STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, review of facility documentation, facility policy review, and interviews for one sampled resident (Resident #1), the facility failed to accurately transcribe a medication order into the electronic Medication Administration Record which resulted in a change in the resident's condition. The findings include: Resident #1's diagnoses included chronic kidney disease, paroxysmal atrial fibrillation, major depressive disorder, and bipolar II disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 made consistent and reasonable decisions regarding tasks of daily life and required limited to extensive assistance of one person with ADL's. The Resident Care Plan (RCP) dated 06/26/2023 identified Resident #1 potential for alteration in mood secondary to depressive disorder and bipolar disorder. Interventions include administering medications as ordered, and to observe for potential side effects or adverse effects of medications, and consult Psych as needed. A pharmacy medication review dated 06/11/23 identified Resident #1 as receiving Citalopram 40 mg/day (an antidepressant). Citalopram has a maximum recommended dose of 20 mg daily in geriatric patients and in patients concurrently on proton pump inhibitor therapy due to increased exposure and risk of QT prolongation (an arrhythmia). Please consider decreasing this dose to 20 mg per day. A psychiatric physician's order sheet dated 07/03/23 directed to discontinue Citalopram 40 mg every day. Initiate Citalopram 30 mg every day per pharmacy request to GDR (gradual dose reduction) as max dose is 20 mg daily. Ordered was verified by RN #1 on 07/03/23 at 1:00 PM. An electronic physician order created by RN #1 on 07/03/23 at 1:13 PM directed to administer Citalopram 30 mg, by mouth, four times a day for depression (order was written for one time a day). An Order Note generated by the eMAR system signed by RN #1 dated 07/03/23 at 1:18 PM identified this medication order as outside of the recommended dose or frequency. Citalopram Hydrobromide Oral Capsule 30 mg. Give 30 mg by mouth four times a day for depression. The alert indicated the daily dose of 120 mg exceeds the usual dose of 10 to 20 mg. The frequency of 4 times per day exceeds the usual frequency of daily. The single dose of 30 mg exceeds the maximum single dose of 20 mg. The usual dose is 10 to 20 mg. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note written by RN #1 dated 07/03/23 at 1:21 PM identified Resident #1 was seen by APRN #1 today with new orders to decrease daily Citalopram dose to 30 mg daily for depression, as part of pharmacy GDR strategy (maximum dose is 20 mg daily). A Facility Reported Incident form dated 07/14/23 identified Resident #1 was ordered Citalopram 30 mg daily, instead, the order was entered as Citalopram 30 mg four (4) times a day. The error was discovered by Pharmacist #1 who alerted RN #1 of the error. APRN #2 was notified and ordered new interventions for a medication dose change and monitoring. Review of the July 2023 MAR (Medication Administration Record) identified Citalopram 30 mg four (4) times a day was administered accordingly, and Resident #1 received 32 extra doses between 7/4 to 7/14/23. A psychiatric physician's note by APRN #2 dated 07/14/23 identified RN #1 reported Citalopram GDR order was incorrectly entered in eMAR (electronic medication administration record) resulting in a medication error. RN #1 reports Resident #1 is at baseline mentation, mood, and behavior. No change in mental status, vital signs stable. Interventions ordered to start Citalopram 20 mg daily for major depressive disorder and to obtain an EKG (electrocardiography) and BMP (basic metabolic panel). Monitor for sedation, fatigue, GI upset, altered mental status, agitation, restlessness, and monitor for signs and symptoms of serotonin syndrome. Follow-up with primary behavioral health physician. A change in condition progress note dated 07/16/23 at 1:45 PM identified Resident #1 was pale, holding hand on chest, nauseous, fully conscious without mental status change. The resident's Neurological signs were intact, blood pressure was 162/90 , a heart rate of 78, oxygen saturation 93% on room air, a respiratory rate of 18, non-labored respirations, and was anxious. Nitroglycerin 0.4 mg sublingual was administered as ordered, the chest pain not resolved after first dose of Nitroglycerin. Blood pressure 130/72, heart rate 71, nausea resolved, second dose administered after 5 minutes at 12:50 PM and the chest pain resolved. Blood pressure 116/68, heart rate 70, oxygenation 96% on room air, Resident #1 verbalized relief and stated he/she feels much better. Resident #1 transferred to hospital for evaluation. The Hospital Discharge Summary dated 07/16/23 at 7:55 PM identified the EKG did not show any new acute ischemic changes the attending physician spoke with the consultants at the poison center for the overdose of Citalopram. There should not have been an issue as the resident has no significant serotonin symptoms and the last dose was on the 14th, and the medication should have cleared h/her system. All labs and tests were unremarkable, resident is hemodynamically stable and at this point, and Resident #1 was be discharged back to the facility. Review of the medication packs of Citalopram 30 mg dispensed on 07/03/23 for Resident #1 identified the facility received a total of 138 doses for Resident #1. Out of the 138 doses, only 14 doses were administered by nursing staff. Although attempted, an interview with RN #1 was unable to be obtained. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Psychiatric APRN #1, on 8/03/23 at 2:05 PM identified a pharmacy recommendation was made to decrease Resident #1's Citalopram from 40 mg to 20 mg, and her plan was to begin a GDR process and first placed an order for Citalopram 30 mg, monitor for two weeks and if there were no contraindications with the resident, then to order Citalopram 20 mg to finish the GDR. APRN #1 noted signs and symptoms of a Citalopram overdose could include chest pain, but a major symptom would be serotonin syndrome (tremors, fever). This would have caused a significant change in condition and require immediate intervention. APRN #1 indicated Resident #1 went to the hospital two days after the medication error was discovered with chest pains but returned same day with no additional interventions placed and medically showed significant improvement. Interview with the Director of Nursing (DON) on 8/03/23 at 3:15 PM identified the process for transcribing medications for the medical providers (Medical Director, Medical APRN) indicated these providers can input their medications directly in the eMAR, but the Psychiatric providers are still on paper and place their orders in the resident's charts. The DON identified during the investigation process, interview with RN #1 identified that she believed she inputted the order correctly into the system and did not realize the frequency was four (4) times a daily versus daily. The DON noted no staff identified the difference until the facilities Pharmacist Consultant caught the error on 07/14/23 and notified the facility staff who immediately notified the error to APRN #2. Prior to this incident, the facility did not require a second nurse to verify the Psychiatric medication orders. Status post the incident, the facility has updated the policy to include a second nurse verification process and staff have received education regarding the new change. Review of the Transcribing/Noting Orders Policy identified that nursing staff should ensure all components of the medication order exist, including: The order was written in the right chart, the correct form of the medication was ordered, the dosage was appropriate, the correct route was indicated, and the frequency as indicated, and the duration of therapy was indicated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682 Based on clinical record review, review of facility documentation, facility policy review, and interviews for one sampled resident (Resident #1), the facility failed to accurately document a resident's medication administration in the clinical records. The findings include: Resident #1's diagnoses included chronic kidney disease, paroxysmal atrial fibrillation, major depressive disorder, and bipolar II disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 made consistent and reasonable decisions regarding tasks of daily life and required limited to extensive assistance of one person with ADL's. The Resident Care Plan (RCP) dated 06/26/2023 identified Resident #1 potential for alteration in mood secondary to depressive disorder and bipolar disorder. Interventions include administering medications as ordered. Observe for potential side effects or adverse effects of medications. Consult Psych as needed. A pharmacy medication review dated 06/11/23 identified Resident #1 is receiving Citalopram 40 mg/day. Citalopram has a maximum recommended dose of 20 mg daily in geriatric patients and in patients concurrently on proton pump inhibitor therapy due to increased exposure and risk of QT prolongation. Please consider decreasing this dose to 20 mg per day. A psychiatric physician's order sheet dated 07/03/23 directed to discontinue Citalopram 40 mg every day. Initiate Citalopram 30 mg every day per pharmacy request to GDR (gradual dose reduction) as max dose is 20 mg daily. Ordered was verified by RN #1 on 07/03/23 at 1:00 PM. An electronic physician order created by RN #1 on 07/03/23 at 1:13 PM directed to administer Citalopram 30 mg, by mouth, four times a day for depression. An Order Note generated by the eMAR system signed by RN #1 dated 07/03/23 at 1:18 PM identified this medication order as outside of the recommended dose or frequency. Citalopram Hydrobromide Oral Capsule 30 mg. Give 30 mg by mouth four times a day for depression. The alert indicated the daily dose of 120 mg exceeds the usual dose of 10 to 20 mg. The frequency of 4 times per day exceeds the usual frequency of daily. A single dose of 30 mg exceeds the maximum single dose of 20 mg. The usual dose is 10 to 20 mg. A nurse's note by RN #1 dated 07/03/23 at 1:21 PM identified Resident #1 was seen by APRN #1 today, a new order was noted to decrease daily Citalopram dose to 30 mg daily for depression, as part of pharmacy GDR strategy (maximum dose is 20 mg daily). The Facility Reported Incident form dated 07/14/23 identified Resident #1 was ordered Citalopram 30 mg daily, instead, the order was entered as Citalopram 30 mg four (4) times a day. The error was discovered by Pharmacist #1 who alerted RN #1 of the error. APRN #2 was notified and ordered new interventions for a medication dose change and monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. Building B. Wing	08/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cobalt Lodge Health Care and Rehabilitation Center	29 Middle Haddam Rd Cobalt, CT 06414

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the July 2023 MAR (Medication Administration Record) identified Citalopram 30 mg four (4) times a day was administered accordingly, and Resident #1 received 32 extra doses between 7/4 to 7/14/23. Review of the medication packs of Citalopram 30 mg dispensed on 07/03/23 for Resident #1 identified the facility received a total of 138 doses for Resident #1. Out of the 138 doses, only 14 doses were administered by nursing staff. Although attempted, an interview with RN #1 was unable to be obtained. Interview with LPN #1 on 08/03/23 at 1:20 PM identified once she was aware of this event; she was surprised she did not catch it sooner. LPN #1 indicated on some days she would only administer the medication once, and other days as prescribed. LPN #1 was unable to verify which days she did not administer the medication and was unable to state why she documented the medication as administered when it was not. LPN #1 believed there was an error on how pharmacy dispensed the medication but could not explain in what manner the error was. Interview with LPN #2 on 08/03/23 at 3:05 PM identified for Resident #1, she would always prepare the medication with the supervisor, but never administered the medication herself. LPN #2 noted the medication is signed off in her name, but noted it was always the supervisor who would administer the medication. LPN #2 identified on an unknown date, she brought up the question to RN #1 of why Resident #1's Citalopram was being administered four times a day, but RN #1 did not pursue any further action upon notification. Interview with the Director of Nursing (DON) on 8/03/23 at 3:15 PM identified during the investigation process, it was noted that only 14 doses of Citalopram 30 mg were administered, even though nursing staff documented in the eMAR that a total of 44 doses were all administered between 7/4 and 7/14/23. DON indicated that although it seems Resident #1 did not receive all the doses as ordered, it raised another area of concern that nursing staff were not following physician orders. The DON performed education on the five (5) rights of medication administration to all nursing staff status post this incident. Although requested, the facility was unable to provide a documentation policy.