident valuables were stored in the business office.</p> <p>During an interview on [DATE] at 11:00 AM, Director of Nursing #1 stated all resident valuables were kept in the business office. When the business office is closed, valuables could be stored in locked medication room, but not in narcotic box. All nursing staff received medication administration education upon hire and throughout year as needed.</p> <p>10 New York Codes, Rules, and Regulations 415.18(d)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Administer the facility in a manner that enables it to use its resources effectively and efficiently.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 36922</p> <p>Based on observation, interview, and record review during a recertification and complaints survey (NY00349706, NY00352500, NY00353512, and NY00359446), the facility did not ensure it was administered in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 9 (Resident #'s 18, 22, 25, 96, 101, 103, 108, 317, and 319) of 9 residents reviewed. Specifically, for Resident #'s 18, 22, 25, 96, 101, 103, 108, 317, and 319, the facility was unable to provide documented proof of electronic medication administration that could identify the actual time the medication was administered to each resident that would support medication was given as ordered. This was evidenced by:</p> <p>Document requests were given to the facility from 12/5/2024 through 12/10/2024 until time of exit on 12/10/2024 at 4:45 PM for checked marked electronic medications administration records that were time stamped demonstrating the time medication were given throughout the day. No documents with time stamping medication administration was provided to surveyors throughout the survey.</p> <p>A facility document titled Consulting Services dated 11/2016 and last reviewed on 4/2024 documents the following:</p> <ol style="list-style-type: none"> <li>1. The Facility Consultant Pharmacists Coordinate Pharmacy policies and procedures within the facility and provide staff development regarding Pharmacy related topics.</li> <li>2. The Facility Consultant Pharmacist shall review the resident's medication regimen and make appropriate recommendations to improve the overall care within the facility. The Consultant Pharmacist's medication regimen review shall include monitoring for appropriate medication use, clinically significant interactions, and side effects, OBRA compliance (Omnibus Budget Reconciliation Act (law that established federal standards for long term care facilities to improve quality of care for residents), and laboratory review.</li> <li>3. All recommendations based on irregularities shall be made in writing</li> <li>4. The facility was responsible to assure that these recommendations were addressed by the appropriate personnel, and that the reports were filed in a retrievable fashion to support compliance with state guidelines regarding Pharmacy Services.</li> <li>5. The pharmacists will also act as a liaison to facilitate communication between the facility's nursing personnel and dispensing Pharmacy.</li> </ol> <p>A facility document titled Medication Administration dated 7/2016 last revised 6/2024 documents the following:</p> <ol style="list-style-type: none"> <li>1. Policy: Medications would be administered by a Licensed Professional Nurse or Registered Nurse. All medication would be administered and documented using the electronic medical record.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>2. Purpose: to administer medications in a way that ensured the resident's safety and satisfies medical and legal concerns.</p> <p>3. Procedure: check all residents orders carefully, and administer according to basic rules, (right drug, right dose, right resident, right time, right route).</p> <p>4. Medications were to be administered no more than 1 hour before and 1 hour after the ordered time. If they believed they would be outside the expected time frame notify the Registered Nurse Supervisor and the Registered Nurse Supervisor will notify the physician.</p> <p>A facility document titled Medication Administration Time Guidelines dated 04/97 last revised 02/2024 documented the following:</p> <p>1. Times were to be used as a guideline, Consult Registered Nurse as appropriated to change medication administration times. Medical Doctor medication orders may override the times indicated below.</p> <p>a. Every day 0700 to 1200</p> <p>b. Two times a day 0700 to 1200 and 1600 to 2100</p> <p>c. 2 times a day diuretics would be administered at 8 am and 4 pm</p> <p>d. Three times a day 0700, 1200, 1900</p> <p>e. Four times a day 0500, 1000, 1500, 2000</p> <p>f. Every 4 hours scheduled 0000, 0800, 1200, 1600, and 2000</p> <p>g. Every 6 hours scheduled 0200, 1000, 1800</p> <p>h. Every night hours of sleep 1900 to 2300</p> <p>i. Insulin scheduled as ordered</p> <p>Resident #18 was admitted with diagnoses of Downs Syndrome, paraplegia (paralysis that affect all or part of the trunk, legs, and pelvic organ), and seizure disorders. The Minimum Data Set (an assessment tool) dated 11/20/2024 documented the resident was sometimes understood and could sometimes understands others with severely impaired cognition for daily decision making.</p> <p>Resident #22 was admitted with diagnoses of anemia, heart failure, and peripheral vascular disease. The Minimum Data Set date 11/26/2024 documented the resident was usually understood and could usually understand others with severely impaired cognition for daily decision making.</p> <p>Resident #25 was admitted to the facility with diagnoses of heart failure, chronic obstructive pulmonary disorder and anxiety. The Minimum Data Set, dated dated dated [DATE], documented the resident was understood and could understand others with intact cognition for daily decision making.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  335543	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/10/2024
NAME OF PROVIDER OR SUPPLIER  Capstone Center for Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE  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.			
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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Resident #96 was admitted to the facility with diagnoses which included non-Alzheimer's dementia, atrial fibrillation, and Anxiety. The Minimum Data Set, dated dated dated [DATE], documented the resident was understood, and could sometimes understand others with severely impaired cognition for daily decision making.</p> <p>Resident #101 was admitted to the facility with diagnoses which included Non-Alzheimer's Dementia, Coronary Artery Disease, and Anxiety. The Minimum Data Set, dated dated dated [DATE], documented the resident was understood, and could usually understand others with severely impaired cognition for daily decision making.</p> <p>Resident #103 was admitted to the facility with diagnoses of chronic venous insufficiency (poor blood flow to extremities), difficulty walking, need for assistance with personal care, and Type 2 diabetes with hyperglycemia (endocrine dysfunction causing high blood sugar and poor insulin production). The Minimum Data Set (an assessment tool) dated 10/03/2024, documented the resident was cognitively intact, able to understand others and be understood.</p> <p>Resident #108 was admitted to the facility with diagnoses which included Non-Alzheimer's Dementia, end-stage renal disease, and anxiety. The Minimum Data Set (an assessment tool) dated 07/18/2024, documented the resident was sometimes understood and could sometimes understand others with severely impaired cognition for daily decision making.</p> <p>Resident #317 was admitted to the facility with diagnoses of bilateral primary osteoarthritis of the hip (pain caused by arthritis and bone deterioration in both hip joints), Type II Diabetes without complications, and Alzheimer's Disease (a type of dementia that affects memory, thinking, and behavior). The Minimum Data Set, dated dated dated [DATE] documented the resident had moderately impaired cognition, could be usually understood and understood others.</p> <p>Resident # 319 was admitted to the facility with the diagnoses of cerebral infarction (a blood clot on the brain causing neurological damage), muscle weakness, need for assistance with personal care, and type 2 diabetes (endocrine dysfunction causing high blood sugar and poor insulin production). The Minimum Data Set, dated dated dated [DATE], documented the resident's admission information only as the resident was admitted [DATE] and had not been in the facility long enough to have a full Minimum Data Set Assessment completed.</p> <p>During an observation on 12/09/2024 at 9:29 AM, Licensed Practical Nurse #5 was observed administering medications on the 2nd floor Unit and had documented in the record that all morning medication for Resident #22 had been given. The resident was not in the building and had gone out for an appointment.</p> <p>During an interview on 12/09/2024 at 9:45 AM, Licensed Practical Nurse #5 stated they could not allow this surveyor to look at their electronic medication administration computer because they had been told by the Director of Nursing and Administrator that the surveyors had access to all records they would need, and that staff was not allowed to let us review any of the documentation on their computers. Medications that were to be given 2 times a day fell under the administration times of 7:00 AM to 12:00 PM and then 4:00 PM to 9:00 PM. Licensed Practical Nurse #5 stated they did not know what was going on in the building, but they did their job, and they had nothing to with anything other than doing their job. They stated medications were not time stamped, they just get checked off on the electronic record.</p> <p>(continued on next page)</p>		

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<p>F 0835</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> <p>Note: The nursing home is disputing this citation.</p>	<p>During an interview on 12/09/2024 at 10:31 AM, the Registered Nurse Unit Manager #1 stated they did not do medication pass. They have a window of time on each shift to pass medications to prevent medication administration from being late. They were not sure how a nurse would know what time a pill had been given or if it was late. That might cause a problem for the next shift if a pill that was twice a day was given late, and the evening nurse gave it early. Administration for most medications, including twice a day, fall into the range of 07:00 AM to 12:00 PM and 4:00 PM to 9:00 PM. If medication was given late in the day the nurse on the next shift should adjust their times, but that could not happen if they were not aware that the medication was given early. They were unaware of any auditing that could be done because the way medications were documented in the record was in a note that did not time stamp the time the medication was given. Nurses should communicate that information to the oncoming nurse. Even with liberal medication administration all nurses should be using nursing judgement. If a medication was 2 times a day, it should be given as directed, knowledge of the medication was required to make sure medication was not given too close together.</p> <p>During an interview on 12/09/2024 at 11:45 AM, Administrator #1 and Director of Nursing #1 stated they were unable to print the electronic medication administration record in a format that would demonstrate the time that the actual medication was given or timestamped. The actual printed form that showed the medications being checked off, that were provided to this surveyor on a document titled Medication /Treatment Variation Report, was Quality Assurance protected. Administrator #1 further stated that if those documents were provided, they needed to be placed in a brown manilla envelope that were clearly marked Quality Assurance protected.</p> <p>During an interview on 12/10/2025 at 10:35 AM, Director of Nursing #1 stated they did not have the records requested for Resident #s 18, 22, and 25 because they had no knowledge of how to print the electronic administration medication records in the format seen by the nurses when administering medications to the resident. The system records the medication as being given in a progress note and does not record the exact time the medication was given. The policy for the liberal administration of medication to residents had been in place when they became Director of Nursing in October of 2024. They were not aware of how an audit could be completed to ensure the medication that required 2 times a day administration was not given to close together because times of administration were not time stamped.</p> <p>During an interview on 12/10/2024 at 10:35 AM, Administrator stated they were unable to provide the electronic medication administration record in any form other than the form that was documented on the formal electronic medical record (computer program for nursing documentation currently used by the facility). They were not knowledgeable on how to print it. The printed medication form documenting medication administration in the monthly and daily check marked format was done by the previous Director of Nursing. They were unable to reach anyone that could access that format. They stated the surveyors had access to all documents that were needed on the program to review all documents. This included review of the medications given to residents. The program did not time stamp any medications given to residents other than PRN (as needed) medications and if the user double clicks on the medication after it has been given it showed the documented time that it was administered. The rest of the medication that was given to a resident, with the liberal times ordered, does not document the exact time the medication was given. Administrator #1 stated the facility could audit whether the medication had been given but not the exact time.</p> <p>10 New York Code Rules and Regulations 415.26</p> <p>(continued on next page)</p>		

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