

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 415129	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/15/2024
NAME OF PROVIDER OR SUPPLIER Summit Commons Rehabilitation and Health Care Cnt		STREET ADDRESS, CITY, STATE, ZIP CODE 99 Hillside Avenue Providence, RI 02906	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>47939</p> <p>Based on record review and staff interview, it has been determined that the facility failed to ensure licensed nurses had the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment for 1 of 1 resident reviewed relative to the need for a Glucagon injection (a medication used to treat low blood sugar) secondary to a critically low blood sugar level, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 3/8/2024 at 5:02 PM, alleges the resident was admitted to the hospital following an unresponsive episode at the nursing facility. There was a question if the unresponsive episode and subsequent emergency room visit, and hospital admission were the results of a medication error. The skilled nursing facility denies the error.</p> <p>Record review of a facility reported incident submitted the Rhode Island Department of Health on 3/8/2024 at 5:15 PM, revealed that the resident was found with an alteration in mental status at approximately 5:30 PM. A code blue (an emergency response) was called as the resident's blood sugar was 31 (normal blood sugar range is between 70-125 milligrams/deciliter (mg/dl). Glucagon was administered and 911 was called. The blood sugar was retaken, and the result was 38 mg/dl. A second dose of Glucagon was administered and 911 arrived and transported the resident to the emergency room for evaluation. The resident was later admitted with a diagnosis of altered mental status.</p> <p>Record review of the Facility Assessment revealed that the facility has identified that they are able to provide care and nursing services for residents in the category of Metabolic disorders including but not limited to Diabetes.</p> <p>Record review of the facility policy titled Hypoglycemia-clinical management of revealed in part, hypoglycemia is defined as fingerstick of serum glucose (blood glucose) less than 60 mg /dl .If the resident is unresponsive, administer Intramuscular (injection in the muscle) or Subcutaneous (injection under the skin) Glucagon as ordered by the physician.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0726</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Record review revealed that Resident ID #1 was admitted to the facility in March of 2024 for short-term rehab. Further record review revealed that s/he is a diabetic and requires the administration of insulin to manage this diagnosis.</p> <p>Record review revealed a physician's order dated 3/7/2024 for Glucagon Emergency Kit - 1 mg- Inject one syringe intramuscularly as needed for hypoglycemic reaction for blood sugar under 60. Recheck blood sugar every 15 minutes until the resident's blood sugar is greater than 70. Notify the MD for blood sugar less than 60.</p> <p>Record review revealed a progress note dated 3/7/2024 at 6:07 PM that the resident was found to be unresponsive with a blood sugar of 31 on 3/7/2024 and a code blue was called. S/he required the administration of Glucagon to raise his/her blood sugar level, which was administered by Registered Nurse, Staff B at 5:40 PM.</p> <p>Further review revealed the resident's blood sugar was taken again and the results were 34 at 5:48 PM, and a second dose of Glucagon was administered to the resident by Registered Nurse Staff, C.</p> <p>During a surveyor interview with Staff C, on 3/12/2024 at 1:06 PM she revealed that on 3/7/2024 she responded to the code blue for Resident ID #1. She indicated that she noticed that the Glucagon bottle that Staff B had pulled to administer to the resident still had the Glucagon powder in the vial. She indicated that the resident's blood sugar was not responding to the first dose of Glucagon because s/he did not receive it, as the medication was not reconstituted, and the resident only received the sterile water. Once she realized that the Glucagon was not administered, she decided to get another vial of Glucagon and administer another dose to the resident.</p> <p>During a surveyor interview with Staff B, on 3/12/2024 at 1:50 PM she revealed that she was unaware that she needed to reconstitute the Glucagon prior to administering it. She acknowledged that she had only administered an injection of the sterile water as she did not reconstitute the medication. Additionally, she revealed that she had not received any trainings or competencies for the use of Glucagon.</p> <p>Record review of Registered Nurse, Staff B's personnel record failed to reveal evidence of a competency related to the reconstitution and administration of Glucagon.</p> <p>Additional record review of the expanded sample revealed that personnel files for Registered Nurses, Staff A, Staff D, Staff E and Licensed Practical Nurse Staff F failed to reveal evidence of competencies related to the reconstitution and administration of Glucagon.</p> <p>During a surveyor interview on 3/12/2024 at 1:40 PM with the Director of Nursing Services, she indicated that she would have expected Staff B, to give the correct dose of Glucagon by reconstituting the medication as required. Additionally, she was unable to provide evidence that Staff A, B, D, E and F received any training and/or competencies related to the reconstitution and administration of Glucagon.</p> <p>Cross Reference F 760</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>47939</p> <p>Ensure that residents are free from significant medication errors.</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that the residents are free from significant medication errors for 1 of 2 residents reviewed, who received insulin, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Record review of a community reported complaint submitted to the Rhode Island Department of Health on 3/8/2024 at 5:02 PM, alleges the resident was admitted to the hospital following an unresponsive episode at the nursing facility. There was a question if the unresponsive episode and subsequent emergency room visit, and hospital admission were the results of a medication error.</p> <p>Record review of a facility reported incident submitted the Rhode Island Department of Health on 3/8/2024 at 5:15 PM, revealed that the resident was found with an alteration in mental status at approximately 5:30 PM. A code blue (an emergency response) was called as the resident's blood sugar was 31 (normal blood sugar range is between 70-125 milligrams/deciliter (mg/dl). Glucagon (a medication used to treat a low blood sugar) was administered and 911 was called. The blood sugar was retaken, and the result was 38. A second dose of Glucagon was administered and 911 arrived and transported the resident to the emergency room for evaluation. The resident was later admitted with a diagnosis of altered mental status.</p> <p>Record review of the facility policy titled Hypoglycemia-clinical management of revealed in part, hypoglycemia is defined as fingerstick of serum glucose (blood glucose) less than 60 mg /dl .If the resident is unresponsive, administer Intramuscular (injection in the muscle) or Subcutaneous (injection under the skin) Glucagon as ordered by the physician.</p> <p>Review of the facility policy titled Medication Administration and Documentation-General revealed that licensed nurses should review physician orders and compare the order against the Medication Administration Record (MAR).</p> <p>1a. Record review revealed Resident ID #1 was admitted to the facility in March of 2024 for short-term rehab.</p> <p>Further record review reveals that s/he is a diabetic and requires the administration of insulin to manage this diagnosis.</p> <p>Record review revealed the following physician's orders:</p> <p>Insulin Aspart injection solution (a fast-acting insulin that starts to work about 15 minutes after, injection peaks in about one hour, and keeps working for 2 to 4 hours) 100 unit/ml (milliliter) inject 40 Units subcutaneously once a day, at 11:00 AM. Hold for a blood sugar less than 200.</p> <p>Insulin Aspart Prot & Aspart subcutaneous Suspension Pen-Injector (70-30) (a mix of fast acting and intermediate-acting insulin that works up to 24 hours) 100 unit/ml inject 36 units subcutaneous, at bedtime. Hold for a blood sugar less than 200.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the March 2024 MAR revealed that the resident's blood sugar was less than 200 on the following dates and s/he received the Aspart 70-30:</p> <ul style="list-style-type: none"> - 3/3/2024- Blood Sugar 198- Administered Aspart 70-30 by Registered Nurse (RN), Staff A - 3/4/2024- Blood Sugar 157- Administered Aspart 70-30 by RN, Staff D - 3/6/2024- Blood Sugar 183- Administered Aspart 70-30 by Staff D <p>Additional record review revealed that on 3/7/2024 at 11:00 AM the resident's blood sugar was 138. Staff A proceeded to administer the resident 40 Units of Aspart, despite his/her order to hold the Aspart for a blood sugar of then less 200.</p> <p>Record review of the resident's progress notes revealed the following entries:</p> <ul style="list-style-type: none"> - 3/7/2024 at 6:39 AM: Received resident in bed resting with eyes closed. Equal and unlabored respirations. Resident alert and oriented. Able to make needs known . - 3/7/2024 documented as late entry at 6:07 PM: Authored by RN, Staff C- This nurse responded to a code blue for Resident ID #1. She indicated that resident was diaphoretic (clammy/sweaty skin) and unresponsive to verbal and tactile stimuli. His/her oxygen saturation level was 88% (Normal range 95-100%) on 2 liters of oxygen. The resident was placed on a non-rebreather at 15 Liters. The residents blood sugar was checked with a result of 31. Glucagon was administered at 5:40 PM. The resident's blood sugar rechecked at 5:48 with result of 34. A second dose of Glucagon was administered to the resident and his/her blood sugar continued to rise slowly with result of 38. During the code blue emergency services arrived on scene. An Intravenous (IV) was placed in his/her left hand by Emergency Medical Services (EMS), with Dextrose 10 (a medication used to increase blood sugar) administered. The resident's blood sugar was rechecked and at this time his/her blood sugar 168. -3/7/2024 at 9:41 PM: Authored by RN, Staff E, - Resident found unresponsive laying down in bed at 5:30 PM. His/her oxygen saturation was 90% on 2 liters via nasal cannula (a thin tube that goes inside the nose and delivers oxygen). His/her blood sugar was 31. The resident was placed on a non-rebreather at 15 liters, oxygen improved to 96%. 1 MG (milligram) of Glucagon was administered at 5:40 PM. The blood sugar was rechecked which resulted in the blood sugar of 34. A second dose of Glucagon 1 MG was administered at 5:48 PM. The blood sugar was rechecked and resulted in a blood sugar of 38. A code blue was called during the event and rescue was also called. The resident was picked up via 911 at 5:55 PM and sent to the hospital. -3/7/2024 11:21 PM: The resident was admitted to the hospital for altered mental status. <p>Record review of the EMS run report revealed that the primary complaint was hypoglycemia (low blood sugar level). EMS arrived and the resident was found to be unstable. His/her blood glucose was checked resulting in a value of 38 mg/dl. Intravenous access was established, and the resident was administered D 10 intravenously and his/her blood sugar was rechecked with a value of 78. Additionally, the resident required supplemental oxygen and became more responsive and alert.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the hospital admission record from 3/7/2024, revealed the following physician progress note, . presenting with unresponsive episode at rehab facility .Patient's blood sugar was checked, blood glucose was 30's. EMS arrived and administered IV dextrose. On arrival to ED [emergency department] patient's glucose improved to the 190's. However [s/he] is confused .thinks [s/he] is in the car .</p> <p>During a surveyor interview with Staff A, on 3/11/2024 at 12:02 PM, she revealed that on 3/7/2024 she obtained the resident's blood sugar of 138 and acknowledged she administered the 40 units of Aspart insulin to the resident on 3/7/2024 and 36 units of 70/30 on 3/3/2024. Additionally, she indicated that she was unable to see that the resident had parameters for administration of his/her ordered insulin, because the entire order is not visible on the screen. She further revealed that she would have to hover her mouse over the order to be able to see that there were parameters in place for the administration of this medication.</p> <p>During a surveyor interview with Staff B, on 3/11/2024 at 3:10 PM she revealed that she was unaware that the resident had parameters to hold his/her insulin for a blood sugar less than 200. Additionally, she revealed that she was not aware that she should hover the mouse over the order to see the order in its entirety. Further she acknowledged she administered the resident insulin outside of ordered parameters on 3/4/2024 and 3/6/2024.</p> <p>During a surveyor interview on 3/11/2024 at 12:53 PM with the Director of Nursing Services in the presence of the Regional Nurse, she acknowledged that the resident received his/her 70/30 insulin on 3/3/2024, 3/4/2024 and 3/6/2024 and should not have. Additionally, she acknowledged that the resident received 40 units of Aspart insulin on 3/7/2024 which required him/her to receive glucagon administration to increase his/her low blood sugar. Lastly, she was unable to provide evidence that Resident ID #1 was kept free from significant medication errors.</p> <p>1b. Record review revealed a physician's order dated 3/7/2024 for Glucagon Emergency Kit - 1 mg- Inject one syringe intramuscularly as needed for hypoglycemic reaction for blood sugar under 60. Recheck blood sugar every 15 minutes until the resident's blood sugar is greater than 70. Notify the MD for blood sugar less than 60.</p> <p>Record review revealed a progress note dated 3/7/2024 at 6:07 PM that the resident was found to be unresponsive with a blood sugar of 31 on 3/7/2024 and a code blue was called. S/he required the administration of Glucagon to raise his/her blood sugar level, which was administered by Registered Nurse, Staff B at 5:40 PM.</p> <p>Further record review revealed the resident's blood sugar was taken again and the results were 34 at 5:48 PM, and a second dose of Glucagon was administered to the resident by Registered Nurse Staff, C.</p> <p>During a surveyor interview with Staff C, on 3/12/2024 at 1:06 PM she revealed that on 3/7/2024 she responded to the code blue for Resident ID #1. She indicated that she noticed that the Glucagon bottle that Staff B had pulled to administer to the resident still had the Glucagon powder in the vial. She indicated that the resident's blood sugar was not responding to the first dose of Glucagon because s/he did not receive it, as the medication was not reconstituted, and the resident only received the sterile water. Once she realized that the Glucagon was not administered, she decided to get another vial of Glucagon and administer another dose to the resident.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During a surveyor interview with Staff B, on 3/12/2024 at 1:50 PM she revealed that she was unaware that she needed to reconstitute the Glucagon prior to administering it. She acknowledged that she had only administered an injection of sterile water and she did not reconstitute the medication. Additionally, she revealed that she had not received any training or competencies for the use of Glucagon.</p> <p>During a surveyor interview on 3/12/2024 at 1:40 PM with the Director of Nursing Services, she indicated that she would have expected Staff B, to give the correct dose of Glucagon by reconstituting the medication as required. Additionally, she was unable to provide evidence of training and/or competency for Staff B related to the reconstitution and administration of the Glucagon medication.</p> <p>Due to the facility's failure Resident ID #1 received insulin when s/he should not have resulting in the resident experiencing a critical low blood sugar, diaphoresis, and unresponsiveness. Further the failure required the resident to receive Glucagon intramuscularly, required 15 liters of oxygen via nonrebreather, due to hypoxia, Intravenous D 10 and subsequent hospital transfer and admission.</p> <p>Cross Reference F 726</p>		