STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495155	A. BUILDING _____ B. WING _____	C 04/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANNANDALE HEALTHCARE CENTER	6700 COLUMBIA PIKE ANNANDALE, VA 22003

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 04/26/22 through 04/28/22. Past Non-Compliance was identified and the facility was in compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four (4) complaints were investigated during the survey: VA00054328-Substantiated with no deficiency; VA00054900-Substantiated without deficiency; VA00054912-Substantiated, with deficiency; VA00054968-Unsubstantiated, lack of sufficient evidence. The census in this 222 certified bed facility was 177 at the time of the survey. The survey sample consisted of 7 current Resident reviews and 2 closed record reviews.	F 000		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) 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 complaint investigation, staff interviews, clinical record review, and facility documentation, the facility staff failed to ensure 1 of 4 residents (Resident #2) in the survey sample were free of significant medication errors. Resident #2 was administered three blood pressure medications (Losartan 100 mg, Carvedilol 12.5 mg, and Amlodipine 10 mg) that were prescribed for another resident. On 04/12/22, Resident #2 was noted hypotensive with a blood pressure reading of 86/52, pulse rate of 58, and complaints of dizziness. Resident #2 was transferred via 911 (emergent) to the local	F 760	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: EXECUTIVE DIRECTOR | (X6) DATE: 5.20.22

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 760	Continued From page 1	F 760		

hospital on 04/12/22. Resident #2 received fluids bolus via intravenous (IV) en route to the hospital for hypotension and bradycardia. This deficiency is cited as past non-compliance, with sufficient evidence of correction

The findings included:

Resident #2's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 02/09/22 coded Resident #2's Brief Interview for Mental Status (BIMS) scored a 12 out of a possible score of 15 indicating moderate cognitive impairment. The MDS coded Resident #2 requiring total dependence of two with bathing, extensive assistance of two with bed mobility, transfer, and toilet use, and extensive assistance of one with dressing, eating, and personal hygiene for Activities of Daily Living (ADL) care.

Resident #2's person-centered care plan with a revision date of 04/13/22 identified the resident received hypertensive medications. The goal set for the resident by the staff was that the resident will have no ill effects from medication(s). Some of the interventions/approaches the staff would use to accomplish this goal is to administer medications as ordered, observe and document signs and symptoms of effectiveness and side effects, do labs as ordered, and monitor vital signs as ordered.

A review of Resident #2's nurse's notes revealed the following documentation entered on 04/12/22 by License Practical Nurse (LPN) #1: "Around 8:15 a.m., Resident #2 was administered the incorrect medications. The medication administered to Resident #2 was prescribed for

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F 760	Continued From page 2	F 760		

another resident. The nurse immediately informed the Unit Manager, Nurse Practitioner (NP), and physician with new orders from the NP to monitor the resident closely by obtaining vital signs assessment every 15 minutes. Within minutes of monitoring the resident's vital signs, the Resident ' s blood pressure went from 129/75 to 100/60 and pulse rate at 60. The second blood pressure was completed with a reading of 86/52 (normal = 120/80), and heart rate at 58 (normal = 60 to100 beats per minute). The resident was given a dose of Midodrine at 9:30 a.m., (for his low blood pressure). Resident #2 remained alert and oriented x 4 but complaint of severe dizziness. The NP and physician were informed of Resident #2's change in condition (continuous drop in blood pressure) with a new order to send Resident #2 to (name of the hospital) for further evaluation."

An interview was conducted with LPN #1 on 04/26/22 at approximately 4:29 p.m., who stated, "I pulled medication for one resident but accidentally administered the meds pulled to Resident #2. I got the beds mixed up." The LPN stated, "I immediately reported the incident to the Unit Manager, Supervisor, Director of Nursing (DON), and NP." The LPN stated, "I was immediately removed from the floor and was in-service on the 5 Rights of medication administration and was not able to return to the floor to pass medication until I was observed administering medication by the Staff Development Coordinator (SDC)."

On 04/12/22, at approximately 10:00 a.m., the NP progress note revealed the following information: "LPN #1 requested for me to assess Resident #2 for post medication error this morning. The nurse

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F 760	Continued From page 3 (LPN #1) stated Resident #2 was given another resident's hypertensive medications which included Losartan 100 mg, Carvedilol 12.5 mg, and Amlodipine 10 mg. The resident was alert with no acute distress noted. Resident #2's blood pressure (B/P) was 100/60 and pulse was 61. New orders were given to check vital signs every hour, STAT Complete Metabolic Panel (CMP), Midodrine 5 mg tablet - give one tablet by mouth every 8 hours as needed for hypotension - give if systolic blood pressure is less than 100. The NP note also included the Medical Director was informed of the above incident with a new order for Sodium Chloride Solution 0.9 %, use 100 ml/hr., (IV) as needed for hypotension until 04/13/2022 for systolic less the 90. Resident #2's blood pressure went down to 60/52 (hypotensive), Midodrine 5 mg was administered to the patient around 9:30 a.m. After the Midodrine 5 mg was administered, Resident #2's blood pressure increased to 86/52 and pulse at 58. Resident #2 is now complaining of being extremely dizzy. New orders were given to send Resident #2 out to the hospital for hypotensive and bradycardia (low pulse) episodes." On 04/27/22 at approximately 12:22 p.m., an interview was conducted with the Unit Manager who said, LPN #1 informed her that she administered Resident #2 another resident's medication. The medication administered were three different hypertensive medications. The Unit Manager stated an order was given for IV fluids if needed and Stat CMP but before the labs were drawn and the IV was placed, Resident #2 became hypotensive and was sent out to the hospital for further evaluation. An interview was conducted with NP on 04/27/22	F 760		

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F 760	Continued From page 4 at approximately 1:45 p.m., who stated she was in the facility when LPN #1 accidentally administered Resident #2 another resident's blood pressure medication. She said the nurse asked if I could assess Resident #2 because his blood pressure was dropping. The NP said the resident was assessed with new orders given for Stat CMP (looking for electrolyte imbalance) vital signs every shift, and to give Midodrione 10 mg (for the decrease in blood pressure if needed). She said the Medical Director was notified that resident #2 received three blood pressure medications that were prescribed for another resident. New orders were given IV fluids if needed. On 04/27/22 at approximately 2:03 p.m., an interview was conducted with (name of physician) who stated, "Resident #2 received blood pressure medication that was not prescribed from him making him at risk for becoming hypotensive (drop in blood pressure) and bradycardia (drop in pulse) so the IV fluids as needed to provide blood volume which will increase the resident's blood pressure." A phone interview was conducted with the SDC on 04/29/22 at approximately 9:00 a.m., who stated she was informed that LPN #1 had accidentally administered Resident #2 another resident's medication. She said the LPN was immediately removed from the medication cart and was in-serviced right away on the 5 Rights of Medication Administration by the DON. She said the LPN was not allowed to return to the floor until medication observation was made to ensure she (LPN) was able to pass administering medication without error. The SDC stated, "I completed a medication administration observation on	F 760		

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F 760	Continued From page 5 04/15/22 with LPN #1 with no medication errors made. A review of the hospital records revealed the following: "Resident #2 presented to the Emergency Department (ED) on 04/12/22 at approximately 10:49 a.m. after he accidentally received another resident's blood pressure medication at the skilled nursing facility. Prior to his arrival, he developed hypotension with his blood pressure in the ' 80s (systolic) along with lightheadedness. According to the Emergency Medical Services (EMS), Resident #2 received a fluid bolus (via IV) while en route to the hospital with the improvement of symptoms. The resident's blood pressure in the (ED) was 146/70 but still, he was still complaining of mild lightheadedness but had improved since fluids were administered." An interview was conducted with the Administrator on 04/27/22 at approximately 2:15 p.m., who stated a Plan of Correction was put in place on the same day LPN #1 administered Resident #2 another resident's blood pressure medications. On the same day at approximately 2:45 p.m., the Administrator presented a Correction Action Plan dated 04/12/22. The Action Plan document the following: Medication Error dated 04/12/22 - Quality Assurance Performance Improvement (QAPI). "Step 1a. - Resident was administered antihypertensive medication in error. The nurse who administered medications was immediately pulled from the floor and educated by the DON on the 5 Rights of Medication Administration and use of 3 checks for proper resident identification.	F 760		

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F 760	Continued From page 6 Step 1b. What immediate interventions were for the affected resident? Medication Pass Observation was performed for the nurse by the DON on 04/12/22. The nurse ' s preceptorship documents were reviewed by the SDC on 04/12/22. Step 2a. What immediate actions were taken to identify all potential affected? Education for all charge nurses on the use of 5 Rights of medication administration and use of three checks for proper identification of residents, completed by the SDC on 04/15/22. Step 2b. What continued and immediate interventions were implemented for the identified resident or systems? Audits are to be reviewed monthly in QAPI. Step 2c. Results of the audits will be submitted to the QAPI Committee monthly for three months, the Committee will determine the need for further audits and/or action plans." This deficiency is cited as past non-compliance, with sufficient evidence of correction, and was in compliance at the time of the survey. A debriefing was conducted with the Administrator and Director of Nursing on 04/28/22 at approximately 2:00 p.m., who was informed of the above findings; no further information was provided prior to exit. On 04/28/22 at approximately 7:09 p.m., the Administrator provided a document titled Medication Administration Observation. The document provided information that all nursing staff was observed for the 5 Rights for	F 760		

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administering medication and the three checks for proper identification of residents.

The facility's policy titled Medication Administration was revised on 01/05/22.

Policy: It is the policy of this facility to provide resident-centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. The safety of the residents, visitors, and employees is a top priority of care. The purpose of this policy is to provide guidance for general medication administration to be provided by personnel recognized as legally able to administer.

Procedures include but are not limited to:

1. a. Administer medication only as prescribed by the provider.
1. b. Licensed or authorized personnel may administer prescribed medication.
1. c. Observed the "five rights: in giving medication: the right resident, the right time, the right medicine, the right dose, and the right route.
1. j. Full attention should be given during preparing of medications.
Avoiding distractions is important for infection prevention and reducing errors.

Definitions

-Hypotension, also known as low blood pressure, is a blood pressure under 90/60 mm/Hg. In many people, it has no symptoms. When it does cause symptoms, these are usually unpleasant or disruptive, including dizziness, fainting, and more. In some cases, hypotension is dangerous, so early diagnosis and treatment are important. One

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F 760	Continued From page 8 way to directly treat hypotension is by increasing blood volume. This method, also known as fluid resuscitation, involves infusing fluids into your blood. Examples of this include intravenous (IV) fluids, and plasma or blood transfusions (https://my.clevelandclinic.org/health/diseases/21156-low-blood-pressure-hypotension). -Complete Metabolic Panel is a test that measures 14 different substances in your blood. It provides important information about your body's chemical balance and metabolism (https://medlineplus.gov/lab-tests/comprehensive-metabolic-panel-cmp). -Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine works by causing blood vessels to tighten, which increases blood pressure (https://medlineplus.gov/druginfo/meds). COMPLAINT DEFICIENCY	F 760		