STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495186	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maimonides Health Center of Virginia Beach	6401 Auburn Dr Virginia Beach, VA 23464

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49455 Based on family interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to respect and honor a resident's right to remain a full code for 1 of 7 residents in the survey sample, Resident #6. The findings included: For Resident #6, the facility staff entered an order for the resident to become a do not resuscitate/do not intubate (DNR/DNI) after the resident was admitted from the hospital as a full code and expressed wishes to remain a full code. On 7/11/24 at 3:35 PM the Administrator and The Director of Nursing were not able to find a signed DNR to support the order placed on 10/18/23-10/23/23 for Resident #6 being a DNR/DNI. Resident #6 was admitted to the facility on [DATE], status post right hip replacement from an acute care hospital. Diagnoses for Resident #6 included but are not limited to right hip replacement, hypertension, diabetes mellitus, and seizure disorder. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 10/24/23 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #6 cognitive abilities for daily decision-making were independent. Resident #6's personal centered care plan dated 10/18/2023, did not include a code status focus, intervention, or goal. Review of Resident #6's discharge summary from the hospital, discharge instructions from the hospital, and report sheet from the facility all dated 10/17/23 and notes the resident was a full code. The order summary for Resident #6 included an order dated 10/18/23 to change the resident to a DNR/DNI and an order dated 10/23/23 to change the resident back to a full code. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted over the phone with Family Member (FM) #2 on 7/10/24 at approximately 3:05 PM. FM #2 shared that the doctor spoke with Resident #6 on 10/18/23 about changing her code status from full code to DNR/DNI. Resident #6 replied no thanks. FM #2 said the doctor proceeded to tell the resident that 30% of hip replacements ends up dying anyway. FM #2 said the resident told the doctor No repeatedly and the doctor left the unsigned DNR/DNI document with the resident. FM #2 asked facility staff for a printout of Resident #6 orders on 10/23/23 to verify medication compliance and saw that Resident #6 was listed as being a DNR/DNI. When FM #2 asked staff to see the signed DNR/DNI document to support the order, they did not have one.FM #2 shared with the nursing staff that Resident #6 did not agree to be a DNR/DNI. The resident's order was changed back to her wishes of being a full code. Resident #6 was receiving dialysis at the time of this interview and was unavailable. An interview was conducted with Licensed Practical Nurse (LPN) #1 on 7/11/24 at approximately 10:50 AM. When asked who speaks with new residents about their code status and advanced directives, she replied, the social worker. An interview was conducted with The Admissions Director on 7/11/24 at approximately 11:15 AM. Who shared her part in residents admissions does not require her to know code status. An interview was conducted with Assistant Director of Nursing (ADON) on 7/11/24 at approximately 12:30 AM. The ADON shared that residents usual come in as a full code from the hospital unless they have a DNR already complete. The ADON voiced that the Doctor would have the conversation with the resident about code status and not the social worker. When asked had she ever witnessed any doctor suggest to a resident that they should change their code status to a DNR, the ADON shared that she had never witnessed it, but in meetings it has been discussed that a doctor may make that suggestion. An interview was held on 7/11/23 at approximately 1:05 PM with one of the facilities medical doctors. This doctor hared that she would not make a suggestion for a resident to become a DNR, but she would make their options very clear. An interview was conducted on 7/11/24 at approximately 2:40 PM with the Social Service Director who shared she does not see the residents until 72 hours after they are admitted to the facility. The facility's your rights and protections as a nursing home resident policy was reviewed with an effective date of 4/14/2003. The policy read, .The right to participate in the decisions that affect your care .To create advanced directives. The above findings were shared with the Administrator and the Director of Nursing on 7/11/2024 at approximately 5:25 PM. No further information was provided prior to the conclusion of the survey.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on resident interview, staff interview, clinical record review, the facility's staff failed to ensure residents were free of significant medication errors for 2 of 7 residents in the survey sample, Resident #7 and Resident #6. The findings included: 1. Resident #7, a post kidney transplant resident was administered 8 days of the wrong medication, Cyclophosphamide, a chemotherapy drug, instead of the prescribed Cyclosporine, a drug used to prevent organ rejection in people who have received a kidney transplant, during his short term stay for rehabilitation. Resident #7 was originally admitted to the facility 4/08/24 after an acute care hospital stay. The current diagnoses included encounter for aftercare following kidney transplant and malignant neoplasm of unspecified kidney except renal pelvis. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/14/24 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #7 cognitive abilities for daily decision making were moderately impaired. The Person-Centered Care Plan dated 4/10/24 read Resident #7 was receiving antibiotic therapy related to post kidney transplant. The goal for Resident #7 was for the resident to be free of any discomfort or adverse side effects of antibiotic therapy through the review date of 4/26/24. The Interventions for Resident #7 included monitor/document/report as needed (PRN) adverse reactions to antibiotic therapy: diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reactions (rashes, welts, hives, swelling face/throat). A review of the April 2024 Physician's order Summary (POS) read Cyclophosphamide Oral Tablet 25 MG (Cyclophosphamide) Give 4 tablet by mouth two times a day for aftercare following a kidney transplant to start on 4/09/24. A review of the April 2024 Medication Administration Record (MAR) revealed that Resident #7 received Cyclophosphamide Oral Tablet 25 MG (Cyclophosphamide) 4 tablets by mouth two times a day in error. A review of the MAR revealed that Resident #7 received a total of 8 doses of Cyclophosphamide (32 tablets) from 4/10/24-4/17/24 at 9:00 AM., and from 4/09/24-4/15/24 Resident received 7 doses of Cyclophosphamide (28 tablets) in error, at 9:00 PM., A review of the MAR revealed that Resident #7 received his first dose of the correct medication, Cyclosporine Capsule 25 MG Give 5 capsule by mouth two times a day for antirejection on 4/17/24 at 9:00 PM. Resident #7 started receiving his correct anti-rejections medication, Cyclosporine for his new Kidney 8 days after being admitted to the long-term care facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**Cyclosporine and cyclosporine (modified) are used with other medications to prevent transplant rejection (attack of the transplanted organ by the immune system of the person who received the organ) in people who have received kidney, liver, and heart transplants. Cyclosporine is a class of medication called immunosuppressants. They work by decreasing the activity of the immune system (https://medlineplus.gov/druginfo/meds/a601207.html#:~:text=Cyclosporine). ***Cyclophosphamide is used to treat cancer of the ovaries, breast, blood and lymph system, and nerves (mainly in children). Cyclophosphamide is also used for retinoblastoma (a type of eye cancer mainly in children), multiple myeloma (cancer in the bone marrow), and mycosis fungoides (tumors on the skin). It belongs to the group of cancer medicines called alkylating agents. Cyclophosphamide is also used for some kinds of kidney disease. Cyclophosphamide interferes with the growth of cancer cells, which are then destroyed by the body. Since the growth of normal body cells may also be affected by cyclophosphamide, other effects will also occur. Some of these may be serious and must be reported to your doctor (https://www.mayoclinic.org/drugs-supplements/cyclophosphamide-oral-route-intravenous-route/description/drg-20063307). On 7/10/24 at approximately 3:15 PM., during a phone conversation with the State Long Term Care Ombudman, it was said that the resident was admitted to the facility on [DATE], with orders for Cyclosporine. The attending physician put in the order to the pharmacy for Cyclophosphamide. The Cyclophosphamide was administered until the staff was able to verify the medication with the kidney doctor on April 17, 2024. The kidney doctor noticed the wrong med and had the resident sent to the hospital for evaluation. The hospital in turn made the change in the medication list and returned the resident to the facility. A review of the Hospital Discharge Summary dated 4/08/24, did not list Cyclosporine as a discharged medication, but read that Resident #7 was transitioned from taking one prescribed medication (Prograf) to start Cyclosporine on 3/25/24. An interview was conducted on 7/11/24 at approximately 10:45 AM., with Licensed Practical Nurse (LPN)/Unit Manager #1. LPN #1 said that the resident was admitted after 5:00 PM., on 4/08/24, the nurse that admitted the resident verified his orders and conducted an admission assessment. LPN #1 also said that the Cyclosporine was not initially listed on the resident's discharge summary until the family member asked them to call the transplant clinic on 4/16/24 concerning the resident's appointment. The Transplant Nurse asked to verify the resident's medication. It was verified as being cyclophosphamide instead Cyclosporine and were asked to send the resident immediately to the hospital so that they could conduct labs, which were okay. On 7/11/24 at approximately 1:15 PM., an interview was conducted with The Medical Doctor (MD)/Other Staff member (OSM) #3. OSM #3 said that as she was re-ordering the new medication, it was written correctly, but ordered incorrectly. The OSM stated,I ordered Cyclophosphamide instead of Cyclosporine. I made a mistake. A review of the above MD's (OSM) #3 History and Physical (H&P) dated 4/09/24 was written correctly as Cyclosporine 100mg twice daily (bid) started. When the medication was being selected, Cyclophosphamide was selected in error from the medications listed in Point Click Care (PCC) per OSM #3. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/11/24 at approximately 1:50 PM., an interview was conducted with Family Member (FM) #1. FM #1 said that the anti-rejection medicine was given to her on the night of Resident #7's discharge. FM #1 also said that the resident didn't get to the facility until 9:00 PM., because she transported him to the nursing facility. FM#1 said, I walked in the facility and handed the medications to the nurse giving the medications at the med cart. She assured me that she would give the medications to the resident. I found out later the facility did not take medications from the outside. FM #1 said that the following day she showed the after-visit summary to OSM #3 because the initial documentation from the hospital showed a discontinued medication on the list that had caused an adverse reaction to Resident #7 in the past. FM #1 also mentioned that she spoke to the Unit Manager (LPN #1), alerting them that the Transplant Center was trying to contact them by phone to increase the Cyclosporine. FM #1 also said the nurse called the transplant center concerning the increased Cyclosporine, and LPN#1 said he was on a chemo medication called Cyclophosphamide. The Transplant Center nurse said to send the resident to the ER. An interview was conducted on 7/11/24 at approximately, 3:15 PM., with the Medical Director. The Medical Director said the resident should have been on Cyclosporine but there was a provider error because the correct medication did not appear on the Medication Reconciliation Form from the hospital. The Medical Director said, The wife's list was accurate. We caught the error within 12 hours and sent the resident to the hospital to get labs, labs were good. On 7/11/24 at approximately 4:08 PM., a phone call was made to Resident #7 concerning the above complaint. Resident #7 said that he felt awkward about receiving the wrong medication for his new kidney, It was a rough ride. According to the DON and Administration, no one had been admitted to the facility with transplant organs. On 7/11/24 at approximately 4:25 PM., a phone call was made to Other Staff Member/OSM #6 at the pharmacy company. OSM #6 said that they received a request to process Cyclophosphamide from the facility on 4/09/24, but in turn had to clarify the medication for tablets because the pharmacy needed to change the medication to capsules. A review of the electronic shipping manifest dated 4/09/24 read Cyclophosphamide 25 mg, give 4 tablets by mouth twice daily Permission to change to capsules. On 4/15/24 at 2:00 PM., an order was reviewed/written by the Kidney Transplant Center that read, increase Cyclosporin 125 mg twice daily. According to the MAR Resident #7 was still receiving Cyclophosphamide in error even after the Transplant Center had verified the correct medication. A review of the After-visit Summary Medication list dated on 4/08/24 at 7:00 PM., read Cyclosporine 25 mg 4 capsules by mouth twice daily (Morning and Evening). The last time given at the hospital was on 4/08/24 at 10:50 AM. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Medication Error Report dated 4/16/24 read that during medication verification with the kidney transplant nurse, a medication error was identified. The medication in error was Cyclophosphamide 25 mg, give 4 tablets twice daily. The correct medication Cyclosporine 25 mg, give 4 tabs to equal 100mg twice daily. The Transplant Medical Doctor (MD), and the facility MD were notified as well as family member. Resident #7 was taken to the hospital for further testing. According to the progress report dated 4/16/24 at 12:36 PM., Resident #7 was sent to the local hospital due to a medication discrepancy to be evaluated with ongoing monitoring, family was made aware. According to the progress note dated on 4/17/24 at 12:18 AM., Resident #7 returned from the hospital with a new prescription for Cyclosporine 25 mg take 5 capsules twice daily. On 7/11/24 at approximately 5:25 PM., the above findings were shared with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided. 49455 2) For Resident #6 the facility failed to administer ordered anti-seizure medication for three (3) days which was a significant medication error. Resident #6 was admitted to the facility on [DATE], status post right hip replacement from an acute care hospital. Diagnoses for Resident #6 included but are not limited to right hip replacement, hypertension, diabetes mellitus, and seizure disorder. Resident #6's personal centered care plan dated 10/18/2023, noted a focus on seizure disorder with an intervention to administer medications per order. Resident #6's order summary dated 10/17/23 has Phenobarbital (luminal) 32.4 mg to be administered at bedtime for seizure disorder. Review of Resident #6's medical administration record (MAR) for October 2023, documented the medication not being available on 10/17/23, 10/18/23, and 10/19/23. On 10/20/23 at 4:19 AM a progress note was written and indicated that nursing staff called and left a message for pharmacy on 10/20/23 at 8:30 PM about phenobarbital not being available for medication administration. Pharmacy called back at on 10/20/23 3:45 AM and stated they did not have a script on file to dispense medication. Review of a pharmacy shipping manifest reflects Resident #6's medication being shipped on 10/20/23 at 12:23 PM and signed for by facility staff on 10/20/23. Resident #6 received the first dose of Phenobarbital the night of 10/20/23. Resident #6 missed three (3) doses of Phenobarbital. Review of the facility emergency cubex contents were reviewed and Phenobarbital was not available at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held on 7/11/24 at approximately 12:30 PM with the Assistant Director of Nursing/Educator (ADON). The ADON shared that the process when a resident is admitted with a medication requiring a script to be sent to the pharmacy is: 1) day shift, the onsite provider will fax the script to the pharmacy or 2) off shift, the nurse must call the on-call provider and they have the capability to send the script to the pharmacy. The ADON indicated, either way, the nurse should call the pharmacy to confirm that the script was received. The ADON shared that the turnaround time to receive medications should be no longer than 12 hours and in the interim the nursing staff should see if the needed medication is in the emergency medication supply The ADON shared if it is not in the emergency medication supply the nurse should notify the practitioner that the medication is unavailable, get an order to discontinue the medication or put it on hold, and/or get a substitute. The ADON also shared that nursing staff should notify the resident and responsible party if applicable of all changes made. An interview was held on 7/11/24 at approximately 1:05 PM with one of the facilities Medical Doctors. When asked what the risk were for a resident missing anticonvulsive medication for 2-5 days. The Doctor shared that it depends based on the resident's current medical condition, comorbidities, etc., but having a seizure was certainly possible. The facility Medication Administration Policy was reviewed. There was no noted approved by, effective, or revision dates. The policy read, .medications will be administered in accordance with the orders . Phenobarbital is used to control seizures. (https://medlineplus.gov/druginfo/meds/a682007.html) The above findings were shared with the Administrator and the Director of Nursing on 7/11/2024 at approximately 5:25 PM. No further information was provided prior to the conclusion of the survey.