| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495432 | A. Building<br>B. Wing | 06/04/2024 |

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| Vierra Falls Church | 2100 Powhatan Street<br>Falls Church, VA 22043 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753<br><br>Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from unnecessary medication for one of five residents in the survey sample, Resident #1.<br><br>The findings include:<br><br>For Resident #1 (R1), the facility staff failed to administer the physician prescribed dose of the IV (intravenous) medication Acyclovir (1). Instead, the facility staff administered ten times the prescribed dose. R1 was transferred to the hospital for evaluation.<br><br>Acyclovir injection is used to treat herpes simplex (a herpes virus infection of the skin and mucus membranes), herpes zoster (shingles; a rash that can occur in people who have had chickenpox in the past), and herpes simplex encephalitis (brain infection with swelling caused by the herpes virus). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681036.html.<br><br>A review of R1's clinical record revealed a physician's order dated [DATE] that documented, Acyclovir Sodium Intravenous Solution 50 MG (milligrams)/ML (milliliter) (Acyclovir Sodium) Use 500 mg intravenously every 12 hours for encephalitis for 10 Days. Give 500 mg into a venous catheter every 12 hours x (times) 10 days. A review of R1's [DATE] MAR (medication administration record) revealed the medication was administered at night on [DATE].<br><br>A nurse's note dated [DATE] at 2:31 a.m. documented, Resident complete [sic] her IV (intravenous) meds and tolerated well but CO (complained of) SOB (shortness of breath), PRN (as needed) O2 (oxygen) 2 liter was given via NC (nasal cannula).<br><br>A nurse's note dated [DATE] at 5:42 a.m. documented, Resident also having chest congestion, one time order of Ipratropium Bromide (2) 0.5mg and Albuterol sulfate (3) 3mg, give 3ml via neb (nebulizer) treatment for SOB. NP (Nurse Practitioner) (name) was made aware. Still monitoring.<br><br>A nurse's note dated [DATE] at 12:59 p.m. documented, Resident noted SOB, Disoriented and confused this morning the beginning of the shift. Vs (Vital signs) Bp (blood pressure) ,d+[DATE] P (pulse)67 Spo2 (oxygen level) 94 on 2 L (liters) oxygen via nasal canula Temp (temperature) 97.6 RR (respiratory rate) 19 wither [sic] notified NP (name) rounded on resident and give [sic] order to send resident ED (Emergency Department) via 911 for farther [sic] evaluation. 911 pick [sic] the resident 10:00 am this morning and transfer to (name of hospital).<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A note signed by the Director of Nursing on [DATE] at 4:31 p.m. documented, On [DATE], at 11am nurse called patient RP (responsible party) (name) to inform him about patient transferred [sic] to ER r/t (related to) AMS (altered mental status). At 15:30 (3:30 p.m.), nurse received a call from ER (emergency room ) MD (Medical Doctor) (name) to get more detailed about the reason for patient's transfer, nurse explained to MD and MD stated that patient is currently at ER for treatment following labs result. At 16:30 (4:30 p.m.), nurse called RP to follow up on patient's status, RP stated that patient is still in ER awaiting lab result.<br><br>A nurse's note dated [DATE] at 10:15 p.m. documented, A follow up call with night nurse (name) who confirmed with writer that resident is been admitted to (name of hospital) for AKI (Acute Kidney Injury) as a result of possible drug overdose.<br><br>A hospital history and physical dated [DATE] documented, Reason for admission: aki (acute kidney injury) in the setting of acyclovir toxicity. Chief Complaint: Altered mental status, acyclovir overdose. Assessment/Plan: Acute kidney injury superimposed on chronic kidney disease, Acyclovir-induced nephrotoxicity .Patient with encephalopathy in the setting of acyclovir overdose (5 G [grams] given overnight instead of the scheduled 500 mg in her nursing home) and clinical diagnosis of encephalitis due to human HSV (herpes simplex virus). Patient in acute on chronic kidney injury with a creatinine [sic] has doubled over the past 2 days in the setting of acyclovir-induced nephrotoxicity .History of Present Illness: (Name of R1) is a 88 y.o. (year old) female .recent admission in the (name) hospital system for ecephalopathy [sic] and a seizure felt to be secondary to HSV encephalitis who presents with altered mental status and acyclovir overdose. The patient was initially hospitalized at (name of hospital) for metabolic encephalopathy, left arm cellulitis, and a superficial thrombosis. A lumbar puncture was discussed but was not performed due to overall goals of care for the patient. Ultimately decision was made to treat the patient empirically for HSV encephalitis with IV acyclovir 500 mg twice daily. The patient was transferred to skilled nursing, but the facility had difficulties obtaining acyclovir so ultimately the patient was admitted to the (name of hospital) from ,d+[DATE] to ,d+[DATE]. Patient was transferred back to the nursing facility on ,d+[DATE] with an appropriate supply of IV acyclovir to last through ,d+[DATE]. The patient is unable to provide any history due to altered mental status. According to her daughter-in-law she was awake alert and coherent last night. It was verified with the nursing facility by both the emergency room physician (name) and the medical HS (hospitalist) (name) that the patient was given 10 bags of 500 mg IV acyclovir overnight (instead of 1 bag of 500 mg). She was transferred to the emergency department as such. In the emergency department she was given IV fluids and had urgent evaluations by multiple consultants including nephrology. Poison control was contacted by the ED team which recommended dialysis .<br><br>A hospital infectious disease consult dated [DATE] documented, Pt (Patient was given 5g (grams) IV Acyclovir yesterday. Plan: No Acyclovir for now. Would need HD (hemodialysis) to remove excess Acyclovir, and family is leaning against it and may elect for comfort measures .Discussed with primary team, family, and pharmacy re: acyclovir dosing and situation. I have urgently evaluated this patient, who is critically ill. Patient is at increased risk of clinical decline .<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | LPN (licensed practical nurse) #3, the nurse who administered the Acyclovir on [DATE], was not available for interview during the survey. A statement signed by LPN #3 on [DATE] documented, At about 1600 pm (4:00 p.m.) came into work saw patient in bed, do [sic] regular assessment. Saw an order in PCC (computer software program) that Acyclovir sodium IV sol (solution) 50 mg/ml. Use 500mg/ml every 12 hours for encephalitis for 10 days. Give 500 mg into a venous catheter every 12 hours x (times) 10 days. I call [sic] pharmacy spoke with (name) and told her to show me how to dilute this meds [sic] before administering. She ask [sic] how many vial [sic] I have and I told 20 vials and she put me on hold and later transfer [sic] me (to name of pharmacist), and (name of pharmacist) ask [sic] me what was the order. I read back the order. 50mg/ml- give 500mg/ml but the bottle has 500 mg per 10 ml (in 50mg/ml). She told me I need 10 vials of 50mg/ml which will give 500mg/10ml and dilute it with 100ml of normal saline (0.9% sodium) to give it to patient with a rate of 100ml/hr (hour). I read back the order to (name of pharmacist) just as she had instructed me and she said that was right, and I should administer the medication. I also told her all the 10 vials should be given at once and she said yes put all the 10 vials into 100 ml of 0.9% sodium chloride and give it to the patient. I drew the 10 ml of each vial and put it in the 100 ml of sodium chloride (0.9%) and runs [sic] it at the rate of 100ml/hr. Resident was stable after administration and all vitals was within normal limit. At about 3:00 a.m. [DATE] writer hear [sic] resident calling for help and when assess [sic] she was having difficulty breathing and her oxygen of 87% on RA (room air). I call [sic] supervisor and we put on oxygen 2 liters via NC (nasal cannula) and oxygen came up to 96%. She was admitted with SOB (shortness of breath), wheezing, chest congestion, I ask {sic} supervisor if we could give her neb (nebulizer) treatment. I notified NP (Nurse Practitioner) (name) and she said will f/u (follow up) with resident when she come [sic] to the facility in the morning.<br><br>The pharmacist who LPN #3 spoke to on [DATE] was not available for interview during the survey. An email sent from the pharmacy account manager to the facility Director of Nursing on [DATE] documented, Spoken to (name of pharmacist) in regards to the verbal instruction that was given to the nurse. She cannot recall the name of the nurse. She confirmed with the nurse twice of what vials she received from the outside pharmacy and was told that the vial says 50mg/ml. Also asked if it was a powder or solution- nurse indicated that it was already a solution. After confirmed that there was no allergies, (name of pharmacist) proceeded to tell her that she will need to withdraw 10 mls from the vials and put it in the 100 ml normal saline bag and infuse that over 60 minutes.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A final summary of a facility synopsis of events dated [DATE] documented, This serves as the final report relating to the facility-reported incident sent to you on [DATE] concerning (R1), who was given an overdose of her IV Acyclovir medication in error by her assigned nurse .On [DATE], the patient was admitted to the facility with orders for Acyclovir 500mg injection every twelve (12) hours for ten (10) days. On [DATE] at approximately 2:30am, the nurse reported that the patient completed her first dose of the medication. At approximately 3:00am, the nurse stated that the patient called for assistance. Upon assessment, the patient was reportedly having difficulty. At this time, the patient's oxygen level was reported to be 87%. The nurse supervisor was notified and ordered Ipratropium Bromide 0.5mg and Albuterol Sulfate 3mg via nebulizer. At approximately 7:00am, the patient was noted with shortness of breath and confusion. At this time, the provider was notified, assessed the patient, and ordered for the patient to be sent to the (name of hospital) Emergency Department (ED). The patient's responsible party (RP) was also notified at this time. The patient was admitted to (name of hospital) for acute kidney injury (AKI). Upon investigation, the nurse who administered the dose of IV Acyclovir 500mg was questioned and stated that she administered ten (10) vials of the medication. When asked why she administered this amount of the medication, the nurse stated that she spoke with a representative of the facility's contracted pharmacy who instructed her to administer this dosage. The nurse was unable to offer an explanation as to why she did not attempt to clarify the medication order with the provider, nurse supervisor, or Director of Nursing. The nurse associated with the medication administration error was, therefore, suspended pending further investigation, and later terminated as a consequence of the outcome of the investigation. A report to the Virginia Board of Nursing has been filed as a result of this error. The facility spoke with the pharmacy representative with whom the nurse consulted, who stated that she instructed the nurse to withdraw the correct amount of medication for infusion. It was reported to the facility that the patient expired in the hospital after the family elected comfort measures on [DATE]. As a result of this incident, a quality improvement process has been initiated to include a review of the facility's IV Therapy policy, a review of the orders of all patients on IV therapy, the observation of the administration of IV medications for nurses with patients on IV therapy, in-servicing to all nurses on IV medication administration, and an ongoing QA (Quality Assurance) audit on all patients on IV therapy to ascertain that dose directions are clear and that no medication error has occurred .<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A facility 5-step action plan with a compliance date of [DATE] documented, 5-STEPS ACTION PLAN: IV THERAPY MANAGEMENT. The Situation: On [DATE] a medication administration error occurred involving (R1), who was given the wrong dose of IV Acyclovir sodium 500mg for encephalitis .Plan: 1. (R1) was assessed by the attending Nurse Practitioner and RP was notified on [DATE]- NP ordered for the patient to be transferred to the ER for further evaluation. Patient transferred to theER on [DATE] and was admitted for AKI. Administrative disciplinary measures initiated against the nurse associated with the medication error. IV Therapy policy reviewed and revised accordingly on [DATE] to prevent similar medication errors in the future. 2. All patients are at risk. Nursing management will review MAR of all patients on IV therapy to ensure dose directions are clear and that there has not been any error in the administration of their IV medications. Nursing management to observe the administration of IV medication for nurses with patients on IV therapy. 3. DON/UMs (Unit Managers)/Appropriate Designee to in-service the nurses on the following: a) NURC-020: Intravenous Therapy policy and procedures. b) Six rights of medication administration- right resident, medication, dose, time, route, and documentation. c) IV therapy protocol as per policy number NURC-020. d) Managing IV therapy. 4. Nursing management will audit 10% of all current patients on IV therapy weekly x 4 weeks and then monthly to ascertain that the dose direction is clear, and no medication error has occurred. Any noted deficient practice will be corrected immediately as appropriate. Result of the audit will also be forwarded to the Weekly Risk Meeting for further review/guidance until the meeting determines that the audit is no longer needed. 5. Date of compliance: [DATE]. All credible evidence regarding the action plan was reviewed and verified during the survey.<br><br>On [DATE] at 8:38 a.m., ASM (administrative staff member) #2 (the Director of Nursing) presented a vial of Acyclovir and stated that was the medication that was administered to R1. The label on the vial documented, ACYCLOVIR SODIUM INJECTION. 500 mg per 10mL* (50 mg per mL). *Each mL contains acyclovir sodium equivalent to 50 mg acyclovir.<br><br>On [DATE] at 9:37 a.m., an interview was conducted with ASM (administrative staff member) #3 (the Nurse Practitioner). ASM #3 stated that prior to [DATE], she had not seen R1 but knew the resident's name because R1 was admitted to the facility during the previous week but was transferred back to the hospital because the facility could not obtain the resident's medication. ASM #3 stated R1 returned to the facility and was on the nurse practitioners' list to be evaluated but had not been seen (prior to [DATE]). ASM #3 stated that on [DATE], the manager asked her to see R1 because the resident was in distress and the staff figured out the resident had been given ten times the prescribed dose of Acyclovir. ASM #3 stated R1 presented with an altered mental status and labored breathing and was sent to the hospital.<br><br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 12:42 p.m., an interview was conducted with ASM #1 (the Administrator) and ASM #2 (the Director of Nursing). ASM #2 stated that R1 was admitted to the facility but then sent back to the hospital because the facility could not obtain the resident's medication. ASM #2 stated that the day prior to R1's return to the facility, the admissions coordinator stated the resident was coming to the facility from the hospital with 20 vials of Acyclovir and the medication could be administered at the facility. ASM #2 stated that on [DATE], a nurse said R1 only had ten vials of Acyclovir, so he checked the medication and confirmed there was only ten vials present. ASM #2 stated he was concerned there was a medication error, so he assessed R1, and she didn't look right so he told the nurse practitioner who assessed R1 and decided to transfer the resident to the ER. ASM #2 stated he spoke with LPN #3 who stated she administered ten vials of Acyclovir. ASM #2 stated LPN #3 was focused on the vial containing 50 milligrams per one milliliter and ignored the vial was a ten-milliliter vial. ASM #2 stated LPN #3 thought there was one milliliter in each vial and confused one milliliter with one vial. ASM #1 stated LPN #3 spoke with the pharmacist and the pharmacist was clear with what she instructed LPN #3 to administer but LPN #3 misunderstood the pharmacist's instructions. ASM #1 stated his assessment was that LPN #3 sincerely misunderstood milligrams, milliliters, and vials.<br><br>On [DATE] at 1:00 p.m., ASM #1 and ASM #2 were made aware of the above concern and the concern for harm.<br><br>The facility policy titled, Intravenous Therapy documented, The facility will adhere to accepted standards of practice regarding infusion practices. Only licensed nurses will perform IV infusion therapy .Intermittent Medication Infusion: 1. Review and verify practitioner's order for infusion solution or medication, dose, frequency, and route of administration .6. Compare medication/solution label against the order for accuracy .<br><br>References:<br><br>(1) Acyclovir injection is used to treat herpes simplex (a herpes virus infection of the skin and mucus membranes), herpes zoster (shingles; a rash that can occur in people who have had chickenpox in the past), and herpes simplex encephalitis (brain infection with swelling caused by the herpes virus). This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681036.html.<br><br>(2) Ipratropium bromide is used to prevent wheezing, difficulty breathing, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html.<br><br>(3) Albuterol sulfate is used to prevent wheezing, difficulty breathing, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html.<br><br>PAST NON-COMPLIANCE |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>31753<br><br>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to implement infection control practices for one of five residents in the survey sample, Resident #3.<br><br>The findings include:<br><br>For Resident #3 (R3), the facility staff failed to implement enhanced barrier precautions (a gown) while administering IV (intravenous) medication to the resident.<br><br>A review of R3's clinical record revealed a physician's order dated 5/15/24 for enhanced barrier precautions for the resident's PICC (1) line on the left upper arm, and a physician's order dated 5/15/24 for Unasyn (2) three grams IV every six hours for empyema (3).<br><br>On 6/4/24 at 8:26 a.m., LPN (licensed practical nurse) #2 was observed administering IV Unasyn to R3. LPN #2 did not wear a gown while administering IV medication to R3. A sign on R3's door documented, ENHANCED BARRIER PRECAUTIONS. EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities. Device care or use: central line .<br><br>On 6/4/24 at 9:19 a.m., an interview was conducted with LPN #1. LPN #1 stated that when a resident has an IV line, the staff are supposed to follow enhanced barrier precautions and wear gloves and a gown while administering IV medications. LPN #1 stated the nurses are in contact with a lot of residents and an IV line goes to a resident's vein, so enhanced barrier precautions are supposed to protect that resident.<br><br>On 6/4/24 at 1:00 p.m., ASM (administrative staff member) #1 (the Administrator) and ASM #2 (the Director of Nursing) were made aware of the above concern.<br><br>The facility policy titled, Enhanced Barrier Precautions documented, 'Enhanced barrier precautions' refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO (multidrug-resistant organism) as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The Centers for Disease Control and Prevention documented, Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). Assuming Contact Precautions do not otherwise apply, Enhanced Barrier Precautions are recommended for residents with any of the following: 1) infection or colonization with a MDRO or 2) a wound or indwelling medical device, even if the resident is not known to be infected or colonized with a MDRO. While prior iterations of the Enhanced Barrier Precautions guidance were intended for use solely during public health response activities, Enhanced Barrier Precautions are currently recommended to be used broadly, in all units across the whole facility, for residents who meet the above criteria. This broader application includes facilities where targeted MDROs have not yet been identified and is intended to minimize the transmission of MDROs in nursing homes. This information was obtained from the website: https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html#:~:text=Enhanced%20Barrier%20Precautions%20are%20an%20infection%20control%20intervention,transmission%20of%20multidrug-resistant%20organisms%20%28MDROs%29%20in%20nursing%20homes.<br><br>References:<br><br>(1) A peripherally inserted central catheter (PICC) is a long, thin tube that goes into your body through a vein in your upper arm. The end of this catheter goes into a large vein near your heart. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000461.htm.<br><br>(2) Unasyn is used to treat certain infections caused by bacteria. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693021.html.<br><br>(3) Empyema is a collection of pus in the space between the lung and the inner surface of the chest wall (pleural space). This information was obtained from the website: https://medlineplus.gov/ency/article/000123.htm. |