STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335543	A. BUILDING _____ B. WING _____	07/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CAPSTONE CENTER FOR REHABILITATION AND NURSING	302 SWART HILL ROAD AMSTERDAM, NY 12010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 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 interviews during an abbreviated survey (Case #NY 301), the facility did not ensure the physician was consulted when there was a need to discontinue an existing form of treatment and for a significant change in mental status for 1 (Resident #1) of 5 residents reviewed. Specifically, the facility did not notify the resident's family or the physician of endocrinology consult recommendations to discontinue a once-daily non-insulin medication used to lower blood sugar levels. Subsequently, the resident continued to receive the medication on 3/7/2020. Additionally, on 3/7/2020, the facility did not immediately notify the resident's physician after experiencing a change in condition. This was evidenced by: The Policy and Procedure (P&P) titled Out of House Appointment Policy last revised 2/2019, documented that, when a resident returned from an out of house appointment, any recommendations they returned with were to be given to the Nurse Manager/Registered Nurse (RN)/Designee for follow up to receive orders from the facility physician as necessary/appropriate. The P&P titled Physician Notification last revised 5/2019, documented the resident's primary care physician was to be contacted in a timely manner for situations as set forth in the policy in order to provide quality care for each resident residing at the facility. All consult recommendations were to be reviewed by the Registered Nurse (RN) Nurse Manager/RN Supervisor when they arrived at the facility. The physician was to be called with the recommendations and orders were to be received as indicated. Resident #1: Resident #1 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 3/3/2020, documented the resident was cognitively intact. The Comprehensive Care Plan (CCP) for Diabetes, last revised on 2/27/2020, documented nursing staff were to observe for weakness and excessive change in personality and monitor closely for signs and symptoms of insulin shock and diabetic coma. The CCP for Nutrition, last revised on 3/6/2020, documented the resident had diabetes and hypercalcemia (calcium level in blood is above normal). On 3/3/2020, a bedtime snack was added due to the resident having low blood sugar in the morning and on 3/6/2020, scheduled snacks were increased to three times daily due to low blood sugar. The CCP for Liver Disease, last revised on 2/27/2020, documented nursing staff were to monitor for complications of liver disease by monitoring for signs and symptoms of hepatic [MEDICAL CONDITION] (confusion, lethargy, and disorientation). A physician's orders [REDACTED]. The Nursing Progress Note dated 3/2/2020 at 1:17 PM, documented Resident#1's morning blood sugar was 56 (below 70 mg/dl is considered low). Orange juice was given and 15 minutes later the resident's blood sugar was 62. The scheduled insulin was held. The Nursing Progress Note dated 3/3/2020 at 9:31 AM, documented the resident remained hypoglycemic in the mornings. The dietary department was made aware and was to add a bedtime snack to the resident's meal cards. The Nutrition Progress Note dated 3/6/2020 at 12:27 PM, documented nourishments, three times daily, were added due to low blood sugar. The resident's meal intake varied but remained fairly poor. The Report of Consultation dated 3/6/2020 at 9:15 AM, documented follow-up with Endocrinology. The provider documented, [MEDICATION NAME] (liraglutide; a once-daily non-insulin medicine that lowers blood sugar) was to be discontinued. There was no documentation in the medical record that the physician and family were notified of the consult, and no documented Physician order [REDACTED]. The resident was sitting up for breakfast and was alert but confused. The LPN documented Nursing would continue to monitor the resident. There was no documentation an RN and/or physician were notified. The Nursing Progress Note dated 3/7/2020 at 9:45 PM by the RN, documented she was called to assess Resident #1 for a change in status. The RN documented the resident spoke Spanish and the family was in the room to translate. The family told the RN the resident was complaining of increased shortness of breath and the family felt the resident's abdomen was larger than it had been. The RN assessed the resident and found: breath sounds with crackles (breath sounds often associated with inflammation or infection), a wet, non-productive cough, and increased lethargy. The resident's blood sugar was 145, the skin was cool and dry; no fever, and the resident had no pain. The family requested the resident be sent to the hospital for evaluation. The physician was made aware of the assessment findings. The Nursing Progress Note dated 3/7/2020 at 10:10 PM, documented emergency medical services (EMS) was called and the resident was transferred to the hospital to be assessed. The Nursing Progress Note dated 3/8/2020 at 6:12 PM, documented the resident was admitted to the hospital with [REDACTED]. During an interview on 7/8/2020 at 11:03 AM, the Director of Nursing (DON) stated that, in 3/2020, she and the Assistant Director of Nursing were responsible for the unit. She said when a resident went for a consult and returned, a staff member was supposed to bring the paperwork to an RN's attention and the RN was then supposed to contact the physician. During an interview on 7/8/2020 at 11:31 AM, physician #1 stated, when he ordered a consult, the nursing home staff were supposed to take care of making the appointment, complete the facility's form for any recommendations, and call him with the recommendations. He said when Resident #1 was sleepy and lethargic on 3/7/2020, it was a change in the resident's condition, and he should have been notified at that time. 10 NYCRR 415.3(e)(2)(ii)(b) 10 NYCRR 415.3(e)(2)(ii)(c)

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