STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015023	A. Building B. Wing	06/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hatley Health Care Inc	300 Medical Center Drive Clanton, AL 35045

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, interviews, review of the State Agency's Online Incident Reporting System Report, and a facility policy Medication Administration, the facility failed to ensure licensed staff clarified medication orders for Paxlovid for Resident Identifier (RI) #182. The resident received an order for Paxlovid on [DATE], the Medication Administration Record (MAR) did not match the medication pharmacy label instructions as to give two tablets twice a day; three nurses administered the medication at the incorrect dose for two days before it was determined to be incorrect dose. This affected one of one resident reviewed for receiving Paxlovid. This deficient practice was cited as a result of investigation for complaint/number AL00042087. Findings Include: On [DATE] the facility submitted an incident through the Alabama Department of Public Health (ADPH) Online Incident Reporting System. The report of the incident documented . Name of staff member alleged to be involved: (Names of Employee Identifier's (EI) #10, EI #9 and EI #11) . Date and time of occurrence: [DATE] . Narrative summary of the incident: Resident tested positive for COVID-19 on [DATE]. On [DATE] an order for Paxlovid was written. When medication arrived from the pharmacy, the directions on the box were different from the Medication Administration Record (MAR). The above nurses failed to clarify order with pharmacy/MD. I was notified on [DATE] around 10am that resident had received incorrect doses of Paxlovid (under-dosed) from Friday-Monday. Resident on Paxlovid for COVID-19. Nurse Practitioner (NP) was made aware and saw resident at 11:33AM. Resident was sent to emergency room (ER) on [DATE] at 1pm due to decline in status. Facility received phone call on [DATE] around 2am stating that resident had expired around 12:52am. A review of the facility policy Medication Administration, dated [DATE], revealed . 11. Compare medication source (bubble pack, vial, .) with the MAR to verify resident name, medication name, form, dose, route, and time. 20. report any discrepancies to nurse manager immediately. A review of the medication order on [DATE] read Paxlovid 150/100 Milligram (mg) by mouth BID (Two times a day) x (times) 5 days (reduced dose due to CKD (chronic kidney disease)) GFR 44. This was verbal order by EI #13, the NP written by EI #8. RN. A review of the MAR revealed, Paxlovid (150/100) Tablet Therapy Pack 10 x 150 MG & 10 x 100MG (Nimatrelvir & Ritonavir 150/100) Give 1 tablet by mouth two times a day for COVID 19 . A review of the pharmacy label of the medication revealed, Paxlovid 150-100MG . GIVE 2 TABLETS BY MOUTH 2 TIMES A DAY X 5 DAYS. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RI #182 admitted [DATE] DX congestive heart failure, Malignant neoplasm of kidney, acquired absence of Kidney, and Pacemaker. On [DATE] at 9:03 AM an interview was conducted with EI #8, Registered Nurse (RN) who said she wrote the order but could not recall much about the resident other than what unit the resident was on and that the resident had tested positive for COVID. EI #8 said EI #13, the NP, gave the order, she wrote it as he said which was a reduced dose due to CKD. EI #8 said she did not know anything about the medication nor what a usual dose was. On [DATE] at 9:58 AM and 11:31 AM the surveyor was unable to reach EI #10, Licensed Practical Nurse (LPN), she no longer worked at the facility. EI #10 was the nurse to administer the first dose of paxlovid. On [DATE] at 10:00 AM during an interview with EI #9, LPN said she recalled RI #182's medication label on the medication was different than the MAR but was not and still not familiar with that medication. EI #9 said she gave it as the MAR directed which was one tablet two times a day. EI #9 said it was started the evening before by EI #10. EI #9 said the medication label from the Pharmacy had Paxlovid 150/100 mg give 2 tablets two times a day for 5 days. When EI #9 was asked how did she verify the medication, she said by the MAR, and she did see it said different on the medication pack but she thought since EI #10 had started it the night before she may had forgotten to place a change in directions label on the medication. EI #9 said she should have called the doctor or the pharmacy to clarify the order when it did not match. EI #9 said she did not do that because she thought EI #10 had already done that and forgot to place a label change on the package. EI #9 said she had never given paxlovid before and was not familiar with how to give it, so she gave it how it read on the MAR. EI #9 was asked what the outcome could be if the medication was not given correctly and she stated symptoms may not improve or could worsen. When EI #9 was asked what was the policy related to medication administration. EI #9 said pull up the MAR, get medication from the cart, match medication from cart to the MAR if they do not match, you should clarify any discrepancies and report it to the DON, which she did not do because she thought EI #10 forgot to change the label. On [DATE] at10:56 AM an interview was conducted with EI #15, Pharmacist. During the interview EI #15, said the order for RI #182 was paxlovid 150/100 mg twice a day for five days a reduced dose due to CKD. EI #15 said the usual dose was 300mg and 100 mg which was two tablets twice day. EI #15 said the reduced dose was 150/100 mg also two tablets twice a day for five days. On [DATE] at 11:30 AM during an interview with EI #11, LPN, she recalled RI #182 had paxlovid ordered, and the MAR had one tablet and the package had two tablets. EI #11 said in report EI #10 said it was the reduced dose to give one tablet. EI #11 said she later found out two tablets should have been given and that was the reduced dose. EI #11 said the incorrect dose was given for two days. EI #11 was asked what should she have done to make sure the correct dose was given. EI #11 said when the MAR said one tablet and package said two she should have either called the doctor or the pharmacy for clarification. EI #11 said they should follow the rules of giving medication, which were right resident, right dose, right medication. EI #11 said the concern with RI #182 not receiving the correct dose of medication was RI #182 may not have received the full dose. On [DATE] at 9:49 AM EI #12, LPN was interviewed. she said the order for paxlovid was 150/100 mg twice a day. EI #12 said she was not sure how many tablets were to be given; she recalled the package, and the MAR did not match so she notified the Director of Nursing (DON) and got clarification of the order. EI #12 said she discovered the medication had not been given as ordered when the package (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said give two tablets and the MAR said give one. EI #12 said this was an error because the wrong dose was given. EI #12 said the first nurse that gave the medication should have clarified the order, she was unsure who that nurse was. EI #12 was asked what was not done that may have prevented giving the incorrect dose. EI #12 said clarifying the order. On [DATE] at 2:08 PM during an interview EI #2, DON, who recalled the Paxlovid order for RI #182 was 150/100mg by mouth twice a day for five days. She did not know the usual dose and said the order was determined by the NP and doctor. EI #2 said EI #10 noticed it Saturday morning and did not do anything to clarify the order. EI #2 said the MAR said one tablet and the package said two, the medication was supposed to be two tablets twice a day for five days. EI #2 said the concern with the Paxlovid not given as medication package directed was that the correct dose was not given for two days. EI #2 said the outcome of the investigation was the medication was ordered, two tablets should have been given, only one was given and nurses did not realize two tablets were the correct dose. The nurse entered in quantity one tablet not realizing it was to be two tablets verses one. The pharmacy did not call facility to verify two tablets verse one. It was the fault of the nurse for not clarifying when she saw one tablet on MAR and two tablets on the Pharmacy package. EI #2 said the nurse EI #10 should have clarified the order, and nurses after her that noticed it should have verified it when they noticed it too. EI #2 was asked what was the policy for staff medication administration. EI #2 said compare MAR to resident with their name, medication name, drug strength to medication package or card. EI #2 said to validate nurses should be sure right resident, right medication, and right dose. EI #2 said three nurses gave the medication without clarifying and they noticed one tablet on MAR and two tablets on medication package label. EI #2 said the medication should be validated before giving medication to a resident, and anytime they noticed a discrepancy they should verify the order. EI #2 said if the MAR and the medication label did not match the nurse should verify or clarify the order which could be done by looking in the resident chart at the orders or call the NP or doctor to get clarification. EI #2 said a concern of the nurses giving medication with the MAR and the medication package not matching would be the accurate dose could not be given.