PRINTED: 10/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					
FATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
				С	
105819		B. WING		10/03/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		

NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
		1	1800 SE HILLMOOR DRIVE			
TIFFANY	AALL NURSING AND REHAB CENTER		PORT SAINT LUCIE, FL 34952			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	TIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION			
F 000	INITIAL COMMENTS	F	000			
	An unannounced Recertification and Complaint survey, complaint number 2019014112, was conducted on - at Tiffany Hall Nursing And Rehab Center. The facility is not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The complaint was unsubstantiated.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed /2019 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.

Agency f	or Health Care Adminis	tration				: 10/22/2019 I APPROVED
STATEMENT	FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SI COMPLE	
		95607	B. WING		10/0	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	ITE, ZIP CODE		
TIFFANY	HALL NURSING AND RE	HAB CENTER	HILLMOOR DRI NNT LUCIE, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 000	INITIAL COMMENTS		N 000			
N 054 SS=D	conducted on Nursing And Rehab C deficiencies at the tim complaint was unsub: 59A-4.107(5), FAC Fo All physician orders n prescribed, and if not	CCR# 2019014112, was - at Tiffany Hall lenter. The facility had se of the survey. The stantiated.	N 054			
	Based on observation review, the facility fall sampled residents ob medication pass obse potential significant mr #26). Thirteen different incorrect dose of y for 22 const. The findings included A medication pass observed the service of the serv	served during the rivations, was free of a ledication error (Resident nt nurses administered the (a medication for ecutive days.		1. Resident #26 was evaluated by Ur Manager on and no negative outcome was noted. The physician w notified by the Unit Manager on and the physician's order was change 500mg 2. An Audit was conducted by the supervisor on regarding residutilizing A full MAR to Carcheck was done of all medications by Unit Managers on No other residents were noted to be affected. G was reeducated by the Unit Managers and a carching medication services and the services of the ser	as d to ents' t the .	

milligrams (mg) was due, but she could only find LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

to find it. The RN explained that

one medication due at that time, and was unable

pack (the packaging used to supply

(X6) DATE TITLE Electronically Signed /19

administration principles to include

verifying the correct dose with the

3. Licensed nursing staff were

Physician's orders.

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administration of the

tablets since

since The surveyor asked the Unit Manager to provide documentation of any and all packs that were delivered to the facility in the last 60 days for Resident #26.

mg tablets. The DON stated she called the pharmacy, and they told her they had received

at 6:02 PM, the Director of Nursing (DON) informed the surveyor that the pharmacy was looking into it, but that it looked like the nurses had been giving the

, instead of the ordered 850

850 mg tablets

Agency fi	or Health Care Adminis	tration				i		: 10/22/2019 I APPROVED
	FOR DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	C	X3) DATE S COMPLE	
		95607		B. WING			10/0	3/2019
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADD	RESS, CITY, STA	TE, ZIP CODE			
******	HALL NURSING AND REI	18	00 SE HII	LLMOOR DRIV	/E			
HEFANY	HALL NURSING AND REI	PC	ORT SAIN	IT LUCIE, FL	34952			
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N 054	Continued From page	2		N 054				
	order to discontinue it pharmacy told the DC facility for confirmation. The DON was unable questioned the pharm follow up, but did not stated she also contact consultant for review stated there would be done for each nurse in agreed with the conce and the lack of any nu for the past 22 days. In for the past 22 days. If the 850 mg dose had delivered between the , and that the	to locate any fax. The DO nacy as to why they didn't get a reason. The DON cted their Pharmacy of the situation. The DON medication error paperwo rvolved. The DON also arm with both the pharmacy, use questioning the dose Further review of the MAR nurses failed to identify the	he DN ork y					
	at 10:00 ÅM Practical Nurse (LPN) the West Unit di where Resident #26 r observation, Staff G v about the medication related to the incorrec Resident #26. Staff G been told as of yet. S with the surveyor and	vas asked if she had heard error identified last evening at dose of for i stated that she had not taff G reviewed the MAR	d d d					

errors. Class III

was 850 mg, and agreed she had given the 500 mg dose. The LPN had no explanation for the

STATE FORM

): 10/22/2019 1 APPROVE
	or Health Care Adminis	tration				
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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TIFFANY I	HALL NURSING AND RE	HAB CENTER	HILLMOOR DRI VINT LUCIE, FL			
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N 101	Continued From page	3	N 101			de la constante de la constant
N 101 SS=D	400.141(1)(j), FS; 59/ Medical Records	4-4.118(2), FAC Resident	N 101			
	discharges; medical et including medical rec history, and identity a other persons who maffairs of the resident care plans, including, prescribed services, seduration, and service open to agency inspe maintain clinical recount of the control of t	iervice frequency and goals. The records must be ction. The licensee shall do on each resident in pled professional standards must be complete, ad, readily accessible, and exed.				
	information to clearly her diagnosis and treat This Statute or Rule Based on interview as failed to ensure accur	must contain sufficient identify the resident, his or atment, and results is not met as evidenced by: not cord review, the facility ate and complete records riewed as evidenced by		Resident #34 was evaluated by the Unit Manager on and no negocitome was noted.		

1. Record review was conducted of Resident

failure to document the re-evaluation of

..... monitoring after ... administration to

medications administrations in the Medication

Administration Records (MARs) for Residents

#30 and #49; and failure to resolve a care plan

and complete an evaluation for Resident #5.

The findings included:

Resident #34; failure to ensure documentation of

Resident #30 was evaluated by the

Unit Manager on and no negative

Resident #49 was evaluated by the

2. An Audit was conducted by the DON regarding the documentation of

medications administered on the

Resident #5 Care Plan was updated by

and no negative

outcome was noted.

outcome was noted.

Unit Manager on

the MDS Lead on

10/03/2019

Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING ___

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

95607

NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
TIFFANY	HALL NURSING AND REHAB CENTER		LMOOR DRI' T LUCIE, FL				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
N	Continued From page 4 #34's MARs (medication administration recot The MARs showed evidence of a Physician order, dated that indicated a that i	units s. Call till she s. Call till she	N 101	Medication Administration Record. Affacted residents' licensed nurses received one on one education by the DON. An audit was conducted by the DON and MDS Lead on			

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concerns:

Review of her

3. Resident #49 was admitted to the facility on with the pertinent diagnosis of . Review of her clinical records conducted on revealed the following

a. A Health Care Provider's (HCP) order, dated, ordered _ . 125 micrograms daily.

administration record (MAR) revealed no initials or evidence documenting the resident received

medication

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psych services. Review of the

current Minimum Data Set (MDS) assessment, , documented the resident lacked any behaviors and was not on any , . , , medications. Review of the orders documented Resident #5 was weaned off her ___, an medication, as of

of the most current evaluation, dated . documented Resident #5 was no longer . . and that her agitation had improved. This physician progress note documented to discontinue the and to discharge from

. Review

Medication Review.

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to keep the care plans current, she stated through communication by the team members. When asked if the care plans are kept current between quarterly assessments, Staff H agreed they should be. Staff H was told the and , . , services had been discontinued , that there was a quarterly MDS on dated ..., and the care plan for , medication use for Resident #5 was still current in the record. The MDS coordinator reviewed the record and agreed the care plan

initially stated with the next quarterly review. When asked who is responsible for keeping the care plans updated, she stated any staff could update them. When asked if there was a process

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The findings included:

at 8:30 AM. Resident #55 was sitting up next to his bed, already dressed and

groomed, eating breakfast. Staff B, the Certified

Nursing Assistant (CNA) caring for Resident #55

explained she had already provided morning

care, to include care. The surveyor

asked the CNA to let her know when she was

going to empty the . . . from the . . . , bag.

An observation was made on _____ beginning

at 1:20 PM. Upon arrival into the room, Resident

#55 was lving in bed, and the ... bag (the devise

1 On

STATE FORM caso IEWA/11 If continuation sheet 9 of 13

outcome noted. Residents who had

residents with

for residents with 3. Nursing staff were reeducated by

were audited by the Unit

Manager on to ensure proper

placement of __ straps. No additional

Staff B. C. D were reeducated by SDC on

SDC/DON/RCD by regarding

proper technique and placement of ___

on the appropriate use of strap

were found without ... straps.

straps for residents with

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

POSTOR SUPPLIES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER:
A BUILDING:
B WING

10/03/2019

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TIFFANY I		SE HILLMOOR DI RT SAINT LUCIE, F		
(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) COMPLETE DATE
N 201	Continued From page 9 to collect the draining from the usually worn during the day) was noted on top of his Staff B confirmed she provided care that morning, but needed to empty the as (a flexible tube to	N 201		
	drain from the) was noted in the lower abdomen, with the tubing extended down to about mid. or slightly longer, and attached to the bag. The tubing was not secured to the resident'sin any manner. The CNA washed her and donned gloves. Staff 8 obtained a graduate container and began to empty the bag. Because Resident #55 was lying down, as the CNA emptied the she had to raise the bag up to about a 30 degree angle from the resident in order to get the bag high enough to angle down and empty into the container. This angle would allow any in the tubing to flow into the bag, and the tubing, coming from the abdomen, was stretched and pulled taunt. Staff 8 di nich notice, so the surveyor intervened in order to stop the CNA from pulling the tubing, staff 8 finished emptying the bag, and cleaned the outside of the bag with a personal cleansing wipe. The CNA frailled to secure the tubing to the resident's upon finishing the task.	h	weeky audis regarding fire appropriate use of thestrap for residents with 4. The results of the audit will be presented to the QA Committee for further review and recommendations monthly for three months and as deemed necessary thereafter.	
	Review of the record revealed Resident #55 was admitted to the facility on with an admitted to the facility on and the most current readmission was on Review of the current Minimum Data Set (MDS) assessment, dated documented Resident #55 was with a () score of 04. This MDS			Novikositositositositositositositositositosit

documented Resident #55 had a related to retention of (difficulty) and

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AHCA Form 3020-0001

This policy also documented, "The resident should not go to bed or take long paps while

 During an observation and interview on at 1:59 PM, Resident #69 was sitting up in her wheel chair. The resident stated she had a bag on and that she thought she was going to

. Resident #69 stated she had a , but

the doctor Friday regarding the

thought it had been treated.

wearing __ bag."

Agency for Health Care Adminis	tration		FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	95607	B. WING	10/03/2019

NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STATI	E, ZIP CODE			
TIFFANY HALL NURSING AND REHAB CENTER		1800 SE HILLMOOR DRIVE PORT SAINT LUCIE, FL 34952					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE: (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
N 201	was not secured to the resident's in am manner. Staff C provided personal care. R #89 stated she was ready to get up. The C explained she wanted to get the resident d and it would take some time to finish, befor changing the night bag to the bag. The surveyor asked the CNA to call her when s ready to change the night bag to the bc During the continued observation at 11:15 Staff C removed a new bag from the packaging, and took a SurePrep wipe (a si	uff C, gg for vashed y gg for vashed y g for tubing y sesident NA ressed, re sesident NA ressed, re with tubing y sesident NA research which will be wipe oing to be that reprepay no hold of No." it to little tubing to be sesked to hold d No." it to	N 201				
	Resident #69 was still in bed. An observati the resident's with Staff C reveale	ion of					

AHCA Form 3020-0001

PRINTED: 10/22/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B WING 95607 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1800 SE HILLMOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER PORT SAINT LUCIE, FL 34952 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) N 201 | Continued From page 12 N 201 . . . tubing still was not secured to her . . When asked if __ straps or another method to secure the tubing was used at the facility, the CNA stated, "Yes, sometimes." Staff C stated she would get one. The CNA went to Staff E, the Registered Nurse (RN) assigned to care for Resident #69, and asked for a ___ strap. The RN was also informed Resident #55 had no secure for his ..., (refer to example #1). Review of the record revealed Resident #69 was admitted to the facility on with the most current readmission on . Review of the current MDS, dated , documented Resident #69 was , , with a score of 14, on a 0 to 15 scale. Review of the orders revealed Resident #69 had a consult scheduled for ... related to ... retention. Review of the laboratory results and discontinued orders revealed Resident #69 had a and was treated with the twice daily for 7 days. Review of the current care plans lacked any

Class III

intervention related to the use of a ___ strap or other devise to secure the tubing. Review of the policy " Care", revised , documented to provide enough slack with the ... to avoid pulling, and secure. This policy documented they may use a Velcro strap to secure the tubing to the . . . Review of the policy "..., Bag", revised documented the use of an

the end of the drainage tube.

STATE FORM caso JFWV11 If continuation sheet 13 of 13

swabs to clean

PRINTED: 10/22/2019 FORM APPROVED Agency for Health Care Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B MING 95607 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1800 SE HILL MOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER PORT SAINT LUCIE, FL 34952 (X433F) SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFEX PREFIX DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CZ814 435,12(2)(b-d), FS Background Screening CZ814 SS=C | Clearinghouse 435.12(2) Care Provider Background Screening Clearinghouse.-(b) Until such time as the ... are enrolled in the national retained print notification program at the Federal Bureau of Investigation. an employee with a break in service of more than 90 days from a position that requires screening by a specified agency must submit to a national screening if the person returns to a position that requires screening by a specified agency. (c) An employer of persons subject to screening by a specified agency must register with the clearinghouse and maintain the employment status of all employees within the clearinghouse. Initial employment status and any changes in status must be reported within 10 business days. (d) An employer must register with and initiate all criminal history checks through the clearinghouse before referring an employee or potential employee for electronic _ , submission to the Department of Law Enforcement. The registration must include the employee's full first name, middle initial, and last name; social security number; date of birth; mailing address; ; and race. Individuals, persons, applicants, and controlling interests that cannot legally obtain a social security number must provide an

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

10 sampled staff reviewed (Staff A).

individual taxpaver identification number. This Statute or Rule is not met as evidenced by: Based on interview and record review, it was

determined the facility failed to ensure persons

subject to screening were registered with the Clearinghouse within 10 business days, for 1 of

> by HR Generalist TITLE (X6) DATE

1. Staff A was added to the Clearinghouse

2. An audit of the AHCA Clearinghouse

Roster with current employees was

Roster by the HR generalist on

conducted on

/19 Electronically Signed STATE FORM JFWV11

if continuation sheet 1 of 2

Agency f	or Health Care Adminis	tration				: 10/22/2019 I APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
		95607	B. WING		10/0	3/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
TIFFANY	HALL NURSING AND RE	HAB CENTER	INT LUCIE, FL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
CZ814	Continued From page	1	CZ814			
	with the HR (Human I beginning al Clearinghouse Roster Generalist acknowled was noted as facility's Clearinghous	record review conducted Resources) Generalist, on 19:50 AM, the vas reviewed. The HR ged Staff A (date) was not listed on the te Roster. She also works over 20 hours each nd should have been		to include staff. Clearinghoroster was complete with current employees and staff. 3. HR generalist was re-educated by on regarding the importance accuracy of the Clearinghouse Roster. NHA/Designee will randomly audit the Clearinghouse Roster. 4. The results of the audits will be presented to the OA Committee for fureview and recommendations monthly three months and as deemed necessithereafter.	NHA of : rther	

AHCA Form 3020-0001

		ID HUMAN SERVICES				RM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A. BUILDING	E CONSTRUCTION		E SURVEY MPLETED
		105819	B. WING		10	0/03/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
TIEF		ILAN OFFITED		1800 SE HILLMOOR DRIVE		
(IFFANT)	HALL NURSING AND RE	HAB CENTER		PORT SAINT LUCIE, FL 34952		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	O Company		
F 690 SS=D	survey, complaint nur conducted on Nursing And Rehab C compliance with 42 C		F 69			
	maintain (of and on ervices and assistance to unless his or her clinical es such that is				
	ensure that- (i) A resident who ent is resident's clinical con (ii) A resident who ent as sessed for remot as possible unless th demonstrates that and (iii) A resident who is	on the resident's siment, the facility must ers the facility without an not unless the dittion demonstrates that eccessary; ters the facility with an subsequently receives one resident's clinical condition is necessary; of treatment and services to and to restore				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed

(X6) DATE /2019

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

FORM CMS-2567(02-99) Previous Versions Obsolete

program participation.

Event tD:JFWV11

Facility ID: 95807

DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105819	B. WING _			10/	03/2019
NAME OF PR	ROVIDER OR SUPPLIER	•		s'	TREET ADDRESS, CITY, STATE, ZIP CODE		
TIFFANY H	HALL NURSING AND RE	HAB CENTER			800 SE HILLMOOR DRIVE ORT SAINT LUCIE, FL 34952		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	§483.25(e)(3) For a r , based of comprehensive assets ensure that a residen receives appropriate restore as much norm possible. This REQUIREMENT by:	esident with fecal on the resident's ssment, the facility must t who is of treatment and services to	F 6	690	1. Resident #55 was evaluated by Ur	it	

The findings included:

3 sampled residents had their

1. On at 8:30 AM, Resident #55 was sitting up next to his bed, already dressed and groomed, eating breakfast. Staff B, the Certified Nursing Assistant (CNA) caring for Resident #55 explained she had already provided morning care, to include care. The surveyor asked the CNA to let her know when she was going to empty the from the bag,

and policy review, the facility failed to ensure 2 of

properly secured and maintained lower than the

level of the , to prevent or

potential (Residents #55 and #69).

An observation was made on beginning at 1:20 PM. Upon arrival into the room. Resident #55 was lying in bed, and the bag (the devise to collect the draining from the usually worn during the day) was noted on top of his ... Staff B confirmed she provided care that morning, but needed to empty the bag. A (a flexible tube to) was noted in the drain from the lower abdomen, with the tubing extended down to about mid __ or slightly longer, and attached to the ... bag. The

Manager on ____, and had a ___ strap with no negative outcome noted

Resident #69 was evaluated by Unit Manager on , and had a _ strap applied on, and had a __ strap applied on with no negative outcome noted.

Residents who had

were audited by Unit Manager on to ensure proper placement of straps. No additional residents with j..., found without ., strap.

Staff B, C, D were educated by SDC on on the appropriate use of the ... strap for residents with

3. Nursing staff were educated by SDC/DON/RCD by regarding proper technique and placement of ... straps for resident with presented to newly hired licensed nurses as part of general orientation.

PRINTED: 10/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

DEPARTMENT OF HEALTH AN	ID HUMAN SERVICES		FORM APPROVED	
CENTERS FOR MEDICARE &	OMB NO. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED	
	105819	B. WING	10/03/2019	

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

1800 SE HILLMOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER

TIFFANY HALL NURSING AND REHAB CENTER			P	ORT SAINT LUCIE, FL 34952			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE		
F 690	tubing was not secured to the resident's any manner. The CNA washed her donned gloves. Staff B obtained a gradu. container and began to empty the _b Because Resident #55 was lying down. CNA emptied the _she had to raise bag up to about a 30 degree angle from resident in order to get the _bag high angle down and empty into the containe angle would allow any in the tubing into the While doing this, i	in and and atte gg. as the the gg. as the the the enough to r. This g to flow the CNA ubling, d and c common and the common an	F 690	DON/Designee will conduct random weekly audits regarding the appropriate use of thestrap for residents with 4. The results of the audit will be presented to the QA Committee for furth review and recommendations monthly for three months and as deemed necessary thereafter.	or		
	(), starting on a						
DRM CMS-256	7(02-99) Previous Versions Obsclete	Event ID: JFWV11	Fac	ility ID: 95607 If continue	ation sheet Page 3 of 1		

PRINTED: 10/22/2019 DEDARTMENT OF HEALTH AND HISMAN CEDWICES

DELIANTIMENT OF TREASMENT DERVIOLE						
CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039			
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED			
	105819	B. WING	10/03/2019			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1800 SE HILLMOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER PORT SAINT LUCIE, FL 34952 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES. (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 690 Continued From page 3 F 690 , with two different Resident #55 has a history of recurrent and was being treated monthly with . . . (an) for three days around the time of the monthly Review of the current care plan, dated with the latest revision on , documented Resident #55 had a , with the goal to remain free of signs and symptoms of a and other complications. This care plan lacked any intervention related to securing the tubing to the resident's . . . Review of the policy " . . . Bag", revised documented, to tape the to the resident's ..., and to keep the drainage bag lower than the at all times. This policy documented to leave slack in the to minimize pressure on the , , and related structures. This policy also documented, "The resident should not go to bed or take long naps while wearing ._ bag." 2. During an observation and interview on at 1:59 PM, Resident #69 was sitting up in her wheel chair. The resident stated she had a , bag on and that she thought she was going to the doctor Friday regarding the . Resident #69 stated she had a ..., but thought it had been treated. An observation of personal care was made on , beginning at 10:24 AM, Both Staff C. the Certified Nursing Assistant (CNA) caring for Resident #69, and Staff D, another CNA, washed their . . . and donned gloves. A large used to drain from the) bag was noted hanging from

Facility ID: 95607

PRINTED: 10/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES

	D PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED
105819 B. WING 10/03/2019				

		105819	B. WING _	_		10/	03/2019
NAME OF P	ROVIDER OR SUPPLIER			- 1	STREET ADDRESS, CITY, STATE, ZIP CODE		
			- 1		800 SE HILLMOOR DRIVE		
TIFFANY I	ALL NURSING AND REI	HAB CENTER			PORT SAINT LUCIE, FL 34952		
	0.0000000000000000000000000000000000000	TOUR OF STREET		_	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ę	(X5) COMPLETION DATE
					DEFICIENCY)		
F 690	Continued From page	4	F 6	390			
	the bed, with a dignity	cover. The tubing					
	was not secured to the						
		ded personal care. Resident					
		eady to get up. The CNA					
		to get the resident dressed,					
		ne time to finish, before					
	changing the night ba						
		NA to call her when she was					
	ready to change the n	ight bag to the bag.					
		observation at 11:15 AM,					
	Staff C removed a nev						
		SurePrep wipe (a skin					
		sed during care, that					
		nd opened it. The surveyor					
		d Staff C verified it was the					
	wipe she was going to						
		about using an wipe					
		confirmed she was going to					
	use the SurePrep. Aft	er the observation, the					
	West Unit Manager in	formed the surveyor that					
		ned the use of the SurePrep.					
		had instructed the CNA to					
	clean the connection						
		·					
	On at 6:00 F	M, Resident #69 was asked					
	if she had ever had a	strap around her _ to hold					
	the tubing in	place, and she stated "No."					
	When asked if they ev	ver taped or secured it to					
	her . jin anyway, Re	sident #69 said "No."					
		n on at 10:48 AM,					
		I in bed. An observation of					
	the resident's	with Staff C revealed the					
		as not secured to her					
	When asked if stra	aps or another method to					
	secure the tu	ibing was used at the					
	facility, the CNA state	d, "Yes, sometimes." Staff C					
	stated she would get	one. The CNA went to Staff					
	E, the Registered Nur	se (RN) assigned to care					

Facility ID: 95607

DEPARTMENT OF HEALTH AND HUMAN SERVICES STA

DEPARTMENT OF HEALTH AN			PRINTED: 10/22/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		P. Harrier	

105819 B. WING 10/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

TIFFANY HALL NURSING AND REHAB CENTER				1800 SE HILLMOOR DRIVE PORT SAINT LUCIE, FL 34952	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFE TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE
F 690	Continued From page 5 for Resident #69, and asked for astrap. The RN was also informed Resident #55 had no secure for his	F	690		
	admitted to the facility of with the firsts current readmission on . Review of the current MDS, dated, documented Resident #69 was, with a score of 14, on a 0 to 15 scale. Review of the orders revealed Resident #69 had a, consult scheduled for related to related to related to related to related to related to as a sof and was treated with the as of and was treated with the twice daily for 7 days.				
	Review of the current care plans tacked any intervention related to the use of a strap or other devise to secure the tubing. Review of the policy "				
	revised , documented to provide enough slack with the to avoid pulling, and secure. This policy documented they may use a Velcro strap to secure the tubing to the				
F 760 SS=D	Review of the policy " Bag", revised documented the use of an swabs to clean the end of the drainage tube. Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	Fì	760	D	***************************************
	The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced				***************************************

PRINTED: 10/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES. ST

ENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	105819	B. WING	10/03/2019

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1800 SE HILLMOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER PORT SAINT LUCIE, FL 34952 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES PREFIX COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 760 Continued From page 6 F 760 hv: Based on observation, interview, and record 1. Resident #26 was evaluated by Unit review, the facility failed to ensure 1 of 10 Manager on ... , and no negative sampled residents observed during the outcome was noted. The physician was medication pass observations, was free of a notified by the Unit Manager on notential significant medication error (Resident and the physician's order was changed to #26). Thirteen different nurses administered the 500ma. incorrect dose of (a medication for) for 22 consecutive days. 2. An audit was conducted by the supervisor on regarding residents The findings included: utilizing A full MAR to Cart check was done of all medications by Unit A medication pass observation was attempted for Managers on No other Resident #26 on at 4:34 PM. Staff F, a residents were noted to be affected. Staff Registered Nurse (RN), looked in her cart for the G was re-educated by Unit Manager on one medication due at that time, and was unable regarding medication to find it. The RN explained that administration principles to include milligrams (mg) was due, but she could only find verifying the correct dose with the pack (the packaging used to supply Physician's order. individual doses of a medication) for 500 mg. The RN summoned the West Unit 3. Licensed nursing staff were Manager, who was also unable to locate a re-educated by SDC/DON/RCD by 850 mg pack in the medication . regarding medication cart. The Unit Manager stated she would look in administration principles to include the overflow medications verifying the correct dose with the Physician's order. The education will be During a subsequent interview on presented to newly hired licensed nurses 5:14 PM, the Unit Manager informed the surveyor as part of general orientation. and Staff F they did not have DON/Designee will conduct random in the Pvxis (storage of extra medications). The weekly audits of medication Unit manager explained she had since phoned administration. the physician, reviewed the recent results with him over the phone, and he changed 4 The results of the audit will be the order 500 mg. Observation presented to the OA Committee for further of the 500 mg pack in the review and recommendations monthly for

tablets were left in the

medication cart revealed an order date of

for the quantity of 60 tablets. Seven

AN

pack. When asked

thereafter.

three months and as deemed necessary,

PRINTED: 10/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED C STAT

CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED

B. WING 105819 10/03/2019

NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
		1800 SE HILLMOOR DRIVE				
TIFFANY	HALL NURSING AND REHAB CENTER	PC	DRT SAINT LUCIE, FL 34952			
(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)	(XS) COMPLETION DATE		
F 760	Continued From page 7 stated they were "on order." Review of the status revealed it had been on order since Review of the orders revealed the 850 mg was to start on with the discontinued order of the 500 mg tablets on Review of the current Medication Administration Record (MAR) documented the administration of the 850 mg tablets since 850 mg tablets since 850 mg tablets since 100 mg tablets mg the 500 mg tablets mg tablets since 100 mg tablets mg	F 760				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/22/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039
ID DI AN OF CORDECTION		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	105819	B. WING		10/03/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	

1800 SE HILLMOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER PORT SAINT LUCIE, FL 34952 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 760 Continued From page 8 F 760 A medication storage observation was made on at 10:00 AM with Staff G, the Licensed Practical Nurse (LPN) who had been assigned to the West Unit during the survey week, and where Resident #26 resided. During this observation. Staff G was asked if she had heard about the medication error identified last evening related to the incorrect dose of Resident #26. Staff G stated that she had not been told as of yet. Staff G reviewed the MAR with the surveyor and was surprised the dose ordered for the previous 22 days was 850 mg, and agreed she had given the 500 mg dose. The LPN had no explanation for the errors. F 842 Resident Records - Identifiable Information F 842 SS=D CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. \$483 70(i) Medical records §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-(i) Complete: (ii) Accurately documented: (iii) Readily accessible; and

() Systematically organized

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	ļ	105819	B. WING	_		10/	03/2019
NAME OF PE	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
TIFFANY H	HALL NURSING AND RE	HAB CENTER		1	1800 SE HILLMOOR DRIVE PORT SAINT LUCIE, FL 34952		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	9	F	842	2		
	all information contain regardless of the form records, except when (i) To the individual, or expresentative where (ii) Required by Law; (iii) For freatment, pay operations, as permit with 45 CFR 164.506 () For public health regiect, or domestic valivities, judicial and law enforcement purp purposes, research pi medical examiners, f. a serious threat to he by and in compliance \$483.70(i)(3) The faci record information agunauthorized use. \$483.70(i)(3) The faci record information agunauthorized use. \$483.70(i)(4) Medical formation agunauthorized use. \$483.70(i)(5) The medical formation agunauthorized use.	or their resident permitted by applicable law; yment, or health care ted by and in compliance; activities, reporting of violence, health oversight administrative proceedings, osses, organ donation unproses, or to coroners, uneral directors, and to avert atth or safety as permitted with 45 CFR 164.512. Illity must safeguard medical ainst loss, destruction, or a records must be retained required by State law; or e date of discharge when int in State law; or are safet a resident reaches law.					

() The results of any preadmission screening

DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES				FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105819	B. WING _			10.	03/2019
NAME OF P	ROVIDER OR SUPPLIER	•		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
			1	11	800 SE HILLMOOR DRIVE		
(IFFANT)	ALL NURSING AND RE	HAB CENTER		Р	ORT SAINT LUCIE, FL 34952		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, services reports as rethis REQUIREMENT by: Based on interview a failed to ensure accur for 4 of 26 records refailure to document the monitoring after moni	valuations and cited by the State; 1s, and other licensed ss notes; and and other diagnostic squired under \$483.50. is not met as evidenced under conditions and record review, the facility rate and complete records viewed, as evidenced by he re-evaluation of r administration to to ensure documentation of the state of th	F	342	1. Resident #34 was evaluated by Ur Manager on and no negative outcome was noted. Resident #30 was evaluated by Uni Manager on and no negative outcome was noted. Resident #49 was evaluated by Uni Manager on and no negative outcome was noted. Resident #50 care plan was updated MDS Lead on	i l by of	
	on of 407 mg/dl at Resident #34's record re-evaluation of the	34 also received 14 units of for elevated .11:30 AM. Review of			Licensed Nurses were re-educated SDC on regarding the documentation principles of medication administration. Licensed nurses were re-educated by SDC/DON/RCD by regarding ensuring the accur	1	

of care plans. The education will be

		MEDICAID SERVICES					RM APPROVED NO. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED				
		105819	B. WING			1	0/03/2019	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
TIFFANY	HALL NURSING AND RE	HAB CENTER			000 SE HILLMOOR DRIVE ORT SAINT LUCIE, FL 34952	32		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	On at 11:14 Resident #34's recore East wing unit manag acknowledged the fin speak to the nurses to On at 12:33 manager voiced she who attended to Resi dates. The nurses cle to document the resu 2. On at 2:0 (medication administr commentations for the orders, of the followin A- 125 mcg f was scheduled for 2:1 evidence of documen the MRR for affects the functioning for 6:00 AM, 2:00 PM no evidence of documen administration in the I PM. C-Merrem	AM, a side by side review of its and interview with the per was conducted. She dings. She stated she will of find out what happened. PM, the East wing unit had spoken to the nurses dent #34 on the mentioned immed that Resident #34's are re-evaluated following imministration, but they forgot its in the resident's records. O PM, the MARs atton record), dated for re reviewed for Resident noted with lack of the following Physician genetications: or (irregular beat) DPM. There was not tation of the administration tation of the administration that g of) was scheduled, and 10:00 PM. There was nentation of the MAR on	F	842	presented to newly hired licensed nur as part of general orientation. DON/Designee will conduct random weekly audits of medication administr records and care plans. 4. The results of the audits will be presented to the OA Committee for fur review and recommendations monthly three months and as deemed necess thereafter.	ation rther y for		
	PM and 10:00 PM. T	scheduled for 6:00 AM, 2:00 here was no evidence of administration in the MAR						

for 2:00 PM.

on

		ID HUMAN SERVICES MEDICAID SERVICES					M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		105819	B. WING			10	/03/2019
NAME OF PROVIDER OR SUPPLIER TIFFANY HALL NURSING AND REHAB CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE		
					1800 SE HILLMOOR DRIVE PORT SAINT LUCIE, FL 34952		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	BE	(X5) COMPLETION DATE
F 842	Continued From page 12 Ona12:30 PM, a side by side review of Resident #30's		F	84	2		
	with the per Review Review Conducted on concerns: a. A Health Care Prov. , ordered	(MAR) revealed no initials ting the resident received or ed , ordered					
	documenting she reco for c. A HCP's order, date , 1 million	eived the dose scheduled					

at 2:00 PM.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		105819	B. WING			10/	03/2019
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				11	800 SE HILLMOOR DRIVE		
TIFFANY	ALL NURSING AND RE	HAB CENTER		P	ORT SAINT LUCIE, FL 34952		
(X4) ID			ID.		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
""					DEFICIENCY)		
= 5.45							
F 842	Continued From page		F	842			
		clinical records revealed no					
		ing whether the resident					
		or not. This was brought to					
		ast Wing Unit Manager on					
		She stated she was familiar ad been discussed with the					
		tated she gave the resident					
		fid not update the MAR.					
	tile medications par c	nd not apaste the mile.					
	4. a. Review of the re	cord revealed Resident #5					
		acility on					
	of the current Minimu						
		, documented the					
		ehaviors and was not on					
		dications. Review of the					
		Resident #5 was weaned off					
		., ., medication, as of the most current					
	evaluation, dated	, documented Resident					
	#5 was no longer,	and that her agitation					
		hysician progress note					
	documented to discor						
	discharge from psych	services.					
	Review of the	Medication Review,					
	dated , and t						
	Medications Quarter						
	,, both docur	mented Resident #5 was still					
	receiving the	The had been					
	discontinued on	and Resident #5 was					
	only taking one other	medication for					
	, control.						
		revealed the current care					
		, with the latest update on					
		d Resident #5 was at risk for					
	side effects related to	, . , , . medication					

use.

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	105819	B. WING	10/03/2019				
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED				
CENTERS FOR MEDICARE & MEDICAID SERVICES							
DEPARTMENT OF REALTH AND HOWAN SERVICES							

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1800 SE HILLMOOR DRIVE TIFFANY HALL NURSING AND REHAB CENTER PORT SAINT LUCIE, FL 34952 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION). TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 842 Continued From page 14 F 842 During an interview on at approximately 11:15 AM, the Unit Manager agreed the had been discontinued on and that the two , . , medication reviews, dated and were not accurate. b. During an interview on . at 11:49 AM, Staff H, a Licensed Practical Nurse (LPN)/MDS coordinator was asked, if a , . , , medication was discontinued, when would the care plan be updated. The MDS coordinator initially stated with the next quarterly review. When asked who is responsible for keeping the care plans updated, she stated any staff could update them. When asked if there was a process to keep the care plans current, she stated through communication by the team members. When asked if the care plans are kept current between quarterly assessments, Staff H agreed they should be. Staff H was told the and , ... services had been discontinued , that there was a quarterly MDS dated ... , and the care plan for , medication use for Resident #5 was still current in the record. The MDS coordinator reviewed the record and agreed the care plan should have been resolved ... in

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