

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  415035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  Lincolnwood Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  610 Smithfield Road North Providence, RI 02904	

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>46715</p> <p>Based on record review and staff interview, it has been determined that the facility failed to provide pharmaceutical services, including procedures that assure the accurate administration of all drugs, relative to chemotherapy medication for 1 of 3 residents reviewed, Resident ID #1.</p> <p>Findings are as follows:</p> <p>Review of a community reported complaint received by the Rhode Island Department of Health on 8/13/2024 alleged that Resident ID #1 did not receive the correct dosage of his/her chemotherapy medication.</p> <p>Record review revealed that the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, malignant neoplasm of the brain (brain cancer) and bipolar disorder.</p> <p>Review of the July 2024 Medication Administration Record (MAR) revealed that the resident received Temozolomide (chemotherapy agent) 125 milligrams (mg) daily from 7/11 until 7/21/2024.</p> <p>Review of a progress note dated 7/22/2024 authored by Nurse Practitioner (NP), Staff A, revealed the resident was transferred to the hospital.</p> <p>Review of a hospital discharge summary dated 7/25/2024 revealed to continue taking the following medications:</p> <ul style="list-style-type: none"> <li>-Temozolomide 5 mg capsule, take one by mouth once daily for 21 days</li> <li>-Temozolomide 20 mg capsule, take one by mouth once daily for 21 days</li> <li>-Temozolomide 100 mg capsule, take one by mouth once daily for 21 days</li> </ul> <p>Review of the July and August 2024 MAR revealed that the resident received Temozolomide 5 mg daily from 7/26/2024 until 8/7/2024 and not the 125 mg as ordered.</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 a surveyor interview on 8/15/2024 at 11:08 AM via telephone with Licensed Practical Nurse, Staff B, she revealed that she transcribed the Temozolomide order inaccurately as a taper instead of each order to equal 125 mg. Additionally, she revealed that she did not reconcile the medication orders from the hospital with the facility MAR prior to the resident's hospitalization .</p> <p>Review of a progress note dated 7/31/2024 authored by the Pharmacy Consultant revealed a Medication Regimen Review was completed and no recommendations were made to the facility.</p> <p>During a surveyor interview on 8/15/2024 at 11:00 AM via telephone with the Pharmacy Consultant, she revealed that she performed a Medication Regimen Review on 7/31/2024, and did not note any discrepancy with the resident's new orders and his/her orders prior to his/her hospitalization . While conducting the interview the Pharmacy Consultant reviewed the hospital paperwork and acknowledged that the resident should have been on 125 mg of Temozolomide daily. Additionally, she indicated that she failed to identify this discrepancy when she completed the resident's Medication Regimen Review on 7/31/2024.</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>46715</p> <p>Based on record review and staff interview it has been determined that the facility failed to ensure that all residents are free from significant medication errors relative to administering the correct dosage and medication in the correct form for 1 of 3 residents reviewed for chemotherapy medication, Resident ID #1.</p> <p>Findings are as follows:</p> <p>A. Review of a facility policy titled, Reconciliation of Medications on Admission last revised in July 2017 states in part, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility .Using an approved medication reconciliation form or other record, list all medications from the medication history, the discharge summary, the previous MAR [Medication Administration Record], and the admitting orders .Review the list carefully to determine if there are discrepancies/conflicts. For example: a. The dosage on the discharge summary does not match the dosage from the resident's previous MAR .If there is a discrepancy or conflict in the medications, dose .determine the most appropriate action to resolve the discrepancy. For example . Contact the resident's secondary physician in the community .</p> <p>Review of a community reported complaint received by the Rhode Island Department of Health on 8/13/2024 alleged that Resident ID #1 did not receive the correct dosage of his/her chemotherapy medication.</p> <p>Record review revealed that the resident was admitted to the facility in June of 2024 with diagnoses including, but not limited to, malignant neoplasm of the brain (brain cancer) and bipolar disorder.</p> <p>Review of the July 2024 MAR revealed that the resident received Temozolomide (chemotherapy agent) 125 milligrams (mg) daily from 7/11 until 7/21/2024.</p> <p>Review of a progress note dated 7/22/2024 authored by Nurse Practitioner (NP), Staff A, revealed the resident was transferred to the hospital.</p> <p>Review of a hospital discharge summary dated 7/25/2024 revealed to continue taking the following medications:</p> <ul style="list-style-type: none"> <li>-Temozolomide 5 mg capsule, take one by mouth once daily for 21 days</li> <li>-Temozolomide 20 mg capsule, take one by mouth once daily for 21 days</li> <li>-Temozolomide 100 mg capsule, take one by mouth once daily for 21 days</li> </ul> <p>Review of the July and August 2024 MAR revealed that the resident received Temozolomide 5 mg daily from 7/26/2024 until 8/7/2024 and not the 125 mg as ordered.</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 a surveyor interview on 8/15/2024 at 11:08 AM via telephone with Licensed Practical Nurse (LPN), Staff B, she revealed that she transcribed the Temozolomide order inaccurately as a taper instead of a combined dose to equal 125 mg. Additionally, she revealed that she did not reconcile the medication orders from the hospital with the facility MAR prior to the resident's hospitalization .</p> <p>During a surveyor interview on 8/15/2024 at 12:37 PM with NP, Staff A, she acknowledged that the 5 mg of Temozolomide was a medication error and that the order should have been for 125 mg daily for a total of 21 days.</p> <p>During a surveyor interview on 8/15/2024 at approximately 10:50 AM with the Director of Nursing Services (DNS) she revealed that Staff B, should have reconciled the medication from the hospital discharge summary with the previous order found on the resident's MAR before s/he was hospitalized . Additionally, she acknowledged that the resident received 5 mg of Temozolomide instead of 125 mg as ordered. The DNS was unable to provide evidence that the facility followed their policy for medication reconciliation upon readmission and that they kept Resident ID #1 free from significant medication errors relative to the dose of this medication.</p> <p>B. Review of a community reported complaint received by the Rhode Island Department of Health on 8/13/2024 alleged that Resident ID #1 was having difficulty swallowing and that the facility was crushing or opening his/her chemotherapy medication to administer it.</p> <p>Review of the Highlights of Prescribing Information for TAMADOR (Temozolomide) section 2.2 states in part, .capsules should not be opened or chewed. They should be swallowed whole with a glass of water. If capsules are accidentally opened or damaged, precautions should be taken to avoid inhalation or contact with skin or mucous membranes .</p> <p>Record review revealed that the resident requires pureed food and his/her medications are to be crushed.</p> <p>During a surveyor interview on 8/15/2024 at 9:56 AM with Registered Nurse, Staff C, she revealed that she was very familiar with this resident, and that s/he takes his/her medications crushed. When asked how the resident's chemotherapy medication was administered Staff C revealed that it is a capsule and she opens it to administer it to the resident.</p> <p>During a surveyor interview on 8/15/2024 at 11:08 AM via telephone with LPN, Staff B, she revealed that the resident takes his/her medications crushed.</p> <p>During a surveyor interview on 8/15/2024 at 12:37 PM with NP, Staff A, she revealed that the staff should not open the capsules of Temozolomide. Additionally, she revealed that the medication must be taken whole.</p>		