STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335600	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAND REHABILITATION AND NURSING AT UTICA	1657 SUNSET AVE UTICA, NY 13502

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview during the abbreviated survey (NY 415) the facility did not ensure the physician was notified of a significant change in resident clinical condition for 1 of 3 residents (Resident #1) reviewed for quality of care. Specifically, Resident #1 was hypoglycemic (low blood sugar) and the physician was not notified of the decline to determine if a change in treatment plan was needed. Findings include: The facility Change in a Resident's Condition or Status policy, dated ,[DATE], documented the nurse will notify the attending physician or physician on-call when there has been a significant change in the resident's physical, emotional, or mental condition, the need to alter the resident's medical treatment significantly, or the need to transfer the resident to a hospital. A significant change of condition includes a major decline or improvement in the resident's status that will not normally resolve itself without intervention by staff and impacts more than one area of the resident's health status. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations, and gather relevant and pertinent information. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. The facility Nursing Care of the Resident with Diabetes Mellitus policy, updated ,[DATE], documented approximate reference ranges for [DIAGNOSES REDACTED] were classified as mild [DIAGNOSES REDACTED] (,[DATE] milligrams per deciliter (mg/dL), moderate [DIAGNOSES REDACTED] (,[DATE] mg/dL), and severe [DIAGNOSES REDACTED] (less than 40 mg/dL). Management of [DIAGNOSES REDACTED] (less than 70 mg/dL, or less than the physician ordered parameter), is determined by a combination of blood sugar results and clinical symptoms. The facility had protocols in place for staff to follow with guidance on how to treat residents experiencing [DIAGNOSES REDACTED] based on their symptoms, whether they could swallow, and whether they were responsive. Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessments dated [DATE] and [DATE] documented the resident was cognitively intact. A physician order [REDACTED]. - On [DATE], [MEDICATION NAME] solution-pen injector, 1.2 mg subcutaneously once daily (a non-insulin injectable diabetes medication). - On [DATE], fingersticks (test to measure blood sugar) before meals and at bedtime every Wednesday, call if less than 60 milligrams (mg)/deciliter (dl) or greater than 450 mg/dl. A nurse practitioner's (NP) progress note dated [DATE] documented the resident's findersticks were within normal range and the plan was to decrease them to every Monday before meals and at bedtime. A nursing progress note dated [DATE] at 3:53 PM by licensed practical nurse (LPN) #2 documented Resident #1 had finger sticks ordered before meals and at bedtime every Monday. The medical practitioner was to be notified if the level was less than 60 mg/dl or greater than 450 mg/dl. The Medication Administration Record [REDACTED]. There was no corresponding physician order [REDACTED]. The documented fingerstick results for [DATE] were as follows: - At 11:30 AM, the resident was identified to be out of the facility so a fingerstick was not done. - At 4:30 PM, the fingerstick was 52 mg/dl. There was no corresponding progress note that the fingerstick was rechecked or if the medical provider was notified. - At 8:00 PM, the fingerstick was 111 mg/dl. A nursing progress note dated [DATE] by RN Supervisor (RNS) #1 documented at approximately 10:40 PM, she was called for a reported blood sugar of 42 mg/dl a few minutes prior and the resident was looking worse and not responding. The resident was pale, diaphoretic (heavily sweating), alert but nonverbal and able to swallow. An oral glucose packet was administered by LPN #2 and RNS #1 finished giving the resident the glucose. The resident became slightly more alert and was moving but the finger stick remained at 42 mg/dl. A second dose of oral glucose was given by RNS #1 and the resident became more obtunded (decreased level of consciousness), sonorous (deep snoring like sound) respirations, and the resident stopped swallowing. [MEDICATION NAME] 1 mg was administered (no route documented) with fingerstick under 40 mg/dl. There was no change in the resident's condition, and a second dose of [MEDICATION NAME] (no route documented) was administered after ,[DATE] minutes. The resident began to respond, color was pink, respirations were unlabored, diaphoresis ceased, and the resident sat up, and talked. The resident's blood sugar was ,[DATE] mg/dl. Instructions were given to the unit staff (LPNs #2 and 3, and CNA #7) to report immediately to the RN any change in the resident's condition. Nothing was reported to RNS #1 by the end of the shift and RNS #1 reported the incident to RNS #4 in report. RNS #1 attempted to report the incident to the on-call provider, placed several calls, asked for a call back as soon as possible, and no call back was received from the provider. A progress note written by LPN #2 at 11:35 PM on [DATE] documented the resident was found unresponsive during room rounds and the blood sugar was 42 mg/dl. RNS #1 responded. Two tubes of liquid glucose and 2 [MEDICATION NAME] (does not specify route of administration) doses were administered. The resident was alert and responsive. The resident's blood sugar was tested and was 156 mg/dl. The ,[DATE] MAR indicated [REDACTED]. The was no documentation the [MEDICATION NAME] was administered on ,[DATE] or [DATE]. A nursing progress note dated [DATE] at 2:20 AM, documented a Code Blue (emergency response) was called for the resident at 11:15 PM. The resident was unable to be resuscitated by EMS (Emergency Medical Services) and expired. A [DATE] at 6:36 AM, nursing progress note written by RNS #1 documented the night supervisor called RNS #1 and stated the on-call provider had called the Supervisor phone requesting to speak with RNS #1 as soon as possible. RNS #1 repeatedly gave her number to the answering service. She had contacted the answering service again, 30 minutes prior, and explained the situation with Resident # 1 and lack of response and provided her phone number. She had not yet received a call back from the on-call provider. An Email dated [DATE], documented the calls made between the on-call physician answering service and the facility. The log dated [DATE] at 7:00 PM through [DATE] at 7:00 AM, documented: - A call from the facility was made at 11:58 PM by RNS #4 (the night supervisor). The filter priority was listed as urgent immediate and was sent to the on-call provider on [DATE] at 12:01 AM. The on-call provider acknowledged the call at 12:13 AM on [DATE]. The message documented the call was from RNS #4. The message was Resident #1 had expired, and a call back was needed. - A call was made to the answering service on [DATE] at 1:59 AM by RNS #1 (evening supervisor) and was acknowledged by the provider at 02:32 AM. The identified reason for the call was the RN needed to speak with the physician on call because Resident #1's blood sugar was very low. -A second call was placed by RN supervisor #1 at 2:29 AM with the message to call back as soon as possible. - A final call was returned to the facility by the on-call provider at 6:21 AM. During the interview with LPN #3 on [DATE] at 2:15 PM, LPN #3 stated it was announced overhead that RNS #1 was needed on the resident's unit. LPN #3 also responded and found Resident #1 with their eyes open and tongue moving, with a reported blood sugar of 42 mg/dl. A physician was supposed to be called when the resident needed the glucose packet. LPN #3 did not know why the on-call physician was not called and thought they had been. LPN #3 was asked by RNS #1 to get [MEDICATION NAME] (injectable) and there was not any in the medication cart so one was taken out of the Pixis (emergency drug supply). An order was needed when [MEDICATION NAME] was taken out of the Pixis and a physician's orders [REDACTED]. LPN #3 stated [MEDICATION NAME] should not be given without a physician's orders [REDACTED]. No one called the physician. Any of the nursing staff could call the physician but that was usually done by the RN. RNS #4 was interviewed by phone at 3:30 PM on [DATE]. RNS #4 stated RNS #1 reported during shift change on [DATE] that Resident #1 had two shots of [MEDICATION NAME] a

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

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.

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F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) few minutes ago. The resident's blood sugar went from 42 mg/dl to 157 mg/dl and the resident was okay. RNS #1 told RNS #4 the on-call answering service was called several times but they did not return the calls. During the night, RNS #4 received a call from RNS #1 asking if the orders for the [MEDICATION NAME] were obtained and RNS #4 stated they were not. Corporate RN #10 was interviewed at 4:30 PM on [DATE] and stated the call log from the on-call medical answering service showed that RNS #1 did not call them during their shift. Because of Resident #1's change in condition, the on-call physician should have been notified. RN #10 stated the resident should have been sent to the hospital before the [MEDICATION NAME] was given because the resident became unresponsive. NP #6 was interviewed by phone on [DATE] at 2:30 PM, and stated she last saw the resident on [DATE] when the resident's insulin coverage was decreased due to the resident having lower blood sugar levels. The NP was told by nursing staff on [DATE] the RNS #1 had notified the on-call provider regarding Resident #1's change in condition. When the printout of service calls was reviewed, there were no calls listed as received prior to the resident expiring. If a resident's blood sugar was low, less than 60 mg/dl, she would expect nursing staff to first take care of the situation and give oral glucose prior to calling medical staff. LPN #2 was interviewed by phone on [DATE] at 11:00 AM, and stated she was the charge nurse on [DATE] and had worked from 2:00 PM on [DATE] until 6:00 AM on [DATE]. She stated she found the resident unresponsive when making rounds after 10:00 PM. The resident's blood sugar was 42 mg/dl. RNS #1 was called and told LPN #2 to give a bag of glucose. RNS #1 came to the floor and finished giving the glucose to the resident. Another bag/tube was given when the resident's blood sugar was 47 mg/dl. LPN #2 was asked by RNS #1 to go to another unit to get injectable [MEDICATION NAME] since the unit they were on had none. The resident's blood sugar level was below 60 mg/dl after the first shot of [MEDICATION NAME]. She asked RNS #1 not to give the second shot, but it was given. LPN #2 stated she did not call the on-call physician service because she thought RNS #1 called. She stated RNS #4 called the on-call service after Resident #1 had passed. 10NYCRR 415.3(e)(2)(ii)(d)