STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335878	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Epic Rehabilitation and Nursing at White Plains	120 Church Street White Plains, NY 10601

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observation, record review, and interview conducted during the Recertification and Abbreviated Surveys (NY00329183) from 10/03/24 to 10/11/24, the facility did not ensure residents were free of significant medication errors for 2 (Resident #202 and #96) of 9 residents reviewed for Medication Administration. Specifically, 1) Resident #202 was administered Lasix (diuretic) 20 milligrams and Losartan (antihypertensive) 100 milligrams without a physician's order, which resulted in the need for blood pressure monitoring every 30 minutes and intravenous fluids. 2) Resident #96 was about to receive a 4 milligram dose of Tizanidine (muscle relaxant) instead of the physician ordered 2 milligram dose during a medication observation that was stopped by the surveyor. The findings are: The facility policy titled Administering Medications dated 7/2019 documented individual administering the medication must check the label three times to verify the right resident, right medication, right dosage, right time, and right method(route) of administration before giving the medication. 1) Resident #202 was admitted with diagnoses including but not limited to chronic lower extremity paralysis, colostomy in left upper quadrant, and multiple sclerosis. The 5-day Minimum Data Set assessment dated [DATE] documented Resident #202 had intact cognition and was not receiving a diuretic. There was no documented evidence in the physician's order for the administration of Lasix or Losartan. The 11/29/23 Medications Care Plan documented to minimize potential complications from prescribed medications and administer medications per physicians' orders. The 11/30/23 Investigative Summary documented on 11/30/23, at approximately 8:30 AM, Resident #202 was given the wrong medication. The medication given was Lasix 20 milligrams and Losartan 100 milligrams. Upon investigation and staff interview, it was determined that the nurse gave the resident their roommate's medication in error. The Nurse Practitioner was notified, assessed the resident, and their blood pressure was stable. Intravenous fluids were started at 75 cubic centimeters per hour for one liter for hypotension, and blood pressure monitoring was ordered to be done every 30 minutes for 24 hours. Upon completion of the investigation and staff interview, the nurse was educated on the policy and procedures of medication administration and disciplinary action was taken. (continued on next page)

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 11/30/23 at 3:01 PM Nursing Progress note by the Assistant Director of Nursing documented Resident #202 experienced an episode of hypotension, the Nurse Practitioner assessed the resident, and gave new orders to administer normal saline, at 75 cubic centimeters per hour, and to monitor the blood pressure every 30 minutes. The 11/30/23 Physicians orders documented Resident #202 was to have their blood pressure monitored every 30 minutes, receive Sodium Chloride 0.9% injection solution infused at 75 cubic centimeters per hour by intravenous route every hour for 12 hours until 1 liter bag was complete, a Urinalysis and Culture done one time, and insert a urinary catheter for urinary retention. During an interview on 10/08/24 01:00 PM, Licensed Practical Nurse #2 stated that on the day of 11/30/23, they administered the wrong medication to Resident #202. They stated they got distracted and mixed it up with the roommate's medications, and did not remember what was happening at the time. Licensed Practical Nurse #2 stated they did not verify the resident prior to administering their medications and made an error., Licensed Practical Nurse #2 stated that they realized they gave Resident #202 the medication after it was too late. During an interview on 10/10/24 at 11:41 AM, the Medical Director stated Lasix would cause an increased urination, lower potassium, and blood pressure, and Losartan could also lower the blood pressure. The Medical Director stated that orders were given for Resident #202 to have their blood pressure monitored and to receive intravenous fluids due to Losartan having a short half-life which can cause hypotension, and because Lasix can cause dehydration from excessive fluid loss. 2) Resident #103 was admitted with diagnoses including hyperlipidemia, major depressive disorder, pain, and paraplegia. The 7/25/24 Quarterly Minimum Data Set documented Resident #103 had intact cognition. The 1/23/24 Medications Care Plan documented to administer medications per physician orders. The physician order dated 10/7/24 documented to administer Tizanidine 2 milligram tablet of at 9:00 AM and 1:00 PM; administer Tizanidine 4 mg tablet at 5:00 PM. On 10/11/24 at 9:35 AM, during a medication administration observation, Licensed Practical Nurse #2 took a 4 milligram tablet of Tizanidine out of a blister pack and placed it inside the medication cup along with the other medication. Licensed Practical Nurse #2 then proceeded to go in the room to administer Resident #103 their medications. Licensed Practical Nurse #2 was stopped before they were able to administer the Tizanidine 4 milligram tablet. Licensed Practical Nurse #2 stated they overlooked the physician order and were going to give the wrong dose of the medication. Licensed Practical Nurse #2 stated that they should have checked the physician orders prior to administering medications, and they made a mistake. During an interview on 10/11/24 at 1:06 PM, the Assistant Director of Nursing stated they performed medication administration competencies with Licensed Practical Nurse #2 and have had continued conversations with Licensed Practical Nurse #2 due to previous medication errors. 10 NYCRR 415.12(m)(2)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48847 Based on observations, record review, and interviews conducted during the Recertification Survey from 10/03/24 to 10/11/24, the facility did not ensure that all drugs and biologicals were stored in accordance with the manufacturer's specifications and professional standard of practice for 2 (Residents #12 and #96) of 8 residents reviewed for Medication Administration; and Medication and Treatment carts were observed unlocked. Specifically, 1.) Resident #12 was found with physicians ordered ipratropium nasal spray and an albuterol sulfate inhaler in their room on their bedside table. 2.) Resident #96 was found with 2 Trelegy inhalers, a Flonase nasal spray, an ipratropium nasal spray, an albuterol sulfate inhaler, and a triamcinolone acetonide ointment, and 3) the 5th Floor Medication Cart and Treatment Carts were left unlocked and open in the hallway accessible to residents, visitors, and unlicensed staff. The findings are: The facility policy titled Storage of Medications dated 7/2019 documented that the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Resident #12 was admitted with the following diagnoses including but not limited to chronic obstructive pulmonary disease, chronic rhinitis, chronic atrial fibrillation, and functional dyspepsia. The 8/10/24 Quarterly Minimum Data Set documented that Resident #12 had intact cognition, had chronic obstructive pulmonary disease, and received 7 days of respiratory therapy. The 5/20/24 Medications Care plan documented to manage and minimize potential complications from prescribed medications. Interventions included administering medications per physicians' orders. Upon review of Care Plans, there were no documented evidence that there was a care plan for Resident #12 to self-administer their medications. The 4/27/24 Physician order documented that Resident #12 was to receive Ipratropium bromide nasal spray and spray 2 sprays by intranasal route 2 times per day for chronic rhinitis. The 8/14/24 Physician order documented that Resident #12 was to receive Albuterol Sulfate aerosol inhaler-inhale 2 puffs by inhalation route two times per day as needed with instructions to rinse mouth with water and spit after each use. On 10/03/24 at 10:05 AM, Resident #12 was observed in their room and the physician ordered ipratropium nasal spray and an albuterol sulfate inhaler were on their bedside table. Resident #12 stated that they used the albuterol twice a day and took it when they needed it and when they got a heavy feeling in their chest. They stated no one monitored them while they used it. Resident #12 stated that after using the albuterol inhaler, they did not rinse their mouth and spit (as per physician's instructions) and stated that they did not need to do that. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) Resident #96 was admitted with chronic obstructive pulmonary disease, chronic atrial fibrillation, chronic rhinitis, and shortness of breath. The 9/7/24 Quarterly Minimum Data Set documented that Resident #96 had intact cognition. Had chronic obstructive pulmonary disease, coronary artery disease, and peripheral vascular disease, and received 7 days of respiratory therapy. The 9/19/24 Physician orders documented to administer: - fluticasone propionate nasal spray in each nostril 2 times per day for allergic rhinitis. - ipratropium bromide nasal spray in each nostril by intranasal route 2 times per day for chronic rhinitis - Trelegy Ellipta for inhalation route once daily at the same time each day for asthma with instructions to rinse mouth with water and spit after use. - albuterol sulfate HFA 90 mcg/actuation aerosol inhaler by inhalation route every 4 hours as needed with instructions to leave the inhaler the room and can self-administer. The only medication with instructions to self-administer was the Albuterol, however review of Resident #96's record revealed no assessment or care plan to self-administer any medications. On 10/03/24 at 10:49 AM, Resident #96 was observed in their room with 2 Trelegy inhalers, a Flonase nasal spray, an ipratropium nasal spray, an albuterol sulfate inhaler, and a triamcinolone acetonide ointment at their bedside. Resident #96 was interviewed during the observation and stated they took the Fluticasone when they felt like they needed it. Resident #96 stated they took Trelegy once a day at any time. They could use ipratropium twice a day if they wanted too and when they felt like it, and the other inhalers they could use when they wanted. Resident #96 stated that they used the inhalers whenever they wanted as they were escape inhalers and they were used when their chest felt tight. On 10/04/24 at 08:39 AM, Resident #96 was observed with a Trelegy Inhaler on the dresser. Resident #96 stated that staff in came in the middle of night and took their escape inhaler and was very upset. Resident #96 began to cough, was breathing heavy and appeared to be having a panic attack and stated they need their escape inhaler. Resident #96 stated they did not understand why it was taken out of their room. The 10/6/24 at 9:51 AM Nursing progress note documented Resident #96 wanted to keep albuterol inhaler at bedside to administer as ordered and refused to return it to the nurse. Resident #96 was able to demonstrate proper usage and education was provided, and as per physician, Resident #96 may self-administer medications. During an interview on 10/10/24 at 12:33 PM, Licensed Practical Nurse #1 stated when a resident can self-administer medications, there usually was a physician's order, and that medication should not be left at the bedside with a physician's order to self-administer medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/10/24 at 02:15 PM, the Medical Director stated residents should be evaluated by the team to self-administer medications. The Medical Director stated that nurses were responsible to make sure that residents were taking the medications by themselves, and that they would discuss with nurses if a resident could self-administer and would give a verbal order that residents could self-administer. Nurses were responsible for putting the order into the computer and stated that it was in the regulation for the facility to have physician's order for a resident to self-administer their medications. During an interview on 10/10/24 at 03:40 PM, the Director of Nursing stated medications should not be left at resident's bedside unless they had an order to self-administer their medications. They stated that any resident that that wanted to carry and self-administer their own medications must be evaluated by the interdisciplinary team and must have a physician order to self-administer medications. 40686 3) On 10/03/2024 at 12:00 PM, the 5th Floor Medication Cart in the south hallway (lower room numbers) was observed unattended with staff, residents, and visitors passing by. The Medication Cart was unlocked, and all drawers were able to be opened. Several vials of injectable medication and inhalers were observed in the top drawer of the Medication Cart. The 2nd drawer of the Medication Cart contained resident blister packs of medication and a locked narcotics box. On 10/03/2024 at 12:20 PM, Registered Nurse #6 was approached, interviewed, and stated they were usually the night nurse and worked a double to cove someone that called out. They were responsible for the 5th Floor Medication Cart and was finished administering medications to the lower half of the floor. The Medication Cart should never be left unlocked. Registered Nurse #6 was asked to observe the Medication Cart and stated the cart was unlocked and they must have forgotten to lock the cart after administering morning medications. Registered Nurse #6 stated the Medication and Treatment Carts on the floor contain prescribed medication and should not be left open to residents, visitors, or non-licensed nursing staff. On 10/03/2024 at 12:59 PM, the 5th Floor Treatment Cart in front of room [ROOM NUMBER] was observed unlocked with several drawers containing prescribed topical ointments and creams, scissors, bandages, and other treatment items. There were no staff observed near the unlocked cart and residents, staff, and visitors passed by the cart without any supervision. On 10/04/2024 at 10:59 AM, the 5th Floor Treatment Cart was observed stationed against the wall outside of the Dayroom. No staff were observed using or stationed at the Treatment Cart which was observed unlocked and opened in the hallway accessible to residents, public, and other staff. At 11:02 AM, Licensed Practical Nurse #20 was interviewed and stated all resident treatments were done for the morning shift. No one was using the Treatment Cart, and it should be kept locked. Licensed Practical Nurse #20 observed the unlocked Treatment Cart and stated they did not know why the Treatment Cart was left unlocked, but the Treatment Cart should always be kept locked. 10 NYCRR 415.18(e)(1-4)