STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335600	A. Building B. Wing	07/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34465 Based on record review and interview during the abbreviated survey (NY00343878), the facility failed to provide residents with treatment and care in accordance with professional standards of practice for 3 of 6 residents reviewed (Residents #1, #5, and #6). Specifically, - Resident #1 had an unwitnessed fall, the medical provider was not notified timely of the fall or outcome of the assessment, and there was no evidence neurological checks were implemented. Subsequently, the resident experienced a significant change in condition, the medical provider ordered the resident to be sent to the hospital, and Emergency Medical Services was not notified immediately for transportation. The resident was transferred to the hospital where they expired from asphyxiation (loss of oxygen) due to choking on their dentures. - Resident #5 had unwitnessed falls and neurological assessments were not initiated or completed. - Resident #6 sustained a fall with a head injury and neurological assessments were not continued after the initial assessment. The facility's failure to complete timely assessments, notify Emergency Medical Services timely, and respond timely to a change in condition for Resident #1 placed 204 residents in the facility at risk. This resulted in actual harm that was Immediate Jeopardy and Substantial Quality of Care to resident health and safety. Findings include: The facility policy, Neurological Evaluation, effective ,d+[DATE] and revised ,d+[DATE], documented a neurological evaluation was indicated upon physician order; following an unwitnessed fall; following a fall or other accident/injury involving head trauma, or when indicated by resident condition. The policy did not document the frequency or duration of the neurological checks. The Neurological Monitoring Sheet (data recording for neurological checks) dated ,d+[DATE] documented neurological checks were to be completed every 15 minutes x 4; every 30 minutes x 4; every hour x 4; every 4 hours x 8; and every 8 hours x 4. The monitoring sheet included pupil evaluation, hand grips, lower extremity evaluation, mental status, headache, and vital signs (blood pressure, heart rate, respiration rate). (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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy, Change in a Resident's Condition or Status, reviewed ,d+[DATE], documented the nurse would notify the resident's attending physician or physician on call after an accident or incident involving the resident or a significant change in the resident's physical/emotional/mental condition (need to alter the resident's medical treatment significantly). A significant change of condition was noted as a major decline or improvement in the resident's status that would not normally resolve without intervention by staff or by implementing standard disease-related clinical interventions; impacted more than one area of the resident's health status; required interdisciplinary review and/or revision to the care plan, and ultimately was based on judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 1) Resident #1 had diagnoses including Alzheimer's disease and a prior stroke. The [DATE] Minimum Data Set assessment documented the resident had severely impaired cognition; required supervision/touch assistance with oral hygiene; was independent with rolling left to right and chair/bed-to-chair transfers; held food in their mouth/cheeks or residual food in their mouth after meals; was on a therapeutic diet; did not have any falls since the last assessment; and did not have loosely fitting full or partial dentures. The [DATE] dental note documented the resident had a well-fitting upper complete denture. The [DATE] comprehensive care plan documented the resident had oral/dental health problems related to being edentulous (no teeth), utilized an upper denture, and they were at risk for falls. Interventions included the resident was independent with eating, needed supervision/touch assistance with transfers and with oral hygiene, they needed denture care, and staff were to anticipate needs. The [DATE] cardiology consult documented the resident was seen for follow-up for their implantable cardioverter defibrillator (device in the chest that monitors heart rate and delivers electrical shocks, when needed, to restore a regular heart rhythm). The [DATE] at 7:33 PM Accident/Incident Report completed by Registered Nurse Supervisor #4 documented the resident had an unobserved fall in their room. The resident was found on the floor on the side of the bed without injury. Nurse Practitioner #5 was notified at 8:12 PM and Emergency Medical Services transferred the resident to the hospital at 9:14 PM. The [DATE] at 8:21 PM Registered Nurse Supervisor #4 progress note documented the resident slipped and had an unwitnessed fall. They were able to wiggle their hands and legs. There was no external rotation of the resident's legs (when a joint is rotated outward from the body, indicating injury). The resident was pursed lip breathing (inhaling through the nose with mouth closed and exhaling through tightly pressed lips) when oxygen was placed . Blood pressure was ,d+[DATE] (resident's blood pressure ranged ,d+[DATE] to , d+[DATE] from [DATE]-[DATE]), pulse 67 beats per minute (normal ,d+[DATE]), respirations 19 breaths per minute (normal ,d+[DATE]), oxygen saturation level 95% (resident's normal range was ,d+[DATE]% without oxygen administration). The resident was now not speaking and that is a change in the assessment. The resident had a pacemaker (an implanted device used to treat irregular heart rhythms) and per the nurse, while taking vitals, the resident's left arm lit up. Nurse Practitioner #5 ordered the resident was to be sent to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] at 8:25 PM Nurse Practitioner #5's progress note documented they were called by Registered Nurse Supervisor #4 for an unwitnessed fall. The resident slipped on spilled water. The resident was initially responsive then suddenly became unresponsive. Staff reported the resident's arm lit up and Nurse Practitioner #5 noted they were not sure what that could have been. The resident was only responsive to painful stimuli, and there was no visible trauma to their head. The resident was positive for COVID-19, and they ordered the resident to be transferred to the hospital. There was no documented evidence the facility was aware of the resident's implantable cardioverter defibrillator. The [DATE] at 9:17 PM Registered Nurse Supervisor #4's progress note documented they were called to the unit for an unwitnessed fall. Upon entering the room, the resident was on the floor, had their head propped on a pillow against the end table, was wearing non-skid socks, but the floor was wet near the bed. The resident was short of breath and 4 liters of oxygen was placed via nasal cannula. Oxygen saturation level was 95% with the oxygen on. The resident was able to lift their arms and wiggle their fingers and follow commands. The resident then started acting odd, stiffening up, and not responding or following commands. The resident was placed in bed and an assessment was completed. Licensed Practical Nurse #2 reported when they checked the resident's pulse prior to their arrival, they noticed the resident's left arm lit up. The resident had a pacemaker. The resident reacted to sternal rub (rubbing the knuckles on the breastbone to cause painful stimuli to see if there is a reaction from an unconscious person) and was swinging their hands at them. Nurse Practitioner #5 was notified and ordered the resident to be transferred to the hospital. The resident left at 9:14 PM. The undated, unsigned Investigative Summary documented on [DATE] at 7:33 PM, the resident was found by Licensed Practical Nurse #2 on the floor near their bed next to a small puddle of water. Licensed Practical Nurse #2 paged Registered Nurse Supervisor #4 who found the resident alert and oriented with no visible signs of a head injury. The resident was transferred to the bed, could follow commands, and the source of water was unclear with no visible leaks to the toilet/sink . During the assessment, the resident appeared short of breath and oxygen was placed at 4 liters per minute bringing their oxygen saturation level up to 95%. The resident became hypotensive (low blood pressure) and only responded to a sternal rub. The on-call medical provider, Nurse Practitioner #5, was notified, and the resident was sent to the hospital at approximately 9:14 PM. The hospital called back and said the resident died from respiratory arrest at 9:59 PM. Based on information, it appeared the resident suffered a fall after experiencing cardiac/respiratory arrest related to pre-existing conditions and acute COVID-19 diagnosis . Abuse, neglect, mistreatment was ruled out. The Prehospital Care Report completed by Emergency Medical Services documented: - at 8:58 PM, they received a call from the facility and were enroute and arrived at the facility at 9:02 PM. - at 9:05 PM, the resident was clammy, cold, cyanotic (bluish color caused by low oxygen), capillary refill was above 4 seconds (the time it takes for blood to refill after applying pressure, normal ,d+[DATE] seconds), and the resident was unresponsive. - at 9:10 PM, 15 liters per minute of oxygen was applied via a non-rebreather (oxygen mask that delivers high concentrations of oxygen) with unchanged resident response. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- at 9:20 PM, intravenous (administered through a vein) Versed (sedative) was administered and a foreign body was removed from the resident's airway. - at 9:22 PM, oxygen at 15 liters per minute via a non-rebreather with improved resident response. The narrative note attached to the report documented they were dispatched to the facility for a fall with possible pacemaker damage. Upon arrival, the resident was found lying in bed. The resident had dentures in their mouth, and they (unclear if referring to staff or Emergency Medical Services) could not get them out. The resident was not responsive and only responded when trying to remove the dentures manually. The dentures were in the back of the throat causing a partial airway obstruction. They attempted to open the resident's airway with modified jaw thrust and grabbing the dentures with forceps, though they were unable to open. The resident was then given Versed for sedation and the dentures were removed. The resident's pupils were now fixed and dilated (not moving and large, sign of serious life-threatening condition). Care was transferred from Emergency Medical Services to the hospital. The [DATE] hospital report documented the resident arrived at the hospital at 9:29 PM, was unresponsive and cyanotic with pupils fixed and dilated. The resident suffered cardiac arrest shortly after arrival and cardiopulmonary resuscitation was unsuccessful. The resident expired. The resident's [DATE] death certificate, signed by Medical Examiner #5 documented the resident's manner of death was an accident, the immediate cause of death was from asphyxiation due to choking on dentures. During a telephone interview on [DATE] at 10:35 AM, Certified Nurse Aide #1 stated the resident wore dentures and needed assistance of 1 with oral hygiene and putting in and removing dentures daily. The resident walked well with a walker. Dentures typically were removed at bedtime, around 7:30 PM. They never noticed any issues with the resident's dentures not fitting correctly. They were assigned to the resident's care on [DATE] and they showered the resident before dinner and brought their dinner tray around 6:00 PM to 6:30 PM. They and Licensed Practical Nurse #2 heard a thump (did not recall the time) and the resident's roommate yelled out for them. The resident was on found on the floor and they stayed with the resident while Licensed Practical Nurse #2 called the Supervisor. They did not see the resident the remainder of the night after the fall and left their shift at 8:00 PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 8:56 AM, Licensed Practical Nurse #2 stated when a resident had an unwitnessed fall, the Supervisor was notified, and neurological checks were started immediately and done every 15 minutes for the first hour. There was a sheet they used to document neurological checks. If a resident had a change in condition, they notified the Registered Nurse or Supervisor, and the Registered Nurse/Supervisor assessed the resident and called the medical provider immediately. If orders were obtained to send the resident to the hospital, then Emergency Medical Services was notified immediately. Resident #1wore dentures, needed assistance to put them in and remove them and the aides assisted with that care. They were notified on [DATE] by the resident's roommate the resident fell , and they did not recall the time. They found the resident lying on their back and when they asked the resident if they were okay, the resident stated no and tried to get themself off the floor. They put a pillow under the resident's head and had the certified nurse aide stay with the resident while they got supplies to do vital signs and call the Supervisor. The resident's oxygen saturation level was close to 60% or below so they applied oxygen and the oxygen saturation improved to 95%. They were not sure if the resident hit their head. The resident did not want to talk and that was not their normal behavior. The resident did follow all Registered Nurse Supervisor #4's requests during the assessment. Licensed Practical Nurse #2 did the original set of neurological checks on the resident and reported them to Registered Nurse Supervisor #4, but they did not start the neurological check sheet. They thought the resident was sent to the hospital quickly and that was why neurological checks did not continue. They believed the medical provider was notified immediately as well as Emergency Medical Services. They stated at one point, they noticed the resident's top denture was sliding down in their mouth and when they attempted to remove them, the resident closed their mouth and would not allow removal. They did not recall what time that occurred and did not recall notifying anyone about the dentures. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 9:57 AM and 5:51 PM, Registered Nurse Supervisor #4 stated after a resident had an unwitnessed fall, they were supposed to be monitored with vital signs and neurological checks and how often those were done was dependent on how the medical provider ordered them. When a resident had a change in condition, the Director of Nursing and the medical provider should be notified. If a medical provider ordered a resident to be sent to the hospital for a change in condition, it would take Registered Nurse Supervisor #3 quite a while to do the transfer paperwork. They did not specify what quite a while meant. On [DATE], the resident was found on the floor. They were not sure how the resident was acting when they assessed them because they did not know the resident's baseline. There were no injuries, and a quick neurological check was done and was normal. The nurse on the unit reported the resident was acting odd when they did vital signs before Registered Nurse Supervisor #4 got to the floor. Licensed Practical Nurse #2 reported when doing the resident's pulse, their whole arm lit up. Registered Nurse Supervisor #4 wondered if that had something to do with the resident's pacemaker. The pacemaker appeared to be in the correct position when they checked. The resident was found short of breath with pursed lip breathing during the assessment, but they knew the resident had chronic obstructive pulmonary disease (lung disease). Oxygen was applied and the resident's oxygen saturation improved to 95%. They did not notify the physician at that time because the resident was answering questions appropriately, had no injuries, and they were not planning to send them to the hospital. After getting the resident in bed, they left the unit. They did not recall if they left monitoring instructions with Licensed Practical Nurse #2 however it was standard procedure for nurses to do neurological checks and vital signs after an unwitnessed fall . They did not recall if they were notified to return to the unit or if they were checking on the resident however, about a half hour later, the resident would no longer respond verbally to questions, they had a blank stare and continued pursed lip breathing. They did a sternal rub and the resident only responded to pain. They told staff they were sending the resident to the hospital and that was when they notified Nurse Practitioner #6 of the fall and change in condition. Registered Nurse Supervisor #4 stated they did not notify Emergency Medical Services until they had all the transfer paperwork completed because it only took Emergency Medical Services 5 minutes to arrive once called. They stated they also needed to go to another unit to tend to one or two other residents peripherally inserted central catheters before they sent Resident #1 out. Nobody notified them the resident's dentures were loose in their mouth and they should have been notified. During an interview on [DATE] at 11:47 AM, the Director of Nursing stated they reviewed and completed the [DATE] investigation. Based on the documentation from the nursing progress notes, they understood the events occurred in succession. They were not aware of any significant gaps in time from when the resident's change of condition was noted, to the medical provider notification, to calling for emergency medical services. If Registered Nurse #4 was made aware of concerns related to the resident's condition immediately after the fall, the medical provider should have been notified at that time. When the resident had a change in condition and their arm was noted to have lit up, the medical provider should have been notified immediately. Once the provider directed staff to send the resident to the hospital, they should have called for an ambulance immediately. They were not made aware that Licensed Practical Nurse #2 observed the resident's dentures loose in their mouth, and stated they should have notified the supervisor immediately. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:49 PM, Nurse Practitioner #5 stated they expected to be notified of a fall immediately after the initial assessment. If a resident experienced a change from their baseline condition, such as low oxygen and pursed lip breathing after a fall, they expected to be notified immediately. Following their order to send the resident to the hospital, they expected nursing staff to notify Emergency Medical Services immediately for transport. The 39-minute time frame to notify the Nurse Practitioner after Resident #1's fall was not timely, it was an excessive amount of time that passed. Waiting 46 minutes to call Emergency Medical Services following the Nurse Practitioner's order to send to the hospital was also not timely. Staff should have called Emergency Medical Services immediately after receiving the order. During an interview on [DATE] at 1:05 PM, the Administrator stated they were involved in the review of Resident #1's fall and hospitalization on [DATE]. Based on the documentation from the nursing progress notes, they understood the events occurred in succession. They were not aware of any significant gaps in time from when the resident's change of condition was noted, to the medical provider notification, to calling for Emergency Medical Services. Forty-six minutes was not timely to notify Emergency Medical Services following an order to send the resident to the hospital. The Administrator was not aware the resident's vital signs and neurological status were not monitored pending hospital transfer and they expected monitoring to occur during that time. They thought events happened quickly and there were no time delays in provider notification or hospital transport. 2) Resident #5 had diagnoses including dementia. The [DATE] Admission Minimum Data Set assessment documented the resident's cognition was intact and they required partial to moderate assistance with rolling left to right and with chair to bed transfers. The resident had no falls prior to admission and had one fall since admission. The [DATE] comprehensive care plan documented the resident was at risk for falls. Interventions included staff were to anticipate needs. The [DATE] at 10:30 AM Assistant Director of Nursing #12's progress note documented they were called to the unit because the resident was found on the floor. The resident was attempting to get out of bed by themselves and slid to the floor. They were observed sitting on the floor with no apparent injuries. The resident was educated to ask for help. There was no documented evidence neurological checks were initiated or completed. The [DATE] Accident/Incident Review Checklist (checklist of items reviewed during the investigation) and Summary of the Investigation completed by Assistant Director of Nursing #15 documented the resident fell with no injuries and fall precautions were initiated. Multiple documents were noted as reviewed including staff statements, the care plan, and Fall Risk Evaluation. Neurological assessments were not documented as reviewed. The [DATE] at 12:22 PM Physician #13's progress note documented the resident was seen for a fall earlier in the day and the plan was to continue monitoring and neurological checks. The [DATE] comprehensive care plan documented the resident had an actual fall. Interventions included non-slip shoes, clutter free environment, and call bell in reach. The [DATE] at 3:07 PM Physician Assistant #14's progress note documented a fall follow-up and continued vital sign monitoring and neurological checks per facility policy. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The [DATE] at 8:03 AM Assistant Director of Nursing #12's progress note documented the resident was found on the floor . The resident was trying to reach for a blanket, the mattress slid over the bed frame causing them to roll out of bed and they had a small abrasion to the knee. There was no documented evidence neurological checks were initiated or completed. The [DATE] Accident/Incident Review Checklist and Summary of the Investigation completed by Assistant Director of Nursing #15 documented the resident's mattress slid off the frame as they reached for an item and the plan was to have maintenance look at the bed frame. Multiple documents were documented as reviewed however neurological checks were not documented as reviewed. During a telephone interview on [DATE] at 12:23 PM, Assistant Director of Nursing #12 stated neurological checks were initiated after unwitnessed falls. The initial check was completed by the assessing nurse and the remaining checks were completed by floor nurses. On [DATE], the resident denied hitting their head and if a resident was alert and oriented, they took their word for it that they did not hit their head. The same was true for the [DATE] fall with the resident stating they did not hit their head. They were not aware the facility policy documented neurological checks for unwitnessed falls. During a telephone interview on [DATE] at 12:34 PM, Assistant Director of Nursing #15 stated the purpose of the Accident/Incident Review Checklist was to ensure all documents were readily accessible and to ensure the packet was completed. Neurological checks were instituted at the time of the fall and continued per policy. If a resident was alert and oriented and could tell you they did not hit their head, then neurological checks were not continued , and this was why the Accident/Incident Review Checklist did not contain neurological checks on [DATE] and [DATE]. They were not aware the facility policy documented that neurological checks were completed for all unwitnessed falls. 3) Resident #6 had diagnoses including dementia, diabetes, and urinary tract infection. The [DATE] Minimum Data Set assessment documented the resident had severe cognitive impairment and had behavioral symptoms including rejection of care. The resident required substantial assistance for bed mobility and was dependent for transfers. The resident had one fall with no injury since the last assessment. The [DATE] Accident and Incident Report completed by Registered Nurse Supervisor #16 documented at 10:15 PM, the resident had an unobserved fall in their room. The resident had a hematoma (pooling of blood from broken blood vessel) on their right forehead and complained of pain in the area. The resident's vital signs were documented and there was no documentation related to a neurological assessment. The [DATE] at 12:52 AM Registered Nurse Supervisor #16's progress note documented the resident was found on the floor and had a 2-centimeter hematoma on their right forehead with faint bruising noted and neurological checks were intact. The on-call medical provider was notified and ordered to send the resident to the hospital for evaluation due to the resident taking a blood thinner. Upon arrival of Emergency Medical Services, the resident refused to go to the hospital, and they were unable to transport the resident. The medical provider was notified and stated to continue neurological checks and notify them of any change in condition. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediate Jeopardy was identified, and the Administrator was notified on [DATE] at 3:04 PM. Immediate Jeopardy was removed on [DATE] at 12:25 PM prior to survey exit based on the following corrective actions taken: - 93% of nursing staff (registered nurses, licensed practical nurses, certified nurse aides) were educated on calling the medical provider after a change in condition, completing neurological checks, immediacy of calling Emergency Medical Services after receiving an order to send to the hospital, and completing assessments including checking the airway. - The facility had a plan to educate the remaining staff prior to the start of their next shift. - Post-tests were issued and reviewed. - Staff education sign in sheets were reviewed and compared to the current nursing staff list and no discrepancies were identified. - 100% of nursing staff working [DATE] received education. - Staff education was verified during an onsite visit [DATE], multiple nursing staff on multiple units were interviewed. - Staff were able to report content of education and confirmed day received and the facility staff who presented the education (Assistant Directors of Nursing or Educator).