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WINDSOR REHABILITATION AND HEALTHCARE CENTER	**1306 SOUTH KING STREET WINDSOR, NC 27983**

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F 000	INITIAL COMMENTS A onsite revisit and complaint investigation was conducted from 11/21/2024 to 11/22/2024 with additional information obtained remotely through 11/26/2024. Onsite validation of the corrective action plans was conducted on 11/26/2024. Therefore, the exit date was 11/26/2024. Event ID # SYK711. The following intakes were investigated: NC00223307 and NC00224404. Three of the three complaint allegations did not result in a deficiency. Past Non-Compliance was identified at: CFR 483.45 at tag F760 at a scope and severity (J) CFR 483.50 at tag F770 at a scope and severity (J) The tag F760 constituted Substandard Quality of Care. Immediate jeopardy began on 10/25/2024, was removed on 11/14/2024, and the facility came back in compliance effective 11/14/2024. A partial extended survey was conducted.	F 000		
F 760 SS=J	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 observation, record review, resident interview, staff interview, nurse practitioner interview, physician interview, pharmacist, and	F 760	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 12/09/2024

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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psychiatry nurse practitioner interview the facility failed to administer 6 doses of a required antipsychotic medication for one (Resident #11) of one resident reviewed for significant medication errors. Resident #11 had an acute psychotic event after missing 6 doses of his antipsychotic medication resulting in a fall with a broken shoulder and hip that required surgical repair, acute blood loss and acute pain. Resident #11 has been bedbound since the incident.
Findings included:

Resident #11 was admitted to the facility on 1/20/2023 with a diagnosis of paranoid schizophrenia.

Resident #11 had a physician's order for 200 milligrams (mg) Clozapine, an antipsychotic, to be administered as one tablet by mouth two times a day for paranoid schizophrenia initiated on 7/9/2024. The administration times listed were 8:00 AM and 8:00 PM.

Documentation in the manufacturer's label for Clozapine revealed the average elimination half-life of Clozapine after a singe 75 mg dose, was 8 hours with a range of 4 to 12 hours, while the average elimination half-life after achieving a steady state with 100 mg twice a day dose, of 12 hours. Half-life is the time it takes for the amount of a drug's active substance in the body to reduce by half. Anemia and vitamin B12 deficiency can be a rare side effect of the medication Clozapine. The abrupt stopping of Clozapine has been associated with agitation and a rapid onset of psychosis.

Documentation in the assessment and plan portion of a psychiatry progress note date

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9/19/2024 revealed Resident #11's paranoid schizophrenia was "chronic" and "stable." The documentation also indicated Resident #11 was adhering to his medication regimen and indicated "a stable mental state."

Documentation on a quarterly Minimum Data Set assessment dated 10/10/24 coded Resident #11 as cognitively intact with no moods or behaviors. Resident #11 was coded as requiring set up/cleanup for eating and personal hygiene, but was dependent for toileting, showers/bathing, personal hygiene, and dressing. Resident #11 was coded as requiring substantial assistance with mobility.

Resident #11 had a physician's order dated as initiated on 9/19/2024 for blood to be drawn for a complete blood count (CBC) and a complete metabolic panel (CMP) on the night shift every 30 days for anemias and vitamin deficiencies to be completed on 10/19/2024 at 7:00 PM. The pharmacy requires blood tests every 30 days for a resident on the medication Clozapine to monitor the neutrophil counts in the blood.

There was no evidence in the electronic medical record of the CBC and CMP test results dated 10/19/2024.

Resident #11 had an additional physician's order written by Nurse Practitioner (NP) #1 dated 10/22/2024 at 11:17 AM for the medication Clozapine to be held for 2 days until 10/24/2024.

Documentation in a progress note written by NP #1 on 10/22/2024 at 7:55 PM revealed in part, "[Resident #11's] schizophrenia appears controlled with current therapy. Will order lab

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work as indicated and continue with therapy as prescribed. Obtain STAT (immediate) CBC (complete blood count) and CMP (comprehensive metabolic panel)."

Documentation on a lab results report for Resident #11 revealed the collection date was 10/23/2024 at 10:31 AM, received at 10/23/2024 at 10:31 AM, and reported to the physician on 10/23/2024 at 11:15 AM.

Documentation on the October Medication Administration Record (MAR) indicated Resident #11 had the medication Clozapine on hold by the practitioner for the 8:00 PM dose on 10/22/2024, the 8:00 AM dose on 10/23/2024, the 8:00 PM dose on 10/23/2024, and the 8:00 AM dose on 10/24/2024. Documentation on the same MAR indicated Resident #11 did not receive the scheduled Clozapine for the 8:00 PM dose on 10/24/2024, and the 8:00 AM dose on 10/25/2024 indicating an explanation would be in the progress notes.

Documentation in the electronic medication administration record (e-MAR) administration notes dated 10/24/2024 at 9:01 PM indicated the medication Clozapine was on order for Resident #11.

Documentation in the e-MAR administration notes dated 10/25/2024 at 9:23 AM had no explanation for why the Clozapine dose was not administered to Resident #11.

Medication Aide (Med Aide) #1 was interviewed on 11/26/2024 at 9:04 AM. Med Aide #1 confirmed she was assigned to administer medications to Resident #11 on 10/24/2024 and

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10/25/2024 on the evening shift. Med Aide #1 recalled that the medication Clozapine was held at one point and then was not available when she was administering medications on the evening shift on 10/24/2024 and 10/25/2024. Med Aide #1 recalled that on the evening shift on 10/24/2024, Resident #11 did not have a good night in that he was acting out with behaviors that made him seem like he was "possessed." Med Aide #1 stated she was aware the medication Clozapine required laboratory values monthly and was a very important medication for Resident #11 to take. Med Aide #1 thought she had reported the absence of the medication Clozapine for Resident #11 to a nurse, but she could not remember which nurse or the details of the conversation.

Nurse #6 was interviewed on 11/25/2024 at 11:36 AM. Nurse #6 confirmed she was the nurse assigned to administer medication to Resident #11 on the morning of 10/25/2024. Nurse #6 stated she did inform the unit manager (Nurse #5) that the Clozapine for Resident #11 was not available on the morning of 11/25/2024. Nurse #6 stated Nurse #5 contacted the pharmacy and sent the required laboratory report to the pharmacy so that the medication Clozapine would be sent to the facility for Resident #11.

NP #1 was interviewed on 11/22/2024 at 9:52 AM. NP #1 revealed the following information. NP #1 was in the facility Monday through Friday as an onsite practitioner. NP #1 explained the reason the Clozapine was put on hold for Resident #11 on 10/22/2024 was because the pharmacy needed laboratory values to be sent to them prior to filling another 30-day supply of the medication to Resident #11. The requirement for the laboratory values to be sent to the pharmacy prior

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F 760	Continued From page 5 to filling the Clozapine for Resident #11 was well known to the facility and there was a reoccurring order for blood to be drawn from Resident #11 for laboratory values each month. The problem, as explained by NP #1, was that the laboratory tests for Resident #11 were not drawn as ordered on 10/19/2024 and were then not faxed to the pharmacy. NP #1 explained on 10/22/2024 she entered an additional order for a CBC (complete blood count) with differential for Resident #11 to be completed STAT (immediately). (A CBC with differential measures the number and types of cells in your blood to help diagnose a variety of conditions to include anemia, infection, or immunodeficiencies.) Documentation in a physician's progress note for Resident #11 dated 10/25/2024 at 1:00 PM written by Medical Doctor (MD) #1 stated in part, "Today, he was quite ornery. He is having acute psychosis event at this point. Very difficult to reconcile, redirect and calm down. He was actually verbally offensive and abusive to many of the staff members as well as me and other residents. The patient became very angry while at the nursing station. Attempted to get out of his wheelchair and I suspect probably attempted to take a swing at a staff member when he fell backward and fell on the ground. We did not move him, but I did assess him the best I could on the floor. He denies complaints at this point. However, I am concerned about his ongoing injury from his fall. He did not strike his head. Neurologically, he had no changes from his fall at this point. Neurological assessment otherwise is his baseline other than psychosis. Brief orthopedic assessment could not be completed after a fall secondary to the patient being stabilized on the ground awaiting EMS	F 760		

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F 760	Continued From page 6 (Emergency Medical Services). His vital signs otherwise are stable at this point. Approximately 15 minutes earlier, he received an IM (intermuscular) injection of Benadryl in his arm to calm him down I believe." Benadryl is an antihistamine that can have a sedative effect. An interview was conducted with the physician for Resident #11, MD #1, on 11/22/2024 at 1:23 PM. MD #1 explained that Resident #11 was rolling around in his wheelchair acting very verbally abusively threatening staff, other residents, and MD #1 on 10/25/2024. MD #1 explained Resident #11 was yelling, cussing, speaking in tongues, and acting in a way he had never seen before for this resident. MD #1 explained that Resident #11 rose up out of his wheelchair and what looked like to him "attempted to take a swing" at one of the staff members nearby, when he fell hard on the ground. MD #1 explained that Resident #11 did periodically have verbal behaviors but "this was something else." MD #1 stated he could not definitively say Resident #11 missing the six doses of Clozapine at the time of the incident and fall on 10/25/2024 was a direct cause of the accident because he was unsure of the half-life of the medication. (The half-life provides an accurate indication of the length of time that the effect of the drug persists in an individual.) MD #1 confirmed there was no reason Resident #11 should have missed getting the required lab work completed and missed doses of Clozapine. Documentation in the nursing progress notes dated 10/25/2024 at 1:46 PM written by Nurse #5 revealed, "Nurse called pharmacy to check status of resident's Clozapine oral tablet 200 mg. Pharmacist requested to have copy of labs. Nurse [#5] faxed lab per request. [NP #1] made	F 760		

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aware."

Nurse #5 was interviewed on 11/25/2024 at 9:52 AM. Nurse #5 stated she was the unit manager, and she was in the office adjacent to the nursing station with NP #1 when Resident #11 fell. Nurse #5 revealed Resident #11 usually had a calm demeanor when he received his medication Clozapine, but when he did not receive his antipsychotic medication, he became almost "demonic." Nurse #5 explained that the medication Clozapine required lab work to be completed prior to the pharmacy filling the medication. Nurse #5 further explained the nurses working at the facility should know Resident #11 required the medication Clozapine and that the lab work must be sent to the pharmacy for him to obtain it from the pharmacy. Nurse #5 stated the nurses who were working on the medication cart should know to call the pharmacy if Resident #11 did not have his Clozapine and the pharmacy would have readily told the nurse the laboratory report was needed. Nurse #5 stated when she saw the manic state Resident #11 was in on 10/25/2024 she called the pharmacy because she surmised, he probably had not received his antipsychotic medication. Nurse #5 indicated after the pharmacy notified her the laboratory report was needed, she immediately faxed the results to the pharmacy, and the pharmacy sent the Clozapine to the facility.

Resident #11 had a physician's order dated 10/25/2024 initiated at 1:46 PM for 50 mg of Benadryl to be injected intramuscularly one time only for agitation for one day and may repeat in one hour if needed.

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F 760	Continued From page 8 Documentation on a transfer form dated as initiated on 10/25/2024 at 1:57 PM written by Nurse #5 indicated Resident #11 was sent to the hospital because, "Resident threw himself on the floor." Documentation on the MAR revealed Resident #11 was administered the ordered dose of Benadryl on 10/25/2024 at 2:30 PM by Nurse #6. Documentation on a SBAR (Situation, Background, Assessment, and Recommendation) communication form and progress note dated 10/25/2024 initiated at 3:15 PM written by Nurse #6 revealed in the nursing assessment, "Resident having outburst with behavior toward staff." Documentation in the nursing progress notes dated 10/25/2024 at 3:21 PM written by Nurse #6 stated, "Resident up and down the hall in wheel[chair] with noted behavior fussing at staff and other residents. Resident talking to self, having out [bursts] toward others. Resident attempted to stand up to hit at staff when resident fell at nursing station. Resident complained of pain, refused help from staff, [Primary Care Physician] onsite, EMS/Police called to escort resident to ER (emergency room). Resident family aware/unit manager aware." Nurse #6 was interviewed on 11/25/2024 at 11:36 AM. Nurse #6 explained she was an agency nurse and was not very familiar with Resident #11, but she did recall the day he fell at the nurses' station. Nurse #6 stated Resident #11 was rolling all around the facility in a wheelchair in a very agitated state cursing at everybody he encountered. Nurse #6 confirmed that prior to	F 760		

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F 760	Continued From page 9 Resident #11 falling at the nurses' station, she had administered Benadryl to him with an order obtained from NP #1. Nurse #6 stated, in addition she went to the unit manager, Nurse #5, to let her know Resident #11 did not have any more Clozapine for administration. Nurse #6 revealed Resident #11 was cursing at MD #1 when he rose up out of his wheelchair and attempted to hit either MD #1 or herself. Nurse #6 stated Resident #11 fell, but was in such a state he would not allow anyone to assess him or for EMS to transport him to the hospital so, the police were called. Documentation on the October MAR indicated Resident #11 did not receive the scheduled Clozapine for the 8:00 PM dose on 10/25/2024 indicating an explanation would be in the progress notes. Documentation in the e-MAR administration notes dated 10/25/2024 at 10:24 PM indicated the medication Clozapine was on order for Resident #11. Record review of an emergency room visit on 10/25/2024 for Resident #11 revealed resident was uncooperative for an x-ray of his left shoulder with continuous refusals. Resident #11 was administered medications intramuscularly to calm him down enough to perform an x-ray of the left shoulder. The x-ray of the shoulder revealed Resident #11 had a fracture of the long bone, between the shoulder and the elbow. Resident #11 was transferred back to the facility with a long-arm splint and sling for support with the recommendation to follow-up with orthopedics the first of the next week.	F 760		

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F 760	Continued From page 10 NP #1 was interviewed on 11/22/2024 at 9:52 AM and additional information was provided. NP #1 revealed the CBC with differential was completed as ordered on 10/23/2024, but the results were not faxed to the pharmacy until 10/25/2024, resulting in Resident #11 missing seven doses of his Clozapine until the pharmacy sent another 30-day supply on 10/26/2024. NP #1 indicated the medication Clozapine did not make Resident #11 lucid but did make him manageable, so he was not hollering and yelling all the time. NP #1 stated she was in her office near the nursing station on 10/25/2024 when Resident #11 started yelling obscenities and could be heard threatening everyone around him. NP #1 stated she saw MD #1 step back away from Resident #11, but she did not actually see Resident #11 fall. NP #1 stated Resident #11 hit the ground so hard it could be heard by everyone. NP #1 explained MD #1 immediately ordered for 911 to be called as Resident #11 needed to be sent out. NP #1 indicated Emergency Medical Services (EMS) arrived very quickly but Resident #11 was so belligerent the police had to be called to assist the EMS workers. An interview was conducted with a pharmacist from the facility's pharmacy on 11/22/2024 at 10:25 AM. The Pharmacist revealed the following information. According to the pharmacy records, Resident #11 ran out of the ordered medication Clozapine on 10/22/2024. The Pharmacist called the facility on 10/22/2024 and notified them a new prescription for the Clozapine and a CBC differential for Resident #11 needed to be faxed to the pharmacy so that another 30-day supply of the medication could be sent to the facility. The Pharmacist did not have any record of who she spoke to at the facility. The pharmacist explained	F 760		

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the neutrophil count was the value the Pharmacist was monitoring because residents on Clozapine had an increased risk for infection. (Neutrophils are a type of white blood cell that help the body fight infection and heal from injury.) On 11/22/2024 at 11:20 AM a new prescription for Resident #11 for the Clozapine was sent to pharmacy. The required CBC with differential for Resident #11 was not sent to the pharmacy on 10/22/2024. The pharmacy received the CBC with differential dated 10/23/2024 for Resident #11 on 10/25/2024. The pharmacy sent a 30-day supply of the Clozapine to the facility on the morning of 10/26/2024. The Pharmacist stated if the medication Clozapine, used for paranoid schizophrenia, was abruptly stopped there was usually rebound psychosis and increase in behaviors related to Clozapine's short duration of action.

Documentation in the Nursing Progress notes dated 10/25/2024 at 5:30 PM written by Nurse #6 revealed, "[Resident #11] return from hospital with a [diagnosis] of closed displaced fracture of the surgical neck of the left humerus (the long bone that runs from upper shoulder to the elbow), unspecified fracture morphology. (Unspecified fracture morphology means the doctor does not have enough information to describe the exact shape or pattern of a bone fracture.) New order to go to Orthopedics in 3 days. Sling to left arm noted."

Documentation in the nursing progress notes dated 10/30/2024 at 9:10 AM written by the Director of Nursing revealed Resident #11 was transferred to another hospital after a diagnosis of a hip fracture was obtained in a local emergency room. The note further went on to

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explain the responsible party for Resident #11 was contacted to update health information regarding Resident #11 and discuss the likelihood of Resident #11 sustaining the hip fracture when he fell on 10/25/2024 because Resident #11 had not had any other falls.

Documentation in a discharge summary from the hospital revealed Resident #11 had a hospitalization from 10/29/2024 to 11/6/2024 for surgical repair of a left hip fracture. Additionally, while in the hospital Resident #11 had the problem areas and procedures of acute blood loss with transfusion of 2 units of blood and acute pain due to trauma.

An interview was conducted with a Nurse Aide (NA) #5 on 11/22/2024 at 12:14 PM. NA #5 revealed she worked on the first (7:00 AM to 3:00 PM) and second (3:00 PM to 11:00 PM) shift routinely. NA #5 indicated she knew the care needs of Resident #11 well. NA #5 stated Resident #11 would occasionally get out of bed with a one person stand and pivot to the wheelchair prior to his fall. NA #5 stated that Resident #11 was a completely different person now and would require a mechanical lift to get out of bed, but he no longer wants to get out of bed. NA #5 stated she knew Resident #11 did not like the mechanical lift.

Resident #11 was observed on 11/22/2024 to be asleep in bed laying on his right side 9:46 AM, 11:10 AM, and 1:04 PM.

An observation and interview were conducted with Resident #11 on 11/22/2024 at 4:29 PM. Resident #11 was laying on his right side in bed with a sling on his left arm. Resident #11 stated

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he had consistent pain in his hip, and he longer felt like he could get out of bed.

An interview was conducted with MD #1 on 10/25/2024 at 11:22 AM. MD #1 stated he visited with Resident #11 on 11/22/2024 to encourage him to work with therapy. MD #1 stated the mentation of Resident #11 was to just stay in bed and not move at this point.

Documentation in a psychiatry progress note dated 11/14/2024 written by NP #2 revealed under the history of present illness portion in part, "Patient ran out of his Clozapine a few days ago, which led to a resurgence of his delusions and hallucinations. This incident escalated to the point where he attempted to physically confront a doctor, resulting in a fall. Since resuming his medication, his symptoms have subsided, and he is reported to be doing well again. The goal is to prevent such an occurrence in the future by ensuring consistent access to his medication. His current medication regimen will be continued without changes, with a follow-up planned in a few weeks."

NP #2 was interviewed on 11/22/2024 at 1:43 PM. NP #2 stated it was hard to say if the behaviors of Resident #11 on 10/25/2024 were due to him missing 6 doses of Clozapine over two and a half days. NP #2 stated the half-life of Clozapine was 26 to 36 hours. NP #2 revealed she visited the facility every two weeks and usually the facility staff reported occasional verbal behaviors from Resident #11 and never reported physical behaviors.

The Director of Nursing was interviewed on 10/22/2024 at 10:45 AM. The Director of Nursing

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acknowledged the facility initially failed to obtain the needed laboratory report required by the pharmacy for the dispensing of the medication Clozapine on 10/19/2024. The DON also acknowledged NP #1 failed to give a separate order for the faxing of the laboratory report to the pharmacy after it was obtained on 10/23/2024, further delaying the dispensing of the medication Clozapine to Resident #11.

The facility was notified of the immediate jeopardy on 11/22/2024 at 3:39 PM.

The facility submitted the following corrective action plan on 11/23/2024:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 10/22/24 at 8:00 pm. Resident #11's medication could not be administered as ordered by the provider due to it not being available. When the nurse notified the pharmacy of the medication not being available to administer the pharmacy stated the medication required lab work to be completed and faxed to the pharmacy prior to dispensing the medication. On 10/22/24 the provider was notified, and an order was obtained to draw stat lab work on 10/22/24. The results of the labs were received on 10/23/24 in the morning and the provider failed to place a physician order to fax the results to the pharmacy so the medication could be dispensed. On 10/25/24 at 1:26 pm the nurse notified the pharmacy the medication was not available to administer. Upon notifying the pharmacy the

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F 760	Continued From page 15 pharmacy stated they had not received the lab results to dispense the medication. The provider was notified and stated the lab work had been completed and needed to be faxed to the pharmacy. The lab results were faxed to the pharmacy and received by the pharmacy at 1:42PM. The pharmacy dispensed the medication at 1:59pm. The facility received Resident #11's medication on 10/26/24 at 2:00 am. On 10/26/24 Resident #11's medication of Clozapine was administered at 8:00am to the resident as ordered by the provider. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all current residents was completed by the Director of Nursing on 10/23/24 to determine if any other residents required lab work previous to medication distribution from pharmacy. No other residents required lab work prior to medication distribution indicating that there were no other residents affected by the deficient practice of significant medication errors. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Licensed nurses were educated on the new process that the provider will enter a physician order for lab work. The order will be on the Medication Administration Record. The Licensed Nurse will ensure a lab form is completed and placed in the lab book for the lab to be drawn. Results of the lab are integrated with the electronic medical records system and once the results are received the provider is notified to	F 760		

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review. When applicable, a separate order will be placed on the medication administration record when a lab is required to be faxed to the pharmacy for medication distribution. The providers were educated on 11/8/24 of the new process by the Director of Nursing. When the order appears on the Medication Administration record the licensed nurse will ensure the lab results are faxed to the pharmacy.

Education was provided by the Director of Nursing to licensed staff and licensed agency staff on 11/12/24 to 11/13/24 that the provider will enter a physician order for lab work. The order will be on the Medication Administration Record. The Licensed Nurse will ensure a lab form is completed and placed in the lab book for the lab to be drawn. Results of the lab are integrated with the electronic medical records system and once the results are received the provider when applicable will order for lab results to be faxed to the pharmacy. The order will be placed on the medication administration record when a lab is required to be faxed to the pharmacy for medication distribution. When the order appears on the medication administration record the licensed nurse will ensure the lab results are faxed to the pharmacy.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 11/4/24 the Quality Assurance team (Administrator, Director of Nursing, Assistant Director of Nursing, nurse practitioner, Medical Director, social services director, admissions director and therapy director) met and a decision

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was made that the Director of Nursing or Designee will audit that includes the following: the provider entered a physician order for lab work; the order was placed on the Medication Administration Record; a lab form was completed and placed in the lab book for the lab to be drawn; an order was placed to fax the results to pharmacy for medication distribution when applicable; the results were received and faxed to pharmacy when applicable; and the medication is administered as ordered by the provider to prevent a significant medication error; and when the order appears on the Medication administration record the licensed nurse will ensure the lab results are faxed to the pharmacy. All ordered lab work will be reviewed from the previous day to ensure results have been reviewed by the provider and as applicable faxed to the pharmacy timely to prevent a significant medication error on Monday through Friday with ordered lab work through the weekend reviewed Monday for two weeks and then weekly for ten weeks. Results of these audits will be presented by the Director of Nursing or Designee to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.

Alleged date of immediate jeopardy removal date and compliance date: 11/14/2024

The corrective action plan was validated on 11/26/24. Interviews were conducted with a sample of nurses to verify education was conducted for nurses regarding processing lab results and pharmacy notification of lab results. Documentation of in-service records were reviewed. The initial audit was verified as well as

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F 760	Continued From page 18 the ongoing monitoring audits to identify residents that required labs for medication administration were verified to be completed. In an interview with the Director of Nursing on 11/26/24 at 12:00 pm, she stated that nurses, had been educated on the process for physician orders for medications that required lab monitoring and the completion of labs, to include to fax results to the pharmacy where indicated. The providers were also educated on the new process. Resident #11's medical record revealed the resident had received all prescribed doses of Clozapine from 11/14/24 through present. He had an order for labs and a separate order to fax lab results related to the medication, clozapine to the pharmacy every 28 days. The facility's immediate jeopardy removal date and compliance date of 11/14/24 was validated.	F 760		
F 770 SS=J	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff interview, nurse practitioner interview, physician interview, pharmacist interview, and psychiatry nurse practitioner interview the facility failed to obtain laboratory tests as ordered and provide laboratory results to	F 770	Past noncompliance: no plan of correction required.	

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the pharmacy as required for antipsychotic medication monitoring for one (Resident #11) of one resident reviewed for laboratory services. Resident #11 had an acute psychotic event after laboratory results were not obtained and faxed to the pharmacy for the renewal of his antipsychotic medication. Resident #11 suffered a fall with a broken shoulder and hip that required surgical repair, acute blood loss and acute pain. Resident #11 has been bedbound since the incident. Abrupt withdrawal from the medication can cause rebound psychosis (sudden return of psychotic symptoms). Findings included:

Resident #11 was admitted to the facility on 1/20/2023 with a diagnosis of paranoid schizophrenia.

Resident #11 had a physician's order for 200 milligrams (mg) Clozapine, an antipsychotic, to be administered as one tablet by mouth two times a day for paranoid schizophrenia initiated on 7/9/2024. The administration times listed were 8:00 AM and 8:00 PM.

Documentation in the manufacturer's label for Clozapine revealed the average elimination half-life of Clozapine after a singe 75 mg dose was 8 hours with a range of 4 to 12 hours, while the average elimination half-life after achieving a steady state with 100 mg twice a day dose, of 12 hours. The abrupt stopping of Clozapine has been associated with agitation and a rapid onset of psychosis.

Documentation in the assessment and plan portion of a psychiatry progress note date 9/19/2024 revealed Resident #11's paranoid schizophrenia was "chronic" and "stable." The

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documentation also indicated Resident #11 was adhering to his medication regimen and indicated "a stable mental state."

Resident #11 had a physician's order dated as initiated on 9/19/2024 for blood to be drawn for a complete blood count (CBC) and a complete metabolic panel (CMP) on the night shift every 30 days for anemias and vitamin deficiencies to be completed on 10/19/2024 at 7:00 PM. Anemia and vitamin B12 deficiency can be a rare side effect of the medication Clozapine.

Documentation on a quarterly Minimum Data Set assessment dated 10/10/24 coded Resident #11 as cognitively intact with no mood issues or behaviors. Resident #11 was coded as requiring substantial assistance with mobility and transfers.

Documentation on the October Medication Administration Record (MAR) revealed on 10/19/2024 at 7:00 PM Nurse #2 completed the order for a CBC and a CMP for Resident #11.

There was no evidence in the electronic medical record for Resident #11 of the CBC and CMP laboratory results from 10/19/2024.

Nurse #2 was interviewed on 10/22/2024 at 11:01 AM. Nurse #2 explained she worked in the facility on the 7:00 PM to 7:00 AM shift. Nurse #2 acknowledged she checked off on the MAR that Resident #11's CBC and CMP were completed on 10/19/2024, but it was not completed. Nurse #2 further explained the order for laboratory services for Resident #11 involved the nursing staff putting the necessary paperwork into a laboratory book so that when the phlebotomist came to draw blood between midnight and 5:00 AM, they would

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F 770	Continued From page 21 have the necessary information to do so. Nurse #2 stated that usually the orders for laboratory services for the residents were acknowledged and the information for the laboratory book was completed by the day shift nursing staff. Nurse #2 stated she must have been distracted or just forgot on 10/19/2024 to put the required information into the laboratory book for the phlebotomist who comes to the facility to draw the blood for Resident #11. Nurse #2 stated she did understand the system and process for residents to obtain laboratory services, but she thought this was the first time she had to obtain laboratory services for Resident #11. Resident #11 had an additional physician's order written by Nurse Practitioner (NP) #1 dated 10/22/2024 at 11:17 AM for the medication Clozapine to be held for two days until 10/24/2024 at 11:17 AM. NP #1 was interviewed on 11/22/2024 at 9:52 AM. NP #1 revealed the following information. NP #1 explained the reason the Clozapine was put on hold for Resident #11 on 10/22/2024 was because the pharmacy needed laboratory tests to be sent to them prior to filling another 30-day supply of the medication to Resident #11. The pharmacy requires the CBC because Clozapine puts a resident at higher risk for infections. The requirement for the laboratory tests to be sent to the pharmacy prior to filling the Clozapine for Resident #11 was well known to the facility and there was a reoccurring order for blood to be drawn from Resident #11 for laboratory tests each month ahead of time prior to Resident #11 running out of Clozapine. The problem, as explained by NP #1, was that the laboratory tests for Resident #11 were not drawn as ordered on	F 770		

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10/19/2024 and were then not faxed to the pharmacy. NP #1 explained on 10/22/2024 she entered an additional order for a CBC with differential for Resident #11 to be completed STAT (immediately) when she was notified Resident #11 ran out of his Clozapine. (A CBC with differential measures the number and types of cells in your blood to help diagnose a variety of conditions to include infection.)

An interview was conducted with a Pharmacist from the facility's pharmacy on 11/22/2024 at 10:25 AM. The Pharmacist revealed that because of the required laboratory tests, the medication Clozapine was not available for the nurses to remove from an electronic medication dispensing cabinet for Resident #11. The Pharmacist explained the laboratory tests were required before the medication could be dispensed from the pharmacy and there was no other way of obtaining the medication for Resident #11.

Documentation in a progress note written by NP #1 on 10/22/2024 at 7:55 PM revealed in part, "[Resident #11's] schizophrenia appears controlled with current therapy. Will order lab work as indicated and continue with therapy as prescribed. Obtain STAT (immediate) CBC and CMP." (A CBC and CMP measure the number and types of cells in your blood to help diagnose a variety of conditions to include infection.)

Documentation on a lab results report for Resident #11 revealed the collection date was 10/23/2024 at 10:31 AM, received at 10/23/2024 at 10:31 AM, and reported to the physician on 10/23/2024 at 11:15 AM.

Documentation on the October Medication

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Administration Record (MAR) indicated Resident #11 had the medication Clozapine on hold by the practitioner for the 8:00 PM dose on 10/22/2024, the 8:00 AM dose on 10/23/2024, the 8:00 PM dose on 10/23/2024, and the 8:00 AM dose on 10/24/2024. Documentation on the same MAR indicated Resident #11 did not receive the scheduled Clozapine for the 8:00 PM dose on 10/24/2024, the 8:00 AM dose on 10/25/2024, and the 8:00 PM dose on 10/25/2024.

Documentation in a physician's progress note for Resident #11 dated 10/25/2024 at 1:00 PM written by Medical Doctor (MD) #1 stated in part, "Today, he was quite ornery. He is having acute psychosis event at this point. Very difficult to reconcile, redirect and calm down. He was actually verbally offensive and abusive to many of the staff members as well as me and other residents. The patient became very angry while at the nursing station. Attempted to get out of his wheelchair and I suspect probably attempted to take a swing at a staff member when he fell backward and fell on the ground. We did not move him, but I did assess him the best I could on the floor. He denies complaints at this point. However, I am concerned about his ongoing injury from his fall. He did not strike his head. Neurologically, he had no changes from his fall at this point. Neurological assessment otherwise is his baseline other than psychosis. Brief orthopedic assessment could not be completed after a fall secondary to the patient being stabilized on the ground awaiting EMS [Emergency Medical Services]. His vital signs otherwise are stable at this point. Approximately 15 minutes earlier, he received an IM [intramuscular] injection of Benadryl in his arm to calm him down I believe." Benadryl is an

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F 770	Continued From page 24 antihistamine that can have a sedative effect. An interview was conducted with the physician for Resident #11, MD #1, on 11/22/2024 at 1:23 PM. MD #1 explained that Resident #11 was rolling around in his wheelchair acting very verbally abusively threatening staff, other residents, and MD #1 on 10/25/2024. MD #1 explained Resident #11 was yelling, cussing, and speaking in tongues and acting in a way he had never seen before for this resident. MD #1 explained that Resident #11 rose up out of his wheelchair and what looked like to him "attempted to take a swing" at one of the staff members nearby, when he fell hard on the ground. MD #1 explained that Resident #11 did periodically have verbal behaviors but "this was something else." MD #1 stated he could not definitively say missing the six doses of Clozapine at the time of the incident and fall on 10/25/2024 was a direct cause of the accident because he was unsure of the half- life of the medication. (The half-life provides an accurate indication of the length of time that the effect of the drug persists in an individual.) MD #1 confirmed there was no reason Resident #11 should have missed getting the required lab work completed and missed doses of Clozapine. Documentation in the nursing progress notes dated 10/25/2024 at 1:46 PM written by Nurse #5 revealed, "Nurse called pharmacy to check status of resident's Clozapine oral tablet 200 mg. Pharmacist requested to have copy of labs. Nurse [#5] faxed lab per request. [NP #1] made aware." Nurse #5 was interviewed on 11/25/2024 at 9:52 AM. Nurse #5 stated she was the unit manager, and she was in the office adjacent to the nursing	F 770		

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station with NP #1 when Resident #11 fell. Nurse #5 revealed Resident #11 usually had a calm demeanor when he received his medication Clozapine, but when he did not receive his antipsychotic medication, he became almost "demonic." Nurse #5 explained that the medication Clozapine required laboratory tests to be completed prior to the pharmacy filling the medication. Nurse #5 further explained the nurses working at the facility should have known Resident #11 required the medication Clozapine and that the laboratory tests must be sent to the pharmacy for the medication to be obtained from the pharmacy. Nurse #5 stated the nurses who were working on the medication cart should have known to call the pharmacy if Resident #11 did not have his Clozapine and the pharmacy would have readily told the nurse the laboratory report was needed. Nurse #5 stated when she saw the manic state Resident #11 was in on 10/25/2024 she called the pharmacy because she surmised, he probably had not received his antipsychotic medication. Nurse #5 indicated after the pharmacy notified her the laboratory report was needed, she immediately faxed the results to the pharmacy, and the pharmacy sent the Clozapine to the facility.

Documentation on a SBAR (Situation, Background, Assessment, and Recommendation) communication form and progress note dated 10/25/2024 initiated at 3:15 PM written by Nurse #6 revealed in the nursing assessment, "Resident having outburst with behavior toward staff."

Documentation in the nursing progress notes dated 10/25/2024 at 3:21 PM written by Nurse #6 stated, "Resident up and down the hall in

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wheel[chair] with noted behavior fussing at staff and other residents. Resident talking to self, having out [bursts] toward others. Resident attempted to stand up to hit at staff when resident fell at nursing station. Resident complained of pain, refused help from staff, [Primary Care Physician] onsite, EMS/Police called to escort resident to [emergency room]. Resident family aware/unit manager aware."

Nurse #6 was interviewed on 11/25/2024 at 11:36 AM. Nurse #6 revealed she was an agency nurse who only periodically worked at the facility. Nurse #6 stated that Resident #11 was in an agitated state rolling around the facility in a wheelchair swearing at everyone around him on 10/25/2024. Nurse #6 indicated she notified the charge nurse, Nurse #5, when during her medication pass administration, she noted Resident #11 did not have his antipsychotic medication, Clozapine. Nurse #6 stated Nurse #5 contacted the pharmacy and was told Resident #11 required laboratory tests to be sent to the pharmacy prior to the distribution of the medication by the pharmacy.

Record review of an emergency room visit on 10/25/2024 for Resident #11 revealed resident was uncooperative for an x-ray of his left shoulder with continuous refusals. Resident #11 was administered medications intramuscularly to calm him down enough to perform an x-ray of the left shoulder. The x-ray of the shoulder revealed Resident #11 had a fracture of the long bone, between the shoulder and the elbow. Resident #11 was transferred back to the facility with a long-arm splint and sling for support with the recommendation to follow-up with orthopedics the first of the next week.

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F 770	Continued From page 27 NP #1 was interviewed on 11/22/2024 at 9:52 AM and the following additional information was provided. NP #1 revealed the CBC with differential was completed as ordered on 10/23/2024, but the results were not faxed to the pharmacy until 10/25/2024, resulting in Resident #11 missing seven doses of his Clozapine until the pharmacy sent another 30- day supply on 10/26/2024. NP #1 indicated the medication Clozapine did not make Resident #11 lucid but did make him manageable, so he was not hollering and yelling all the time. NP #1 stated she was in her office near the nursing station on 10/25/2024 when Resident #11 started yelling obscenities and could be heard threatening everyone around him. NP #1 stated she saw MD #1 step back away from Resident #11, but she did not actually see him fall. NP #1 stated Resident #11 hit the ground so hard it could be heard by everyone. NP #1 explained MD #1 immediately ordered for 911 to be called as Resident #11 needed to be sent out. NP #1 indicated Emergency Medical Services (EMS) arrived very quickly but Resident #11 was so belligerent the police had to be called to assist the EMS workers. NP #1 indicated that after the incident on 10/25/2024 she questioned if the results of the CBC from 10/23/2024 were ever faxed to the pharmacy because Resident #11 was acting like he was not on his psychoactive medication. NP #1 stated at that point someone called the pharmacy to check if they received the laboratory results for Resident #11. An interview was conducted with a pharmacist from the facility's pharmacy on 11/22/2024 at 10:25 AM. The Pharmacist revealed the following information. According to the pharmacy records,	F 770		

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Resident #11 ran out of the ordered medication Clozapine on 10/22/2024. The Pharmacist called the facility on 10/22/2024 and notified them of a need for a CBC differential for Resident #11 to be faxed to the pharmacy so that another 30-day supply of the medication could be sent to the facility. The Pharmacist did not have any record of who she spoke to at the facility. The Pharmacist explained the pharmacy requires the blood test CBC with differential every 30 days for a resident on the medication Clozapine to monitor the neutrophil counts in the blood. Residents taking Clozapine can develop dangerously low neutrophil counts. Neutrophils are the cells that fight off infection in the body and if someone had very low levels of neutrophils; he or she can be vulnerable to infections. The required CBC with differential for Resident #11 was not sent to the pharmacy on 10/22/2024. The pharmacy received the CBC with differential dated 10/23/2024 for Resident #11 on 10/25/2024. The pharmacy sent a 30-day supply of the Clozapine to the facility on the morning of 10/26/2024. The Pharmacist stated if the medication Clozapine, used for paranoid schizophrenia, was abruptly stopped there was usually rebound psychosis and increase in behaviors related to Clozapine's short duration of action.

Documentation in the Nursing Progress notes dated 10/25/2024 at 5:30 PM written by Nurse #6 revealed, "[Resident #11] return from hospital with a [diagnosis] of closed displaced fracture of the surgical neck of the left humerus, unspecified fracture morphology. New order to go to Orthopedics in 3 days. Sling to left arm noted." The humerus is the long bone that runs from the upper shoulder to the elbow. Unspecified fracture morphology means the doctor does not have

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enough information to describe the exact shape or pattern of a bone fracture.

Documentation in a nursing progress note dated 10/29/2024 at 6:07 PM revealed that Resident #11 was sent to the emergency room for a difference in legs and swelling to his knee.

Documentation in a discharge summary from the hospital revealed Resident #11 had a hospitalization from 10/29/2024 to 11/6/2024 for surgical repair of a left hip fracture. Additionally, while in the hospital Resident #11 had the additional problem areas and procedures of acute blood loss with transfusion of 2 units of blood and acute pain due to trauma.

An interview was conducted with a Nurse Aide (NA) #5 on 11/22/2024 at 12:14 PM. NA #5 revealed she worked on the first (7:00 AM to 3:00 PM) and second (3:00 PM to 11:00 PM) shift routinely. NA #5 indicated she knew the care needs of Resident #11 well. NA #5 stated Resident #11 would occasionally get out of bed with a one person stand and pivot to the wheelchair prior to his fall. NA #5 stated that Resident #11 was a completely different person now and required a mechanical lift to get out of bed, but he no longer wants to get out of bed. NA #5 stated she knew Resident #11 did not like the mechanical lift.

Resident #11 was observed on 11/22/2024 to be asleep in bed laying on his right side at 9:46 AM, 11:10 AM, and 1:04 PM.

An observation and interview were conducted with Resident #11 on 11/22/2024 at 4:29 PM. Resident #11 was laying on his right side in bed

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with a sling on his left arm. Resident #11 stated he had consistent pain in his hip, and he longer felt like he could get out of bed.

An interview was conducted with MD #1 on 10/25/2024 at 11:22 AM. MD #1 stated he visited with Resident #11 on 11/22/2024 to encourage him to work with therapy. MD #1 stated the mentation of Resident #11 was to just stay in bed and not move at this point.

Documentation in a psychiatry progress note dated 11/14/2024 written by NP #2 revealed under the history of present illness portion in part, "Patient ran out of his clozapine a few days ago, which led to a resurgence of his delusions and hallucinations. This incident escalated to the point where he attempted to physically confront a doctor, resulting in a fall. Since resuming his medication, his symptoms have subsided, and he is reported to be doing well again. The goal is to prevent such an occurrence in the future by ensuring consistent access to his medication. His current medication regimen will be continued without changes, with a follow-up planned in a few weeks."

NP #2 was interviewed on 11/22/2024 at 1:43 PM. NP #2 explained that Clozapine had side effects with one of them being the possibility of a severe decrease in white blood cell counts, although rare was a possibility. NP #2 further explained the pharmacy was required to monitor the neutrophils by receiving the laboratory values of Resident #11 monthly prior to sending the Clozapine to the facility to make sure he was not having any adverse side effects. NP #2 stated it was hard to say if the behaviors of Resident #11 on 10/25/2024 were due to him missing 6 doses of

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Clozapine over two and a half days. NP #2 stated the half-life of Clozapine was 26 to 36 hours. NP #2 revealed she visited the facility every two weeks and usually the facility staff reported occasional verbal behaviors from Resident #11 and never reported physical behaviors.

The Director of Nursing (DON) was interviewed on 10/22/2024 at 10:45 AM. The DON stated she felt the root cause of the failure to obtain the Clozapine medication for Resident #11 began with Nurse #2 not following the physician order and not putting the required information in the laboratory book for the laboratory order to be carried out. The DON stated she felt like an additional root cause was the failure of NP #1 to separate out the orders so that one order was to obtain the laboratory services for Resident #1 and then a second order should have been written to fax the results to the pharmacy.

The facility was notified of the immediate jeopardy on 11/22/2024 at 3:39 PM.

The facility submitted the following corrective action plan on 11/23/2024:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 10/22/24 at 8:00 pm, Resident #11's medication could not be administered as ordered by the provider due to it not being available. When the nurse notified the pharmacy of the medication not being available to administer the pharmacy stated the medication required lab work to be completed and faxed to the pharmacy

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F 770	Continued From page 32 prior to dispensing the medication. On 10/22/24 the provider was notified, and an order was obtained to draw stat lab work on 10/22/24. The results of the labs were received on 10/23/24 in the morning and the provider failed to place a physician order to fax the results to the pharmacy so the medication could be dispensed. On 10/25/24 at 1:26 pm the nurse notified the pharmacy the medication was not available to administer. Upon notifying the pharmacy the pharmacy stated they had not received the lab results to dispense the medication. The provider was notified and stated the lab work had been completed and needed to be faxed to the pharmacy. The lab results were faxed to the pharmacy and received by the pharmacy at 1:42PM. The pharmacy dispensed the medication at 1:59pm. The facility received Resident #11's medication on 10/26/24 at 2:00 am. On 10/26/24 Resident #11's medication of Clozapine was administered at 8:00am to the resident as ordered by the provider. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit of all current residents was completed by the Director of Nursing on 10/23/24 to determine if any other residents required lab work previous to medication distribution from pharmacy. No other residents required lab work prior to medication distribution indicating that there were no other residents affected by the deficient practice of not obtaining lab services as ordered by the provider. Address what measures will be put into place or systemic changes made to ensure that the	F 770		

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deficient practice will not recur:

Licensed nurses were educated on the new process that the provider will enter a physician order for lab work. The order will be on the Medication Administration Record. The Licensed Nurse will ensure a lab form is completed and placed in the lab book for the lab to be drawn. Results of the lab are integrated with the electronic medical records system and once the results are received the provider is notified to review. When applicable, a separate order will be placed on the medication administration record when a lab is required to be faxed to the pharmacy for medication distribution. The providers were educated on 11/8/24 of the new process by the Director of Nursing. When the order appears on the Medication Administration record the licensed nurse will ensure the lab results are faxed to the pharmacy.

Education was provided by the Director of Nursing to licensed staff and licensed agency staff on 11/12/24 to 11/13/24 that the provider will enter a physician order for lab work. The order will be on the Medication Administration Record. The Licensed Nurse will ensure a lab form is completed and placed in the lab book for the lab to be drawn. Results of the lab are integrated with the electronic medical records system and once the results are received the provider when applicable will order for lab results to be faxed to the pharmacy. The order will be placed on the medication administration record when a lab is required to be faxed to the pharmacy for medication distribution. When the order appears on the medication administration record the licensed nurse will ensure the lab results are faxed to the pharmacy.

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Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

On 11/4/24 the Quality Assurance team (Administrator, Director of Nursing, Assistant Director of Nursing, nurse practitioner, Medical Director, social services director, admissions director and therapy director) met and a decision was made that the Director of Nursing or Designee will audit that includes the following: the provider entered a physician order for lab work; the order was placed on the Medication Administration Record; a lab form was completed and placed in the lab book for the lab to be drawn; an order was placed to fax the results to pharmacy for medication distribution when applicable; when the order appears on the medication administration record the licensed nurse ensured the lab results were faxed to the pharmacy, and the results were received and faxed to pharmacy when applicable. All ordered lab work will be reviewed from the previous day to ensure results have been reviewed by the provider and as applicable faxed to the pharmacy timely to prevent an omission of ordered lab services on Monday through Friday with ordered lab work through the weekend reviewed Monday for two weeks and then weekly for ten weeks. Results of these audits will be presented by the Director of Nursing or Designee to the facility Quality Assurance and Performance Improvement (QAPI) Committee monthly for three months for review and, if warranted, further action.

Alleged date of immediate jeopardy removal date and compliance date: 11/14/2024

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F 770	Continued From page 35 The facility's correction action plan was validated on 11/26/24. Interviews were conducted with a sample of nurses to verify education was conducted for nurses regarding processing lab results and pharmacy notification of lab results. Documentation of in-service records were reviewed. The initial audit was verified as well as ongoing monitoring audits to ensure labs were obtained were verified to be completed. In an interview with the Director of Nursing on 11/26/24 at 12:00 pm, she stated that nurses had been educated on the process for physician orders for medications that required lab monitoring and the completion of labs, to include to faxing results to the pharmacy where indicated. The providers were also educated on the new process. Resident #11's medical record revealed the resident had received all prescribed doses of Clozapine from 11/14/24 through present. He had an order for labs and a separate order to fax lab results related to the medication, clozapine to the pharmacy every 28 days. The facility's immediate jeopardy removal date and compliance date of 11/14/24 was validated.	F 770		