STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105819	A. BUILDING ______ B. WING ______	C 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 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 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.	F 000		

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

TITLE

(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 program participation.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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N 000	INITIAL COMMENTS An unannounced Relicensure survey and complaint inspection, CCR# 2019014112, was conducted on - at Tiffany Hall Nursing And Rehab Center. The facility had deficiencies at the time of the survey. The complaint was unsubstantiated.	N 000		
N 054 SS=D	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.	N 054		
	This Statute or Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 of 10 sampled residents observed during the medication pass observations, was free of a potential significant medication error (Resident #26). Thirteen different nurses administered the incorrect dose of (a medication for) for 22 consecutive days. The findings included: A medication pass observation was attempted for Resident #26 on at 4:34 PM. Staff F, a Registered Nurse (RN), looked in her cart for the one medication due at that time, and was unable to find it. The RN explained that 850 milligrams (mg) was due, but she could only find a pack (the packaging used to supply		1. Resident #26 was evaluated by Unit Manager on , and no negative outcome was noted. The physician was notified by the Unit Manager on and the physician's order was changed to 500mg 2. An Audit was conducted by the supervisor on regarding residents' utilizing . A full MAR to Cart check was done of all medications by the Unit Managers on . No other residents were noted to be affected. Staff G was reeducated by the Unit Manager on regarding medication administration principles to include verifying the correct dose with the Physician's orders. 3. Licensed nursing staff were	

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N 054	Continued From page 1 individual doses of a medication) for 500 mg. The RN summoned the West Unit Manager, who was also unable to locate a 850 mg pack in the medication cart. The Unit Manager stated she would look in the overflow medications. During a subsequent interview on at 5:14 PM, the Unit Manager informed the surveyor and Staff F they did not have 850 mg in the Pyxis (storage of extra medications). The Unit manager explained she had since phoned the physician, reviewed the recent results with him over the phone, and he changed the order to 500 mg. Observation of the 500 mg pack in the medication cart revealed an order date of for the quantity of 60 tablets. Seven tablets were left in the pack. When asked about the 850 mg tablets, the Unit Manager 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 . 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. On 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 500 mg tablets since , instead of the ordered 850 mg tablets. The DON stated she called the pharmacy, and they told her they had received	N 054	reeducated by SDC/DON/RCD by regarding medication administration principles to include verifying the correct dose with the Physician's order. The education will be presented to newly hired licensed nurses as part of the general orientation. DON/Designee will conduct random weekly audits of medication administration. 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.	

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N 054	Continued From page 2	N 054		

the order for the 850 mg, but never received the order to discontinue the 500 mg tablets. The pharmacy told the DON they had sent a fax to the facility for confirmation, but never heard . The DON was unable to locate any fax. The DON questioned the pharmacy as to why they didn't follow up, but did not get a reason. The DON stated she also contacted their Pharmacy Consultant for review of the situation. The DON stated there would be medication error paperwork done for each nurse involved. The DON also agreed with the concern with both the pharmacy and the lack of any nurse questioning the dose for the past 22 days. Further review of the MAR revealed 13 different nurses failed to identify that the 850 mg dose had not been ordered or delivered between the dates of and , and that the 13 nurses provided the wrong dose of the .

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 for 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.

Class III

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N 101	Continued From page 3	N 101		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results This Statute or Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate and complete records for 4 of 26 records reviewed, as evidenced by failure to document the re-evaluation of ... monitoring after ... administration to Resident #34; failure to ensure documentation of 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: 1. Record review was conducted of Resident	N 101	1. Resident #34 was evaluated by the Unit Manager on and no negative outcome was noted. Resident #30 was evaluated by the Unit Manager on ... and no negative outcome was noted. Resident #49 was evaluated by the Unit Manager on and no negative outcome was noted. Resident #5 Care Plan was updated by the MDS Lead on ... 2. An Audit was conducted by the DON on ... regarding the documentation of medications administered on the	

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N	Continued From page 4 #34's MARs (medication administration records). The MARs showed evidence of a Physician order, dated , that indicated a with the following instructions: if was greater than 400 (mg/dl), give 14 units of and recheck in 1 ½ hours. Call the Medical Doctor if the was still elevated. Resident #34's records evidenced she had received 14 units of on for elevated of 448 mg/dl at 11:30 AM. Resident #34 also received 14 units of on for elevated of 407 mg/dl at 11:30 AM. Review of Resident #34's records lacked evidence of re-evaluation of the level, following the administrations on the mentioned dates. On at 11:14 AM, a side by side review of Resident #34's records and interview with the East wing unit manager was conducted. She acknowledged the findings. She stated she will speak to the nurses to find out what happened. On at 12:33 PM, the East wing unit manager voiced she had spoken to the nurses who attended to Resident #34 on the mentioned dates. The nurses claimed that Resident #34's levels were re-evaluated following the 14 units administration, but they forgot to document the results in the resident's records. 2. On at 2:00 PM, the MARs (medication administration record), dated for , were reviewed for Resident #30. The MARs were noted with lack of documentations for the following Physician orders, of the following medications: A- 125 mcg for (irregular beat) was scheduled for 2:00 PM. There was no	N 101	Medication Administration Record. Affected residents' licensed nurses received one on one education by the DON. An audit was conducted by the DON and MDS Lead on regarding the accuracy of Care Plans. No other residents were noted to be affected. 3. Licensed Nurses were reeducated by SDC on regarding the documentation principles of medication administration. Licensed nurses were reeducated by SDC/DON/RCD by regarding ensuring the accuracy of Care Plans. The education will be presented to newly hired licensed nurses as part of the general orientation. DON/Designee will conduct random weekly audits of medication records and care plans. 4. The results of the audits will be presented to the QA Committee for further review and recommendations monthly for three months and as deemed necessary, thereafter.	

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N 101	Continued From page 5	N 101		

evidence of documentation of the administration in the MAR for .

B- , for , , (that affects the functioning of .) was scheduled for 6:00 AM, 2:00 PM, and 10:00 PM. There was no evidence of documentation of the administration in the MAR on for 2:00 PM.

C- Merrem for , (bone) was scheduled for 6:00 AM, 2:00 PM and 10:00 PM. There was no evidence of documentation of the administration in the MAR on for 2:00 PM.

On at 2:30 PM, a side by side review of Resident #30's , MARs were conducted with the East wing unit manager. In interview, she acknowledged the findings. She stated she will speak to the attending nurse who worked that day, to find out what happened. On at 4:16 PM, the East side unit manager returned with follow up information. She divulged that she spoke to the attending nurse, who revealed she was sure she administered the medications but forgot to document it in the MARs.

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

a. A Health Care Provider's (HCP) order, dated , ordered 125 micrograms daily. Review of her , medication administration record (MAR) revealed no initials or evidence documenting the resident received

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N 101	Continued From page 6 the dose scheduled for b. A HCP's order, dated , ordered 40 milligrams. Review of her MAR revealed no initials or evidence documenting she received the dose scheduled for c. A HCP's order, dated , ordered 1 milligram every 8 hours. Review of her MAR revealed no initials or evidence documenting she received the dose scheduled for at 2:00 PM. Further review of her clinical records revealed no documentation showing whether the resident received these doses or not. This was brought to the attention of the East Wing Unit Manager on at 9:38 AM. She stated she was familiar with the situation; it had been discussed with the nurse involved who stated she gave the resident the medications but did not update the MAR. 4. Review of the record revealed Resident #5 was admitted to the facility on . Review of the current Minimum Data Set (MDS) assessment, dated , 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 . Review 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 psych services. Review of the Medication Review,	N 101		

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N 101	Continued From page 7 dated ..., and the ... Medications Quarterly Evaluation, dated ..., both documented Resident #5 was still receiving the ... The ... had been discontinued on ... and Resident #5 was only taking one other medication for ... control. Review of the record revealed the current care plan, dated ..., with the latest update on ..., documented Resident #5 was at risk for side effects related to ... medication use. 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. 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 on ..., 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	N 101		

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N 101	Continued From page 8 should have been resolved in Class III	N 101		
N 201 SS=D	400.022(1)(l), FS Right to Adequate and Appropriate Health Care The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services, if available; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan, with established and recognized practice standards within the community, and with rules as adopted by the agency. This Statute or Rule is not met as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to ensure 2 of 3 sampled residents had their properly secured and maintained lower than the level of the , to prevent or potential (Residents #55 and #69). The findings included: 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. 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	N 201	1. Resident #55 was evaluated by the Unit Manager on , and had a strap applied on with no negative outcome noted. Resident #69 was evaluated by the Unit Manager on , and had a strap applied on with no negative outcome noted. 2. Residents who had were audited by the Unit Manager on to ensure proper placement of straps. No additional residents with were found without straps. Staff B, C, D were reeducated by SDC on on the appropriate use of strap for residents with 3. Nursing staff were reeducated by SDC/DON/RCD by regarding proper technique and placement of straps for residents with	

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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 bag. A (a flexible tube to 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's in any manner. The CNA washed her and donned gloves. Staff B 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 . While doing this, the CNA pulled on the bag, and the tubing, coming from the abdomen, was stretched and pulled taunt. Staff B did not notice, so the surveyor intervened in order to stop the CNA from pulling the tubing. Staff B finished emptying the bag, and cleaned the outside of the bag with a personal cleansing wipe. The CNA failed to secure the tubing to the resident's upon finishing the task. Review of the record revealed Resident #55 was admitted to the facility on , with an , 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 documented Resident #55 had a related to retention of (difficulty) and	N 201	. This education will be presented to newly hired licensed nurses as part of the general orientation. DON/Designee will conduct random weekly audits regarding the appropriate use of the strap 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.	

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N 201	Continued From page 10 , (inability of to drain through the tract). Additional diagnoses included (of the) and long-term use of . Review of laboratory results and orders revealed Resident #55 was treated for ( ), starting on and , 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 changes, starting in of 2019. 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.	N 201		

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N 201	Continued From page 11 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 the bed, with a dignity cover. The tubing was not secured to the resident's in any manner. Staff C provided personal care. Resident #69 stated she was ready to get up. The CNA explained she wanted to get the resident dressed, and it would take some time to finish, before changing the night bag to the bag. The surveyor asked the CNA to call her when she was ready to change the night bag to the bag. During the continued observation at 11:15 AM, Staff C removed a new bag from the packaging, and took a SurePrep wipe (a skin protectant normally used during care, that did contain) and opened it. The surveyor asked what it was, and Staff C verified it was the wipe she was going to use. The surveyor questioned the CNA about using an wipe instead, but the CNA confirmed she was going to use the SurePrep. After the observation, the West Unit Manager informed the surveyor that the CNA had questioned the use of the SurePrep, and the Unit Manager had instructed the CNA to clean the connection with an wipe. On at 6:00 PM, 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 ever taped or secured it to her in anyway, Resident #69 said "No." During an observation on at 10:48 AM, Resident #69 was still in bed. An observation of the resident's with Staff C revealed the	N 201		

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	95607	A. BUILDING: ______ 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 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 12 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 as of and was treated with the twice daily for 7 days. Review of the current care plans lacked any 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 swabs to clean the end of the drainage tube. Class III	N 201		

Agency for Health Care Administration

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CZ814 SS=C	435.12(2)(b-d), FS Background Screening 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 individual taxpayer 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 10 sampled staff reviewed (Staff A).	CZ814	1. Staff A was added to the Clearinghouse Roster by the HR generalist on . 2. An audit of the AHCA Clearinghouse Roster with current employees was conducted on by HR Generalist	

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CZ814	Continued From page 1 The findings included: During interview and record review conducted with the HR (Human Resources) Generalist, on beginning at 9:50 AM, the Clearinghouse Roster was reviewed. The HR Generalist acknowledged Staff A (date was noted as) was not listed on the facility's Clearinghouse Roster. She also acknowledged Staff A works over 20 hours each week for this facility and should have been entered on the Clearinghouse Roster. Unclassified	CZ814	to include staff. Clearinghouse roster was complete with current employees and staff. 3. HR generalist was re-educated by NHA on regarding the importance of accuracy of the Clearinghouse Roster. NHA/Designee will randomly audit the Clearinghouse Roster. 4. The results of the audits will be presented to the QA Committee for further review and recommendations monthly for three months and as deemed necessary, thereafter.	

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	105819	A. BUILDING ______ B. WING ______	10/03/2019

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F 000	INITIAL COMMENTS 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.	F 000		
F 690 SS=D	CFR(s): 483.25(e)(1)-(3) §483.25(e) . §483.25(e)(1) The facility must ensure that resident who is of and on admission receives services and assistance to maintain unless his or her clinical condition is or becomes such that is not possible to maintain. §483.25(e)(2)For a resident with , based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an is not unless the resident's clinical condition demonstrates that was necessary; (ii) A resident who enters the facility with an or subsequently receives one is assessed for removal of the as soon as possible unless the resident's clinical condition demonstrates that is necessary; and (iii) A resident who is of receives appropriate treatment and services to prevent , and to restore to the extent possible.	F 690		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(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 program participation.

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F 690	Continued From page 1 §483.25(e)(3) For a resident with fecal , based on the resident's comprehensive assessment, the facility must ensure that a resident who is of receives appropriate treatment and services to restore as much normal function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to ensure 2 of 3 sampled residents had their properly secured and maintained lower than the level of the , to prevent or potential . (Residents #55 and #69). The findings included: 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. 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 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	F 690	1. Resident #55 was evaluated by Unit Manager on , and had a strap applied on 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. 2. Residents who had were audited by Unit Manager on to ensure proper placement of straps. No additional residents with 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 . The education will be presented to newly hired licensed nurses as part of general orientation.	

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F 690	Continued From page 2 tubing was not secured to the resident's in any manner. The CNA washed her and donned gloves. Staff B 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 . While doing this, the CNA pulled on the bag, and the tubing, coming from the abdomen, was stretched and pulled taunt. Staff B did not notice, so the surveyor intervened in order to stop the CNA from pulling the tubing. Staff B finished emptying the bag, and cleaned the outside of the bag with a personal cleansing wipe. The CNA failed to secure the tubing to the resident's upon finishing the task. Review of the record revealed Resident #55 was admitted to the facility on , with an , 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 documented Resident #55 had a related to retention of (difficulty) and (inability of to drain through the tract). Additional diagnoses included (of the) and long-term use of . Review of laboratory results and orders revealed Resident #55 was treated for ( ), starting on and	F 690	DON/Designee will conduct random weekly audits regarding the appropriate use of the strap 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.	

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F 690	Continued From page 3 , 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 changes, starting in of 2019. 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	F 690		

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F 690	Continued From page 4 the bed, with a dignity cover. The tubing was not secured to the resident's in any manner. Staff C provided personal care. Resident #69 stated she was ready to get up. The CNA explained she wanted to get the resident dressed, and it would take some time to finish, before changing the night bag to the bag. The surveyor asked the CNA to call her when she was ready to change the night bag to the bag. During the continued observation at 11:15 AM, Staff C removed a new bag from the packaging, and took a SurePrep wipe (a skin protectant normally used during care, that did contain) and opened it. The surveyor asked what it was, and Staff C verified it was the wipe she was going to use. The surveyor questioned the CNA about using an wipe instead, but the CNA confirmed she was going to use the SurePrep. After the observation, the West Unit Manager informed the surveyor that the CNA had questioned the use of the SurePrep, and the Unit Manager had instructed the CNA to clean the connection with an wipe. On at 6:00 PM, 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 ever taped or secured it to her in anyway, Resident #69 said "No." During an observation on at 10:48 AM, Resident #69 was still in bed. An observation of the resident's with Staff C revealed the 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	F 690		

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F 690	Continued From page 5 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 as of and was treated with the twice daily for 7 days. Review of the current care plans lacked any 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 swabs to clean the end of the drainage tube.	F 690		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) 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	F 760		

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F 760	Continued From page 6 by: Based on observation, interview, and record review, the facility failed to ensure 1 of 10 sampled residents observed during the medication pass observations, was free of a potential significant medication error (Resident #26). Thirteen different nurses administered the incorrect dose of (a medication for) for 22 consecutive days. The findings included: A medication pass observation was attempted for Resident #26 on at 4:34 PM. Staff F, a Registered Nurse (RN), looked in her cart for the one medication due at that time, and was unable to find it. The RN explained that 850 milligrams (mg) was due, but she could only find a pack (the packaging used to supply individual doses of a medication) for 500 mg. The RN summoned the West Unit Manager, who was also unable to locate a 850 mg pack in the medication cart. The Unit Manager stated she would look in the overflow medications. During a subsequent interview on at 5:14 PM, the Unit Manager informed the surveyor and Staff F they did not have 850 mg in the Pyxis (storage of extra medications). The Unit manager explained she had since phoned the physician, reviewed the recent results with him over the phone, and he changed the order to 500 mg. Observation of the 500 mg pack in the medication cart revealed an order date of for the quantity of 60 tablets. Seven tablets were left in the pack. When asked about the 850 mg tablets, the Unit Manager	F 760	1. Resident #26 was evaluated by Unit Manager on , and no negative outcome was noted. The physician was notified by the Unit Manager on and the physician's order was changed to 500mg. 2. An audit was conducted by the supervisor on regarding residents utilizing . A full MAR to Cart check was done of all medications by Unit Managers on . No other residents were noted to be affected. Staff G was re-educated by Unit Manager on regarding medication administration principles to include verifying the correct dose with the Physician's order. 3. Licensed nursing staff were re-educated by SDC/DON/RCD by regarding medication administration principles to include verifying the correct dose with the Physician's order. The education will be presented to newly hired licensed nurses as part of general orientation. DON/Designee will conduct random weekly audits of medication administration. 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.	

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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 . 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. On 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 500 mg tablets since , instead of the ordered 850 mg tablets. The DON stated she called the pharmacy, and they told her they had received the order for the 850 mg, but never received the order to discontinue the 500 mg tablets. The pharmacy told the DON they had sent a fax to the facility for confirmation, but never heard . The DON was unable to locate any fax. The DON questioned the pharmacy as to why they didn't follow up, but did not get a reason. The DON stated she also contacted their Pharmacy Consultant for review of the situation. The DON stated there would be medication error paperwork done for each nurse involved. The DON also agreed with the concern with both the pharmacy and the lack of any nurse questioning the dose for the past 22 days. Further review of the MAR revealed 13 different nurses failed to identify that the 850 mg dose had not been ordered or delivered between the dates of and , and that the 13 nurses provided the wrong dose of the .	F 760		

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F 760	Continued From page 8 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 for 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 760		
F 842 SS=D	Resident Records - Identifiable Information 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	F 842		

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F 842	Continued From page 9	F 842		

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
( ) The results of any preadmission screening

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	105819	A. BUILDING ______ 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

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F 842	Continued From page 10 and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, , and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure accurate and complete records for 4 of 26 records reviewed, as evidenced by failure to document the re-evaluation of monitoring after administration to Resident #34; failure to ensure documentation of 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: 1. Record review was conducted of Resident #34's MARs (medication administration records). The MARs showed evidence of a Physician order, dated , that indicated a with the following instructions: if was greater than 400 (mg/dl), give 14 units of and recheck in 1 ½ hours. Call the Medical Doctor if the was still elevated. Resident #34's records evidenced she had received 14 units of on for elevated of 448 mg/dl at 11:30 AM. Resident #34 also received 14 units of on for elevated of 407 mg/dl at 11:30 AM. Review of Resident #34's records lacked evidence of re-evaluation of the level, following the administrations on the mentioned dates.	F 842	1. Resident #34 was evaluated by Unit Manager on and no negative outcome was noted. Resident #30 was evaluated by Unit Manager on and no negative outcome was noted. Resident #49 was evaluated by Unit Manager on and no negative outcome was noted. Resident #5 care plan was updated by MDS Lead on . 2. An audit was conducted by DON on regarding the documentation of medications administered on the Medication Administration Record. Affected residents licensed nurses received one on one education by the DON. An audit was conducted by the DON & MDS Lead on regarding the accuracy of care plans. No other residents were noted to be affected. 3. Licensed Nurses were re-educated by SDC on regarding the documentation principles of medication administration. Licensed nurses were re-educated by SDC/DON/RCD by regarding ensuring the accuracy of care plans. The education will be	

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F 842	Continued From page 11 On at 11:14 AM, a side by side review of Resident #34's records and interview with the East wing unit manager was conducted. She acknowledged the findings. She stated she will speak to the nurses to find out what happened. On at 12:33 PM, the East wing unit manager voiced she had spoken to the nurses who attended to Resident #34 on the mentioned dates. The nurses claimed that Resident #34's levels were re-evaluated following the 14 units administration, but they forgot to document the results in the resident's records. 2. On at 2:00 PM, the MARs (medication administration record), dated for , were reviewed for Resident #30. The MARs were noted with lack of documentations for the following Physician orders, of the following medications: A- 125 mcg for (irregular beat) was scheduled for 2:00 PM. There was no evidence of documentation of the administration in the MAR for . B- for (that affects the functioning of) was scheduled for 6:00 AM, 2:00 PM, and 10:00 PM. There was no evidence of documentation of the administration in the MAR on for 2:00 PM. C- Merrem for (bone) was scheduled for 6:00 AM, 2:00 PM and 10:00 PM. There was no evidence of documentation of the administration in the MAR on for 2:00 PM.	F 842	presented to newly hired licensed nurses as part of general orientation. DON/Designee will conduct random weekly audits of medication administration records and care plans. 4. The results of the audits will be presented to the QA Committee for further review and recommendations monthly for three months and as deemed necessary, thereafter.	

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F 842	Continued From page 12 On at 2:30 PM, a side by side review of Resident #30's , MARs were conducted with the East wing unit manager. In interview, she acknowledged the findings. She stated she will speak to the attending nurse who worked that day, to find out what happened. On at 4:16 PM, the East side unit manager returned with follow up information. She divulged that she spoke to the attending nurse, who revealed she was sure she administered the medications but forgot to document it in the MARs. 3. Resident #49 was admitted to the facility on with the pertinent diagnosis of . Review of her clinical records conducted on revealed the following concerns: a. A Health Care Provider's (HCP) order, dated , ordered 125 micrograms daily. Review of her medication administration record (MAR) revealed no initials or evidence documenting the resident received the dose scheduled for . b. A HCP's order, dated , ordered 40 milligrams. Review of her MAR revealed no initials or evidence documenting she received the dose scheduled for . c. A HCP's order, dated , ordered 1 milligram every 8 hours. Review of her , MAR revealed no initials or evidence documenting she received the dose scheduled for at 2:00 PM.	F 842		

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F 842	Continued From page 13 Further review of her clinical records revealed no documentation showing whether the resident received these doses or not. This was brought to the attention of the East Wing Unit Manager on at 9:38 AM. She stated she was familiar with the situation; it had been discussed with the nurse involved who stated she gave the resident the medications but did not update the MAR. 4. a. Review of the record revealed Resident #5 was admitted to the facility on . Review of the current Minimum Data Set (MDS) assessment, dated , 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 . Review 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 psych services. Review of the Medication Review, dated , and the Medications Quarterly Evaluation, dated ,, both documented Resident #5 was still receiving the . The had been discontinued on and Resident #5 was only taking one other medication for , control. Review of the record revealed the current care plan, dated , with the latest update on , documented Resident #5 was at risk for side effects related to medication use.	F 842		

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F 842	Continued From page 14 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 on , 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 .	F 842		