STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455871	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LYNWOOD NURSING AND REHABILITATION LP	**803 S ALAMO LEVELLAND, TX 79336**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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** Based on observation, interview and record review, the facility failed to ensure that its Residents are free of any significant medication errors, in that: a)The facility failed to ensure that 1 of 4 residents (Resident #1) on antipsychotic medications was not free of significant medication errors. Resident #1 was not administered her physician ordered [MEDICATION NAME] 120mg daily for 22 days (3/26/20 thru 4/16/20) due to staff misinterpretation of a telephone order. These problems could result in residents experiencing medication withdrawal side effects. The findings include: Background: Record review of the admission record and current clinical record for Resident #1 revealed that she was admitted to the facility on [DATE] and was discharged to the hospital on [DATE]. The resident was [AGE] years old and had [DIAGNOSES REDACTED]. site, Abnormal reflex, [MEDICAL CONDITION], unspecified, Morbid (severe) obesity due to excess calories, Chronic [MEDICAL CONDITIONS], Abrasion of abdominal wall, sequela, and [DIAGNOSES REDACTED]. On 4/22/20 at 12:52 PM a resident tour began with LVN #4. She stated that Resident #1 fell and was currently in the hospital. She also added that the resident had behaviors, was [MEDICAL CONDITION] and hallucinated. [MEDICATION NAME] Order History and Information: Record review of the Physician Order Report: 2/1/20 - 2/29/20 revealed an order for [REDACTED]. The order originated from Physician #1. Record review of the pharmacy consultant reports for February 2020 thru April 2020 revealed a note to attending physician/prescriber dated 2/14/20 with a recommendation that stated, This resident is currently receiving [MEDICATION NAME] 120 mg once a day . Please evaluate the current regimen and consider a dose reduction to [MEDICATION NAME] 80 mg once a day. The physician, Physician #1 agreed to the recommendation on 2/25/20. Record review of the telephone orders for Resident #1 revealed an order on 2/29/20 at 10:35 AM that stated, Discontinue [MEDICATION NAME] 120 mg. Start [MEDICATION NAME] 80 mg at bedtime . This order originated from Physician #1. Record review of the telephone order dated 3/17/20 1319 revealed an order that stated, Discontinue [MEDICATION NAME] 80 mg QHS for a [DIAGNOSES REDACTED].#1. Further record review of telephone orders for Resident #1 revealed an order dated 3/17/20 at 1319 that stated, Increase [MEDICATION NAME] to 120 mg QHS. [DIAGNOSES REDACTED].#1. Record review of the handwritten portion of the Medication Flowsheet for Resident #1 dated 3/1/20 through 3/31/20 revealed that on the PRN medications flowsheet the resident received [MEDICATION NAME] 80 mg QHS from 3/1/20 through 3/16/20. It was further documented that the 80 mg [MEDICATION NAME] was discontinued on 3/17/20. Also documented on a PRN medication flowsheet for the resident revealed an order for [REDACTED]. This documentation was written by LVN #1. Record review of the Psychiatric Service #1 (Psychiatrist #1) report dated 3/25/20 revealed the following documentation, . Unless noted otherwise, a [MEDICAL CONDITION] gradual dose reduction (GDR) is contraindicated. Plan. Continue current medication any attempted dose reduction would likely impair the patient's function, increased distress behavior, or cause psychiatric instability by exacerbating and underlying psychiatric disorder . Physician knowledge of previous failed dose reduction attempts not included in resident nursing home chart. Failed GDR [MEDICATION NAME] 2/25/20. Primary care changes. PCP (Primary Care Physician) decreased [MEDICATION NAME] per pharmacy consultant and then had to increase back to regular dose due to hallucinations and delusions . Record review of the telephone orders for Resident #1 revealed that on 3/25/20 there was an order from Psychiatrist #1/Psychiatric NP #1 that stated, Failed GDR to [MEDICATION NAME] 2/25/20. [MEDICATION NAME] 0.5 mg QHS X 7 days. May give extra dose now . [DIAGNOSES REDACTED]. Record review of the Medication Flowsheet for Resident #1 dated 4/1/20 thru 4/30/20 revealed no documentation that the resident received [MEDICATION NAME] 120 mg at bedtime for her [MEDICAL CONDITION] disorder, [MEDICAL CONDITION] type. It documented that the order started on 3/17/20 but there was a handwritten note that stated that it was Discontinued on 3/25/20. Further record review of the medication flowsheets revealed additional handwritten documentation that stated [MEDICATION NAME] 120 mg QHS for a [DIAGNOSES REDACTED]. It was noted that this was administered to the resident on 4/17/20 through 4/19/20. Record review of the Physician Order Report: 4/1/20 - 4/30/20 revealed an order that stated [MEDICATION NAME] 120 mg one tab for [DIAGNOSES REDACTED]. It was ordered by Physician #1 with a start date of 3/17/20. Record review of the telephone orders for Resident #1 revealed that there was an order dated 4/14/20 for [MEDICATION NAME] 5 mg QHS for acute [MEDICAL CONDITION] and [MEDICAL CONDITION] by Physicians #2 and #1. Record review the telephone orders for Resident #1 revealed that there was an order dated 4/17/20 at 1400 for [MEDICATION NAME] 120 mg QHS . The telephone order was from Psychiatric PA #1 for a [DIAGNOSES REDACTED].#1 clinical record, telephone orders, physician orders, pharmacy consultant reports revealed no evidence of a physician initiated discontinue order for [MEDICATION NAME] 120 mg (3/25/20 thru 4/16/20). On 4/22/20 7:38 PM the DON was asked if there was a discontinue order for Resident #1's [MEDICATION NAME] 120mg daily, she stated, There was never a discontinue order for the [MEDICATION NAME]. They (Physicians/PAs) didn't DC it. She further stated on 4/22/20 at 8:10 PM, I clarified it with Psychiatric PA #1 and she says she did not discontinue it. Order Misinterpretation Related to [MEDICATION NAME]: On 4/22/20 at 8:35 PM an interview was conducted with LVN #3 regarding the [MEDICATION NAME] orders for Resident #1. She stated, When I left and was off, it happened. I came back, and LVN #1 said that the [MEDICATION NAME] needed to be canceled. She said no one reviewed the chart. She said, She does not need an order to discontinue the [MEDICATION NAME]. It was a big mess when I came back. She said we were idiots and that Resident #1 didn't need to be on [MEDICATION NAME] anymore because of her lab work. When asked if the discontinue order was found she stated, It wasn't anywhere. I never saw a DC order. LVN #1 was supposed to go in and put in the order. She (Resident #1) didn't get it,([MEDICATION NAME]). She (LVN #1) said you don't need an order. She took it upon herself and canceled the order without the providers permission. She said we were idiots to start up the [MEDICATION NAME] again. She was going off of a failed treatment (GDR). LVN #1 said, 'On elevated labs you don't need an order.' I think she (Resident #1) had an elevated creatinine and BUN. LVN #1 wrote the DC order. The LVN was then asked if Resident #1 behavior had changed. She stated, They (staff) say before she went to the hospital her behaviors were worse. She sat on the floor and picked at her scabs. On 4/22/20 at 8:53 PM an interview was conducted via telephone with LVN #1 regarding Resident #1 [MEDICATION NAME] orders. She stated, It ([MEDICATION NAME] discontinue order) came from a pharmacy recommendation. That she failed the GDR. The Physician approved the discontinuation of [MEDICATION NAME]. LVN #4 restarted the [MEDICATION NAME]. I told her she should not be on it because of the (GDR) test. They started her on [MEDICATION NAME] for seven days and then they were to reevaluate it. I showed it (DC order) to LVN #4. I know it was there Saturday or Sunday morning. On 4/28/20 at 7:10 AM an interview was conducted with LVN #1 regarding Resident #1s' [MEDICATION NAME] order. She stated, I looked in the chart and it was actually the Xarelto order I saw. On 3/25/20 (LVN #3) wrote the DC order for [MEDICATION NAME]. Record review of the 24-hour report dated 3/25/20 revealed documentation that stated, Discontinue [MEDICATION NAME]. Change to [MEDICATION NAME] 0.5 mg QHS x 7(days) Resident #1. This sheet was signed by the 6P to 12A LVN #1. On 4/22/20 at 9:15 PM LVN #2 was interviewed regarding documentation on a 24-hour report that she made on 3/25/20 stating that [MEDICATION NAME] was discontinued for Resident #1. She stated, I didn't write it. They told me that in report. On 4/22/20 at 9:25 PM the DON stated She (LVN #4) said 'It's that telephone order dated 3/25/20 that's in the chart (she was told was the dc order)'. It does not state it's a DC order for [MEDICATION NAME] it states the resident failed the GDR. Also, at that time the DON looked through the pharmacy consultant recommendations regarding Resident #1 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 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) was unable to find any recommendation stating to discontinue or recommend discontinuing the [MEDICATION NAME]. She also could not locate any pharmacy recommendations signed by the physician agreeing to discontinue the [MEDICATION NAME] after 3/25/20. On 4/27/20 at 4:26 PM an interview was conducted with LVN #4. She was asked what LVN #1 had shown her as a discontinue order for [MEDICATION NAME] for Resident #1. She stated, She opened the chart and pointed at it and it said [MEDICATION NAME] and then she closed the chart. I went back on Sunday and looked at the chart again and what she had pointed out was the telephone order saying the resident had failed the [MEDICATION NAME] GDR. Medication Administration Related In-services: On 4/27/20 at 9:07 PM an interview was conducted with LVN #1. She was asked if she or any of the nurses had received any retraining or in-service regarding procedures related to orders after Resident #1 [MEDICATION NAME] medication error. She stated, They did have an in-service on orders procedures. It talked about writing orders out and calling the physician to clarify an order if needed. LVN #1 stated that the date on the in-service was 4/23/20. She stated that she had just returned to work today so she received the in-service materials on 4/27/20. Record review of the facility in-service dated 4/23/20 revealed an in-service was conducted regarding medications order guidelines in which nurses and medication aids attended. Attached to the in-service was the facility's policy regarding medication administration which stated that medications will be administered and documented as ordered by the physician and in accordance with state regulations. Record review of an email sent by the DON on 5/01/20 at 12:19 PM revealed that the most current in-service related to medications, since 4/23/20, was given by the RN #1 on 11/04/2019 and the pharmacy consultant on 10/23/18. Record review of the in-service sheet dated 11/04/19 revealed that the topic was Liquid Medication Measuring for Administration. Record review of the in-service sheet dated 10/23/18 revealed the topic was Med Pass. Behaviors: Record review of Resident #1's psychiatric reports, MDS and nurses' notes revealed that there was increased documentation of resident behaviors during the later part of the [MEDICATION NAME] dose reduction period (2/29/20 - 3/17/20) and continued once it was discontinued without a physician's order (3/25/20 - 4/17/20): Record review of the quarterly MDS for Resident #1 dated 3/13/20 revealed there was no documentation of the resident experiencing hallucinations. Record review of the Psychiatric Service #1 report dated 1/23/20 and 2/25/20 20 revealed no documentation of the resident experiencing hallucinations and delusions and the report documented, no adverse effect of [MEDICAL CONDITION] agents. Record review of the Psychiatric Service #1 report dated 3/25/20 revealed the following documentation, Subjective . The patient reports, I'm OK. I am seeing dogs running around in my room. I know it's not real Delusions and hallucinations . Assessment . No adverse effect of [MEDICAL CONDITION] agents. Unless noted otherwise, a [MEDICAL CONDITION] gradual dose reduction (GDR) is contraindicated. Plan. Continue current medication any attempted dose reduction would likely impair the patient's function, increased distress behavior, or cause psychiatric instability by exacerbating and underlying psychiatric disorder . Physician knowledge of previous failed dose reduction attempts not included in resident nursing home chart. Failed GDR [MEDICATION NAME] 2/25/20. Primary care changes. PCP decreased [MEDICATION NAME] per pharmacy consultant and then had to increase back to regular dose due to hallucinations and delusions . Record review of Resident #1 Nurses Notes from 2/11/20 thru 4/16/20 revealed that the resident had a documented increase in behaviors between 3/18/20 and 4/16/20 which included hallucinations. The documentation was as follows: -3/18/20 the resident asked staff if she was going to be arrested. -3/19/20 The resident accused staff of talking about her. -3/24/20 the resident was confused, tearful, agitated and experienced delusion. She stated that staff and residents were having drug parties. -3/25/20 LVN #3 documented a new order that canceled [MEDICATION NAME]. It was also noted the same day on the 6P to 6A shift that the initial dose of [MEDICATION NAME] (for 7 days) was given and that [MEDICATION NAME] was discontinued. This was documented by LVN #1. -3/26/20 the resident was paranoid and had an involuntary mouth and tongue movement. She made unfounded accusations of being given a date rape drug by staff and was hallucinating. The resident stated, They are standing outside my window right now and They are going to send me away. -3/27/20 the resident exhibited paranoid behavior stating staff were talking about her and spoke of a needle with blue liquid being between her toes. -3/31/20 the resident continued exhibiting delusional behavior regarding a staff member giving her a date rape drug. -4/1/20 the resident was talked to by the DON about self-inflicted bruises on her arms and right chest, which she admitted to. -4/3/20 at 1940 the resident was documented as hallucinating and delusional. -4/11/20 the resident had verbal outburst, was delusional and yelling. The resident accused a staff member of killing all the residents. It was also noted that the resident was on the call light. -4/12/20 it was noted that the resident had multiple towels and sheets on her restroom floor and had the restroom call light on. The resident was confused and attempted to give away items. She was paranoid and cursing. The resident stated that staff were talking about her. -4/14/20 the resident exhibited paranoid behavior and stated that staff were out to kill her. Psychiatric PA #1 was contacted and an order for [REDACTED].#1. The resident was exhibiting delusional behavior and stating that she had just gotten off an airplane. On 4/22/20 at 7:30 PM an interview was conducted with LVN #2 regarding Resident #1. She stated, There's been a recent increase in behaviors. It was more pronounced in the last two weeks. We kept Physician #1 informed. Policy: Record review of the facility policy labeled Administration Policy, Nursing Policy and Procedure, Section M, Subject: Medication - Administration, revised 6/2012, revealed the following documentation, Policy. It is the policy of this home that medications will be administered and documented as ordered by the physician and in accordance with state regulations . Record review the facility policy labeled Unusual Occurrences, Nursing Policy and Procedure, Section M, Subject: Medication - Unusual Occurrences, Revised Date: 3/2012, revealed the following documentation, Policy. It is the policy of this home to administer medications within the standards of practice and in compliance with regulatory guidelines .