STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105711	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SINAI PLAZA NURSING & REHAB CENTER	**201 NE 112TH STREET MIAMI, FL 33161**

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 0755 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the provision of medication to meet the needs of each resident. This was evidenced by the failure to implement a procedure for acquiring, administering and monitoring the administration of medication in a timely manner for 1 of 1 sample residents (Resident #1) who requires ongoing long term [MEDICAL CONDITION] and pain management treatment for [REDACTED]. The findings include: In an interview with Resident #1 on 9/2/2020 at 12:00 PM, the resident was observed sitting in a motorized wheelchair. She was alert, oriented and able to express her thoughts when questioned about her health status. The resident stated that she had a [DIAGNOSES REDACTED]. Resident #1 stated that the medications allows her to be comfortable, but at times she also relied on pain medication. She stated that she was very concerned since she had not been consistently receiving the prescribed [MEDICAL CONDITION] medications for months. Resident #1 stated that she had personally made phone calls to her Oncologist's office in an attempt to obtain the medications and she had discussed the situation with the facility management staff. Review of Resident #1's medical records indicated the resident medical [DIAGNOSES REDACTED]. The records indicated that Resident #1 is confined to a wheelchair and is unable to ambulate. The record further indicated that the resident is prescribed [MEDICATION NAME] for pain as needed. Review of Resident #1's Oncologist [MEDICAL CONDITION] plan/order dated on 1/13/2020 indicated the resident was ordered Revlimid (Lenalidomide) 10 milligram (mg) by mouth for a 28 day cycle, which consisted of a daily dose for 21 days and then off 7 days. The order indicated a continuous repeating cycle every 28 days. Additionally, the order indicated Resident #1 was to receive [MEDICATION NAME], given in a cycle of 40 mg orally daily for 4 days, Day 1-4 then off 4 days, Day 5-8. Then repeat the cycle, administering the medication on Day 9-12 and off Day 13-16 and then again administer on Day 17- 20 and off Day 21-24. The order indicated to repeat this medication cycle. Review of a nursing progress note for Resident #1, dated on 2/14/2020 indicated the resident visited her oncologist and had begun the [MEDICAL CONDITION] treatment of [REDACTED].#1 was complaining of a headache and the Oncologist ordered the medications to be held until a follow up appointment could be conducted on 2/21/2020. Review of Resident #1's February 2020 electronic Medication Administration Record [REDACTED]. Further view indicated no order to stop or restart the medication. Further review of the February 2020 MAR indicated [REDACTED]. Review of the February -March 2020 MAR indicated [REDACTED]. Further review of the electronic March 2020 MAR indicated [REDACTED]. Additionally, the March 2020 MAR indicated [REDACTED]. In an interview with the Director of Nursing on 9/3/2020 at 9:00 AM she provided documentation of nursing progress notes, which reflected contact with the resident's oncologist on 2/14/2020. The documentation indicated the next contact made was on 5/27/2020. Review of Resident #1's April 2020 electronic MAR indicated [REDACTED]. Review of Resident #1's May 2020 electronic MAR indicated [REDACTED]. Review of the facility nursing progress note dated on 5/27/2020 indicated a telemedical consultation between Resident #1 and Oncologist was conducted and no changes were made to the resident's medication orders. Review of Resident #1's Oncologist office note dated on 5/27/2020 indicated the resident was seen via telehealth. The note indicated Resident #1 remains on [DIAGNOSES REDACTED] medication regimen -Revlimid/ [MEDICATION NAME]. The note further indicated the facility nurse was requested to send recent blood work results for review and Resident#1 was to be seen again in 4 weeks. Review of Resident #1's June 2020 electronic MAR indicated [REDACTED]. The resident received the [MEDICATION NAME] medication only 4 days, on 6/1- 6/4/2020. Review of the nursing progress notes from June 2020 indicated no documentation of any notifications to the oncologist to discuss any missed medication doses. Review of Resident #1's Oncologist office note dated on 6/26/2020 indicated the resident was seen via telehealth. The note indicated Resident #1 remains on [DIAGNOSES REDACTED] medication regimen -Revlimid/ [MEDICATION NAME]. The note stated that the nursing home will send recent blood work results to the office and the resident was to continue on the medication regimen. Review of Resident #1's July 2020 electronic MAR indicated [REDACTED]. Review of the nursing progress notes for July 2020 revealed no documentation of any notifications to the Oncologist to discuss any missed medications. Review of Resident #1's Oncologist office note dated on 7/24/2020 indicated the resident was seen via telehealth. The note indicated Resident #1 remains on [DIAGNOSES REDACTED] medication regimen -Revlimid/ [MEDICATION NAME]. The note indicated Resident #1 was complaining of mild to moderate intermittent bone pain over the past few days. The note further indicted that Resident #1 had not taken her medication regimen for the past 2 weeks and was waiting for medication delivery from the pharmacy. The note indicated that the oncologist ordered a bone scan due to the resident's complaint of pain and the resident was to be seen for a follow-up visit in 2 weeks. Review of the facility nursing notes for August 2020 indicated no documentation of the bone scan being completed. The nursing notes indicated on 8/4/2020 the resident complains of pain that is not relieved by prescribed pain medications. The resident is transferred to the hospital for evaluation of abdominal pain and then readmitted back to the facility on [DATE], with treatment orders including abdominal ultrasound and [MEDICATION NAME] antibiotic therapy. In an interview with the Nurse Manager for Unit A on 9/2/2020 at 9:45 AM, she stated that Resident #1 had a [DIAGNOSES REDACTED]. The Nurse Manager stated that the Revlimid medication was supplied by an outside pharmacy, not the contracted facility pharmacy, and therefore when the Revlimid needed to be reordered, the Oncologist would be called each time to place an order with the specialty pharmacy. The Nurse Manager further stated that she was unaware of any specific procedure to procure/ receive specialty medications and there was no documentation of any contacts made to the Oncologist or the pharmacy in an attempt to refill the prescription. The Nurse Manager stated she was unaware that Resident #1 had not been consistently receiving her [MEDICAL CONDITION] treatments as ordered by the Oncologist. In an interview with the facility Consultant Pharmacist on 9/2/2020 at 2:25 PM, she was informed of the surveyor findings related to the procurement and administration of Resident #1's [MEDICAL CONDITION] medications. The Consultant Pharmacist stated that the Revlimid, most likely, was not available from the facility's contracted pharmacy and therefore the medication would need to be reordered on an as needed bases. She stated that she was aware that Resident #1 was prescribed Remlivid, but was not aware that the resident had not been administered the medication as prescribed. The pharmacist stated that since it was a specialty medication, she expected nursing documentation of when a refill order was placed and when the medication was received by the facility. She stated that the missed doses of Remlivid and [MEDICATION NAME] for Resident #1 should be investigated and a plan implemented to prevent this from re-occurring in the future. She stated that she would expect to see documentation of nursing notification to the Oncologist of any missed doses or concerns related to the prescribed [MEDICAL CONDITION] treatment. In an interview with Resident#1's Oncologist on 9/2/2020 at 3:20 PM, he stated that Resident #1 had the [DIAGNOSES REDACTED]. The Oncologist stated that the regimen was a continuous cyclical treatment consisting of Revlimid 10 mg by mouth for 21 days and then pause/ off for 7 days and then resuming the medication. The Oncologist stated that the [MEDICATION NAME] 40 mg was to be administered daily for 4 days, then paused for 4 days and resumed for 2 more cycles. The Oncologist was informed by the surveyor of the findings for numerous missed doses of the Revlimid and

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

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.

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F 0755 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) [MEDICATION NAME] over a 7 month period of time. The Oncologist stated that the treatment regimen should be given as ordered, and Resident #1 had a chronic [DIAGNOSES REDACTED]. The Oncologist stated that Resident #1 had informed him in July 2020 about missed medication doses and he had spoken directly with the facility nursing staff to address the reordering issue. The Oncologist stated that he had requested specific blood work to determine how Resident #1 was responding to her medication regimen, but he had not received the results for months. Review of the facility's policy on Administering Medications dated 12/2012 indicated that medications must be administered in accordance with the orders, including any required time frame. Review of the facility's Medication Utilization and Prescribing Clinical protocol dated 9/2012 indicated that the consultant pharmacist can help by reviewing facility medication usage patterns and trends and by intensifying medication reviews of individuals taking medications that present higher risks. In an interview with the Administrator and Director of Nursing (DON)on 9/2/2020 at 4:30 PM, the DON reviewed Resident #1's [MEDICAL CONDITION] medication orders dated 1/13/2020 for Revlimid and [MEDICATION NAME] and she stated that she was unaware that the medications required a continuous cyclical administration regimen. She stated that she had not contacted Resident #1's Oncologist to clarify any orders and was unaware that Resident #1 had not been consistently receiving her [MEDICAL CONDITION] medications as ordered. The Administrator stated that he recalled some discussion months ago about the procurement of the [MEDICAL CONDITION] medication, Revlimid for Resident #1 but he could not describe the facility's policy/ procedure for obtaining the medication. Both the Administrator and the DON stated they would immediately contact Resident #1's Oncologist and formulate a plan to correct any issues with procuring, administering and monitoring the administration of Resident #1's [MEDICAL CONDITION] medication regimen.