STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225493	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph Rehab & Nursing Care Center	321 Centre Street Dorchester, MA 02122

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)
F 0756 Level of Harm - Actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 43963 Based records reviewed and interviews for one of three sampled residents (Resident #1), whose admission physician's orders included the administration of Eliquis (anticoagulant), the Facility failed to ensure that upon completion of his/her Admission Medication Regimen Review (MRR) by the Consultant Pharmacist that nursing reviewed and addressed the pharmacy recommendation related to his/her dosage of Eliquis timely, as a result for more than a month, Resident #1 was overmedicated with Eliquis, he/she experienced an acute change in medical status due to being administered excess Eliquis, and required hospital transfer with admission, where he/she received blood transfusions and additional treatments to stabilize his/her condition. Findings Include: Review of the Facility's Policy titled Admission Medication Regimen Review (MRR), dated as last revised 06/01/24, indicated that an admission MRR will be performed within 72 hours of admission or an agreed upon timeframe of admission by a licensed pharmacist per authorization of the facility. Significant medication issues, considered to be time sensitive, identified by the consultant pharmacist during the admission MMR, must be communicated to the physician/prescriber or designees and resolved by 11:59 P.M. of the following day, per the IMPACT Act. The Policy further indicated the following: -Upon completion of the Admission MMR, the pharmacy consultant recommendations may be made electronically or by printed copy and are submitted to the DON or designee who will notify the prescriber for review; -When a time sensitive medication issue is identified that requires immediate attention of the prescriber, the pharmacist will call the facility. Resident #1 was admitted to the Facility in April 2024, diagnoses include septic shock due to a stage IV (wound tunnels through all layers of the skin and expose bone) decubitus ulcer, sickle-cell anemia (inherited group disorder that causes blood cells to become misshapen and break down), diabetes mellitus, a deep vein thrombosis (blood clot) to both lower extremities, and a pulmonary embolism (blood clot in the lung) to his/her left lower lung. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Actual harm Residents Affected - Few	Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 06/10/24, indicated (per the hospital discharge summary) Resident #1 was supposed to be transitioned to Eliquis 5 milligrams (mg) by mouth two times a day (for a total of 10 mg a day) upon admission to the facility, and that the Hospital discharge medication list had Eliquis 10 mg by mouth twice daily that had been reconciled (by nursing) with the physician with no stop date or clarification. Review of Resident #1's Hospital Discharge Summary, dated 04/11/24, indicated that he/she was started on Eliquis 10 mg twice daily (total of 20 mg a day), last dose to be administered on the evening of 04/11/24, and then transition resident to Eliquis 5 mg twice daily thereafter. Review of Resident #1's Facility Medication Reconciliation Form, dated 04/11/24, indicated he/she was to be administered Eliquis 5 mg, 2 tablets, (total of 10 mg) by mouth daily. However, Resident #1's order for Eliquis, as written and indicated on the Medication Reconciliation Form, was still incorrect, since the Hospital Discharge Summary indicated he/she was to be administered Eliquis 5 mg, two times a day (for a total of 10 mg a day), and not 10 mg, as a one time dose daily. Review of Resident #1's admission Physician's Orders, dated 04/11/24, indicated to administer Eliquis 5 mg, give two tablets (10 mg) by mouth two times a day for blood clots (which totaled 20 mg a day). Review of Resident #1's Pharmacy Consultation Report, dated 04/15/24, indicated it contained a time sensitive recommendation requiring a prescriber response and facility action by 11:59 P.M. on 04/16/24 per federal impact act requirements. The Consult indicated the following: Resident #1 is ordered Eliquis 10 mg twice a day for blood clots without a stop date for use (typically for 7 days acutely). The Consult further indicated to reevaluate continued use at this dose and document stop date. During a telephone interview on 7/17/24 at 10:11 A.M., and a follow-up telephone interview at 2:46 P.M., the Consultant Pharmacy Manager said the Consultant that completed Resident #1's MMR on 4/15/24, had emailed the recommendations to the Director of Nurses and 4 other designated staff members at the facility that same day. The Manager said the body of the email indicated it contained a recommendation that was time sensitive and that when they flag an email in the PCC system on their end, it is also flagged in the email on the facility end. The Manager could not explain why the Pharmacy had not conducted a follow-up to see if the recommendation had been completed. Review of Resident #1's electronic and hard copy Medical Record, indicated there was no documentation to support nursing staff addressed this time sensitive pharmacy recommendation by the Consultant with the MD or the NP. Review of Resident #1's Medication Administration Record (MAR) dated 04/15/24 to 05/28/24, indicated that despite the pharmacy recommendation to address the dosage of Eliquis, he/she was still administered 10 mg two times a day (for a total of 20 mg a day) during the above referenced time frame. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Actual harm Residents Affected - Few	On 5/29/24 Resident #1 was transferred to the Hospital Emergency Department with shortness of breath, weakness, nausea, vomiting, and critically a low Hemoglobin (Hgb, protein in red blood cells that carries oxygen) 6.4 (normal range is between 12.3 and 15.3) and critically low Hematocrit (Hct, measures the volume of red blood cells compared to the total blood volume) 19.2 (normal range is between 36-48)) requiring blood transfusions and a spinal Arteriovenous (AV) fistula (an abnormal connection between an artery and a vein). Review of Resident #1's Hospital Discharge Summary, dated 06/07/24, indicated he/she had been admitted for anemia in setting of an excessive anticoagulation dose, was found to have a spinal AV fistula, requiring blood transfusion and embolization (procedure used to block a blood vessel, used to stop bleeding). Review of Resident #1's Medication Error Report, dated 06/11/24, indicated the Unit Manager had been sent a pharmacy recommendation for his/her Eliquis on 04/15/24, that had not been completed. During an interview on 07/08/24 at 1:19 P.M., Unit Manager #1 said that on 06/11/24, the Director of Nurses (DON) informed her that the Admission Medication Regimen Review (MRR) by their Pharmacy Consult which had included a recommendation regarding the dosage of Eliquis, had been completed for Resident #1 on 04/15/24, and that the recommendations had not been addressed or followed up on by nursing. The Unit Manager said that she had not remembered seeing any pharmacy recommendations for Resident #1 and said typically the pharmacy will electronically mail (e-mail) a copy of the recommendations to both the unit manager and the DON. Unit Manager #1 said that it was her responsibility to follow through with pharmacy recommendations, and said that prior to this incident there had not been a good system in place and that was why the recommendation had been missed. During an interview on 07/08/24 at 12:15 P.M., the Nurse Practitioner (NP) said typically nursing staff will leave a whole bunch of pharmacy recommendations for them to review and sign for the providers. The NP said she was unaware of Resident #1's pharmacy recommendation from 4/15/24. During a telephone interview on 07/11/24 at 10:20 A.M., the Former Director of Nurses (DON) said that she was made aware of Resident #1's 04/15/24 pharmacy recommendations that had been missed by nursing, while he/she was in the hospital after being sent out acutely for critically low blood laboratory work. The DON said typically all pharmacy recommendations are sent to the unit manager and herself for review and said that recommendations are expected to be completed in a timely manner. The DON said she was unaware of the missed recommendation until 06/10/24 when the Pharmacy sent a message stating that the 4/15/24 recommendation had not been completed. During an interview on 07/08/24 at 3:34 P.M., the Interim DON said that he had only now became aware of the missed pharmacy recommendation for Resident #1. The Interim DON said that is the Facility's expectation that all pharmacy recommendations be reviewed by nursing and completed according to the Facility policy and procedures and completed in a timely manner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 43963 Based on records reviewed and interviews, for one of three sample residents (Resident #1), whose Hospital Discharge Summary indicated that the daily dosage of his/her Eliquis (anticoagulant) was to be decreased from 10 milligrams (mg) two times a day, to 5 mg two times a day, the facility failed to ensure Resident #1 was free from a significant medication error when due to a medication reconciliation error upon admission by nursing, he/she continued to be administered Eliquis 10 mg two times a day for more than a month after his/her admission. Resident #1 experienced an acute change in medical status which include shortness of breath, weakness and critically low blood laboratory work related to being overmedicated with Eliquis, he/she was transferred and admitted to the Hospital where he/she required blood transfusions and additional treatment in order to stabilize his/her condition. Findings include: Review of the Facility Policy titled, Reconciliation of Medication on Admission Guideline, dated 01/26/23, indicated medication reconciliation is to ensure medication safety by accurately for the resident's medications, routes and dosages upon admission or readmission to the facility. The Policy indicated the following guidelines; -Medication reconciliation reduces medication errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission process; -Medication reconciliation helps to ensure that all medications, routes and dosages on the list are appropriate for the resident and their condition; and -Medication reconciliation helps to ensure the medications, routes and dosages have been accurately communicated to the Attending Physician and care team. Review of the Report submitted by the Facility via the Health Care Facility Reporting System (HCFRS), dated 06/10/24, indicated (per the hospital discharge summary) Resident #1 was supposed to be transitioned to Eliquis 5 milligrams (mg) by mouth two times a day upon admission to the facility, and that the Hospital discharge medication list had Eliquis 10 mg by mouth twice daily that had been reconciled with the physician with no stop date or any additional clarification. The Report indicated that, on 05/29/24, Resident #1 was transferred to the Hospital Emergency Department secondary to weakness, nausea, vomiting, and a critically low Hemoglobin (Hgb, protein in red blood cells that carries oxygen) 6.4 (normal range is between 12.3 and 15.3) requiring transfusion of two units of blood. Resident #1 was admitted to the Facility in April 2024, diagnoses include septic shock due to a stage IV (wound tunnels through all layers of the skin and expose bone) decubitus ulcer, sickle-cell (inherited group disorders that causes blood cells to become misshapen and break down) anemia, diabetes mellitus, a deep vein thrombosis (blood clot) to both lower extremities, and a pulmonary embolism (blood clot in the lung) to his/her left lower lung. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Hospital Discharge Summary, dated 04/11/24, indicated that he/she was started on Eliquis 10 mg twice daily (total of 20 mg a day), last dose to be administered on the evening of 04/11/24, and then transition resident to Eliquis 5 mg twice daily (for a total of 10 mg a day) thereafter. Review of Resident #1's Facility Medication Reconciliation Form, dated 04/11/24, indicated he/she was to be administered Eliquis 5 mg 2 tablets by mouth daily (for a total of 10 mg a day). However, Resident #1's order for Eliquis, as written and indicated on the Medication Reconciliation Form, was still incorrect, since the Hospital Discharge Summary indicated he/she was to be administered Eliquis 5 mg, two times a day (for a total of 10 mg a day), not 10 mg as a one time dose daily. Review of Resident #1's admission Physician's Orders, dated 04/11/24, indicated to administer Eliquis 5 mg, give two tablets (10 mg) by mouth two times a day for blood clots (for a total of 20 mg a day). However, the facility's Medication Reconciliation and physicians orders, were not consistent with the Hospital Discharge Summary that indicated Resident #1 was to be transitioned to and administered Eliquis 5 mg, two times a day (for a total of 10 mg a day) after the 4/11/24 evening dose. Review of Resident #1's auto-populated Alert Order Progress Note, (generated by Point Click Care, PCC, the Facility's electronic medical record) which is auto-generated by PCC once an alert is identified regarding a physician's order, dated 04/12/24, indicated his/her Eliquis order was outside of the recommended dose or frequency; The auto-populated Alert Order Progress Note further indicated: Eliquis oral tablet 5 mg (2 tablets) by mouth two times a day for blood clots. -The daily dose of 4 tablets exceeds the usual dose of 1 to 2 tablets; and -The single dose of 2 tablets exceeds the maximum single dose of 1 tablet. The usual dose is 1 to 2 tablets. Review of Resident #1's electronic and hard copy Medical Record, indicated there was no documentation to support that nursing staff had addressed the Alert Order related to the dosage of his/her Eliquis with his/her physician or nurse practitioner. Review of Resident #1's Nurse Practitioner (NP) Progress Note, dated 04/12/24, indicated his/her current medication included Eliquis 5 mg tablet, take 2 tablets (10 mg) by mouth 2 times a day (for a total of 20 mg a day). However, this was inconsistent with the Hospital Discharge Summary that indicated Resident #1 was to be transitioned to Eliquis 5 mg, two times a day (total of 10 mg day), after receiving his/her 4/11/24 evening dose. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Physician's (MD) Progress Note, dated 04/15/24, indicated his/her current medication included Eliquis 5 mg tablet, take 2 tablets (10 mg total) by mouth 2 times a day (for a total of 20 mg a day). However, this was inconsistent with the Hospital Discharge Summary that indicated Resident #1 was to be transitioned to Eliquis 5 mg, two times a day (total of 10 mg day), after receiving his/her 4/11/24 evening dose. Review of Resident #1's Medication Administration Record (MAR), date 04/12/24 through 5/29//24, indicated he/she received Eliquis 5 mg, two tablets (10 mg) by mouth two times a day, for a total of 20 mg a day (instead of total of 10 mg a day as indicated in the Hospital Discharge Summary). Review of Resident #1's Complete Blood Counts (CBC) laboratory work, for the month of May 2024, indicated he/she had abnormal lab values that were steadily declining, which included the following: (HGB - Hemaglobin, protein in red blood cells that carry oxygen, normal range is between 12.3 and 15.3) (HCT - Hematocrit, percentage by volume of red blood cells in the blood, normal range is between 36-48) 05/01/24-HGB 9.6 and HCT 28.8 05/08/24-HGB 9.5 and HCT 28.6 05/15/24-HGB 9.0 and HCT 27.7 05/22/24-HGB 8.0 and HCT 24.1 05/29/24-HGB 6.4 and HCT 19.2 Review of Resident #1's Nurse Progress Note, dated 05/21/24, indicated he/she had a very large and bloody wound to his/her buttocks. Review of Resident #1's Nurse Progress Note, dated 05/22/24, indicated his/her buttocks wound had bloody drainage and required an abdominal pad dressing for the excessive drainage. Review of Resident #1's Nurse Progress Note, dated 05/29/24, indicated he/she complained of nausea and vomiting times three, weakness, and shortness of breath. Resident #1 was transferred to the Hospital Emergency Department on 5/29/24 for evaluation and was admitted for treatment. Review of Resident #1's Hospital Discharge Summary, dated 06/07/24, indicated he/she had been admitted for anemia in setting of an excessive anticoagulation dose, was found to have a spinal AV fistula, requiring blood transfusion and embolization (procedure used to block a blood vessel, used to stop bleeding). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's Medication Error Report, dated 06/11/24, indicated that the Assistant Director of Nurses (ADON), neglected to note the recommendations from the Hospital Discharge Summary to decrease his/her Eliquis dose to 5 mg after the last 10 mg dose due to be given in the evening on 04/11/24. During an interview on 07/08/24 at 2:17 P.M., the Assistant Director of Nurses (ADON) said at the time of the incident she had been working as the evening nursing supervisor, that she recalled assisting with the admission process for Resident #1 and said she had completed his/her medication reconciliation form. The ADON said that she was unaware there was medication reconciliation error for Resident #1, until the DON informed her on 06/11/24. The ADON said Resident #1's Eliquis dose should have been changed to 5 mg by mouth twice a day (for a total of 10 mg a day) upon admission, but had not and that it was an error. The ADON said that once the auto-generated Alert Order Progress Note (for Resident #1's Eliquis order), had been generated by PCC, the physician should have been made aware and clarification of his/her Eliquis should have been completed at that time. During an interview on 07/08/24 at 12:46 P.M., the Charge Nurse said that once an Alert Order Progress Note from PCC appears in the resident's electronic medical record, the nurse is then responsible for informing the practitioner of the alert and obtaining a clarification order. During an interview on 07/08/24 at 1:19 P.M., Unit Manager #1 said she was unaware of the medication reconciliation error regarding Resident #1 until 06/11/24 when the former DON informed her. Unit Manager #1 said nurses should be reading the resident entire hospital discharge summary prior to reconciling the medications, that there are a lot of admissions, and some things get lost in translation. Unit Manager #1 said that either herself or the Charge Nurse should be reviewing all new admission and readmission medication reconciliation forms for accuracy. Unit Manager #1 said she had missed the change in Resident #1's Eliquis order and never saw the Alert Order Progress Note in PCC to address the Eliquis dose with a prescriber. During an interview on 07/08/24, the Interim Director of Nurses (DON) said that the former DON had made him aware of Resident #1's medication error in relation to medication administration sometime in June 2024. The Interim DON said that is the Facility's expectation for nurses to follow all policies and procedures for medication reconciliation, including having two licensed nurses sign the Medication Reconciliation Form to ensure accuracy and that the Management Staff double check all new admission as soon as possible.