

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 095026	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024
NAME OF PROVIDER OR SUPPLIER Knollwood Hsc		STREET ADDRESS, CITY, STATE, ZIP CODE 6200 Oregon Ave NW Washington, DC 20015	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47555</p> <p>Based on record reviews and staff interviews for one (1) of three (3) sampled residents, facility staff failed to accurately transcribe a physician's order for Lorazepam (a benzodiazepine approved to treat anxiety, insomnia) medication. Subsequently, Resident #1 was administered the medication incorrectly five (5) times on 03/29/24.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE] with multiple diagnoses that included: Cerebral Infarction due to embolism of left middle cerebral artery, Hemiplegia and Hemiparesis following cerebral infarction and Aphasia.</p> <p>According to an American Nurses Association Issue Brief dated 4/2021 documented in part, The administration of medications involves complex thinking and application of scientific knowledge. What began with five rights has now been extended to the eight rights of medication administration, the: Right Patient, Right Medication, Right Dose, Right Route, Right Time, Right Documentation, Right Reason, and Right Response. https://www.nursingworld.org.</p> <p>An Admission Order dated 03/28/24 documented in part, Admit to [Name of Hospice] . Lorazepam concentrate 2mg/ml (milligram/milliliter) give 0.5mg (0.25ml) Q (every) 4 hrs (hours) PRN (as needed) PO (by mouth)- Dx: (diagnoses) anxiety/restlessness.</p> <p>It should be noted that the previous orders were reviewed by Employee #10 (Registered Nurse/RN) and Employee #4 (RN) on 03/28/24 for accuracy of transcription.</p> <p>A review of a Physician's Order Report dated 03/09/24 - 04/09/24 documented in part, Lorazepam 2mg/ml give 0.5mg (0.25ml) Q (every) 4 hrs (hours) PRN (as needed) PO (by mouth) for anxiety/restlessness with a start date of 03/28/24.</p> <p>A review of Resident #1's March 2024 electronic Medication Administration History [Record] documented in part the following order:</p> <p>Lorazepam 2mg/ml; Amount to administer 0.5mg (0.25ml); oral; Frequency- Every 4 hours; Special Instructions: .Give 0.5mg (0.25ml); . by mouth every 4 hours PRN for agitation/restlessness; start date of 03/28/24 .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 03/29/24 at 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM Lorazepam 2mg/ml was administered to Resident #1 lacking documented evidence that the resident exhibited signs of agitation or restlessness prior to the administration of Lorazepam.</p> <p>A Facility Reported Incident (FRI) received by the State Agency on 04/05/24 documented, On 3/28/24, an order was obtained for Ativan (Lorazepam) 0.25 ml po q 4 hrs PRN. Nurse who entered the order did not check the PRN (as needed) box, and order appear[ed] as routine. Resident received 6 doses on 3/29/24 before an error was noticed and medication re-entered as PRN. Resident remains on Hospice services for comfort care.</p> <p>During a face-to-face interview conducted on 04/10/24 at 9:05AM, Employee #2 (Director or Nursing/DON) stated that, Employee #10 (RN) did not transcribe the Lorazepam order correctly in the resident's electronic Medication Administration Record. Employee #2 then said that Employee #10 should have indicated that the medication was prescribed as a PRN order. Instead, he indicated that the medication was to be administered routinely and that's why staff administered Lorazepam five (5) times on 03/29/24.</p> <p>During a telephone interview conducted on 04/10/24 at 4:30 PM, Employee #10 stated, In the special instructions I wrote it exactly as it is, q4h but I just didn't check the PRN box. I totally accept responsibility for this mistake.</p>		