

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/03/2021
NAME OF PROVIDER OR SUPPLIER NEWPORT NEWS NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE NEWPORT NEWS, VA 23602	
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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard (Complaint) survey was conducted 06/01/21 through 06/03/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Six complaints were investigated during the survey, VA00051869, VA00050271, VA00050388, VA00050020, VA00050667 and VA00051590. The census in this 102 certified bed facility was 97 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Residents 1 through 2) and 5 closed record reviews (Residents 3 through 7).	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to follow professional standards of practice for transcribing physician directives into orders in the electronic clinical record, obtain weekly weights and assure the administration of a blood pressure medication for 3 of 7 residents in the survey sample, Resident #5, Resident #2 and Resident #6. The findings included: 1. Resident # 5 was admitted to the facility on	F 658	1. Residents #5, #2, and #6 no longer reside at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and nurse management team conducted a review of orders of the admissions/readmissions for the past 30 days to verify orders were accurately transcribed and reviewed by physician. Discrepancies were immediately corrected in respective resident medical records, and MD was immediately	7/13/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

06/25/2021

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

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F 658	<p>Continued From page 1</p> <p>1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis, Osteoporosis and Cerebral Vascular Accident.</p> <p>The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making.</p> <p>Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part, as follows:</p> <p>Medications: Home Medication List at Time of Discharge Take these medications:</p> <p>Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day</p> <p>Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants.</p> <p>Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.</p> <p>Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day</p>	F 658	<p>notified.</p> <p>Consultant recommendations were reviewed by the DON on Monday, 06/07/2021 to verify communication to the physician, orders obtained, or documentation of rationale of the decline.</p> <p>3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated nurses on conducting thorough review of admission orders, hospital discharge orders, reviewing discrepancies and clarifying orders with physician, entering orders into the medical record, then reconciling discharge orders against orders entered the medical record for each admission/readmission to verify orders have been accurately transcribed. The DON/Designee also educated nurses on reviewing consultant physicians other clinical service consultant recommendations (e.g. dietician, pharmacy consultants), communicating recommendations to the physician and obtaining orders.</p> <p>The DON/Designee will review records of each admission/readmission at next clinical morning meeting to verify discharge orders have been reconciled, discrepancies clarified and accurately transcribed.</p> <p>4. The DON/Designee will review consultant recommendations to verify they have been communicated to the physician and resulting orders five days per week for two week, then random audits of 10</p>		

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F 658	<p>Continued From page 2 noted.</p> <p>Resident #5's Medication Reconciliation dated and locked on 1/9/21 at 8:54 P.M. by LPN (Licensed Practical Nurse) #5 was reviewed and is documented in part, as follows:</p> <p>Section A: 1. Complete medication reconciliation utilizing the following data sources (check all that apply); 1. History and Physical 2. Discharge Summary.</p> <p>Section B: 1. List Medications needing clarification: No Medication Issues Identified.</p> <p>Section C: Physician Contact 1. Physician Name-Blank 2. Date and Time Physician contacted-Blank 3. Physician contacted via-Blank</p> <p>On 6/3/21 at 10:15 A.M. a phone interview was conducted with LPN #5 regarding Resident #5's admission orders. LPN #5 was asked to explain the process for transcribing admission orders. LPN #5 stated, "When I get the discharge summary from the hospital, I verify the orders with the medical doctor on call. Then I put the orders into the computer and send them to the pharmacy."</p> <p>On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, "Every morning during stand up meetings, with the Interdisciplinary team (IDT), new admissions are</p>	F 658	<p>consultant recommendations per week for four weeks, then 10 recommendations per month for two months or until resolved.</p> <p>The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

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F 658	<p>Continued From page 3</p> <p>discussed and the 24 hour report also reveals important information. From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders. By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem."</p> <p>The facility policy titled "4.1 Physician/Prescriber Authorization and Communication of orders to Pharmacy" last revised 10/1/18.</p> <p>8. Facility should reconcile transfer/transition and admission orders before they are communicated to Pharmacy.</p> <p>9. Facility should verify transfer/transition and admission orders with the resident's physician/prescriber before they are communicated to the pharmacy.</p>	F 658			

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F 658	<p>Continued From page 4</p> <p>9.1 Once admission orders are verified, staff should promptly transmit medication orders to the Pharmacy.</p> <p>On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM(Administrative Staff member) #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared.</p> <p>2. The facility staff failed to follow their standard of practice to implement the hospital's orders for medications, as indicated in the hospital discharge summary for Resident #2. The resident was to continue Metoprolol for the treatment of high blood pressure upon admission to the nursing facility.</p> <p>Resident #2 was admitted to the nursing facility on 5/12/21 for skilled services due to status post fracture of left ankle. The resident was admitted with a diagnosis of high blood pressure.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 5/18/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated she possessed independent and intact cognitive skills for daily decision making.</p> <p>The General Discharge Summary dated 5/10/21 identified metoprolol 75 milligram (mg) by mouth (po) as one of the medications the resident was taking daily in the hospital prior to her admission to the nursing facility. According to the General Discharge Summary, Metoprolol was to continue as a scheduled daily medication for the treatment and control of high blood pressure.</p>	F 658			

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F 658	<p>Continued From page 5</p> <p>Upon review of the Medication Administration Records (MAR), Resident #2 was not started on the Metoprolol upon admission until 5/18/21. There were no physician orders, nurse practitioner (NP) orders nor entries in the nurse's notes to indicate that the medication was on hold.</p> <p>On 6/1/21 at approximately 12:15 p.m., Resident #2 was interviewed to say she took Metoprolol as a long standing medication for years and questioned the nurse about why she was not taking the medication when she was first admitted to the nursing facility. She said, "It finally got on board."</p> <p>On 6/3/21 at 5:00 p.m., according to the Unit Manager, Licensed Practical Nurse (LPN #2) the resident missed 5 or 6 days of Metoprolol from 5/12-17/21. She stated it was standard practice that the Interdisciplinary Team (IDT) review new admissions during their stand-up meetings, reviews all hospital discharge medications and verify's all orders. She said she spoke to the NP to determine if the medication was held for low blood pressure readings, but she could not recall if that was the case and there was no documentation to support holding the medication. LPN #2 stated, "We missed this medications for several days. No one knows how we discovered it was missed, but I am happy her blood pressure readings were okay until the medication was re-started here."</p> <p>On 6/3/21 at approximately 6:30 p.m. during the debriefing, with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services, no further information was provided regarding the aforementioned issue.</p>	F 658			

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F 658	<p>Continued From page 6</p> <p>According to the facility's policy and procedures titled Administering Medications dated as revised on 4/2019, medications are administered in accordance with prescriber's orders, including any required time frame.</p> <p>3. The facility staff failed to obtain weekly weights as recommended by the Registered Dietitian (RD.) Resident #6 was originally admitted to the nursing facility on 10/19/19.</p> <p>Diagnosis for Resident #6 included but not limited to morbid obesity. Resident #6 Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date of 09/01/20 coded Resident # 6 Brief Interview for Mental Status (BIMS) score of 08 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #6 total dependence of two with personal hygiene, total dependence of one with bathing and dressing, extensive assistance of two with bed mobility and toilet use and supervision with eating for Activities of Daily Living care.</p> <p>Resident #6's person centered care plan with a revision date 09/03/20 documented a problem which read; has a nutritional problem or potential nutritional problem related to hypertension, anxiety, depression and obesity. The goal: will maintain adequate nutritional status as evidenced by maintaining weight, no signs or symptoms of malnutrition and consuming at least (50%) of meals daily. Some of the interventions to manage goal: Registered Dietitian (RD) to evaluate and make diet change recommendations as needed and obtain and monitor lab/diagnostic work as ordered and report results to the physician for follow up as indicated.</p>	F 658			

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F 658	<p>Continued From page 7</p> <p>The care plan also include a desired weight loss due to morbid obesity. The goal is to consume at least 50% of meals through 09/03/20 and will maintain a slow and steady weight loss. Some of the interventions to manage goal is to obtain labs as ordered and report results to the physician and ensure the dietitian is aware, monitor and evaluate any weight loss.</p> <p>A phone interview was conducted with the RD on 06/02/21 at approximately 4:39 p.m. She said Resident #6's weight loss started off as a desired weight loss due to the possibility of having weight loss surgery. She said Resident #6 started pocketing food and her meal consumption was less than 50%. She said Resident #6 was seen on 10/19/20 with the recommendation to start weekly weights; there should have been a weight obtained on 10/22/20 and 10/29/20.</p> <p>Review of the RD note written on 10/19/20 included the following information: There is a history of desired weight loss; however, this is a change with Resident #6 with swallowing issues. The following recommendation is made: monitor intake and weekly weights. During the review of Resident #6's weight summary revealed the last weight was obtained on 10/15/20 @ 256.2 lbs.</p> <p>A phone interview was conducted with the Assistant Director of Nursing (ADON) on 06/03/21 at approximately 3:37 p.m. She stated, "I saw where the dietitian recommended weekly weights for Resident #6 starting on 10/19/20 but it was never taken off, transcribed and the weight was never done." The ADON was asked "What is the purpose for getting weekly weights" she replied, "To monitor for stabilization." She said the staff should have notified the physician, got</p>	F 658			

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F 658	Continued From page 8 an order for weekly weights, put the order in Point Click Care (PCC), obtain and documented the weights in Resident #6's clinical record. The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/03/21 at approximately 4:45 p.m. The facility did not present any further information about the findings. The facility's policy titled: Weighing the Resident with a revision date of (09/05/17.) Policy: Resident of the facility shall be weighed upon admission and monthly and as needed unless ordered otherwise by the physician. Procedure include but not limited: -Weights will be completed as indicated and documented in the clinical record.	F 658			
F 661 SS=D	COMPLAINT DEFICIENCY Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with	F 661		7/13/21	

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F 661	<p>Continued From page 9</p> <p>the consent of the resident or resident's representative.</p> <p>(iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interviews and a complaint investigation the facility staff failed to make the necessary Post-Discharge medical services for continued care for one resident (Resident #4) in the survey sample of 7 residents upon discharge home.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on 01/16/21 and discharged on 02/25/21. Diagnoses for this resident included Metabolic Encephalopathy, history of COVID-19, fracture of right femur, muscle weakness, acute kidney failure, EOTH, anemia, unilateral Inguinal hernia, hyponatremia, and dementia with behavioral disturbance.</p> <p>An Admission's Minimum Data Set (MDS) dated 1/22/21 assessed this resident in the area of Cognitive Impairment as scoring a (3) on the Brief</p>	F 661	<ol style="list-style-type: none"> 1. Resident #4 no longer resides at the facility. 2. Current residents have the potential to be affected. On 06/22/2021, reviews were conducted of current discharging resident's Discharge Summaries to ensure that Post-Discharge medical services were identified and arranged prior to respective discharges. 3. On 06/21/2021, Social Services Director and Assistant were educated by the Executive Director on policies and procedures related to Discharge Planning, and specifically related to the arrangement of Post-Discharge medical services. <p>Social Services will review discharge plans including follow up appointments,</p>		

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F 661	<p>Continued From page 10</p> <p>Interview for Mental Status (BIMS). In the area of Activity's for Daily Living (ADL'S) this resident was assessed as requiring one staff physical assistants with bed mobility, in the area of dressing this resident was coded as a (2/3) requiring one person physical assist. In the area of toileting and personal hygiene this resident was coded as requiring extensive assist.</p> <p>A Care Plan dated 1/28/21 indicated: Focus- Resident #4 plan to return to home where he lives with his wife. Referral to home health will be made according to his discharge needs. Goal- Resident #4's wife will be able to verbalize/communicate required assistance post-discharge and the services required to meet needs before discharge. Interventions- Establish a pre-discharge plan with Resident #4's wife/care givers and evaluate progress and revise plan as needed. Evaluate/record Resident #4's abilities and strengths, with representative/care givers/IDT. Determine gaps in abilities which will affect discharge. Address gaps by community referrals to needed agencies/disciplines. Resident #4 is able to (Specify communicate/describe needs, book appointments, ADL's, housekeeping, communication) on discharge to community.</p> <p>A hospital discharge summary dated 01/16/21 indicated: "Discharge Diagnosis: Large right inguinal hernia." "Hospital Course: Patient also was found to have large right inguinal hernia on CT, will follow with general surgery outpatient. Patient feels better and stable to be discharged to SNF to follow-up with his primary care physician, orthopedic, urology and general surgery outpatient." "Large right inguinal hernia-No</p>	F 661	<p>services, and equipment five times per week in daily clinical review meeting to ensure they are in place on the day of discharge.</p> <p>4. Audit of Discharge Summaries and the arrangement of Post-Discharge medical services therein to be performed by the Executive Director weekly times six weeks then monthly for three months. He will report findings of reviews to the Quality Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

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F 661	<p>Continued From page 11 abdominal/inguinal pain Follow with general surgery outpatient."</p> <p>A hospital history and physical dated 01/19/21 indicated: "Patient was found to have a large right inguinal hernia on CT and is to follow up with general surgery as an outpatient."</p> <p>A nursing note dated 01/18/21 indicated: "Foley catheter patient with amber colored, noted to have large Rt. sided Inguinal Hernia. Requires extensive to total assist of 1-2 staff for the completion of ADL care."</p> <p>A Nursing Note dated 02/24/21 indicated: "Discharge summary: patient was recently seen for COVID 19 and sent here for progressive weakness and the need for inpatient therapy. Patient had a Foley which we removed during his stay but was recently reinserted by urologist and he will follow it on discharge. Resident denies chest pain, denies shortness of breath, denies abdominal pain, denies nausea or vomiting. Diagnoses include metabolic encephalopathy, COVID 19, hyponatremia, urinary tract infection, right hip fracture, alcohol abuse, inguinal hernia, medication see mar (medication administration record), exam alert oriented x 3 white male no acute distress. Normocephalic lungs are clear heart sounds are normal, abdomen is soft non tender Foley in place. Assessment/Plan: severe sepsis-resolved COVID 19, aki-monitor dementia, right hip fracture: s/p nailing therapy while inpatient, follow up outpatient surgery for hernia. Follow up with pcp with in 2 weeks take medications as prescribed sending home with wheelchair due to inability to stand for long</p>	F 661			

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F 661	Continued From page 12 periods and tend to ADL's. Patient can propel himself freely through out the house on the first floor with a wheelchair. Will be discharging home to wife, home health pt/ot/sn/sw/aide eval and treat. Home health to follow Foley catheter care and change q month." During an interview at 9:23 a.m. on 06/03/21 with Resident #4's wife, she stated, "The facility never scheduled follow-up care hernia surgery." A review of the clinical records did not indicate that Resident #4 was provided with a physician's order for hernia surgery upon discharge from the facility. There was indication that arrangements were made for Resident #4's follow up care and post-discharge medical services. During an interview on 06/03/21 at 10:17 a.m. with the Director of nursing, she stated, Resident #4 was not given a prescription for hernia surgery by the discharging physician nor were arrangements made for out patient hernia surgery for Resident #4.	F 661			
F 711 SS=E	Complaint Deficiency Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3) §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress	F 711		7/13/21	

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F 711	<p>Continued From page 13 notes at each visit; and</p> <p>§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to ensure the Physician Review of Admission Orders based on the discharge summary was a reconciled/accurate for 3 of 7 residents in the survey sample in regards to a significant seizure medication, an anti-depressant and a anti-hypertensive, Resident #5, Resident #7 and Resident #2.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Resident # 5 was admitted to the facility on 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis, Osteoporosis and Cerebral Vascular Accident. Resident #5 was discharged from the facility on 1/17/21. <p>The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making.</p> <p>Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part,</p>	F 711	<ol style="list-style-type: none"> Residents #5, #7, and #2 no longer reside at the facility. On 06/01/2021, the orders of the admissions/readmissions for the past 30 days were reviewed to verify orders were accurately transcribed. Discrepancies were clarified, and resulting new orders were obtained. On 06/14/2021, the Executive Director and Director of Nursing (DON) educated physicians on conducting thorough reviews of admission/readmission orders to verify that hospital discharge orders are accurately transcribed and discrepancies clarified prior to signing. The DON/Designee will audit records of each admission/readmission on next clinical morning meeting to verify discharge orders have been reconciled, discrepancies clarified, and accurately transcribed. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify that physician reconciliations have been completed within 72 hours, then randomly 		

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F 711	<p>Continued From page 14 as follows:</p> <p>Medications: Home Medication List at Time of Discharge Take these medications:</p> <p>Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day</p> <p>Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants.</p> <p>Vimpat Medication Guide provide by OSM(Other Staff Member) #1 was reviewed and is documented in part, as follows:</p> <p>Vimpat is a prescription medicine (anticonvulsant) used to treat partial-onset seizures and with other medicines to treat primary generalized tonic-clonic seizures.</p> <p>What is the most important information I should know about VIMPAT?: DO not stop taking VIMPAT without first talking to your healthcare provider. Stopping VIMPAT suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>How long does it take for Vimpat to kick in? After taking lacosamide, the highest blood levels are reached in 1 to 4 hours. It takes about 13 hours for the amount of medicine in the bloodstream to fall by at least 50%. This means that the medicine should be taken twice a day, about 12 hours apart.</p>	F 711	<p>audit five admissions/readmissions weekly for four weeks, then five admissions/readmissions per month for two months or until resolved.</p> <p>The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

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F 711	Continued From page 15 Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted. Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted. Resident #5's Physician Medication Admit History and Physical dated 1/11/21 signed by ASM(Administrative Staff Member) #4 was reviewed and is documented in part, as follows: History of Present Illness: The patient is a pleasant 56-year-old black female who has a history of seizure disorder. Past Medical History: 12. Seizure Disorder Medications: Medications have been reviewed. Please see MAR (Medication Administration Record). Plan: Medications have been reviewed and signed. On 6/2/21 at 5:00 P.M. a phone interview was conducted with ASM (Administrative Staff Member) #4 regarding Resident #5's anti-seizure medication Vimpat. ASM #4 was made aware that the medication was not transcribed from the discharge summary dated 1/8/21 and that Resident #5 had not received the Vimpat the entire facility stay. ASM #4 stated, "When I come	F 711			

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F 711	<p>Continued From page 16</p> <p>in to see the patient I read over everything, the hospital records and the discharge summary then I go see the patient. I spend well over an hour with new admissions. If the Vimpat was on the discharge summary on the medication list, it should have been transcribed over. It shouldn't have happened, when I do admits I find lots of errors and correct them. This one got by me."</p> <p>On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, "From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem."</p>	F 711			

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F 711	<p>Continued From page 17</p> <p>The facility policy titled "Medical Care/Standards of Practice" last revised 3/3/2021 was reviewed and is documented in part, a follows:</p> <p>A physician supervises the medical care of each resident. Physician supervision includes, but is not limited to:</p> <ul style="list-style-type: none"> -Admission orders are consistent with the resident's current physical and mental status. -Admission orders are verified on admission. <p>The attending physician will complete a history and physical on all residents as required by the applicable state law.</p> <ul style="list-style-type: none"> -The discharge summary completed by the physician at the time of discharge from the hospital may be used as the Admission history and physical provided the following conditions exist: -The admitting physician verifies within 48 hours of admission to the Center the information is accurate and relevant and/or adds additional information as needed to update the discharge summary to reflect current resident status. <p>On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared.</p> <p>2. For Resident #7 the facility staff failed to ensure the Physician Review of Admission Orders based on the discharge summary was accurate for an anti-depressant. As a result, Resident #7 received Zoloft/Sertraline for two days before the facility staff discontinued the</p>	F 711			

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F 711	<p>Continued From page 18 medication.</p> <p>Resident #7 was originally admitted to the facility on 04/05/21 and discharged on 04/13/2021 to the community. Diagnosis for Resident #7 included but not limited to Dysphagia, Oropharyngeal Phase, Unsteadiness on the Feet and Adult Failure to Thrive.</p> <p>The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 4/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #7 cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing and personal hygiene. Requiring set up help with eating. Requires limited assistance of one person with toileting. Requiring total dependence of one person with bathing.</p> <p>The Care Plan Reads: Focus: Resident #7 is at risk for falls r/t (related/to) confusion. Goal: Minimize the risk of falls through next review date. (Director of Clinical Services, RN) Target Date: 04/24/2021 Minimize the side effects of medication(s) contributing to gait disturbance, balance disturbance, syncope, movement disorders; increasing the resident's fall risk will be reduced by the review date. Interventions: Ensure proper footwear, non-skid footwear. Ensure that the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use</p>	F 711			

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F 711	<p>Continued From page 19 it for assistance as needed.</p> <p>The Physician order summary active orders as of 4/05/21 reads: Zoloft Tablet 25 MG Give 1 tablet by mouth in the evening related to adult failure to thrive. Order Date 4/05/21. Start Date 4/06/21.</p> <p>A review of the MAR (Medication Administration Record) reveal that Resident #7 received 2 doses of Zoloft on 4/06/21 and 4/07/21 at 1700 (5:00 PM) before the medication was discontinued by the facility staff.</p> <p>According to the MAR Zoloft 25 MG 1 Tablet by mouth in the evening was discontinued on 4/08/21 at 1521 (3:21 PM).</p> <p>A review of the hospital discharge summary reads: STOP taking these medications: sertraline (ZOLOFT) 25 mg PO TABS. Comments: Reason for Stopping: Changed to Remeron.</p> <p>A review of nursing notes dated 4/8/2021 at 15:15 (3:15 PM) reveal that Resident #7's daughter called and spoke with the DON (Director of Nursing/Admin. Staff #2) and with the unit managers regarding the list of the resident medications and requested for the Zoloft to be d/c (discontinued) and spoke with NP (Nurse Practitioner) to d/c the Zoloft per family request, per NP the medication was d/c'd.</p> <p>Review of progress notes show 4/05/21- LPN (Licensed Practical Nurse) #7 received a drug (s) interaction warning on 4/5/2021 20:18 (8:18 PM).</p> <p>The system has identified a possible drug interaction with the following orders: Zoloft Tablet 25 MG. Give 1 tablet by mouth in the evening related to ADULT FAILURE TO THRIVE (R62.7).</p>	F 711			

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F 711	<p>Continued From page 20</p> <p>Severity: Severe. Interaction: Additive serotonergic effects may occur during co administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine Tablet 7.5MG, and the risk of developing serotonin syndrome may be increased.</p> <p>A review of progress notes reveal: 4/5/2021 20:18 Orders Progress Note Note Text: The order you have entered Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime related to ADULT FAILURE TO THRIVE. Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction.</p> <p>A review of the hospital clinical record reads: Prior to starting Remeron he (Resident #7 was on low-dose Zoloft which was discontinued.</p> <p>Current Discharge Medication List reads: Stop taking these medications: Sertraline/Zoloft 25 MG. Comments: Reason for stopping: Changed to Remeron.</p> <p>A review of the hospital medication administration record reveal that Sertraline/Zoloft 25 mg was ordered on 3/24/21 and discontinued on 3/27/21.</p> <p>A review of the facility discharge prescriptions show no copy of Zoloft/Sertraline.</p> <p>On 6/02/21 at approximately 4:35 PM., an interview was conducted with the OSM (Other Staff Member) #5 concerning Resident #7. She stated, ASM (Administrative Staff Member) #4 does the initial H&P (History and Physical). He was given Remeron to help pick up his eating. Even if he had the Zoloft for two days it's a low dose antidepressant that stays in the system for 2</p>	F 711			

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F 711	<p>Continued From page 21</p> <p>days. He was on Remeron to increase his appetite. He should have not been on Zoloft at all."</p> <p>On 6/03/21 an interview was conducted with LPN (Licensed Practical Nurse) #7 at approximately 10:30 AM., concerning Resident #7. He stated, "I don't remember the resident." He was asked by the surveyor to explain flags on new admissions. He stated, "On new admissions it flags on the doctor if there is a black box warning. That goes on the 24 hour report. You have to get the meds verified by the doctor. No issues. When they are discharged we print out the prescriptions. Most discharged paper work is done by Social services.</p> <p>An interview was conducted on 6/03/21 at approximately 12:20 PM with OSM #1 concerning Resident #7 being prescribed Zoloft and Remeron due to the black box warning. He stated, "Remeron helps with depression and sleep. They gave the Zoloft for a few days and stopped it! His discharge summary from the hospital reads on 4/05/21 it says stop taking Zoloft change to remeron. They missed the fact it was to be changed. It appears they should have stopped it. They were suppose to change from Zoloft to remeron.</p> <p>On 6/03/21 at approximately 2:50 PM an interview was conducted with ASM #2 concerning Resident #7. She stated, "It was discontinued at the hospital. I got the NP (Nurse Practitioner) to discontinue the Zoloft. Per family request. Basically, on the discharge summary it stated to discontinue. It should have never been placed on there (the medication/Zoloft listed on the discharge summary)."</p>	F 711			

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F 711	Continued From page 22 On 6/03/21 at 5:00 PM a returned phone call was received from OSM #1 concerning Resident #7. He stated, the medication was already discontinued before I got there. It was missed by the admissions pharmacist. It said pretty clearly to stop the drug and they didn't." On 6/03/21 at approximately 5:10 PM an interview was conducted with ASM #4 concerning Resident #7. When they (residents) come from the hospital. I verify the medications, go through the discharge summary. The nurses could have made a mistake and given it. Sometimes errors come from the hospital." On 6/03/21 at approximately 5:21 PM an interview was conducted with ASM #1, ASM #2 and Corporate staff #1 concerning Resident #7's allegations. No questions were voiced. On 6/03/21 at approximately 5:30 PM a return phone call was made from Others Staff Member #1(OSM/Pharmacist) concerning Resident #7. He stated, "When I visited the facility on 4/22/21 he was already discharged. The previous pharmacist did not have access to PCC (Point Click Care) at the time. She was doing a review based on limited information." On 6/03/21 A phone call was made at 5:34 PM to the previous pharmacist mentioned in question by OSM #1. A voice message was left. No return phone call was received by surveyor. On 6/03/21 at approximately 6:50 PM during the exit conference the Administrative Staff Members were asked to explain the admissions summary process concerning medications for a resident	F 711			

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F 711	<p>Continued From page 23</p> <p>being admitted to their facility from the hospital. The ASM #2 stated, " When they come in with the admissions summary we will call the doctor or Nurse Practitioner to verify medications on the discharge summary and also they verify medications and diagnoses through the doctor as well. He will take 72 hours to review medications. We review new meds in the morning meeting and the doctor comes in within 48 hours to review the discharge summary."</p> <p>On 6/03/21 at approximately 4:00 PM an email was sent to the facility Administrator asking him to email the following policies: Medication administration procedures. Significant medication errors and unnecessary medications. None of the above policies were received.</p> <p>Serotonin syndrome symptoms often begin hours after you take a new medication that affects your serotonin levels or after you raise your dose of a current drug. Symptoms may include: Confusion, Agitation or restlessness, Dilated pupils, Headache, Nausea, Vomiting, digestive disorders, digestive disorders, diarrhea, Loss of muscle control or twitching. In severe cases, serotonin syndrome can be life-threatening. Call 911 or go to the emergency room if you have any of these symptoms: High fever, Seizures, Uneven heartbeat, Passing out.</p> <p>Serotonin Syndrome Causes and Risk Factors: Medications usually cause serotonin syndrome, especially certain antidepressants. You might be at higher risk if you take two or more drugs and/or supplements</p> <p><https://www.webmd.com/vitamins-and-supplements/lifestyle-guide that affect your serotonin levels. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of</p>	F 711			

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F 711	<p>Continued From page 24</p> <p>antidepressants. They work by raising your serotonin levels. These drugs include: Sertraline/Zoloft. https://www.webmd.com/drugs/mono-8095-SERTRALINE+-+ORAL.aspx?drugid=35&drugname=zoloft+oral>)</p> <p>https://www.webmd.com/depression/guide/serotonin-syndrome-causes-symptoms-treatments.</p> <p>3. Resident #2's attending physician failed to include in the review of the total program of care to include reconciliation of all medications to be continued from the hospital, namely metoprolol for management of hypertension (high blood pressure).</p> <p>Resident #2 was admitted to the nursing facility on 5/12/21 for skilled services due to status post fracture of left ankle. The resident was admitted with a diagnosis of high blood pressure.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 5/18/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated she possessed independent and intact cognitive skills for daily decision making. Resident #2 was not assessed for hypertension as an active diagnosis.</p> <p>The General Discharge Summary dated 5/10/21 identified metoprolol 75 milligram (mg) by mouth (po) as one of the medications the resident was taking daily in the hospital prior to her admission to the nursing facility. According to the General Discharge Summary, Metoprolol was to continue as a scheduled daily medication for the treatment and control of high blood pressure.</p>	F 711			

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F 711	<p>Continued From page 25</p> <p>On 6/3/21 at 5:00 p.m., according to the Unit Manager, Licensed Practical Nurse (LPN #2) the resident missed 5 or 6 days of Metoprolol from 5/12-17/21. She stated the physician visits within 24-48 hours of a resident's admission, reconciles all medications with the hospital discharge summary's list of medications to make sure a continued flow of administered medications from the hospital. LPN #2 stated that they physician ordered the medication on 5/18/21, She said, "We missed this medications for several days. No one knows how we discovered it was missed, but I am happy her blood pressure readings were okay until the medication was re-started here."</p> <p>On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "Every morning during stand up meetings, with the Interdisciplinary team (IDT), new admissions are discussed and the 24 hour report also reveals important information. From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders." It was determined the metoprolol was missed by the physician.</p> <p>On 6/3/21 at approximately 6:30 p.m. during the debriefing, with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services, no further information was provided regarding the aforementioned issue.</p> <p>COMPLAINT DEFICIENCY</p>	F 711			

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F 756 SS=E	<p>Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)</p> <p>§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take</p>	F 756 F 756		7/13/21	

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F 756	<p>Continued From page 27</p> <p>when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by:</p> <p>3. The facility staff failed to reconcile and ensure accuracy of medications based on the hospital's discharge summary within 72 hours of admission to the nursing facility for Resident #2.</p> <p>Resident #2 was admitted to the nursing facility on 5/12/21 for skilled services due to status post fracture of left ankle. The resident was admitted with a diagnosis of high blood pressure.</p> <p>The Admission Minimum Data Set (MDS) assessment dated 5/18/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 15 out of a possible score of 15 which indicated she possessed independent and intact cognitive skills for daily decision making. Resident #2 was not assessed for hypertension as an active diagnosis.</p> <p>The General Discharge Summary dated 5/10/21 identified metoprolol 75 milligram (mg) by mouth (po) as one of the medications the resident was taking daily in the hospital prior to her admission to the nursing facility. According to the General Discharge Summary, Metoprolol was to continue as a scheduled daily medication for the treatment and control of high blood pressure.</p> <p>On 6/3/21 at 5:00 p.m., according to the Unit Manager, Licensed Practical Nurse (LPN #2) the resident missed 5 or 6 days of metoprolol from 5/12-17/21. She stated the pharmacy ensures all medications for the new admissions are reviewed reconciled and accurate within 72 hours of their admission, but it was not recognized the</p>	F 756	<ol style="list-style-type: none"> 1. Resident #7 no longer resides at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and the nurse management team conducted an audit of the records of new admits/readmits within the last 30 days. Discrepancies were immediately corrected in respective resident medical records, and MD was immediately notified. No outstanding pharmacy reviews were noted. 3. On 06/10/2021, the pharmacy consultant was educated by the DON related to policy and procedure for completing review of orders on admissions/readmissions, ensuring accuracy and completeness within 72 hours. 4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify that pharmacy reviews have been completed, recommendations have been communicated to the physician, and that subsequent orders have been entered into the medical record. Random audits of five admissions/readmissions weekly for four weeks will then be conducted followed by another audit of five admissions per month for two months or until resolved. 		

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F 756	<p>Continued From page 28</p> <p>metoprolol was not continued from the hospital. LPN #2 stated that they physician ordered the medication on 5/18/21, She said, "We missed this medications for several days. No one knows how we discovered it was missed, but I am happy her blood pressure readings were okay until the medication was re-started here."</p> <p>On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, " By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents." It was determined that the pharmacy review failed to identify the metoprolol was not continued based on the discharge medication list.</p> <p>On 6/3/21 at approximately 6:30 p.m. during the debriefing, with the Administrator, Director of Nursing (DON) and the Regional Director of Clinical Services, no further information was provided regarding the aforementioned issue. Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to ensure a 72 hour new admission pharmacy review based on the discharge summary was reconciled/accurate for 3 of 7 residents in the survey sample in regards to a significant seizure medication, an anti-depressant and a anti-hypertensive, Resident #5, Resident #7, and Resident #2.</p> <p>The findings included:</p> <p>1. Resident # 5 was admitted to the facility on 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis,</p>	F 756	<p>The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

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F 756	<p>Continued From page 29</p> <p>Osteoporosis and Cerebral Vascular Accident. Resident #5 was discharged from the facility on 1/17/21.</p> <p>The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making.</p> <p>Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part, as follows:</p> <p>Medications: Home Medication List at Time of Discharge Take these medications:</p> <p>Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day</p> <p>Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants.</p> <p>Vimpat Medication Guide provide by OSM(Other Staff Member) #1 was reviewed and is documented in part, as follows:</p> <p>Vimpat is a prescription medicine (anticonvulsant) used to treat partial-onset seizures and with other medicines to treat primary generalized tonic-clonic seizures.</p> <p>What is the most important information I should</p>	F 756			

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F 756	<p>Continued From page 30</p> <p>know about VIMPAT?: DO not stop taking VIMPAT without first talking to your healthcare provider. Stopping VIMPAT suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>How long does it take for Vimpat to kick in? After taking lacosamide, the highest blood levels are reached in 1 to 4 hours. It takes about 13 hours for the amount of medicine in the bloodstream to fall by at least 50%. This means that the medicine should be taken twice a day, about 12 hours apart.</p> <p>Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.</p> <p>Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.</p> <p>Resident #5's Progress Noted dated 1/13/21 was reviewed and is documented in part, as follows:</p> <p>1/13/2021 14:45 Pharmacy Consultant Note Text: This resident ' s medical record including electronic documentation was reviewed on this date. See report for any noted irregularities and/or recommendations. Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgment that at such time, the resident's medication</p>	F 756			

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F 756	<p>Continued From page 31</p> <p>regimen contained no new irregularities (as defined in SOM Appendix PP 483.60(c)). For purposes of the foregoing statement, the term "irregularity" means an event or circumstance that is substantially inconsistent with customary, accepted clinical approaches to providing pharmaceutical products and services, or that could reasonably be expected to impede or interfere with the achievement of intended or reasonably expected outcomes.</p> <p>On 6/2/20 at 7:48 P.M. a phone interview was conducted with OSM(Other Staff Member) #1 regarding the medication Vimpat for Resident #5. OSM #1 stated, "I wasn't the pharmacist for this facility them, however I have access to see what was found on the 72 hour new admission pharmacy reconciliation for the resident. The discharge summary was in the system on 1/9/21 and it was reviewed by the pharmacist on 1/13/21. I see on the discharge summary the resident should have been on Keppra, Clobazam and Vimpat. I see where no errors were found by the pharmacist. I do see on the discharge summary the Vimpat was the second to last medication. It appears to me it was missed by the review."</p> <p>On 6/3/21 at 2:30 P.M. a phone interview was conducted with the ASM #2 regarding Resident #5 not receiving Vimpat while a resident in the facility. The ASM #2 stated, "It was a situation that should not have happened. It should have been caught earlier, multiple people and hands here missed it. We need to pay more close attention."</p> <p>On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON),</p>	F 756			

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F 756	<p>Continued From page 32</p> <p>the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, " By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem."</p> <p>On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared.</p> <p>2. For Resident #7, the facility staff failed to ensure a 72 hour new admission pharmacy review based on the discharge summary was reconciled/accurate for Resident #7 in regards to a significant anti-depressant.</p> <p>Resident #7 was originally admitted to the facility</p>	F 756			

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F 756	<p>Continued From page 33</p> <p>on 04/05/21 and discharged on 04/13/2021 to the community. Diagnosis for Resident #7 included but not limited to Dysphagia, Oropharyngeal Phase, Unsteadiness on the Feet and Adult Failure to Thrive.</p> <p>The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 4/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #X cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing and personal hygiene. Requiring set up help with eating. Requires limited assistance of one person with toileting. Requiring total dependence of one person with bathing.</p> <p>The Care Plan Reads: Focus: Resident #7 is at risk for falls r/t (related/to) confusion. Goal: Minimize the risk of falls through next review date. (Director of Clinical Services, RN) Target Date: 04/24/2021 Minimize the side effects of medication(s) contributing to gait disturbance, balance disturbance, syncope, movement disorders; increasing the resident's fall risk will be reduced by the review date. Interventions: Ensure proper footwear, non-skid footwear. Ensure that the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.</p> <p>The Physician order summary active orders as of</p>	F 756			

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F 756	<p>Continued From page 34</p> <p>4/05/21 reads: Zoloft Tablet 25 MG Give 1 tablet by mouth in the evening related to adult failure to thrive. Order Date 4/05/21. Start Date 4/06/21.</p> <p>A review of the MAR (Medication Administration Record show that Resident #7 received 2 doses of Zoloft on 4/06/21 and 4/07/21 at 1700 (5:00 PM).</p> <p>According to the MAR Zoloft 25 MG 1 Tablet by mouth in the evening was discontinued on 4/08/21 at 1521 (3:21 PM).</p> <p>A review of the hospital discharge summary reads: STOP taking these medications: sertraline (ZOLOFT) 25 mg PO TABS. Comments: Reason for Stopping: Changed to Remeron.</p> <p>A review of the hospital clinical discharge notes dated 4/05/21 reads: Prior to starting Remeron he was on low-dose Zoloft which was discontinued.</p> <p>Current Discharge Medication List dated 4/05/21 reads: Stop taking these medications: Sertraline/Zoloft 25 MG. Comments: Reason for stopping: Changed to Remeron.</p> <p>A review of the hospital medication administration record reveal that Sertraline/Zoloft 25 mg was ordered on 3/24/21 and discontinued on 3/27/21.</p> <p>A review of the facility discharge prescriptions show no printed copy of Zoloft/Sertraline was given at discharge on 4/13/21.</p> <p>A review of nursing notes dated 4/8/2021 at 15:15 (3:15 PM) reveal that Resident #7's daughter called and spoke with the DON (Director of Nursing/Admin. Staff #2) and with the unit managers regarding the list of the resident</p>	F 756			

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F 756	<p>Continued From page 35</p> <p>medications and requested for the Zoloft to be d/c (discontinued) and spoke with NP (Nurse Practitioner) to d/c the Zoloft per family request, per NP the medication was d/c'd.</p> <p>A Review of progress notes show on 4/05/21 that LPN (Licensed Practical Nurse) #7 received a drug (s) interaction warning on 4/5/2021 20:18 (8:18 PM). The system has identified a possible drug interaction with the following orders: Zoloft Tablet 25 MG. Give 1 tablet by mouth in the evening related to ADULT FAILURE TO THRIVE (R62.7). Severity: Severe Interaction: Additive serotonergic effects may occur during co administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine Tablet 7.5MG, and the risk of developing serotonin syndrome may be increased.</p> <p>On 6/02/21 at approximately 4:35 PM., an interview was conducted with the OSM (Other Staff Member) #5 concerning Resident #7. She stated, ASM (Administrative Staff Member) #4 does the initial H&P (History and Physical). He was given Remeron to help pick up his eating. Even if he had the Zoloft for two days it's a low dose antidepressant that stays in the system for 2 days. He was on Remeron to increase his appetite. He should have not been on Zoloft at all."</p> <p>On 6/03/21 an interview was conducted with LPN (Licensed Practical Nurse) #7 at approximately 10:30 AM., concerning Resident #7. He stated, "I don't remember the resident." He was asked by the surveyor to explain flags on new admissions. He stated, "On new admissions it flags on the</p>	F 756			

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F 756	<p>Continued From page 36</p> <p>doctor if there is a black box warning. That goes on the 24 hour report. You have to get the meds verified by the doctor. No issues. When they are discharged we print out the prescriptions. Most discharged paper work is done by Social services.</p> <p>An interview was conducted on 6/03/21 at approximately 12:20 PM with OSM #1 concerning Resident #7 being prescribed Zoloft and Remeron due to the black box warning. He stated, "Remeron helps with depression and sleep. They gave the Zoloft for a few days and stopped it! His discharge summary from the hospital reads on 4/05/21 it says stop taking Zoloft change to remeron. They missed the fact it was to be changed. It appears they should have stopped it. They were suppose to change from Zoloft to remeron.</p> <p>On 6/03/21 at approximately 2:50 PM an interview was conducted with ASM #2 concerning Resident #7. She stated, "It was discontinued at the hospital. I got the NP (Nurse Practitioner) to discontinue the Zoloft. Per family request. Basically, on the discharge summary it stated to discontinue. It should have never been placed on there. (the medication/Zoloft listed on the discharge summary)."</p> <p>On 6/03/21 at 5:00 PM a returned phone call was received from OSM #1 concerning Resident #7. He stated, the medication was already discontinued before I got there. It was missed by the admissions pharmacist. It said pretty clearly to stop the drug and they didn't."</p> <p>On 6/03/21 at approximately 5:10 PM an interview was conducted with ASM #4 concerning</p>	F 756			

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F 756	<p>Continued From page 37</p> <p>Resident #7. When they (residents) come from the hospital. I verify the medications, go through the discharge summary. The nurses could have made a mistake and given it. Sometimes errors come from the hospital."</p> <p>On 6/03/21 at approximately 5:21 PM an interview was conducted with ASM #1, ASM #2 and Corporate staff #1 concerning Resident #7's allegations. No questions were voiced.</p> <p>On 6/03/21 at approximately 5:30 PM a return phone call was made from Others Staff Member #1(OSM/Pharmacist) concerning Resident #7. He stated, "When I visited the facility on 4/22/21 he was already discharged. The previous pharmacist did not have access to PCC (Point Click Care) at the time. She was doing a review based on limited information.</p> <p>On 6/03/21 A phone call was made at 5:34 PM to the previous pharmacist mentioned in question by OSM #1. A voice message was left. No return phone call was received from the pharmacist mentioned above.</p> <p>On 6/03/21 at approximately 6:50 PM during the exit conference the Administrative Staff Members were asked to explain the admissions summary process concerning medications for a resident being admitted to their facility from the hospital. The ASM #2 stated, " When they come in with the admissions summary we will call the doctor or Nurse Practitioner to verify medications on the discharge summary and also they verify medications and diagnoses through the doctor as well. He will take 72 hours to review medications. We review new meds in the morning meeting and the doctor comes in within 48 hours to review the discharge summary."</p>	F 756			

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F 756	Continued From page 38 On 6/03/21 at approximately 4:00 PM an email was sent to the facility Administrator asking him to email the following policies: Medication administration procedures. Significant medication errors and unnecessary medications. None of the above policies were received. Serotonin syndrome symptoms often begin hours after you take a new medication that affects your serotonin levels or after you raise your dose of a current drug. Symptoms may include: Confusion, Agitation or restlessness, Dilated pupils, Headache, Nausea, Vomiting, digestive disorders, digestive disorders, diarrhea, Loss of muscle control or twitching. In severe cases, serotonin syndrome can be life-threatening. Call 911 or go to the emergency room if you have any of these symptoms: High fever, Seizures, Uneven heartbeat, Passing out. Serotonin Syndrome Causes and Risk Factors: Medications usually cause serotonin syndrome, especially certain antidepressants. You might be at higher risk if you take two or more drugs and/or supplements < https://www.webmd.com/vitamins-and-supplements/lifestyle-guide that affect your serotonin levels. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of antidepressants. They work by raising your serotonin levels. These drugs include: Sertraline/Zoloft. https://www.webmd.com/drugs/mono-8095-SERTRALINE+-+ORAL.aspx?drugid=35&drugname=zoloft+oral > . https://www.webmd.com/depression/guide/serotonin-syndrome-causes-symptoms-treatments .	F 756			

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F 758	Continued From page 39	F 758			
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758 F 758	7/13/21		

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F 758	<p>Continued From page 40</p> <p>prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 7 Residents were free of unnecessary medications, Resident #7, a closed record Resident.</p> <p>The findings included:</p> <p>Resident #7 was originally admitted to the facility on 04/05/21 and discharged on 04/13/2021 to the community. Diagnosis for Resident #7 included but not limited to Dysphagia, Oropharyngeal Phase, Unsteadiness on the Feet and Adult Failure to Thrive.</p> <p>The current Minimum Data Set (MDS), an admission assessment with an Assessment Reference Date (ARD) of 4/12/2021 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #X cognitive abilities for daily decision making were intact. In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of one person with bed mobility, transfers, dressing and personal hygiene. Requiring set up help with eating. Requires limited assistance of one person</p>	F 758	<ol style="list-style-type: none"> Residents #5, #2, and #6 no longer reside at the facility. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and nurse management team conducted an audit of the records of new admits/readmits within the last 30 days. Discrepancies were immediately corrected in respective resident medical records, and MD was immediately notified. Pharmacy reviews were verified as complete with none outstanding. On 06/04/2021 and on 06/07/2021, the DON/Designee educated nurses on conducting thorough review of hospital discharge orders, reviewing discrepancies, clarifying orders with the physician, entering orders into the medical record, then reconciling discharge orders against orders entered into the medical record for each admission/readmission to verify orders have been accurately transcribed, including psychotropic medications. 		

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F 758	<p>Continued From page 41 with toileting. Requiring total dependence of one person with bathing.</p> <p>The Care Plan Reads: Focus: Resident #7 is at risk for falls r/t (related/to) confusion. Goal: Minimize the risk of falls through next review date. (Director of Clinical Services, RN) Target Date: 04/24/2021 Minimize the side effects of medication(s) contributing to gait disturbance, balance disturbance, syncope, movement disorders; increasing the resident's fall risk will be reduced by the review date. Interventions: Ensure proper footwear, non-skid footwear. Ensure that the resident is wearing appropriate footwear/non-skid socks when ambulating or mobilizing in w/c. Anticipate and meet the resident's needs. Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.</p> <p>The Physician order summary active orders as of 4/05/21 reads: Zoloft Tablet 25 MG Give 1 tablet by mouth in the evening related to adult failure to thrive. Order Date 4/05/21. Start Date 4/06/21.</p> <p>A review of the MAR (Medication Administration Record show that Resident #7 received 2 doses of Zoloft on 4/06/21 and 4/07/21 at 1700 (5:00 PM).</p> <p>According to the MAR Zoloft 25 MG 1 Tablet by mouth in the evening was discontinued on 4/08/21 at 1521 (3:21 PM).</p> <p>A review of the Physician's active Order summary as of 4/05/21 reads: Mirtazapine Tablet 7.5 MG Give 1 tablet by mouth at bedtime related to Adult Failure to Thrive. Order Date 4/05/21 and Start Date is 4/05/21.</p>	F 758	<p>On 06/10/201, the DON educated the pharmacy consultant related to the policy and procedure for completing review of orders for each admission/readmission, ensuring accuracy and completeness of psychotropic drug orders within 72 hours of admission.</p> <p>The DON/Designee will review records of each admission/readmission on next clinical morning meeting to verify discharge orders have been reconciled, and that discrepancies are clarified and accurately transcribed.</p> <p>4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify that pharmacy reviews have been completed within 72 hours, recommendations have been communicated to the physician and subsequent orders have been entered into the medical record. A random audit of five admissions/readmissions to be conducted weekly for four weeks, then another to be conducted monthly for two months or until resolved.</p> <p>The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

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F 758	<p>Continued From page 42</p> <p>A review of the MAR show that Resident #7 received 8 doses of Mirtazapine 7.5 mg at 2100 (9:00 PM) from 4/05/21 - 4/12/21.</p> <p>A review of the hospital discharge summary reads: STOP taking these medications: sertraline (ZOLOFT) 25 mg PO TABS. Comments: Reason for Stopping: Changed to Remeron.</p> <p>A review of nursing notes dated 4/8/2021 at 15:15 (3:15 PM) reveal that Resident #7's daughter called and spoke with the DON (Director of Nursing/Admin. Staff #2) and with the unit managers regarding the list of the resident medications and requested for the Zoloft to be d/c (discontinued) and spoke with NP (Nurse Practitioner) to d/c the Zoloft per family request, per NP the medication was d/c'd.</p> <p>Review of progress notes show on 4/05/21 that LPN (Licensed Practical Nurse) #7 received a drug (s) interaction warning on 4/5/2021 20:18 (8:18 PM). The system has identified a possible drug interaction with the following orders: Zoloft Tablet 25 MG. Give 1 tablet by mouth in the evening related to ADULT FAILURE TO THRIVE. Severity: Severe. Interaction: Additive serotonergic effects may occur during co administration of selective serotonin reuptake inhibitors (SSRIs) and Mirtazapine Tablet 7.5MG, and the risk of developing serotonin syndrome may be increased.</p> <p>The above interaction warning reveal that Zoloft and Remeron should not be taken together due to having severe serontnergic effects.</p> <p>A review of progress notes reveal: 4/5/2021 20:18 Orders Progress Note Text: The order you have</p>	F 758			

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F 758	<p>Continued From page 43 entered Mirtazapine Tablet 7.5 MG.</p> <p>Give 1 tablet by mouth at bedtime related to ADULT FAILURE TO THRIVE. Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction.</p> <p>A review of the hospital discharge summary reads: Prior to starting Remeron he was on low-dose Zoloft which was discontinued.</p> <p>A review of the current hospital discharge Medication List reads: Stop taking these medications: Sertraline/Zoloft 25 MG. Comments: Reason for stopping: Changed to Remeron.</p> <p>A review of the hospital medication administration record reveal that Sertraline/Zoloft 25 mg was ordered on 3/24/21 and discontinued on 3/27/21.</p> <p>A review of the facility discharge prescriptions show no copy of Zoloft/Sertraline. On 6/02/21 at approximately 4:35 PM., an interview was conducted with the OSM (Other Staff Member) #5 concerning Resident #7. She stated, ASM (Administrative Staff Member) #4 does the initial H&P (History and Physical). He was given Remeron to help pick up his eating. Even if he had the Zoloft for two days it's a low dose antidepressant that stays in the system for 2 days. He was on Remeron to increase his appetite. He should have not been on Zoloft at all."</p> <p>On 6/03/21 an interview was conducted with LPN (Licensed Practical Nurse) #7 at approximately 10:30 AM., concerning Resident #7. He stated, "I don't remember the resident." He was asked by the surveyor to explain flags on new admissions. He stated, "On new admissions it flags on the</p>	F 758			

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F 758	<p>Continued From page 44</p> <p>doctor if there is a black box warning. That goes on the 24 hour report. You have to get the meds verified by the doctor. No issues. When they are discharged we print out the prescriptions. Most discharged paper work is done by Social services.</p> <p>An interview was conducted on 6/03/21 at approximately 12:20 PM with OSM #1 concerning Resident #7 being prescribed Zoloft and Remeron due to the black box warning. He stated, "Remeron helps with depression and sleep. They gave the Zoloft for a few days and stopped it! His discharge summary from the hospital reads on 4/05/21 it says stop taking Zoloft change to remeron. They missed the fact it was to be changed. It appears they should have stopped it. They were suppose to change from Zoloft to remeron.</p> <p>On 6/03/21 at approximately 2:50 PM an interview was conducted with ASM #2 concerning Resident #7. She stated, "It was discontinued at the hospital. I got the NP (Nurse Practitioner) to discontinue the Zoloft. Per family request. Basically, on the discharge summary it stated to discontinue. It should have never been placed on there (the medication/Zoloft listed on the discharge summary)."</p> <p>On 6/03/21 at 5:00 PM a returned phone call was received from OSM #1 concerning Resident #7. He stated, the medication was already discontinued before I got there. It was missed by the admissions pharmacist. It said pretty clearly to stop the drug and they didn't."</p> <p>On 6/03/21 at approximately 5:10 PM an interview was conducted with ASM #4 concerning</p>	F 758			

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F 758	<p>Continued From page 45</p> <p>Resident #7. When they (residents) come from the hospital. I verify the medications, go through the discharge summary. The nurses could have made a mistake and given it. Sometimes errors come from the hospital."</p> <p>On 6/03/21 at approximately 5:21 PM an interview was conducted with ASM #1, ASM #2 and Corporate staff #1 concerning Resident #7's allegations. No questions were voiced.</p> <p>On 6/03/21 at approximately 5:30 PM a return phone call was made from Others Staff Member #1(OSM/Pharmacist) concerning Resident #7. He stated, "When I visited the facility on 4/22/21 he was already discharged. The previous pharmacist did not have access to PCC (Point Click Care) at the time. She was doing a review based on limited information.</p> <p>On 6/03/21 A phone call was made at 5:34 PM to the previous pharmacist mentioned in question by OSM #1. A voice message was left. No return phone call was received by surveyor.</p> <p>On 6/03/21 at approximately 6:50 PM during the exit conference the Administrative Staff Members were asked to explain the admissions summary process concerning medications for a resident being admitted to their facility from the hospital. The ASM #2 stated, " When they come in with the admissions summary we will call the doctor or Nurse Practitioner to verify medications on the discharge summary and also they verify medications and diagnoses through the doctor as well. He will take 72 hours to review medications. We review new meds in the morning meeting and the doctor comes in within 48 hours to review the discharge summary."</p>	F 758			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/03/2021
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F 758	Continued From page 46 On 6/03/21 at approximately 4:00 PM an email was sent to the facility Administrator asking him to email the following policies: Medication administration procedures. Significant medication errors and unnecessary medications. None of the above policies were received. Serotonin syndrome symptoms often begin hours after you take a new medication that affects your serotonin levels or after you raise your dose of a current drug. Symptoms may include: Confusion, Agitation or restlessness, Dilated pupils, Headache, Nausea, Vomiting, digestive disorders, digestive disorders, diarrhea, Loss of muscle control or twitching. In severe cases, serotonin syndrome can be life-threatening. Call 911 or go to the emergency room if you have any of these symptoms: High fever, Seizures, Uneven heartbeat, Passing out. Serotonin Syndrome Causes and Risk Factors: Medications usually cause serotonin syndrome, especially certain antidepressants. You might be at higher risk if you take two or more drugs and/or supplements < https://www.webmd.com/vitamins-and-supplements/lifestyle-guide that affect your serotonin levels. Selective serotonin reuptake inhibitors (SSRIs) are the most commonly prescribed class of antidepressants. They work by raising your serotonin levels. These drugs include: Sertraline/Zoloft. https://www.webmd.com/drugs/mono-8095-SERTRALINE+-+ORAL.aspx?drugid=35&drugname=zoloft+oral > . https://www.webmd.com/depression/guide/serotonin-syndrome-causes-symptoms-treatments .	F 758			
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		7/13/21	

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F 760	<p>Continued From page 47 CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, medical record review, staff interviews and facility document review the facility staff failed to ensure that 1 of 7 residents in the survey sample was free of a significant medication error, Resident #5.</p> <p>The findings included:</p> <p>Resident # 5 was admitted to the facility on 1/9/21 with diagnoses to include but not limited to Seizure Disorder, left leg Deep Vein Thrombosis, Osteoporosis and Cerebral Vascular Accident. Resident #5 was discharged from the facility on 1/17/21.</p> <p>The most recent comprehensive (MDS) Minimum Data Set was a 5-day with an (ARD) Assessment Reference Date of 1/15/21. The (BIMS) Brief Interview for Mental Status for Resident #5 was scored as an 11, which indicated the resident was mildly cognitively impaired but capable of daily decision making.</p> <p>Resident #5's General Discharge Summary dated 1/8/21 was reviewed and is documented in part, as follows:</p> <p>Medications: Home Medication List at Time of Discharge Take these medications:</p>	F 760	<ol style="list-style-type: none"> 1. Residents #5, #2, and #6 no longer reside at the facility. 2. Current residents have the potential to be affected. On 06/01/2021, the Director of Nursing (DON) and the nurse management team conducted an audit of the records of new admits/readmits within the last 30 days to verify orders were accurately transcribed and reviewed by physician. Physician was immediately notified of discrepancies and new orders obtained. Pharmacy reviews were noted as complete with none outstanding. 3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated nurses on conducting thorough review of hospital discharge orders, reviewing discrepancies and clarifying orders with physician, entering orders into the medical record, then reconciling discharge orders against orders entered into the medical record for each admission/readmission to verify orders have been accurately transcribed to prevent significant medication errors. <p>DON educated pharmacy consultant on 06/10/2021 related to policy and procedure for completing review of orders on each admission/readmission, ensuring accuracy and completeness of drug</p>		

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F 760	<p>Continued From page 48</p> <p>Vimpat 200 MG (milligram) tablet Generic drug: lacosamide 1 tablet, Oral 2 times a day</p> <p>Other Instructions: Please take the medications on a daily basis as instructed including Seizure medications and anticoagulants.</p> <p>Vimpat Medication Guide provide by OSM (Other Staff Member) #1 was reviewed and is documented in part, as follows:</p> <p>Vimpat is a prescription medicine (anticonvulsant) used to treat partial-onset seizures and with other medicines to treat primary generalized tonic-clonic seizures.</p> <p>What is the most important information I should know about VIMPAT?: DO not stop taking VIMPAT without first talking to your healthcare provider. Stopping VIMPAT suddenly can cause serious problems. Stopping seizure medicine suddenly in a patient who has epilepsy can cause seizures that will not stop (status epilepticus).</p> <p>How long does it take for Vimpat to kick in? After taking lacosamide, the highest blood levels are reached in 1 to 4 hours. It takes about 13 hours for the amount of medicine in the bloodstream to fall by at least 50%. This means that the medicine should be taken twice a day, about 12 hours apart.</p> <p>Resident #5's Order Summary Report (Physician Orders) dated 1/9/2021 -1/15/2021 was reviewed and under Pharmacy there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted.</p>	F 760	<p>orders within 72 hours of admission to prevent significant medication errors.</p> <p>The DON/Designee will review records of each admission/readmission in next clinical morning meeting to verify discharge orders have been reconciled, discrepancies clarified and accurately transcribed.</p> <p>4. The DON/Designee will audit records of each admission/readmission five days per week for four weeks to verify the pharmacy reviews have been completed within 72 hours, recommendations have been communicated to the physician, and that subsequent orders have been entered into the medical record. Random audits of five admissions/readmissions will then be conducted weekly for four weeks, then another five admissions/readmissions monthly for two months or until resolved.</p> <p>The DON will report findings of audits to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

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F 760	Continued From page 49 Resident #5's (MAR) Medication Administration Record dated 1/1/2021-1/31/2020 was reviewed and there was no physician order for Vimpat 200 MG (milligram) tablet, 1 tablet, Oral 2 times a day noted. Resident #5's Progress Note dated 1/13/21 at 9:36 P.M. was reviewed and is documented in part, as follows: Type: Nursing Progress Note Note Text: Resident had seizure activity at 19:55 (8:55) P.M. CNA (Certified Nursing Assistant) staff called for nursing staff. Resident was laying back on bed not responding but by sternal rub resident showed signs of responsiveness. Resident had fixed eyes and had chattering of the jaw, was unable to communicate. It lasted 3 minutes, resident came too and became combative. A few minutes later resident was able to relax and lay down. No further distress noted. NP (Nurse Practitioner), supervisor and MD (Medical Doctor) aware. Resident #5's Medication Reconciliation dated and locked on 1/9/21 at 8:54 P.M. by LPN (Licensed Practical Nurse) #5 was reviewed and is documented in part, as follows: Section A: 1. Complete medication reconciliation utilizing the following data sources (check all that apply); 1. History and Physical 2. Discharge Summary. Section B: 1. List Medications needing clarification: No Medication Issues Identified. Section C: Physician Contact 1. Physician Name-Blank 2. Date and Time	F 760			

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F 760	<p>Continued From page 50</p> <p>Physician contacted-Blank 3. Physician contacted via-Blank</p> <p>On 6/3/21 at 10:15 A.M. a phone interview was conducted with LPN #5 regarding Resident #5's admission orders. LPN #5 was asked to explain the process for transcribing admission orders. LPN #5 stated, "When I get the discharge summary from the hospital, I verify the orders with the medical doctor on call. Then I put the orders into the computer and send them to the pharmacy."</p> <p>Resident #5's Physician Medication Admit History and Physical dated 1/11/21 signed by ASM(Administrative Staff Member) #4 was reviewed and is documented in part, as follows:</p> <p>History of Present Illness: The patient is a pleasant 56-year-old black female who has a history of seizure disorder.</p> <p>Past Medical History: 12. Seizure Disorder</p> <p>Medications: Medications have been reviewed. Please see MAR (Medication Administration Record).</p> <p>Plan: Medications have been reviewed and signed.</p> <p>On 6/2/21 at 5:00 P.M. a phone interview was conducted with ASM (Administrative Staff Member) #4 regarding Resident #5's anti-seizure medication Vimpat. ASM #4 was made aware that the medication was not transcribed from the discharge summary dated 1/8/21 and that Resident #5 had not received the Vimpat the entire facility stay. ASM #4 stated, "When I come</p>	F 760			

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F 760	<p>Continued From page 51</p> <p>in to see the patient I read over everything, the hospital records and the discharge summary then I go see the patient. I spend well over an hour with new admissions. If the Vimpat was on the discharge summary on the medication list, it should have been transcribed over. It shouldn't have happened, when I do admits I find lots of errors and correct them. This one got by me." ASM #4 was asked if Vimpat was a significant medication and if seizures were harmful. ASM #4 stated, "Yes it is a significant medication it is an anti-seizure medication. Seizures can be harmful because repeated seizures can affect the brain."</p> <p>On 6/2/20 at 7:48 P.M. a phone interview was conducted with OSM(Other Staff Member) #1 regarding the medication Vimpat for Resident #5. OSM #1 stated, "I wasn't the pharmacist for this facility them, however I have access to see what was found on the 72 hour new admission pharmacy reconciliation for the resident. The discharge summary was in the system on 1/9/21 and it was reviewed by the pharmacist on 1/13/21. I see on the discharge summary the resident should have been on Keppra, Clobazam and Vimpat. I see where no errors were found by the pharmacist. I do see on the discharge summary the Vimpat was the second to last medication. It appears to me it was missed by the review." The OSM #1 was asked if Vimpat was considered a significant medication and if not having it was harmful to Resident #5. The OSM #1 stated, "Yes, it is because it is a seizure medication. There is nothing else that acts like Vimpat. In my professional opinion her not having the Vimpat, yes was harmful to her."</p> <p>On 6/3/21 at 2:30 P.M. a phone interview was conducted with the ASM #2 regarding Resident</p>	F 760			

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F 760	<p>Continued From page 52</p> <p>#5 not receiving Vimpat while a resident in the facility. The ASM #2 stated, "It was a situation that should not have happened. It should have been caught earlier, multiple people and hands here missed it. We need to pay more close attention." The ASM #2 was also asked if Vimpat was a significant medication. The ASM #2 stated, "Yes, any seizure medication is significant."</p> <p>On 6/3/21 at 11:30 a.m., Surveyor #2 conducted an interview with the Director of Nursing (DON), the Administrator requested that he join the interview. The DON stated, "We never recognized throughout her stay that she was not administered the Vimpat upon her admission (1/9/21), according to her hospital discharge summary." She continued to say, "Every morning during stand up meetings, with the Interdisciplinary team (IDT), new admissions are discussed and the 24 hour report also reveals important information. From a resident's admission, the nurse calls the physician and reviews the resident's hospital discharge medications, verifies, reconciles and then they are uploaded into the system. Within 24-48 hours, the physician comes in, reviews the meds and officially signs the orders. By 72 hours, the pharmacy will review the discharge medications and the uploaded medications in the system for residents. We all missed it." The Administrator stated that during a phone interview with Surveyor #1 on 6/2/21, it was identified Resident #5 never received the Vimpat from admission, thus an immediate audit of all admissions was completed and he identified other residents affected by the same practice. He stated, "We own this problem and accept what happened to (Resident #5's name), and we will fix it. Our concern will always be for the residents." The Administrator had an</p>	F 760			

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F 760	Continued From page 53 extensive stack of collated papers and said, "We did an immediate QUAPI, audit and extensive education with all licensed nurses, and will continue educating until all licensed nurses are educated along with monitoring to ensure this does not happen again. Like I said, we own and accept the problem." The facility policy titled "4.1 Physician/Prescriber Authorization and Communication of orders to Pharmacy" last revised 10/1/18. 8. Facility should reconcile transfer/transition and admission orders before they are communicated to Pharmacy. 9. Facility should verify transfer/transition and admission orders with the resident's physician/prescriber before they are communicated to the pharmacy. 9.1 Once admission orders are verified, staff should promptly transmit medication orders to the Pharmacy. On 6/3/21 at approximately 3:28 P.M. a pre-exit debriefing was conducted via phone with ASM #1, ASM #2, ASM #3 and CSM (Corporate Staff Member) #1 were the above information was shared. Prior to exit no further information was shared.	F 760			
F 842 SS=D	This is a Complaint Deficiency. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is	F 842		7/13/21	

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F 842	<p>Continued From page 54</p> <p>resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <ul style="list-style-type: none"> (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized <p>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <ul style="list-style-type: none"> (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p>	F 842			

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F 842	<p>Continued From page 55</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview and facility documentation review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 7 residents (Resident #6) in the survey sample.</p> <p>The findings included:</p> <p>Resident #6 was originally admitted to the nursing facility on 10/19/19. Diagnosis for Resident #6 included but are not limited to Prediabetes and Morbid (severe) obesity.</p> <p>Resident #6 Minimum Data Set (MDS) an annual assessment with an Assessment Reference Date of 09/01/20 coded Resident # 6 Brief Interview for</p>	F 842	<p>1. Resident #6 no longer resides at the facility.</p> <p>2. Current residents have the potential to be affected. A 30-day lookback audit of current resident MARS and TARS for missed documentation to be conducted by Director of Nursing (DON) and nurse management team with a completion date of 07/02/2021. Missed documentation to be addressed by means of immediate MD notification.</p> <p>3. On 06/04/2021 and on 06/07/2021, the DON/Designee educated licensed nursing staff related to the policy and procedure of</p>		

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F 842	<p>Continued From page 56</p> <p>Mental Status (BIMS) score of 08 out of a possible score of 15 indicating moderate cognitive impairment. In addition, the MDS coded Resident #6 total dependence of two with personal hygiene, total dependence of one with bathing and dressing, extensive assistance of two with bed mobility and toilet use and supervision with eating for Activities of Daily Living care. The MDS was coded for always incontinent of bowel and bladder. In addition, under section M (skin conditions) was coded to have an unstageable that was present upon admission/reentry into the building and under other skin problems was coded for Moisture Associated Skin Damage (MASD.)</p> <p>Resident #6's person centered care plan dated 09/03/20 had a problem which read; at risk for skin breakdown or pressure injury development r/t Severe Morbid Obesity, Impaired Immobility, Incontinence and Bilateral lower extremity lymphedema and Erythema Interigo. The goal: will have intact skin, free of redness, blisters or discoloration by the next review date of 12/02/20. Some of the interventions to manage goal: administer treatments as ordered and monitor for effectiveness, educate the resident/resident representative as to causes of skin breakdown.</p> <p>An assessment for predicting pressure ulcers (Braden Scale) was completed on 10/21/20 with a score of 14.0 indicating "moderate risk for developing pressure ulcers."</p> <p>Review of Resident #6's Weekly Skin Integrity Review dated 10/26/20 included the following areas: under abdominal fold red and yeasty, intact blister left iliac crest (front), under both breast-red and breaks in the skin (yeast), top of</p>	F 842	<p>reviewing the Electronic Medication Administration Record (eMAR) after medication pass or providing treatments, and at the end of each shift to verify that medications and treatments have been administered as ordered and documented accordingly.</p> <p>The DON/Designee will review for missed documentation in clinical morning meeting, follow up with nurses to verify medications/treatments administered, complete documentation and/or physician notification as indicated. Nurses will be re-educated and/or receive progressive performance reviews when missed medication/treatment administration and/or documentation identified.</p> <p>4. The DON/Designee will review missed documentation in clinical morning meeting five days per week for two weeks. Random audit of missed documentation to then be conducted weekly for four weeks, then 10 times per month for two months or until resolved.</p> <p>The DON will report findings of the reviews to the Quality Assurance Performance Improvement Committee monthly for three months or until resolved.</p> <p>5. Date of Compliance: 07/13/2021</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/03/2021
NAME OF PROVIDER OR SUPPLIER NEWPORT NEWS NURSING & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 12997 NETTLES DRIVE NEWPORT NEWS, VA 23602		
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F 842	<p>Continued From page 57</p> <p>right chest-yeast rash with open area, under left and right under arm (yeast), multiple open areas to left and right gluteal fold.</p> <p>Review of Resident #6's Weekly Skin Integrity Review dated 10/05/20 included the following areas: redness, rash, and skin tears under bilateral axilla and bilateral breast to the chest area, skin tears in abdominal folds, red rash to the abdomen, Moisture Associated Skin Disorder (MASD) to right and left thigh (rear), right and left buttock and sacrum, skin tears in folds to the left lower leg (front) and right lower leg (front.)</p> <p>Review of Resident #6's Treatment Administration Record (TAR) for October 2020 indicated the following treatment orders:</p> <p>1. Clean abdominal fold with soap and water; dry the skin, apply barrier ointment every day and evening shift for prevention starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (10/09, 10/11, 10/14, 10/17/20.)</p> <p>2. Greer Goo Cream - apply to back of thighs topically every day and evening shift for wound healing. Apply to affected area as directed starting on 09/25/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (10/09, 10/11, 10/14, 10/17/20.)</p> <p>3. Apply barrier ointment to buttock and posterior thighs every shift for preventions starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (10/09, 10/11, 10/14, 10/17/20.)</p>	F 842			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 842	Continued From page 58 Review of Resident #6's (TAR) for September 2020 indicated the following treatment orders: 1. Clean abdominal fold with soap and water; dry the skin, apply barrier ointment every day and evening shift for prevention starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (09/05, 09/11, 09/20, 09/24, 09/25 and 09/30/20.) 2. Apply barrier ointment to buttock and posterior thighs every shift for preventions starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (09/05, 09/11, 09/20, 09/24, 09/25 and 09/30/20.) Review of Resident #6's (TAR) for August 2020 indicated the following treatment orders: 1. Clean abdominal fold with soap and water; dry the skin, apply barrier ointment every day and evening shift for prevention starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (08/02, 08/03, 08/08, 08/12, 08/14, 08/17, 08/19 and 08/29/20.) 2. Apply barrier ointment to buttock and posterior thighs every shift for preventions starting on 07/30/20. Further review of the TAR evidenced there were no initials by the nurse; indicating treatment was not completed on the following days: (08/02, 08/03, 08/08, 08/12, 08/14, 08/17, 08/19 and 08/29/20.)	F 842			

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F 842	<p>Continued From page 59</p> <p>A phone interview was conducted with the Assistant Director of Nursing (ADON) on 06/03/21 at approximately 3:37 p.m. The ADON said the nursing staff are expected to follow the treatment as ordered and sign off when completed. She said if the treatment is not signed off on the TAR, there is no way to validate the treatment was actually done.</p> <p>The Administrator, Director of Nursing and Regional Director of Clinical Services was informed of the finding during a briefing on 06/03/21 at approximately 4:45 p.m. The facility did not present any further information about the findings.</p> <p>The facility's policy titled: Clinical Guidelines Skin and Wound (Effective date 04/01/17.) Overview: To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure ulcers.</p> <p>Complaint deficiency.</p>	F 842			