STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335374	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 46276 Based on record review and interviews during the abbreviated survey (NY00308422), the facility did not ensure the residents' environment remained free of accident hazards and residents received adequate supervision to prevent accidents for 1 of 1 resident (Resident #2) reviewed. Specifically, Resident #2 had an unwitnessed fall and complained of pain the following morning. The medical provider was not notified until 2 days after the fall, an x-ray was not completed until 2 days and 17 hours after the resident complained of pain, and an investigation was not initiated timely to rule out abuse. Subsequently, the resident was hospitalized and was diagnosed with a left hip fracture. Findings include: The facility policy, Fall Prevention Program, revised 9/2017, documented residents at risk for falls were identified on the certified nurse aide assignment sheet. Residents were assessed for fall risks on admission, re-admission, change in condition, and quarterly thereafter. Interventions included assess environment for lighting, floor, bathroom, bed height, appropriate chair, and accessible storage. Monitor staff compliance with fall prevention measures including assistance with transfers, ambulation and other activities as needed and followed directions for Resident care as indicated on the Resident care flow sheets. The facility policy, Accident/Incident Policy and Procedure, revised 12/2018, documented it was the responsibility of staff to report all incidents and accidents that occurred at the facility. The accident/incident form would be filled out by the person with knowledge of the situation. The Registered Nurse Supervisor would complete the document and document the assessment of the resident's condition and notify the attending physician and family representative. The accident/incident report must be completed on the shift the incident occurred; the nursing supervisor was responsible for starting an investigation and obtaining witness statements. The investigation must be completed within 72 hours. If the injury was unknown from a fall, statements were obtained going back 24-48 hours to determine the cause of the injury. The Director of Nursing reviewed all accident/incident reports for accuracy and completed documentation of the incident to determine if there was credible evidence to substantiate an allegation of abuse, neglect, or mistreatment. Resident #2 had diagnoses of dementia, history of falls, and unsteady balance. The 11/24/2022 Minimum Data Set assessment documented the resident had severely impaired cognition, required extensive assistance of 2 for bed mobility and transfers, was dependent for bathing, toileting and personal hygiene, had no functional limitations in either upper and lower extremities, and used a wheelchair. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER: The Pines at Utica Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 1800 Butterfield Ave Utica, NY 13501	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Comprehensive Care Plan initiated 9/22/2021 documented the resident had a history of falls with/without injury. Interventions included continue interventions on the at-risk plan, encourage rest periods in-between meals, floor mats next to bed on both sides, if noted to be near edge of bed during 1-2 hour rounds, re-position to middle of bed, low bed, rounding every 1-2 hours to anticipate needs, non-skid socks on while in bed, offer to put resident to bed between 9:00-10:00 PM unless resident appeared tired, send to emergency room for evaluation for any falls with head injury, keep resident in area where staff could monitor while awake, neuro checks per facility policy, monitor/document/report to physician as needed any signs/symptoms of pain, bruising, change in mental status, new onset, confusion, inability to maintain posture, agitation. The 1/3/2023 at 9:15 PM Registered Nurse Supervisor #6 progress note documented they were called to the resident's unit for a fall. Resident #2 was found on the floor next to their bed. An assessment was completed, the resident's hips were palpated (felt) and pelvis was pressed on, no injuries were noted. The resident was assisted back to bed via a lift sheet. The resident's family representative was made aware of the fall. There was no documented evidence if the fall was witnessed, the medical provider was notified, or an investigation was initiated to rule out abuse, neglect, or mistreatment. The 1/4/2023 at 6:18 PM nursing progress note by Registered Nurse #6 documented they were made aware of the resident experiencing pain to their left hip, the resident was a poor historian, could have Tylenol (pain reliever) 650 milligrams for pain, and the family representative was aware x-rays could be completed if needed. There was no documented evidence the medical provider was notified of the resident's increased complaints of pain. The 1/4/2023 at 6:30 PM Licensed Practical Nurse #21 progress note documented the resident was given 650 milligrams of Tylenol for pain. At 7:28 PM Licensed Practical Nurse #21 documented the pain medication administration was effective with a follow-up pain level of 2 (on a 1-10 pain scale). The 1/6/2023 at 1:08 PM nursing progress note by Registered Nurse Unit Manager #3 documented the resident representative was concerned about the unwitnessed fall 2 days prior. The resident was transferred to bed for an assessment. Swelling was noted to the left upper thigh/hip area with some shortening in comparison to the right leg. The resident complained of discomfort with touch around the hip area. Nurse Practitioner #15 was updated on the condition, an x-ray was requested, and an order obtained. The X-ray report returned with a result of acute displaced and slightly impacted intertrochanteric fracture of the left hip (a bone break to the hip joint where the bone ends were slightly pushed into each other). The resident representative was notified and pending transfer to the emergency room . Resident left the facility by ambulance at 12:40 (did not include AM or PM). The 1/6/2023 at 11:10 AM X-ray report results documented Resident #2 had an acute displaced and slightly impacted intertrochanteric fracture of the left hip. The 1/6/2023 at 1:53 PM hospital emergency room progress note documented Resident #2 arrived for evaluation, had sustained a fall 2 days prior and x-rays prior to arrival documented a fracture to the left hip. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 1/9/2023 at 9:00 PM nursing progress note by Registered Nurse Supervisor #6 documented the resident returned to the facility from the hospital and had a left hip fracture repair. Surgical dressing was intact, and the resident was to follow up with the orthopedic surgeon. The 1/10/2023 at 3:51 PM facility Accident/Incident report and Investigation Summary completed by Registered Nurse #20 (7 days after the resident's unwitnessed fall) documented Resident #2 had a fall out of bed on 1/3/2023. The investigation determined the resident was left in a high position in the bed by Certified Nurse Aide #8 and a care plan violation had occurred. Resident #2 fell out of bed from the high position and sustained a left hip fracture. Medical was notified on 1/6/2023, X-rays obtained, and the Resident was sent to the emergency room for evaluation. Certified Nurse Aide #8 was issued a disciplinary notice for a care plan violation and Registered Nurse Supervisor #6 was issued a disciplinary notice for not notifying medical and had not initiated an investigation. The Accident/Incident Report did not include witness statements. There was no documented evidence how the facility determined abuse, neglect, or mistreatment did not occur from 1/3/2023-1/6/2023. During an interview on 1/27/2025 Certified Nurse Aide #1 stated during resident care, the aides would often raise the beds up to their waist level, perform care and then lower the bed back down when finished. If a bed malfunctioned, they would never leave the resident alone. They were expected to put the call light on or yell for help for another staff member. They stated Resident #2 required total care and assistance of 2 staff. Certified Nurse Aide #1 stated they had been out on medical leave for a period so were unaware if the resident had a fall. During an interview on 1/27/2025 at 1:23 PM, Registered Nurse Unit Manager #3 stated assessments and neurological checks were completed when a resident sustained an unwitnessed fall, and the medical provider and family representative were called. Certified nurse aides knew how to care for residents by the resident Kardex, and a shift huddle at the beginning of shifts by the nurses was done to verbalize any reports to the aides. Residents should never be left in bed in a high position, if a bed was not working properly then staff should yell for help or put the call light on. Registered Nurse Unit Manager #3 stated they did not recall the incident with Resident #2. During an interview on 1/27/2025 at 1:39 PM, Licensed Practical Nurse #2 stated they thought Resident #2 had a fall but was unsure of the incident. A Supervisor should be called to the Unit if a resident had a fall. They recalled hearing the resident had a fractured hip but did not recall details. They stated a resident should never be left in a bed left in a high position. Certified nurse aides knew how to care for residents by looking at the Kardex. During an interview on 1/28/2025 at 3:30 PM, Certified Nurse Aide #9 stated they were working on the evening Resident #2 fell out of bed. They stated they helped transfer Resident #2 to bed with Certified Nurse Aide #8 and left the room. They stated they told Certified Nurse Aide #8 to please make sure the resident's bed was put in the low position before they exited the room. Certified Nurse Aide #9 stated approximately 10 minutes later they returned to the hall outside of the resident's room to retrieve linen and saw the resident on the floor next to the bed in their room. The bed was in a high position. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/28/2025 at 3:35 PM, Registered Nurse Supervisor #6 stated they were called to the resident's Unit for a fall. Resident #2 was found lying on the floor next to the bed on a floor mat and when they entered the room, the bed was in the low position. They stated staff did not advise them the resident's bed was in a high position when the resident was found on the floor. They completed an assessment and did not observe any injuries. They stated Resident #2's son was aware of the incident, but they did not notify the medical provider and did not initiate an investigation. They stated they did not initiate an investigation due to staff not advising them the bed was high, and their assessment might have changed with that knowledge. Registered Nurse Supervisor #6 stated the resident had previously falls, and agency certified nurse aides received training on resident safety. They stated Certified Nurse Aide #8 was terminated. They stated they received a disciplinary notice for not reporting the incident, not notifying medical or completing an investigation. WHEN? During an interview on 1/29/2025 at 9:23 AM, Licensed Practical Nurse #7 stated they were on duty the evening Resident #2 had a fall. They were alerted to the fall and when they entered Resident #2's room, the resident was on the floor and the bed was in a high position, approximately chest level- above waist level but below shoulder level. They stated they alerted Registered Nurse Supervisor #6 of the fall, obtained vital signs on Resident #2 and contacted the family representative. Resident #2 was care planned for a low bed and fall mats, and interventions carried over to the Kardex. Licensed Practical Nurse #7 stated the resident fell from a high bed after the certified nurse aide left the room, facility protocol was one certified nurse aide always remained with a resident during care, and you never left a resident alone in a high bed. Agency certified nurse aides received the same training as regular staff. During a telephone interview on 1/29/2025 at 11:52 AM, Certified Nurse Aide #8 stated they worked for the facility's agency company and worked the evening of Resident #2's fall. Resident #2 was on their assignment. They stated they had raised the bed up to change and wash Resident #2 and when they finished, they could not lower the bed. They stated they left Resident #2 in the bed in a high position approximately at their hip level and exited the room to tell a nurse. They stated they were not aware they could not leave a resident in a high bed position alone. They stated the resident's bed malfunctioned, and they did not know to unplug or re-plug it into the wall to make it work. During an interview on 1/29/2025 at 2:26 PM, Registered Nurse #20 stated they were the former Director of Nursing at the facility, was not alerted to Resident #2's fall until they reviewed a 24-hour report 3 days later. They immediately initiated an investigation and obtained witness statements. They determined Registered Nurse Supervisor #6 did not initiate an investigation to rule out abuse and Certified Nurse Aide #8 had a care plan violation for leaving Resident #2 unattended in a high bed position. Both staff members were issued disciplinary notices. Registered Nurse #20 stated protocol was to always notify medical and a family representative of a resident's fall even if they did not present with injuries. An accident/incident report should be initiated as well as an investigation to rule out abuse. The accident/incident report guided staff on how to conduct the investigation. Registered Nurse Supervisor #6 should have initiated an investigation into the fall and ruled out abuse and should have notified medical. Staff involved in the Resident's care should be suspended until abuse was ruled out. If Resident #2 complained of pain the following day, Registered Nurse #6 should have called medical and obtained an X-ray order then. It was unacceptable to not follow through with an investigation and reporting. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/31/2024 at 1:50 PM, Director of Nursing #21 stated the Kardex determined how to care for a resident. If a Resident was in bed in a high position, it was unacceptable for a certified nurse aide to leave the room. Aides were trained raise a Resident ' s bed during care and to immediately lower it when care was completed. If a resident had a fall, protocol was to call a Registered Nurse Supervisor to the unit. The Registered Nurse Supervisor was responsible for conducting a resident assessment and notifying medical and the family representative. Medical should be notified whether or not the resident had an injury. The accident/incident form, which included a full investigation to rule out abuse or neglect, should be initiated by the Supervisor and witness statements should be obtained. It was important to notify medical and investigate to ensure an injury or other situation was not missed. If a resident was in a bed in a high position, it was unacceptable for a certified nurse aide to leave the room. Aides were trained raise a resident's bed during care and to immediately lower it when care was completed. 10NYCRR 415.12(h)(I)

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F 0711

Level of Harm - Actual harm

Residents Affected - Few

Note: The nursing home is disputing this citation.

Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.

46276

Based on record review and interviews during the abbreviated survey (NY00309249) the facility did not ensure the physician reviewed the total program of care, including medications and treatments, for one (1) of four (4) residents (Resident #1) reviewed. Specifically, Resident #1's hospital discharge orders included routine short-acting insulin and sliding scale (the amount of insulin administered was based on the results of blood glucose finger sticks) short-acting insulin. The resident did not have admission orders for routine short-acting insulin and sliding scale short-acting insulin as recommended. Subsequently, Resident #1 was hospitalized for hyperosmolar hyperglycemic state (severely high blood glucose levels with severe dehydration and confusion). This resulted in actual harm to Resident #1 that was not Immediate Jeopardy.

Findings include:

The facility policy, Transcription of Orders, was issued 1/2024, after the incident. There were no transcription policies available for 2023.

Resident #1 had diagnoses including type 2 diabetes (the body does not use insulin effectively or does not produce enough insulin) and multiple sclerosis (a central nervous system disease). The admission Minimum Data Set assessment was not completed prior to the resident's discharge to the hospital on 1/21/2023.

The hospital physician discharge summary dated 1/9/2023 at 2:42 PM, documented the resident's diabetes was poorly controlled. The resident was started on Lantus (glargine, long acting insulin) 10 units twice daily, in addition to Humalog (lispro, short-acting insulin) per sliding scale coverage, plus Humalog 3 units with meals. Chemstrips (fingerstick glucose readings) were improving.

The 1/11/2023 at 10:59 AM Hospital discharge summary physician orders documented:

- insulin glargine (a long-acting insulin) 100 units per milliliter injection, inject 10 units under the skin in the morning and 10 units before bedtime.

- insulin lispro (a short-acting insulin) 100 units per milliliter injection, inject 5 units in the morning, 5 units at noon and 5 units in the evening. Inject with meals.

- insulin lispro 100 units per milliliter injection, inject 0-14 units (sliding scale) under the skin four times a day before meals and nightly.

- stop taking glimepiride (an oral anti-diabetic medication) 4 milligrams.

The facility admission physician orders documented:

- on 1/11/2023 (untimed) insulin glargine (Lantus, a long-acting insulin) solution 100 units per milliliter, inject 10 units subcutaneously (under the skin) twice a day for diabetes.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- on 1/11/2023 at 5:09 PM (telephone order) documented accuchecks (finger sticks) before and after meals and at bedtime for diabetes. Call medical if less than 70 milligrams/deciliter and greater than 450 milligrams/deciliter. The order was entered into the computer at 5:11 PM by Registered Nurse #22 with the order type documented as standard other. The order was signed by Nurse Practitioner #15 on 1/13/2023 at 5:46 PM. There was no documented evidence of a facility admission physician order for routine short acting insulin and sliding scale insulin per the hospital discharge orders. The Weight and Vital Signs Summary did not include blood sugar (accuchecks) results prior to 1/21/2023. The 1/12/2023 Nurse Practitioner #15 progress note documented they reviewed external medical records. Hospital labs and consults were reviewed. The plan was to continue with Lantus 10 units twice daily and follow accuchecks (blood glucose finger sticks). There was no documented evidence Nurse Practitioner #15 reviewed accuchecks or the hospital discharge summary which included routine short acting insulin and sliding insulin scale. The 1/16/2023 Physician #14 History and Physical documented hospital labs and consults were noted and reviewed. The resident had controlled type 2 diabetes. The plan was to continue with Lantus 10 units twice daily and follow. There was no documented evidence Physician #14 reviewed accuchecks or the hospital discharge summary which included routine short-acting insulin and sliding insulin scale. The 1/21/2023 at 1:38 PM nursing progress note by Licensed Practical Nurse #23, documented the resident had a heart rate of 124 beats per minute. Physician #31 was updated on the resident's status and ordered the resident be sent to the emergency room for evaluation. An ambulance was called, and a message was left for the family representative. Licensed Practical Nurse #23 documented at 1:53 PM, the resident was admitted to the hospital for hyperkalemia (high blood potassium levels). The 1/21/2023 at 6:42 PM hospital physician progress note documented Resident #1 presented to the emergency room with an increased heart rate and mental status changes. They were found to have an elevated blood sugar level of 1192 milligrams/deciliter (drawn at 2:45 PM, normal for non-diabetic 75-115) and an elevated potassium level (7.0 milliequivalents/liter, normal 3.5-5.2). The resident was administered an insulin drip via intravenous (by vein) route and was started on medication to reduce their elevated potassium levels. Physician #29 documented the resident would be admitted into the Intensive Care Unit. Repeat blood work showed the resident continued with elevated blood sugar levels. The 1/25/2023 at 2:47 PM facility Physician #14 progress note documented Resident #1 was seen for a history and physical on 1/16/2023, medications and medication administration records were reviewed, and plan was to continue insulin glargine 10 units twice a day for type 2 diabetes. The progress note did not identify the instructions from the 1/11/2023 hospital discharge summary or identify Resident #1 had no accuchecks or short-acting insulin since admission. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Pines at Utica Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 1800 Butterfield Ave Utica, NY 13501	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 1/26/2023 at 10:37 AM hospital discharge summary documented the resident's discharge diagnosis was hyperosmolar hyperglycemic state (severely high blood glucose levels and other high level of substances in the blood). The resident had poorly controlled diabetes with a Hemoglobin A1C of 10.7% (a blood test that measures average blood glucose levels over the past 2-3 months, normal is less than 5.7%). The plan was to follow up with endocrinology as an outpatient. During an interview on 2/19/2025 at 10:49 AM with Nurse Practitioner #15, they stated hospital discharge orders were initially reviewed by staff who approved the admission and then forwarded to nursing. Nursing reviewed the orders, and verbal orders were given by the providers until they could see the resident, typically within 48-72 hours of their arrival. Nursing would initially review orders and call with any discrepancies, and they would review orders and labs when they arrived. They were not aware if Resident #1 had orders for short-acting insulin as it was two years ago. They stated hospitals often prescribed short-acting insulin for diabetics but became problematic if the resident did not eat. Nurse Practitioner #15 stated they would have kept the order for short-acting insulin for Resident #1 due to their history of uncontrolled diabetes and their A1C lab value (a lab value that measures blood glucose levels over time) of 10.7%. This clearly showed Resident #1's diabetes was not under control and they needed close monitoring. Anytime a resident with diabetes had complications including hospitalization , they always required glucose monitoring to determine how stable their blood glucose levels were. It was important to monitor Resident #1's blood glucose levels and administer appropriate insulin. They stated progress notes written by them were signed within two (2) days and reflected the resident's current plan of care. During an interview on 2/20/2025 at 9:18 AM, Physician #14 stated they had been the Medical Director of the facility for the past two years. They oversaw all residents in the facility. They stated hospital discharge/admission orders were first reviewed by nursing and then the nurse practitioners. They would not see newly admitted residents for a week. They stated they reviewed records the best they could but had to check records on three different computer systems that were not connected to one another. Residents with diabetes should have their blood glucose monitored and receive short or long-acting insulin if ordered. They could not recall Resident #1 or if they had active blood glucose or insulin orders. They stated hyperosmolar hyperactive state was a complication of diabetes and could happen if a resident's blood sugars were not monitored or insulin was not administered. Progress notes written by them were not signed or dated on the same day, but within two (2) days and reflected the Resident's current plan of care. 10NYCRR 415.15(b)(2)(iii)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. 46276 Based on record review and interviews during the abbreviated survey (NY00309249), the facility failed to ensure residents were free of significant medication errors for one (1) of four (4) residents (Resident #1) reviewed. Specifically, Resident #1's hospital discharge orders included routine short acting insulin and sliding scale (the amount of insulin administered is based on the results of blood glucose finger sticks) short acting insulin. The resident's admission physician orders included long-acting insulin and blood glucose monitoring before and after meals, and at bedtime. The physician orders were not transcribed to the Medication Administration Record and the resident did not have blood glucose level readings completed for 10 days. Additionally, the resident did not have admission orders for routine short acting insulin and sliding scale short acting insulin as recommended. Subsequently, Resident #1 was hospitalized for hyperosmolar hyperglycemic state (severely high blood glucose levels with severe dehydration and confusion). This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. The facility policy, Medication Requisition Worksheet, revised 2/2015, documented medication reconciliation occurred at the time of admission and within 24 hours for each new resident admitted to the facility. The first reconciliation occurred by the pharmacist upon submission of the physician orders. The second reconciliation was completed when nursing reviewed all the medications listed on the hospital discharge summary/transfer sheet by way of a medication reconciliation worksheet. Nursing would complete the medication reconciliation worksheet before notifying the physician for initial verification of orders. Nursing would carefully review medications recommended by the hospital at discharge and list medications that needed clarification. Nursing would notify the physician of any discrepancies. The servicing pharmacy would conduct their own internal reconciliation upon receipt of orders and communicate any discrepancies to the ordering physician or nursing supervisor for clarification. The facility policy, Diabetes Management Protocol, issued 6/2014 and 3/2023, documented for insulin dependent diabetic residents, the responsible nurse administered routine insulin as ordered, performed finger sticks as ordered, administered short acting insulin per sliding scale, monitored residents for symptoms of hypoglycemia/hyperglycemia (low or high blood sugar levels in the blood), documented finger stick results, dose of insulin, where administered, and re-evaluated requirements of sliding scale insulin periodically to optimized routine orders. Resident #1 had diagnoses including Type 2 diabetes (the body does not use insulin effectively or does not produce enough insulin) and multiple sclerosis (a central nervous system disease). There was no Admission Minimum Data Set assessment yet completed prior to the resident's discharge to the hospital on 1/21/2023. The hospital physician discharge summary dated 1/9/2023 at 2:42 PM documented the resident's diabetes was poorly controlled. The resident was started on Lantus (glargine, long acting insulin) 10 units twice daily, in addition to Humalog (lispro, short acting insulin) per sliding scale coverage, plus Humalog 3 units with meals. Chemstrips (fingerstick glucose readings) were improving. The 1/11/2023 at 10:59 AM hospital discharge orders documented: (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- Insulin glargine 100 units per milliliter injection, inject 10 units under the skin in the morning and 10 units before bedtime. - insulin lispro 100 units per milliliter injection, inject 5 units in the morning, 5 units at noon, and 5 units in the evening. Inject with meals. - insulin lispro 100 units per milliliter injection, inject 0-14 units (sliding scale,) under the skin 4 (four) times a day before meals and nightly. - stop taking glimepiride (an oral anti-diabetic medication) 4 milligrams. The facility admission physician orders documented: - on 1/11/2023 (untimed) insulin glargine solution 100 units per milliliter, inject 10 units subcutaneously (under the skin) twice a day for diabetes. - on 1/11/2023 at 5:09 PM (telephone order) accuchecks (blood glucose finger sticks) before and after meals and at bedtime for diabetes. Call medical if less than 70 milligrams/deciliter and greater than 450 milligrams/deciliter. The order was entered into the computer at 5:11 PM by Registered Nurse #22 with the order type documented as standard other. The order was signed by Nurse Practitioner #15 on 1/13/2023 at 5:46 PM. There was no documented evidence of an admission physician order for routine short acting insulin and sliding scale insulin. The Comprehensive Care Plan initiated 1/11/2023, documented the resident had diabetes mellitus. Interventions included diabetes medications as ordered, monitor/document for side effects/effectiveness, dietary consult for nutritional regimen and ongoing monitoring, finger stick blood sugars as ordered by physician, monitor/document/report as needed signs/symptoms of hyperglycemia (high blood sugar), including increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps and pain, Kussmaul's breathing (rapid breathing), acetone (fruity) breath, coma. The 1/2023 Medication Administration Record documented insulin glargine inject 10 units subcutaneously two (2) times per day for diabetes with a start date of 1/11/2023. There was no documented evidence of orders or results for accuchecks from 1/11/2023-1/21/2023. The Weight and Vital Signs Summary did not include blood sugar (accuchecks) results prior to 1/21/2023. The 1/12/2023 Nurse Practitioner #15 progress note documented they reviewed external medical records. Hospital labs and consults were reviewed. The plan was to continue with Lantus 10 units twice daily and follow accuchecks (blood glucose finger sticks). There was no documented evidence Nurse Practitioner #15 reviewed accuchecks or the hospital discharge summary which included routine short acting insulin and sliding scale insulin. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 1/16/2023 Physician #14 History and Physical documented hospital labs and consults were noted and reviewed. The resident had controlled type 2 diabetes. The plan was to continue with Lantus 10 units twice daily and follow. There was no documented evidence Physician #14 reviewed accuchecks or the hospital discharge summary which included routine short acting insulin and sliding scale insulin. The 1/19/2023 at 8:26 PM progress note by Licensed Practical Nurse #33 documented the resident was alert and oriented and able to make needs known. No complaints of pain or discomfort voiced. Licensed Practical Nurse #23 progress notes documented: - on 1/21/2023 at 11:53 AM the resident followed verbal directions but did not respond verbally. The resident had an elevated heart rate of 128 beats per minute (normal 60-100 beats per minute), and neurological checks were within normal limits. The resident had no signs of distress. Director of Nursing #20 and on-call Physician #31 were notified. There was no documented evidence the resident's blood glucose level was checked. - on 1/21/2023 at 12:38 PM Physician #31 ordered labs including a complete blood count, comprehensive metabolic panel, ammonia level, and a urinalysis with culture and sensitivity (determines possible presence of a urinary tract infection). Continue neurological checks and monitor the resident's vital signs in 1-2 hours. If the resident's heart rate did not come down, the provider would order medication. The resident responded verbally and denied pain or discomfort. The resident's heart rate was 122 beats per minute. - on 1/21/2023 at 1:38 PM the resident had a heart rate of 124 beats per minute. Physician #31 was updated and ordered the resident be sent to the emergency room for evaluation. An ambulance was called, and a message was left for the family representative. - on 1/21/2023 at 1:53 PM the resident was admitted to the hospital for hyperkalemia (high blood potassium levels). The Weights and Vital Signs Report documented on 1/21/2023 the resident's blood glucose results were 118 milligrams/deciliter at 11:33 AM and 118 milligrams/deciliter at 11:34 AM. The 1/21/2023 at 6:42 PM hospital physician progress note documented Resident #1 presented to the emergency room with an increased heart rate and mental status changes. The resident had an elevated blood sugar level of 1192 milligrams/deciliter (drawn at 2:45 PM, normal for non-diabetics 75-115 milligrams per deciliter) and an elevated potassium level (7.0 milliequivalents/liter, normal 3.5-5.2 milliequivalents/liter). The resident was administered an insulin drip via intravenous (into a vein) route and was started on medication to reduce their elevated potassium levels. The resident would be admitted into the Intensive Care Unit. Repeat blood work showed the resident continued with elevated blood sugar levels. The 1/26/2025 at 10:37 AM hospital discharge summary documented the resident's discharge diagnosis was hyperosmolar hyperglycemic state. The resident had poorly controlled diabetes with a Hemoglobin A1C of 10. 7% (a blood test that measures average blood glucose levels over the past 2-3 months, normal is less than 5. 7%). The plan was to follow up with endocrinology as an outpatient. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Utica Center for Nursing and Rehab	1800 Butterfield Ave Utica, NY 13501

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The 1/24/2023 at 9:55 AM Facility accident/incident investigation summary completed by the Administrator documented: - On 1//11/2023 Resident #1 was admitted to the facility and their physician orders for blood glucose monitoring did not transcribe to the Medication Administration Record. The order was inputted as a standard order instead of a MAR order. - On 1/21/2023 at 1:55 PM, Resident #1 had increased pulse, lethargy (tiredness), and confusion and was sent to the hospital and was found to have hyperglycemia. - On 1/23/2023 at 8:00 AM, the hospital updated the Administrator. Resident #1 was admitted with a high blood glucose level, hyperkalemia, and hypernatremia (high blood sodium levels). The resident's blood glucose level was 1192. The Health Care Proxy was at bedside and stated they did not believe the resident had received blood glucose finger sticks or insulin since their admission to the facility. - On 1/23/2023 at 8:30 AM, the facility became aware Resident #1 had a blood glucose level of 1192. The resident's blood glucose prior to transfer was 118. The facility verified a care plan violation had occurred, and the resident's blood glucose monitoring did not transcribe and reflect on the medication or treatment administration records. The allegedly responsible employee (unidentified) was issued a disciplinary notice and re-educated on transcription of orders and secondary verification by a second nurse. During an interview on 1/27/2025 at 1:39 PM, Licensed Practical Nurse #2 stated registered nurses, and licensed practical nurses were responsible for entering provider orders into the computer system once the provider had issued an order. Nursing input the order and scheduled the time of administration based on the physician order. An order for a blood glucose (sugar) fingerstick would be entered into the computer to be done before and after meals, did not require a specific time, and nursing was trained to know what before and after meals indicated. Nursing had one hour before or after the scheduled time to administer medications. Licensed Practical Nurse #2 was unsure if additional boxes needed to be checked when the order was entered into the computer. During an interview on 1/28/2025 at 11:58 AM, Licensed Practical Nurse # 26 stated physician orders were entered into the computer. If an order for a blood glucose fingerstick was before and after meals and at bedtime, it was entered as a new order. They ensured the category standard medication-electronic medical record box was checked. This allowed nursing to see the order on the resident's electronic medication administration record. If the correct box was not checked, the physician order would only show up under general physician orders in the medical chart and would not transfer to the medication administration records and the fingerstick would be missed. The Director of Nursing was interviewed: - on 1/31/2025 at 1:50 PM, they stated orders were issued on paper by the nurse practitioner or physician and licensed nurses were responsible for putting the orders into the computer. A blood glucose monitoring fingerstick order would need to be placed under the category standard-electronic medical record, or electronic medication administration record order, for it to show on the medication administration record. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: The Pines at Utica Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 1800 Butterfield Ave Utica, NY 13501	

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- on 2/3/2025 at 8:23 AM, they stated they or the Assistant Director of Nursing reviewed hospital discharge orders. The current second check system occurred when they entered orders, and a second person checked them. They did not check their own entries. Another second check occurred the next day by the nurse practitioner. Once orders were entered, the after-visit summary which included the resident's discharge medications, would be scanned into the resident's electronic medical record under the miscellaneous tab. This was completed by 5:00 PM each day. It was rare that a nursing supervisor or off-shift nurse entered orders. If they did, the Director of Nursing or Assistant Director of Nursing would do the second check the following day. The only way to know if an order was transcribed incorrectly would be during a second check the following day. It was important for residents with diabetes to have their orders transcribed appropriately and receive their accuchecks and insulin or it could pose a serious health risk to the resident. It was considered a medication error if the orders were not transcribed correctly. During an interview on 2/6/2025 at 9:47 AM, Licensed Practical Nurse #28 stated Resident #1 was a bad diabetic. They stated they did not recall monitoring the resident's blood sugars from admission. Their nursing judgement would be to check the resident's blood glucose level before they administered insulin and call the physician for an order. Resident #1's blood sugars could have been low if they received insulin without their blood sugar being monitored. Licensed Practical Nurse #28 stated if Resident #1's physician order for finger sticks did not show up on the medication records then whomever placed the order made an error. The medication administration record would issue a reminder at least 1/2 half an hour before the fingerstick was due. Nurse Practitioner #15 was interviewed: - on 2/6/2025 at 10:17 AM, they stated all newly admitted diabetic residents received orders to monitor their blood sugars. Blood sugars (finger sticks) were monitored for at least five (5) days to evaluate whether the resident was stable and needed higher or lower doses of insulin or less frequent blood sugar monitoring. They expected nursing to enter the orders and check them for accuracy and review the resident's results with the provider after 5 days. Nurse Practitioner #15 stated they were Resident #1's primary care provider before admission, and the resident had uncontrolled diabetes for many years. They should have had blood glucose monitoring every day per their order. They were not aware the resident's finger sticks were not being obtained and did not know Resident #1 was hospitalized for a blood sugar of 1192. They stated the resident's emergency room diagnosis was a direct result of their finger sticks not being obtained. Hyperosmolar hyperglycemic state was a life-threatening condition caused from prolonged high blood sugars. Resident #1 not having their blood sugar monitored could have led to their death if they were not hospitalized . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER The Pines at Utica Center for Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 1800 Butterfield Ave Utica, NY 13501	

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	- on 2/19/2025 at 10:49 AM, they stated hospital discharge orders were initially reviewed by staff who approved the admission and then forwarded to nursing. Nursing reviewed the orders, and verbal orders were given by the providers until they could see the resident, typically within 48-72 hours of their arrival. Nursing would initially review orders and call with any discrepancies, and they would review orders and labs when they arrived. They were not aware if Resident #1 had orders for short-acting insulin as it was two years ago. They stated hospitals often prescribed short-acting insulin for diabetics but that became problematic if the resident did not eat. Nurse Practitioner #15 stated they would have kept the order for short-acting insulin for Resident #1 due to their history of uncontrolled diabetes and their lab value A1C level of 10.7%. This clearly showed Resident #1's diabetes was not under control and needed close monitoring. It was important to monitor Resident #1's blood glucose levels and administer insulin. If blood glucose levels were too high, kidney disease, ketoacidosis, cardiac or vascular disorders such as stroke could occur. - on 2/20/2025 at 9:48 AM, they stated Resident #1's blood glucose level of 118 decimeters per milliliter prior to their emergency room transfer could have been altered if nursing did not wait for alcohol to dry on their finger before obtaining the fingerstick reading. A blood glucose level of 1192 decimeters per milliliter could only result from a lab draw because glucometers did not read above 600. The facility glucometers were checked monthly for calibration and controls. During an interview on 2/7/2025 at 12:39 PM, Registered Nurse #20 stated licensed nurses were trained during orientation on how to put physician orders into the computer. They had an extra day during training to learn the various types of orders. The facility had a two-person check system. When a new physician order was entered into the computer it would go into a queue and a second nurse would sign into the computer to verify the order. The second nurse's username and password would time stamp and sign their name and that indicated the order had been checked. During an interview on 2/20/2025 at 9:18 AM, Medical Director #14 stated hospital discharge/admission orders were first reviewed by nursing and then the nurse practitioners. They saw newly admitted residents in the first week. They reviewed records the best they could but had to check records on three different computer systems that were not connected to one another. Residents with diabetes should be monitored for their blood sugars and receive short or long-acting insulin if ordered. They could not recall Resident #1 or if they had active blood glucose or insulin orders. They stated hyperosmolar hyperactive state was a complication of diabetes and could happen if a resident's blood sugars were not being monitored or insulin was not administered. 10NYCRR 415.12 (m)(2)