

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335176	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Rosa Coplon Jewish Home and Infirmary		STREET ADDRESS, CITY, STATE, ZIP CODE 2700 North Forest Road Getzville, NY 14068	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43802</p> <p>Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00321782) the facility did not provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs) to meet the needs of each resident for one (Resident #2) of four residents reviewed. Specifically, medication, Adderall (central nervous system stimulant), prescribed to Resident #2 was not acquired from the pharmacy and administered as ordered, 7/16/24-7/19/24.</p> <p>The finding is:</p> <p>1. Resident #2 had diagnosis that included attention-deficit hyperactivity disorder, joint replacement surgery and anxiety disorder. The hospital discharge summary dated 7/15/24 documented Resident #2 was alert and oriented to person, place, time, and event.</p> <p>During an interview on 7/26/24 at 12:26 PM, Resident #2 stated they have had a terrible time with getting their medication at the facility. Resident #2 stated all they got were excuses, medication wasn't transcribed right, you're not supposed to get that, doctor hasn't approved it yet. Resident #2 stated they finally jut gave up, begging people, about their medication. Resident #2 stated they did eventually start getting their Adderall (Amphetamine-Dextroamphetamine 15 milligrams).</p> <p>Review of facility Order Summary Report for active orders as of 7/26/24 documented Resident #2 had active order status for Amphetamine-Dextroamphetamine (Adderall-central nervous system stimulant) 15 milligrams, 1 tablet by mouth every day for attention deficit hyperactivity disorder. The Amphetamine-Dextroamphetamine order date was 7/15/24, with a start date of 7/16/24.</p> <p>The July 2024 Medication Administration Record documented to administer Amphetamine-Dextroamphetamine 15 milligrams, 1 tablet by mouth every day at 9:00 AM with a start date of 7/16/24. The Amphetamine-Dextroamphetamine was not initialed as administered until 7/23/24. Between 7/16/24 through 7/22/24 the record was blank, without initials or chart/follow up codes indicated as to the rational the medication was not administered as ordered.</p> <p>Review of Resident #2's Controlled Substance Inventory Record dated 7/19/24 for Amphetamine-Dextroamphetamine 15 milligrams documented first dose being administered on 7/20/24 at 9:00 AM. There was no documented evidence that Resident #2 received ordered Amphetamine-Dextroamphetamine 15 milligrams from 7/16/24 through 7/19/24 (4 doses omitted).</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/29/24 at 10:20 AM, Licensed Practical Nurse #1 stated if a medication wasn't available that was ordered they would contact the pharmacy and let the supervisor know. They stated if they didn't have Amphetamine-Dextroamphetamine 15 milligrams, Resident #2 wouldn't have received it. They stated the electronic medication administration record indicated signature pending for the availability of the Amphetamine-Dextroamphetamine 15 milligrams. They stated the pharmacy wouldn't sent the Amphetamine-Dextroamphetamine until it was confirmed with the medical provider and that they notified the Registered Nurse #5, Unit Manager. They stated that the Amphetamine-Dextroamphetamine 15 milligrams wasn't received from the pharmacy until 7/19/24. Additionally, they stated they notified Resident #2 that their Amphetamine-Dextroamphetamine wasn't available, and that Resident #2 stated they needed their medication.</p> <p>During an interview on 7/29/24 at 10:30 AM, Registered Nurse #5, Unit Manager, stated nobody informed them that Amphetamine-Dextroamphetamine 15 milligrams wasn't available to be given. They stated they were informed that a medical providers signature was needed by Licensed Practical Nurse #1. They stated there was a delay in communicating a signature was required to the proper medical provider and that was on them. They stated that Medical Doctor #1, the prescribing provider, wasn't notified until 7/18/24 that a signature was required by pharmacy.</p> <p>During an interview on 7/29/24 at 11:06 AM, Pharmacist #1 stated that an order for Amphetamine-Dextroamphetamine 15 milligrams was entered into their system for Resident #2 on 7/15/24 but the electronic script wasn't signed until 7/18/24 by a medical provider. Pharmacist #1 stated they didn't know how medical providers were notified that a signature was needed. They stated the pharmacy had to order the Amphetamine-Dextroamphetamine and that it was delivered to the facility on [DATE].</p> <p>During an interview on 7/29/24 at 11:30 AM, Medical Doctor #1 stated that if a medication isn't available, they would expect the nurse to call the pharmacy to determine why the medication isn't available, then contact, notify a medical provider to ask what could be done. They stated there needs to be communication if a controlled substance needs to be signed for. Medical Doctor #1 stated they cannot be constantly checking their application to see if a signature is needed. They stated there was a lag in being notified and there shouldn't have been. They were not informed until 7/18/24 at 10:50 AM via text that a signature for Resident #2 controlled substance was required.</p> <p>During an interview on 7/29/24 at 11:45 AM, Director of Nursing #1 stated they expected a Nursing Supervisor/Unit Manager to be notified if a medication isn't available so it can be investigated why it isn't available. They stated then the Primary Care Physician should be notified for instructions/orders and the conversation should be documented.</p> <p>10 NYCRR 415.18(a)</p>		

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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>Ensure that residents are free from significant medication errors.</p> <p>43802</p> <p>Based on interview and record review conducted during an Abbreviated survey (Complaint #NY00321782) the facility did not ensure that residents were free of any significant medication errors for 1 (Resident #1) of four residents reviewed. Specifically, on 5/4/24 Licensed Practical Nurse #2 erroneously administered Resident #1 another Resident's (#4) morning medications that resulted in a significant medication error. Additionally, there was no documented evidence Resident #1 was monitored per the medical providers recommendation as documented on the discrepancy form.</p> <p>The finding is:</p> <p>The policy and procedure titled Medication Administration Policy updated 9/21 documented Administration of Medication: identify resident using 2 resident identifiers (name, ID band, picture), follow five rights to medication administration.</p> <p>The policy and procedure titled Medication Discrepancy Form revised 12/04 documented purpose was to assure quality resident care and safe environment for all residents regarding distribution of medications and to expedite information to the nurse eliminating repeated medication errors. A medication discrepancy is defined as any deviation from established procedure for the administration of medication or acceptable standards of nursing practice.</p> <p>1. Resident #1 had diagnosis including encephalopathy (disease that affects the brain), age related physical debility, and depression. The Minimum Data Set (a resident assessment tool) dated 4/26/24 documented Resident #1 had moderately impaired cognition, was usually understood, and usually understands.</p> <p>The comprehensive care plan initiated 4/21/24 documented Resident #1 had impaired cognitive function, and impaired long/short term memory. With an intervention that staff would anticipate needs.</p> <p>Review of facility Medication Discrepancy Form documented on 5/4/24 at 9:40 AM a medication error was made by Licensed Practical Nurse #2 involving Resident #1. The form documented Licensed Practical Nurse #2 got residents mixed up and gave Resident #1, Resident #4's medications. Licensed Practical Nurse #2 discovered medication error when they went to give Resident #4 their medications. No effect on Resident #1 at that time. The form documented the medical provider was notified and made recommendations to place Resident #1 on report to monitor for adverse reaction for 2 days. It was documented the responsible party was notified on 5/4/24 at 11:00 AM. Medication Discrepancy Form was signed by Licensed Practical Nurse #2 and Registered Nurse #3 Supervisor on 5/4/24. There were no additional signatures documented on the form that indicated the error was reviewed by Director of Nursing Service, Medical Doctor, or Administrator. Attached to the discrepancy form was Resident #4's medication record that highlighted which of the medications were given erroneously to Resident #1 which included Ferrous Sulfate, Senna, Clonazepam, Levitracetam and Memantine.</p> <p>(continued on next page)</p>		

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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>During an interview on 7/19/24 at 11:30 AM, Medical Doctor #1 stated they would expect to be notified immediately of medication discrepancies so the resident can be monitored for any detrimental medication interaction. Medical Doctor #1 stated they were not aware of the medication discrepancy with Resident #1 on 5/4/24. Medications given in error were reviewed at this time with Medical Doctor #1. Medical Doctor #1 stated the only significant medication given would have been the administration of the Clonazepam, cause sedation. They stated they would have monitored for lethargy and safety concerns (falls).</p> <p>During a telephone interview on 7/26/24 at 8:41 AM, the complainant stated they were notified by the facility around noon on 5/4/24 that Resident #1 had received the incorrect medications, that were ordered for another resident. Complainant stated they arrived about an hour later to see Resident #1, who was somnolent with altered mental status and slurred speech. Resident #1 the day after receiving incorrect medications was feeling weak, dizzy, and generally not well per the complainant. Complaint stated Resident #1 received Ferrous Sulfate (iron supplement) 325 milligrams, Senna Plus (stool softener and laxative) 8.6/50 milligrams, Clonazepam (benzodiazepine (scheduled 4 controlled substance-depressant) 0.5 milligrams, Levetiracetam (anticonvulsant-treat seizures) 250 milligrams and Memantine (used to slow progression of Alzheimer's disease) 5 milligrams.</p> <p>During an interview on 7/26/24 at 3:30 PM, Registered Nurse #5, Unit Manager, stated that a controlled substance given in error would be significant as you don't know how a resident was going to respond.</p> <p>During a telephone interview on 7/29/24 at 3:28 PM the On- Call provider stated they did not recall if they had been notified of the error and made recommendations or not.</p> <p>During a telephone interview on 8/1/24 at 9:00 AM, Licensed Practical Nurse #2 stated they didn't remember the whole incident but probably did give the wrong medication. They stated it would have been an honest mistake and they would have reported to it to the supervisor immediately. They stated it was important to report if the wrong medications were given in case something were to go wrong with the resident. They stated nobody followed up with them about the medication discrepancy after it occurred, and they weren't given any protocol to follow. Additionally, they stated that some nursing supervisors were more thorough than others but that they cover their butt and report any resident concerns to the nursing supervisor.</p> <p>b. Review of Progress Notes dated 5/4/24 at 11:56 AM, Registered Nurse #3 Supervisor documented Resident #1 was alert, drowsy, arouses easily. Verbal responses appropriate. Vital signs stable (VSS). Monitoring for adverse effects was given wrong medication. On call provider and resident representative notified. Resident #1 sitting in recliner. Frequent checks.</p> <p>Continued review of the progress notes revealed there was no additional documented evidence of frequent checks and monitoring completed until 5/6/24 at 9:49 PM.</p> <p>During an interview on 7/26/24 at 2:34 PM, the Assistant Director of Nursing stated the unit 24 Hour Report Log Sheet dated 5/4/24 was unable to be located.</p> <p>Review of the provided unit 24 Hour Report Log Sheets dated 5/5/24 through 5/8/24, revealed there was no documented evidence that Resident #1 was monitored for potential side effects/changes in condition and that a medication discrepancy occurred on 5/4/24.</p> <p>(continued on next page)</p>		

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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>During an interview on 7/26/24 at 11:39 AM, Licensed Practical Nurse #1 stated if a medication error occurred, they would report to the supervisor, get the resident's vital signs, the medical provider and family would need to be notified. They stated recent recommendations given by the medical provider would be followed and they would place the resident on report.</p> <p>During an interview on 7/26/24 at 11:51 AM, Licensed Practical Nurse #7, Nursing Supervisor, stated it was important for the medical provider to be notified of medication discrepancy to keep communication open, so the nursing staff were properly monitoring the resident. Additionally, they stated they did not recall being notified or made aware of a medication discrepancy with Resident #1.</p> <p>During a telephone interview on 7/26/24 at 1:38 PM, Registered Nurse #3, Supervisor stated they recalled being notified of the medication discrepancy on 5/4/24. They stated Resident #1 was drowsy, but arousable when they assessed them. They stated they left a voicemail for the on call medical provider but didn't recall if they received a call back from the provider or if they received any new orders. They stated if they had received new orders from a medical provider, they would have placed them in Resident #1's electronic medical record. Registered Nurse #3, Supervisor, stated they discussed over the phone the medication discrepancy with Director of Nursing #2 and that all the forms/paperwork for the discrepancy were left for them to review. Additionally, they recalled speaking with the complainant and reassured them that they were monitoring Resident #1. They stated that it is important to monitor a resident after a medication discrepancy in case there was a reaction or change in a resident's condition.</p> <p>During an interview on 7/29/24 at 12:30 PM, the Director of Nursing #1 stated they would expect nursing staff to evaluate a resident for 48-72 hours for adverse reactions after administration of the wrong medications and for evaluations to be document in the resident's progress notes. They stated process was not followed and there was not documented evidence that Resident #1 was monitored.</p> <p>Attempts made on 7/29/24 at 8:51 AM and 8/1/24 at 9:27 AM to contact Director of Nursing #2 with no response or return call.</p> <p>10 NYCRR 415.12(m)(2)</p>		