STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105666	A. BUILDING _____ B. WING _____	C 11/29/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANIER TERRACE	12740 LANIER ROAD JACKSONVILLE, FL 32226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey, CCR #2017014139, was conducted on at Lanier Terrace. The facility was not in compliance with 42 CFR 483, Requirements for Long Term Care Facilities. .	F 000		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer physician-ordered medication according to accepted standards of clinical practice for 9 (Residents #1, #3, #4, #5, #6, #7, #9, #10 and #11) of 11 sampled residents. The findings include: During a complaint investigation conducted on , four Licensed Practical Nurses (LPNs) were scheduled to pass medications during the 7:00 a.m. to 3:00 p.m. shift. LPN C and LPN D were assigned to medication carts on the South Unit, and LPN E and LPN F were assigned to medication carts on the North Unit. An interview was conducted with Resident #1 and the resident's son on at 9:00 a.m. The resident was visibly tremulous, especially of the	F 658	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the regulations. Resident #1 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #3 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #4 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #5 was evaluated for adverse side effects	

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

Electronically Signed

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 658	Continued From page 1 upper extremities. Both the resident and son reported that the resident frequently received her anti-Parkinson's medication an hour before or 1-3 hours after it was scheduled to be administered. The son stated that when they reported this to the Director of Nursing (DON), she told them that the nurses could administer the medication up to two (2) hours after it was ordered. Resident #1 complained that due to the variance in the times that the staff administered her anti-Parkinson's medication, she felt that her symptoms were getting worse. She complained about not receiving the medication earlier on this day ( ). A review of Resident #1's Electronic Medication Administration Record (e-MAR) at approximately 9:20 a.m., after the interview, confirmed that the resident had still not received her anti-Parkinson's medication that was scheduled at 6:00 a.m. this morning ( ). In an interview with Employee F, LPN, on at 11:18 a.m., she reported that she was currently administering 9:00 a.m. medications, and that she had started the medication pass at 7:30 a.m. At 11:39 a.m., Employee F reported that she was still currently administering 9:00 a.m. medications, and she showed the surveyor the e-MAR revealing that four residents (Residents #5, #6, #7, and #8) had still not received their 9:00 a.m. medications. An observation of Employee C, LPN, was conducted on at 12:02 p.m. She reported that she was passing 9:00 a.m. medications. At 12:05 p.m., she was observed preparing the medications for Resident #9, and she marked in the e-MAR that the reason for late administration was "charted late". When the surveyor asked Employee C why she chose that	F 658	by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #6 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #7 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #9 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #10 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #11 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. LPN C, D, E and F received in-service on timely medication administration, accurate documentation, and American Nurses Association (ANA) Standards of Practice by ADON on . Other Residents having potential to be affected: All residents receiving medication have the potential to be affected by the deficient practice. In coordination with the medical director, medication administration times have been staggered to ensure that medication is administered in accordance with the	

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F 658	Continued From page 2	F 658		

rationale, she logged back into the system at 12:04 p.m., looked at the options, and changed the reason to "administered late".

Review of the [redacted] 2017 MAR for Resident #11 revealed that her 9:00 a.m. medications were charted at 11:01 a.m., and were noted as "Late Administration, Charted Late, administered on time" by Employee C, LPN.

During an interview at 12:16 p.m. on [redacted] with Employee D, LPN, she stated that she "just completed" her morning medication pass. She reported that she generally did not need to give medication outside of the ordered timeframes, but that if she did give a medication late, she would choose the rationale "charted late" versus "administered late", and would document that the resident was in the shower, or at [redacted] etc.

This surveyor conducted a review of 11 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) e-Mar records for the months of [redacted] and [redacted] 2017, which revealed that medications were administered more than one hour before or after they were ordered on many occasions for 9 (Residents #1, #3, #4, #5, #6, #7, #9, #10 and #11) of 11 residents as follows:

Review of the [redacted] 2017 Medication Administration Record (MAR) for Resident #1 revealed that there were eight (8) days during the month when 9:00 a.m. medications were administered more than one hour before or one hour after they were scheduled. ([redacted], 2, 8, 9, 18, 19, 22, and 29) Review of the [redacted] 2017 MAR revealed that Resident #1's medications were charted as administered late on nine (9) occasions. ([redacted], 4, 6, 10, 11, 14,

standards of practice (Please refer to systemic changes for a detailed description of the staggering of administration times). Licensed Nurses received in-service education related to the new schedules of administration times, timely medication administration, accurate documentation, and American Nurses Association (ANA) Standards of Practice by ADON on [redacted].

Measurements or systemic changes: After review, the facility identified a high volume of medications with 9AM and 5PM administration times. Nursing administration, in coordination with the medical director, reviewed the current medication administration times and developed a plan that involved staggering the 9AM and 5PM administration times of medications. One half of the residents on each hallway received new administration times for 9AM, 5PM, and 9PM doses. The dosage times were approved by and have a corresponding physician's orders. For residents whose times were changed, the new times are now 10AM, 6PM, and 10PM. As with all medications, staff will monitor residents to ensure no adverse effects result from the changing of the administration times. Licensed Nurses received in-service education related to the new schedules of administration times, timely medication administration, accurate documentation, and American Nurses Association (ANA) Standards of Practice by ADON on [redacted].

Monitoring to ensure the deficient practice

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F 658	Continued From page 3 18, and 21) (Evidence obtained) Review of the [redacted] 2017 MAR for Resident #3 revealed that at least one of his daily doses of [redacted], -levidopa 25-250 milligrams (mg) on each day from 2-20, 2017 was administered late or charted late, as evidenced by (AEB) "Late Administration: Charted Late; Comment: given or administered on time." At least one of his daily doses on , 25, 30, and 31, 2017 was administered late or charted late, AEB "Late Administration: Charted Late; Comment: given or administered on time." (Evidence obtained) During medication pass at 11:17 a.m. on with Employee E, LPN, she was observed removing , 5 mg orally for Resident # 4. As she removed the medication for the resident, she clicked the box on the eMAR for administration, and the system flagged the medication as late. Employee E then documented, "Late administration. Med given at 11:21 a.m." This surveyor left Employee E while she continued removing the resident's remaining 9:00 a.m. medication from the cart. The time was 11:39 a.m. Later the same day this surveyor reviewed the MAR for Resident #4. Other medications scheduled at 9:00 a.m. for this resident were reviewed and the following was noted: , was documented at 11:39 a.m., and was noted as "Given on time." , was documented at 11:39 a.m., and was noted "Issues with computer. Given on time." was documented at 11:39 a.m., and was noted "Issues with computer. Given on time." , was documented at 12:14 p.m., and was noted as "Given on time."	F 658	will not reoccur: Audits of medication administration will be conducted at least 2 x a week across all shifts with education measures implemented promptly, if needed, by Unit managers or designee, for 1 month then 1 x a week across all shifts x 1 month. Audits will then be conducted 2 x a month across all shifts for 1 month, then 1 x month across all shifts x 6 months. Findings will be reported to the Director of Nursing or designee. Director of Nursing or designee will review the findings from the audits at monthly QAPI meetings for three months then quarterly x 2 quarters.	

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F 658	Continued From page 4	F 658		

Review of the 2017 MAR for Resident #4 revealed that on 10 occasions, his 9:00 a.m. , / , was administered more than one hour before or one hour after it was scheduled. (Evidence obtained)

Review of the 2017 MAR for Resident #5 revealed that on 6 occasions, her 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. The MAR also revealed three occasions during which her . . . . patch was not applied because it was "not available". (Evidence obtained) The surveyor observed on at 11:39 a.m., that Resident #5 had still not received her 9:00 a.m. medication. Upon reviewing the MAR later in the afternoon, the documentation at 1:26 p.m., indicated that the 9:00 a.m. scheduled medication was administered "on time".

Review of the 2017 MAR for Resident #6 revealed that there were eight occasions during which her 9:00 a.m. medications were administered more than one hour before or one hour after they were scheduled. (Evidence obtained)

Review of the . . . . . 2017 MAR for Resident #7 revealed that on 12 occasions, his 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. (Evidence obtained)

Review of the . . . . . 2017 MAR for Resident #8 revealed that on 11 occasions, her 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. (Evidence obtained)

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F 658	Continued From page 5	F 658		

Review of the 2017 MAR for Resident #9 revealed that the 9:00 a.m. medications were signed off at 12:04 p.m., and were marked as "Late Administration. Administered late."

Review of the 2017 MAR for Resident #10 at 12:48 p.m. revealed that all 9:00 a.m. medications for today ( ) had not yet been marked as given. A re-check of the MAR at 2:20 p.m. revealed that the resident's 9:00 a.m. medications had still not been documented as given. No documentation was present. (Evidence obtained)

Review of the 2017 MAR for Resident #11 revealed that her 9:00 a.m. medications were charted at 11:01 a.m., and were noted as "Late Administration, Charted Late, administered on time" by Employee C, LPN. (Evidence obtained)

A review of the facility's policy and procedure entitled Administering Medications, under section Policy Interpretation and Implementation, stated: #4 - Medications must be administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). It also stated: #3 - Medications must be administered in accordance with the orders, including any required time frame.

In an interview with the South Unit Manager on at 2:15 p.m., she stated that she was unaware that 9:00 a.m. medications were being administered at 12:00 p.m. She stated that she did not perform audits on the times at which medications were administered by the floor

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F 658	Continued From page 6 nurses. In an interview with the Director of Nursing on at 12:47 p.m., she confirmed that it was her expectation that all nurses administer medications within an hour before or an hour after they were ordered. She continued on to say that if the medication was given outside of this time frame, a rationale should be documented. "They shouldn't be documenting administered late/charted late/and given on time, because there's no way to definitively determine when the medication was given. We need to keep accurate records." .	F 658		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		

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F 755	Continued From page 7 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure timely administration of physician-ordered medication to meet the needs of 9 (Residents #1, #3, #4, #5, #6, #7, #9, #10 and #11) out of 11 sampled residents. The findings include: During a complaint investigation conducted on [redacted], four Licensed Practical Nurses (LPNs) were scheduled to pass medications during the 7:00 a.m. to 3:00 p.m. shift. LPN C and LPN D were assigned to medication carts on the South Unit, and LPN E and LPN F were assigned to medication carts on the North Unit. An interview was conducted with Resident #1 and the resident's son on [redacted] at 9:00 a.m. The resident was visibly tremulous, especially of the [redacted] upper extremities. Both the resident and son reported that the resident frequently received her anti-Parkinson's medication an hour before or 1-3 hours after it was scheduled to be administered. The son stated that when they	F 755	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the regulations. Resident #1 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #3 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #4 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #5 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #6 was evaluated for adverse side effects by the unit manager. No side	

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F 755	Continued From page 8	F 755		

reported this to the Director of Nursing (DON), she told them that the nurses could administer the medication up to two (2) hours after it was ordered. Resident #1 complained that due to the variance in the times that the staff administered her anti-Parkinson's medication, she felt that her symptoms were getting worse. She complained about not receiving the medication earlier on this day ( ). A review of Resident #1's Electronic Medication Administration Record (e-MAR) at approximately 9:20 a.m., after the interview, confirmed that the resident had still not received her anti-Parkinson's medication that was scheduled at 6:00 a.m. this morning ( ).

In an interview with Employee F, LPN, on at 11:18 a.m., she reported that she was currently administering 9:00 a.m. medications, and that she had started the medication pass at 7:30 a.m. At 11:39 a.m., Employee F reported that she was still currently administering 9:00 a.m. medications, and she showed the surveyor the e-MAR revealing that four residents (Residents #5, #6, #7, and #8) had still not received their 9:00 a.m. medications.

An observation of Employee C, LPN, was conducted on at 12:02 p.m. She reported that she was passing 9:00 a.m. medications. At 12:05 p.m., she was observed preparing the medications for Resident #9, and she marked in the e-MAR that the reason for late administration was "charted late". When the surveyor asked Employee C why she chose that rationale, she logged back into the system at 12:04 p.m., looked at the options, and changed the reason to "administered late".

Review of the 2017 MAR for Resident

effects were noted. Medication will be provided in accordance with the standards of practice. Resident #7 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #9 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #10 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #11 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. LPN C, D, E and F received in-serviced on timely medication administration, accurate documentation, and Policy and Procedures on obtaining timely refill of medications and/or obtaining medications from Emergency Dispense Kit (EDK) ensure Resident medication needed are met as ordered by ADON on .

Other Residents having potential to be affected: All residents receiving medication have the potential to be affected by the deficient practice. In coordination with the medical director, medication administration times have been staggered to ensure that medication is administered in accordance with the standards of practice (Please refer to systemic changes for a detailed description of the staggering of

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F 755	Continued From page 9	F 755		

#11 revealed that her 9:00 a.m. medications were charted at 11:01 a.m., and were noted as "Late Administration, Charted Late, administered on time" by Employee C, LPN.

During an interview at 12:16 p.m. on with Employee D, LPN, she stated that she "just completed" her morning medication pass. She reported that she generally did not need to give medication outside of the ordered timeframes, but that if she did give a medication late, she would choose the rationale "charted late" versus "administered late", and would document that the resident was in the shower, or at , , etc.

This surveyor conducted a review of 11 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) e-Mar records for the months of and 2017, which revealed that medications were administered more than one hour before or after they were ordered on many occasions for 9 (Residents #1, #3, #4, #5, #6, #7, #9, #10 and #11) of 11 residents as follows:

Review of the 2017 Medication Administration Record (MAR) for Resident #1 revealed that there were eight (8) days during the month when 9:00 a.m. medications were administered more than one hour before or one hour after they were scheduled. (, 2, 8, 9, 18, 19, 22, and 29) Review of the 2017 MAR revealed that Resident #1's medications were charted as administered late on nine (9) occasions. (, 4, 6, 10, 11, 14, 18, and 21) (Evidence obtained)

Review of the 2017 MAR for Resident #3 revealed that at least one of his daily doses of , -levidopa 25-250 milligrams (mg) on

administration times). Licensed Nurses received in-service education related to the new schedules of administration times, timely medication administration, accurate documentation, and Policy and Procedures on obtaining timely refill of medications and/or obtaining medications from Emergency Dispense Kit (EDK) ensure Resident medication needed are met as ordered by ADON on .

Measurements or systemic changes: After review, the facility identified a high volume of medications with 9AM and 5PM administration times. Nursing administration, in coordination with the medical director, reviewed the current medication administration times and developed a plan that involved staggering the 9AM and 5PM administration times of medications. One half of the residents on each hallway received new administration times for 9AM, 5PM, and 9PM doses. The dosage times were approved by and have a corresponding physician's orders. For residents whose times were changed, the new times are now 10AM, 6PM, and 10PM. As with all medications, staff will monitor residents to ensure no adverse effects result from the changing of the administration times. Licensed Nurses received in-service education related to the new schedules of administration times, timely medication administration, accurate documentation, and Policy and Procedures on obtaining timely refill of medications and/or obtaining medications from Emergency Dispense Kit (EDK) ensure Resident medication needed are

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 10 each day from [redacted] 2-20, 2017 was administered late or charted late, as evidenced by (AEB) "Late Administration: Charted Late; Comment: given or administered on time." At least one of his daily doses on [redacted], 25, 30, and 31, 2017 was administered late or charted late, AEB "Late Administration: Charted Late; Comment: given or administered on time." (Evidence obtained) During medication pass at 11:17 a.m. on [redacted] with Employee E, LPN, she was observed removing [redacted] 5 mg orally for Resident # 4. As she removed the medication for the resident, she clicked the box on the eMAR for administration, and the system flagged the medication as late. Employee E then documented, "Late administration. Med given at 11:21 a.m." This surveyor left Employee E while she continued removing the resident's remaining 9:00 a.m. medication from the cart. The time was 11:39 a.m. Later the same day this surveyor reviewed the MAR for Resident #4. Other medications scheduled at 9:00 a.m. for this resident were reviewed and the following was noted: [redacted] was documented at 11:39 a.m., and was noted as "Given on time." [redacted] was documented at 11:39 a.m., and was noted "Issues with computer. Given on time." [redacted] was documented at 11:39 a.m., and was noted "Issues with computer. Given on time." [redacted] was documented at 12:14 p.m., and was noted as "Given on time." Review of the 2017 MAR for Resident #4 revealed that on 10 occasions, his 9:00 a.m. [redacted] was administered more than one hour before or one hour after it was	F 755	met as ordered by ADON on [redacted]. Monitoring to ensure the deficient practice will not reoccur: Audits of medication administration will be conducted at least 2 x a week across all shifts with education measures implemented promptly, if needed, by Unit managers or designee, for 1 month then 1 x a week across all shifts x 1 month. Audits will then be conducted 2 x a month across all shifts for 1 month, then 1x month across all shifts x 6 months. Findings will be reported to the Director of Nursing or designee. Director of Nursing or designee will review the findings from the audits at monthly QAPI meetings for three months then quarterly x 2 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105666	A. BUILDING _____ B. WING _____	C 11/29/2017

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F 755	Continued From page 11 scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #5 revealed that on 6 occasions, her 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. The MAR also revealed three occasions during which her , patch was not applied because it was "not available". (Evidence obtained) The surveyor observed on at 11:39 a.m., that Resident #5 had still not received her 9:00 a.m. medication. Upon reviewing the MAR later in the afternoon, the documentation at 1:26 p.m., indicated that the 9:00 a.m. scheduled medication was administered "on time". Review of the 2017 MAR for Resident #6 revealed that there were eight occasions during which her 9:00 a.m. medications were administered more than one hour before or one hour after they were scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #7 revealed that on 12 occasions, his 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #8 revealed that on 11 occasions, her 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #9 revealed that the 9:00 a.m. medications were signed off at 12:04 p.m., and were marked as "Late Administration.	F 755		

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F 755	Continued From page 12 Administered late." Review of the [redacted] 2017 MAR for Resident #10 at 12:48 p.m. revealed that all 9:00 a.m. medications for today ([redacted]) had not yet been marked as given. A re-check of the MAR at 2:20 p.m. revealed that the resident's 9:00 a.m. medications had still not been documented as given. No documentation was present. (Evidence obtained) Review of the 2017 MAR for Resident #11 revealed that her [redacted] 9:00 a.m. medications were charted at 11:01 a.m., and were noted as "Late Administration, Charted Late, administered on time" by Employee C, LPN. (Evidence obtained) A review of the facility's policy and procedure entitled Administering Medications, under section Policy Interpretation and Implementation, stated: #4 - Medications must be administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). It also stated: #3 - Medications must be administered in accordance with the orders, including any required time frame. In an interview with the South Unit Manager on at 2:15 p.m., she stated that she was unaware that 9:00 a.m. medications were being administered at 12:00 p.m. She stated that she did not perform audits on the times at which medications were administered by the floor nurses. In an interview with the Director of Nursing on at 12:47 p.m., she confirmed that it was her expectation that all nurses administer	F 755		

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F 755	Continued From page 13 medications within an hour before or an hour after they were ordered. She continued on to say that if the medication was given outside of this time frame, a rationale should be documented. "They shouldn't be documenting administered late/charted late/and given on time, because there's no way to definitively determine when the medication was given. We need to keep accurate records." .	F 755		

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N 000	INITIAL COMMENTS An unannounced complaint survey, CCR #2017014139, was conducted on [redacted]. Lanier Terrace (License #12880962) had licensure deficiencies at the time of the survey. .	N 000		
N 054 SS=E	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to follow physicians' orders regarding administration times for medications for 9 (Residents #1, #3, #4, #5, #6, #7, #9, #10 and #11) of 11 sampled residents. The findings include: During a complaint investigation conducted on [redacted], four Licensed Practical Nurses (LPNs) were scheduled to pass medications during the 7:00 a.m. to 3:00 p.m. shift. LPN C and LPN D were assigned to medication carts on the South Unit, and LPN E and LPN F were assigned to medication carts on the North Unit. An interview was conducted with Resident #1 and the resident's son on [redacted] at 9:00 a.m. The	N 054	Without admitting or conceding either the existence or scope or severity of the deficiencies, Lanier Terrace submits this plan of correction in order to be in compliance with the regulations. Resident #1 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #3 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #4 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance	

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N 054	Continued From page 1 resident was visibly tremulous, especially of the upper extremities. Both the resident and son reported that the resident frequently received her anti-Parkinson's medication an hour before or 1-3 hours after it was scheduled to be administered. The son stated that when they reported this to the Director of Nursing (DON), she told them that the nurses could administer the medication up to two (2) hours after it was ordered. Resident #1 complained that due to the variance in the times that the staff administered her anti-Parkinson's medication, she felt that her symptoms were getting worse. She complained about not receiving the medication earlier on this day ( ). A review of Resident #1's Electronic Medication Administration Record (e-MAR) at approximately 9:20 a.m., after the interview, confirmed that the resident had still not received her anti-Parkinson's medication that was scheduled at 6:00 a.m. this morning ( ). In an interview with Employee F, LPN, on at 11:18 a.m., she reported that she was currently administering 9:00 a.m. medications, and that she had started the medication pass at 7:30 a.m. At 11:39 a.m., Employee F reported that she was still currently administering 9:00 a.m. medications, and she showed the surveyor the e-MAR revealing that four residents (Residents #5, #6, #7, and #8) had still not received their 9:00 a.m. medications. An observation of Employee C, LPN, was conducted on at 12:02 p.m. She reported that she was passing 9:00 a.m. medications. At 12:05 p.m., she was observed preparing the medications for Resident #9, and she marked in the e-MAR that the reason for late administration was "charted late". When the surveyor asked Employee C why she chose that	N 054	with the standards of practice. Resident #5 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #6 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #7 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #9 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #10 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. Resident #11 was evaluated for adverse side effects by the unit manager. No side effects were noted. Medication will be provided in accordance with the standards of practice. LPN C, D, E and F received in-serviced on timely medication administration and accurate documentation by ADON on . Other Residents having potential to be affected: All residents receiving medication have the potential to be affected by the deficient practice. In coordination with the medical director, medication administration times have been staggered to ensure that medication is administered in accordance with the standards of practice (Please refer to	

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N 054	Continued From page 2 rationale, she logged back into the system at 12:04 p.m., looked at the options, and changed the reason to "administered late". Review of the 2017 MAR for Resident #11 revealed that her 9:00 a.m. medications were charted at 11:01 a.m., and were noted as "Late Administration, Charted Late, administered on time" by Employee C, LPN. During an interview at 12:16 p.m. on with Employee D, LPN, she stated that she "just completed" her morning medication pass. She reported that she generally did not need to give medication outside of the ordered timeframes, but that if she did give a medication late, she would choose the rationale "charted late" versus "administered late", and would document that the resident was in the shower, or at etc. This surveyor conducted a review of 11 residents (Residents #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, and #11) e-Mar records for the months of and 2017, which revealed that medications were administered more than one hour before or after they were ordered on many occasions for 9 (Residents #1, #3, #4, #5, #6, #7, #9, #10 and #11) of 11 residents as follows: Review of the 2017 Medication Administration Record (MAR) for Resident #1 revealed that there were eight (8) days during the month when 9:00 a.m. medications were administered more than one hour before or one hour after they were scheduled. (, 2, 8, 9, 18, 19, 22, and 29) Review of the 2017 MAR revealed that Resident #1's medications were charted as administered late on nine (9) occasions. (, 4, 6, 10, 11, 14, 18, and 21) (Evidence obtained)	N 054	systemic changes for a detailed description of the staggering of administration times). Licensed Nurses received in-service education related to the new schedules of administration times and accurate documentation. Measurements or systemic changes: After review, the facility identified a high volume of medications with 9AM and 5PM administration times. Nursing administration, in coordination with the medical director, reviewed the current medication administration times and developed a plan that involved staggering the 9AM and 5PM administration times of medications. One half of the residents on each hallway received new administration times for 9AM, 5PM, and 9PM doses. The dosage times were approved by and have a corresponding physician's orders. For residents whose times were changed, the new times are now 10AM, 6PM, and 10PM. As with all medications, staff will monitor residents to ensure no adverse effects result from the changing of the administration times Licensed Nurses received in-service education related to the new schedules of administration times and accurate documentation by ADON on . Monitoring to ensure the deficient practice will not reoccur Audits of medication administration will be conducted at least 2 x a week across all shifts with education measures implemented promptly, if needed, by Unit managers or designee, for 1 month then 1 x a week across all shifts x 1 month. Audits will then be	

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N 054	Continued From page 3 Review of the 2017 MAR for Resident #3 revealed that at least one of his daily doses of , -levidopa 25-250 milligrams (mg) on each day from 2-20, 2017 was administered late or charted late, as evidenced by (AEB) "Late Administration: Charted Late; Comment: given or administered on time." At least one of his daily doses on , 25, 30, and 31, 2017 was administered late or charted late, AEB "Late Administration: Charted Late; Comment: given or administered on time." (Evidence obtained) During medication pass at 11:17 a.m. on with Employee E, LPN, she was observed removing , 5 mg orally for Resident # 4. As she removed the medication for the resident, she clicked the box on the eMAR for administration, and the system flagged the medication as late. Employee E then documented, "Late administration. Med given at 11:21 a.m." This surveyor left Employee E while she continued removing the resident's remaining 9:00 a.m. medication from the cart. The time was 11:39 a.m. Later the same day this surveyor reviewed the MAR for Resident #4. Other medications scheduled at 9:00 a.m. for this resident were reviewed and the following was noted: ., was documented at 11:39 a.m., and was noted as "Given on time." ., was documented at 11:39 a.m., and was noted "Issues with computer. Given on time." was documented at 11:39 a.m., and was noted "Issues with computer. Given on time." ., was documented at 12:14 p.m., and was noted as "Given on time." Review of the 2017 MAR for Resident	N 054	conducted 2 x a month across all shifts for 1 month, then 1x month across all shifts x 6 months. Findings will be reported to the Director of Nursing or designee. Director of Nursing or designee will review the findings from the audits at monthly QAPI meetings for three months then quarterly x 2 quarters.	

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N 054	Continued From page 4 #4 revealed that on 10 occasions, his 9:00 a.m. , / , was administered more than one hour before or one hour after it was scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #5 revealed that on 6 occasions, her 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. The MAR also revealed three occasions during which her , , patch was not applied because it was "not available". (Evidence obtained) The surveyor observed on at 11:39 a.m., that Resident #5 had still not received her 9:00 a.m. medication. Upon reviewing the MAR later in the afternoon, the documentation at 1:26 p.m., indicated that the 9:00 a.m. scheduled medication was administered "on time". Review of the 2017 MAR for Resident #6 revealed that there were eight occasions during which her 9:00 a.m. medications were administered more than one hour before or one hour after they were scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #7 revealed that on 12 occasions, his 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #8 revealed that on 11 occasions, her 9:00 a.m. medication was administered more than one hour before or one hour after it was scheduled. (Evidence obtained) Review of the 2017 MAR for Resident #9 revealed that the 9:00 a.m.	N 054		

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N 054	Continued From page 5 medications were signed off at 12:04 p.m., and were marked as "Late Administration. Administered late." Review of the 2017 MAR for Resident #10 at 12:48 p.m. revealed that all 9:00 a.m. medications for today ( ) had not yet been marked as given. A re-check of the MAR at 2:20 p.m. revealed that the resident's 9:00 a.m. medications had still not been documented as given. No documentation was present. (Evidence obtained) Review of the 2017 MAR for Resident #11 revealed that her 9:00 a.m. medications were charted at 11:01 a.m., and were noted as "Late Administration, Charted Late, administered on time" by Employee C, LPN. (Evidence obtained) A review of the facility's policy and procedure entitled Administering Medications, under section Policy Interpretation and Implementation, stated: #4 - Medications must be administered within (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). It also stated: #3 - Medications must be administered in accordance with the orders, including any required time frame. In an interview with the South Unit Manager on at 2:15 p.m., she stated that she was unaware that 9:00 a.m. medications were being administered at 12:00 p.m. She stated that she did not perform audits on the times at which medications were administered by the floor nurses. In an interview with the Director of Nursing on at 12:47 p.m., she confirmed that it was	N 054		

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N 054	Continued From page 6 her expectation that all nurses administer medications within an hour before or an hour after they were ordered. She continued on to say that if the medication was given outside of this time frame, a rationale should be documented. "They shouldn't be documenting administered late/charted late/and given on time, because there's no way to definitively determine when the medication was given. We need to keep accurate records." Class III	N 054		