STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335338	A. Building B. Wing	10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bishop Rehabilitation and Nursing Center	918 James Street Syracuse, NY 13203

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 0624 Level of Harm - Actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37385 Based on record review and interview during the abbreviated survey (NY00284477) conducted on [DATE], the facility failed to provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility in a form and manner that the resident can understand for 1 of 3 residents reviewed (Resident #1). Specifically, Resident #1, who lacked medical decision-making capacity and was non-English speaking, was discharged without a representative present, and their medications were not reviewed or verified at the time of discharge. Resident #1 was discharged with a supply of medications that were ordered for Resident #2. Resident #1 ingested those medications for 7 days after discharge resulting in medical complications from a high potassium level, including bradycardia (low heart rate) and cardiac arrest (sudden stop of the heart) requiring cardiopulmonary resuscitation (CPR, chest compression) and intubation (breathing tube insertion). This resulted in actual harm to Resident #1 that was not Immediate Jeopardy. Findings include: The facility Discharge Plan policy, revised ,d+[DATE], documents: - a post-discharge plan which includes a plan for medications shall be provided to the resident, and/or their representative at the time of discharge. - The post-discharge plan will include current medications, including narcotics, analgesics with the type, dose, and prescribed to the resident discharged ; a description of how the resident and family needs to prepare for the discharge. - Prior to discharge, a reconciliation of all discharge medications is conducted with pre-admission medications, including prescribed and over the counter medications. - Social services or designee reviews the plan with the resident and family before the discharge is to take place. Resident #1 had diagnoses including stage 4 chronic kidney disease, type 2 diabetes mellitus (DM), and chronic obstructive pulmonary disease (COPD). The [DATE] Minimum Data Set (MDS) assessment documented the resident had severe cognitive impairment. (continued on next page)

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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F 0624 Level of Harm - Actual harm Residents Affected - Few	Resident #1's Medical Orders for Life-Sustaining Treatment (MOLST) signed by the physician on [DATE], documented the resident lacked decision-making capacity and a family member was identified as their Public Health Law (PHL) surrogate (immediate family member identified when there was no healthcare proxy). Social worker (SW) #2's [DATE] progress note documented they spoke to the resident's PHL surrogate to review discharge plans for [DATE] and the PHL surrogate and another relative planned to pick up the resident on [DATE] at 2:00 PM. Registered nurse (RN) #6's progress note on [DATE] documented RN #6 spoke to the resident's PHL surrogate about the resident's insulin. The PHL surrogate stated they were comfortable administering insulin and was able to verbally review the steps to doing finger sticks (checking blood sugar) and administering insulin with a pen (injection). There was no documented evidence the facility communicated discharge medication orders (other than insulin) or discharge instructions to Resident #1's PHL surrogate. The [DATE] pharmacy delivery manifest (30 day medication supply to be sent home with the resident), signed as received by RN supervisor (RNS) #9, documented Resident #1's medication order contained a one month supply of the following medications: albuterol sulfate (inhaler), amlodipine (blood pressure medication), atorvastatin (cholesterol medication), clopidogrel (blood thinner), eliquis (blood thinner), isosorbide monotritate ER (extended release, heart medication), nitroglycerin SL (heart medication), semglee (insulin), tamsulosin (prostate medication), tradjenta (diabetes medication), and trazodone (ati-depressant and sedative). In addition, Resident #1's Medication Discharge Form dated [DATE] documented the following discharge instructions which were incorrect as they were not consistent with the resident's physician's orders and/or the ,d+[DATE] Medication Administration Record (MAR): - isosorbide monotritate ER, 30 milligrams (mg) tablet, documented to take as needed on the Discharge Form when the physician's orders documented it was a routine medication to be taken daily. - Eliquis 2.5 mg tablet, 1 tablet twice a day with the next dose due on [DATE]. This was incorrect as it was ordered for twice a day and the ,d+[DATE] MAR documented the resident received only one dose on [DATE]. - Atorvastatin, 40 mg tablet, was crossed off on the Discharge Plan when there was no documentation in the physician's orders that this medication was discontinued. The form had initials (illegible) above the area for the resident's name. Resident #1's [DATE] Discharge Plan Instructions documented: - the medication list was attached, the resident's family member was able to verbalize doing fingersticks and administering insulin, and a copy was given to the resident. - The questions whether skilled education was given and if the resident/responsible party were able to return demonstration was not answered. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	- The above sections of the Discharge Plan were documented as completed by RN Manager #1. - SW #2 documented they completed other sections of the form related to the discharge plan including who the resident was going home with and services needed. - The resident's initials were on the signature line. The [DATE] pharmacy Discharge Acknowledgement of Receipt of Medications form documented: - Resident #1's name, date of birth, and phone number were written on the form and the area for the resident's initials to provide consent and agreement for the pharmacy's services was left blank. - The resident's PHL surrogate was named as the responsible party. - SW #2's name was printed after Signature of Discharging Resident/Responsible Party. - Name and Signature of Facility Staff Member was left blank. The [DATE] nurse practitioner's (NP) Discharge summary documented: - The resident was initially admitted for post-acute care secondary to coronary artery disease after complications with stents, sepsis (infection that spread to the blood) and chronic kidney disease. The resident required temporary hemodialysis. - The resident was medically stable to be discharged to their relative's home in another state. - The discharge medications were well documented in the permanent medical record and a 30-day supply of medications given to the resident. On [DATE], the resident's primary care physician (PCP #8) in the community reported the following to the New York State Department of health (NYS DOH) via email: - Resident #1 was discharged from the nursing facility and moved out of state where PCP #8 took over their care. - Resident #1 came to PCP #8's office on [DATE] for an appointment and brought the discharge paperwork and medications received from the nursing facility. The discharge paperwork included some of another resident's discharge paperwork (Resident #2) and several sheets of Resident #1's discharge paperwork were missing. - PCP #8 reviewed the pill packs Resident #1 received from the facility and noticed there were pills labeled for Resident #2. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	- Resident #1 received medications that were not ordered for them including gabapentin (anticonvulstant), levothyroxine (thyroid medication), and cyclobenzaprine (medication for muscle spasms). PCP #8 noted Resident #1 had chronic kidney disease and was elderly and some of the medications provided could worsen kidney function and are generally unsafe in the elderly. PCP #8 noted levothyroxine in someone with normal thyroid function can cause hyperthyroidism (over-active thyroid function) which can be deadly. - PCP #8 checked the resident's blood work and noted the resident was in renal (kidney) failure possibly related to these medications and had hyperkalemia (high potassium). The resident was referred urgently to the emergency room (ER) where Resident #1 went into cardiac arrest (sudden stopping of the heart), possibly due to elevated potassium levels. During a telephone interview with PCP #8 on [DATE] at 11:18 AM, PCP #8 stated when Resident #1 came to their office on [DATE], their PHL surrogate brought the medications the resident was sent home with from the nursing facility. PCP #8 stated Resident #1's medications were attached to medications for Resident #2. The PHL surrogate stated they gave Resident #1 medications from both of the pill packets (Residents #1 and #2's medications). PCP #8 stated, Resident #1 had taken Resident #2's potassium which was most concerning to PCP #8 as Resident #1 had kidney disease. PCP #8 stated individuals with kidney disease should avoid potassium because the kidneys cannot remove excess potassium. PCP #8 stated the resident's PHL surrogate told them Resident #1 took Resident #2's potassium for 7 days. The resident had bloodwork completed at the office and had a potassium, level of 7.4 milimoles per liter (mmol/L, normal = 3XXX, d+[DATE].2 mmol/L), which indicated a very high risk of cardiac arrest. PCP #8 instructed the resident's PHL surrogate to take the resident to the emergency room (ER) immediately. The resident's potassium had since come down and they were stable, which led the physician to believe the hyperkalemia was related to taking supplemental potassium from [DATE] to [DATE]. PCP #8 stated other factors for the resident's elevated potassium level were ruled out including the need for dialysis and the resident no longer needed dialysis. Resident #2 had diagnoses including anemia, hypothyroidism (low thyroid levels), and anemia. Per the medical record, Resident #2 was scheduled for discharge on the same date as Resident #1 ([DATE]) and the discharge was delayed related to a fall and the need for additional therapy. The [DATE] hospital ER record documented: - the resident presented with weakness and bradycardia (slow heart rate). - At an appointment that morning, it was discovered the resident had been taking medications prescribed to someone else, labs were drawn, and their potassium was found to be 6.7 mmol/L (normal=3XXX,d+[DATE].0 mmol/L) and creatinine (measure of kidney function) was 4.09 mg/deciliter (dL, normal= 0XXX,d+[DATE].2 mg/dL). - In the ER, the resident was put on a cardiac monitor and their heart rate was noted to be in the 20's (normal range = ,d+[DATE]). - During the examination, the resident seized and became unresponsive, went into cardiac arrest, was given one round of CPR (cardiopulmonary resuscitation), intubated (breathing tube inserted), and renal (kidney doctor) was consulted. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	- Hospital laboratory results documented the resident's potassium level was 7.4 mmol/L(normal=3XXX, d+[DATE] mmol/L) on [DATE] at 2:48 AM. - The resident presented with hyperkalemia and was now in the MICU (medical intensive care unit) after suffering bradycardic (low heart rate) arrest likely from hyperkalemia. During an interview with SW #2 on [DATE] at 11:23 AM, they stated their role in the discharge process included setting up the discharge meeting, reviewing home needs, and ensuring services were in place. The facility had a program with the pharmacy to provide residents a 30-day supply of medications at the time of discharge to home. SW #2 was responsible to send residents' orders to the pharmacy within 1 to 2 days prior to discharge so the medications were available residents when they left the facility. SW #2 began the discharge paperwork and other departments (therapy, nursing, etc.) completed their sections of the discharge. Once the discharge paperwork was completed, SW #2 printed the discharge instructions and the nurse reviewed the paperwork with the resident or their representative upon discharge. SW #2 did not review discharge medications, that was done by a nurse at the time of discharge. Resident #1 was limited in speaking English, understood some communication, and the facility utilized the language line or had the family translate when needed. SW #2 stated it would not be appropriate for a staff member to review the discharge paperwork or medication instructions with Resident #1 due to their language barrier. RN Manager #1 stated in an interview on [DATE] at 12:18 PM: - on the day of discharge, RN Manager #1 obtained the 30-day supply of medications from the medication room to be sent home with the resident. - At the time of discharge, RN Manager #1 checked the Medication Discharge form against the physician's orders to ensure there were no discrepancies and highlighted or circled what the resident needed to take later that day or what they already took that day. - RN Manager #1 stated they normally reviewed the Medication Discharge form with the resident and placed the form and discharge instructions in the pharmacy bag with the 30 day supply of medications. If the resident was unable to understand the discharge instructions, the family would be called to review the discharge instructions and this would be documented in the resident's record. Family members were not permitted to the units for discharge related to limiting visitors to the unit due to COVID-19 concerns so RN Manager #1 would review the instructions with the resident, and another staff member brought the resident to the lobby for pick-up. - Resident #1 did not speak English and prior to discharge, RN Manager #1 stated they spoke to the resident's PHL surrogate about the discharge. - Other family members picked the resident up on [DATE] and RN Manager #1 did not see the family or speak to them. - RN Manager #1 stated they reviewed the discharge paperwork with Resident #1 and did not open the bag of medications (30 day supply of medications) or review them as the resident could not speak English. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	- RN Manager #1 stated they did not look in the bag of medications to ensure they were the correct medications as they expected the nurse who received the order from the pharmacy to verify they were correct. - When Resident #1 was discharged on [DATE], RN Manager #1 provided them with their medications, did not see the family, did not look in the bag of medications, and a certified nurse aide (CNA) brought the resident to the lobby. During an interview on [DATE] at 3:20 PM, the Director of Nursing (DON) stated when the 30 day medication supply was received form pharmacy, the receiving nurse was to review the medications and sign the pharmacy form. After hours, this nurse was the RN Supervisor (RNS). During a telephone interview with Resident #1's PHL surrogate on [DATE] at 12:59 PM, they stated: - prior to the resident's discharge, they spoke to a nurse about insulin and checking blood sugar, and no one called them about other medications or discharge instructions. - They stated they live in another state so other family members picked the resident up from the facility. They stated no one from the facility spoke to the other family members at the time of discharge about instructions. - The resident arrived to PHL surrogate's home with 2 pharmacy bags, one with their name on it and one with Resident #2's name, although they did not notice Resident #2's name at the time. Since the pill packets were stapled together, they did not realize the pills were for Resident #2. Both Residents #1 and #2's medications were given to Resident #1 from [DATE] to [DATE]. - One bag also contained discharge paperwork for Resident #2 and a lab report for another unidentified resident. - On [DATE], the resident had an appointment with PCP #8 and the PHL surrogate brought all of the medications to the appointment and at the appointment, PCP #8 noticed some of the medications Resident #1 had been taking were for Resident #2. - Blood tests were completed and the resident had a high potassium level. They went to the ER and shortly after checking into the ER, the resident went into cardiac arrest and had a heart attack. The resident's condition following the heart attack declined, as they now had difficulty swallowing, declined mental status, and could not walk as they could before. They stated they thought the resident would now require another stay in a rehabilitation center before they were able to go home. On [DATE] at 11:55 AM, the resident's PHL surrogate provided photographs of the pill packet sheets given to the resident at the time of discharge from the facility. The photos showed two large pill packet sheets, stapled together with the flat label sides facing in. One pill packet sheet was labeled with Resident #1's name, and the other with Resident #2's name. During a telephone interview with pharmacist #7 on [DATE] at 1:41 PM, they stated Residents #1 and #2 had discharge medications sent to the facility on [DATE]. Discharge medication orders were always packaged separately in different bags and were not stapled together by the pharmacy. (continued on next page)

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F 0624 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with RNS #9 on [DATE] at 11:53 AM, they stated when receiving pharmacy orders, they checked the bag, signed the packing slip and brought the medications to the office. When accepting medication deliveries off-hours, the RNS did not reconcile the orders against the resident's records, as the Nurse Manager would be responsible to do so the following day and/or prior to discharge. During a follow-up telephone interview with RN Manager #1 on [DATE] at 1:39 PM, they stated they were unaware of how Resident #2's medications were in Resident #1's pharmacy bag and did not recall seeing a second pharmacy bag. RN Manager #1 stated they did not review the medications in the bag prior to giving them to the resident and did not staple any pill packet sheets together. They stated they were unaware of how the discharge paperwork for Resident #2 was included with Resident #1's paperwork. The RN Manager #1 stated it was their responsibility to verify the medications and orders prior to sending them home with the resident and they did not do so. During a telephone interview with the DON on [DATE] at 2:15 PM, they stated they were unaware Resident #2's medications were sent home with Resident #1. RNS #9, who received the pharmacy order, was expected to verify the correct medications as well as RN Manager #1, who discharged the resident on [DATE]. The medications and discharge information should always be verified. If a resident lacked capacity or had a language barrier, nursing staff were expected to talk to the representative picking up the resident at the time of the discharge to ensure the correct medications were provided and the family/representative knew what they were. During a telephone interview with the facility's attending physician (physician #10) on [DATE] at 1:27 PM, they stated the resident had chronic kidney disease, was not on dialysis, and taking added potassium could place the resident at risk of hyperkalemia and cardiac arrest. A normal potassium level was between 3.0 to 4. 4 mmol/L and if potassium, was 7.4 mmol/L, the resident would need urgent care. The physician stated they expected nursing to review all medications and instructions with the resident at the time of discharge. If the resident was unable to understand, the caregiver should be fully informed of the medications and instructions. 10NYCRR415.11(d)(3)