STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION,

Petitioner,

v. AHCA No. 2018004847

SF CARNEGIE, LLC d/b/a WAVE CREST HEALTH AND REHABILITATION CENTER,

Respondent.
_____/

FINAL ORDER

Having reviewed the Administrative Complaint, and all other matters of record, the Agency for Health Care Administration finds and concludes as follows:

1. The Agency issued the attached Administrative Complaint and Election of Rights form to the Respondent. (Ex. 1). The Election of Rights form advised of the right to an administrative hearing. The Respondent returned the Election of Rights form selecting "Option 1" (Ex. 2), thus waiving the right to a hearing to contest the allegations and sanction sought in the Administrative Complaint.

Based upon the foregoing, it is **ORDERED:**

2. The findings of fact and conclusions of law set forth in the Administrative Complaint are adopted and incorporated by reference into this Final Order.

3. The Respondent shall pay the Agency $46,000.00. If full payment has been made, the cancelled check acts as receipt of payment and no further payment is required. If full payment has not been made, payment is due within 30 days of the Final Order. Overdue amounts are subject to statutory interest and may be referred to collections. A check made payable to the "Agency for Health Care Administration" and containing the AHCA ten-digit case number should be sent to:

Central Intake Unit
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 61
Tallahassee, Florida 32308

4. Conditional licensure status is imposed on the Respondent beginning January 5, 2018, and ending January 31, 2018.

ORDERED at Tallahassee, Florida, on this 5 day of June, 2018.

Justin M. Senior, Secretary
Agency for Health Care Administration

NOTICE OF RIGHT TO JUDICIAL REVIEW

A party who is adversely affected by this Final Order is entitled to judicial review, which shall be instituted by filing one copy of a notice of appeal with the Agency Clerk of AHCA, and a second copy, along with filing fee as prescribed by law, with the District Court of Appeal in the appellate district where the Agency maintains its headquarters or where a party resides. Review of proceedings shall be conducted in accordance with the Florida appellate rules. The Notice of Appeal must be filed within 30 days of rendition of the order to be reviewed.

CERTIFICATE OF SERVICE

I CERTIFY that a true and correct copy of this Final Order was served on the below-named persons by the method designated on this 6th day of June, 2018.

Richard J. Shoop, Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 3
Tallahassee, Florida 32308
Telephone: (850) 412-3630

Facilities Intake Unit Agency for Health Care Administration (Electronic Mail)	Central Intake Unit Agency for Health Care Administration (Electronic Mail)
Thomas J. Walsh II, Senior Attorney Office of the General Counsel Agency for Health Care Administration (Electronic Mail)	Shegetta Williams, Administrator SF Carnegie, LLC d/b/a Wave Crest Health and Rehabilitation Center 1415 South Hickory Street Melbourne, Florida 32901

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

vs.

Case No.	2018004847
License No.	10740961
File No.	70502
Facility Type:	Nursing Home

SF CARENGIE, LLC d/b/a
WAVE CREST HEALTH AND REHABILITATION CENTER,

Respondent.
_____/

ADMINISTRATIVE COMPLAINT

COMES NOW the Agency for Health Care Administration (hereinafter "Agency"), by and through the undersigned counsel, and files this Administrative Complaint against SF Carnegie, LLC d/b/a Wave Crest Health and Rehabilitation Center (hereinafter "Respondent"), pursuant to §§120.569 and 120.57 Florida Statutes (2017), and alleges:

NATURE OF THE ACTION

This is an action to change Respondent's licensure status from Standard to Conditional commencing January 5, 2018, to impose administrative fines in the amount of forty thousand dollars ($40,000.00), and the imposition of a two (2) year survey cycle and its six thousand dollars ($6,000.00) fee, based upon Respondent being cited for four (4) isolated State Class I deficiencies.

JURISDICTION AND VENUE

1. The Agency has jurisdiction pursuant to §§ 120.60 and 400.062, Florida Statutes (2017).

2. Venue lies pursuant to Florida Administrative Code R. 28-106.207.

EXHIBIT 1

PARTIES

3. The Agency is the regulatory authority responsible for licensure of nursing homes and enforcement of applicable federal regulations, state statutes and rules governing skilled nursing facilities pursuant to the Omnibus Reconciliation Act of 1987, Title IV, Subtitle C (as amended), Chapters 400, Part II, and 408, Part II, Florida Statutes, and Chapter 59A-4, Florida Administrative Code.

4. Respondent operates a one hundred thirty-eight (138) bed nursing home, located at 1415 South Hickory Street, Melbourne, Florida 32901, and is licensed as a skilled nursing facility license number 10740961.

5. Respondent was at all times material hereto, a licensed nursing facility under the licensing authority of the Agency, and was required to comply with all applicable rules, and statutes.

COUNT I

6. The Agency re-alleges and incorporates paragraphs one (1) through five (5), as if fully set forth herein.

7. That Florida law provides "All physician orders shall be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift." Rule 59A-4.107(5), Florida Administrative Code.

8. That on January 5, 2018, the Agency completed a survey of Respondent and its facility.

9. That based upon observation, the review of records, and interview, Respondent failed to follow physician orders, and if not document the reason why, including Respondent's administration of medications to a resident in a total dosage in excess of eighty (80) times the prescribed amount, the same being contrary to the mandates of law.

10. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted:

a. The resident was eighty-nine (89) years of age and was admitted to the facility on September 7, 2017 with diagnoses including chronic obstructive pulmonary disease (COPD) and atrial fibrillation.

b. Prior to admission, the resident resided at home with an adult child and was under the care of hospice for end stage COPD.

c. The resident was admitted to the Respondent facility for respite care with plans to remain living there as a long term care resident under hospice care.

d. A Psychiatric Initial Mental Status Exam, dated September 21, 2017 provided:

i. The psychiatrist's recommendation was "Will give trial Haldol times 2 weeks and follow."

ii. The psychiatrist wrote an order in the medical record for Haldol 0.25 mg [milligrams] every 2PM and bedtime for 14 days for a diagnosis of major depressive disorder.

e. A Medication Order Summary Recapitulation dated 9/1/17-1/31/18, documented:

i. An order for "Haloperidol tablet 20 MG-Give 1 tablet two times a day for psychosis."

ii. It did not indicate the Haldol was ordered for fourteen (14) days.

iii. The facility schedule for twice a day is 9:00 a.m. and 5:00 p.m.

f. The resident's medication administration record showed four doses of the Haldol 20 mg medication were administered: September 22, 2017 at 9:00

a.m.; September 23, 2017 at 9:00 a.m. and 5:00 p.m.; and September 24, 2017 at 9:00 a.m.

g. There was no physician's order for the resident to be provided 20 mg of Haldol twice a day for psychosis.

h. A Medication Discrepancy Report dated September 21, 2017 documented, "Order was written for Haldol 0.25 MG, nurse entered order for Haldol 20 MG. Increased lethargy noted. Attending physician notified on 9/24/17 and family notified on 9/25/17. [Resident] placed on hospice continuous crisis care to monitor adverse effects of the excessive dose of Haldol."

i. A Medication Discrepancy Report dated September 25, 2017, indicated "Resident received an unordered dose of medication. Order was written for Haldol 0.25 mg. Nurse entered order for Haldol 20 mg, increased lethargy noted. Family, physician and hospice notified. Crisis care provided, Haldol discontinued."

j. A hospice Continuous Care Shift Care Note, dated September 26, 2017, indicated the resident was "rubbing hands on pillow, kicking at sheets and resident sliding [] heels over the bed all night nearly causing blisters."

k. A Progress Note dated September 27, 2017, indicated the resident was sent to the hospital emergency department for evaluation.

l. Hospital records for the resident reflect:

   i. A Progress Note, dated September 27, 2017, provides "Given Haldol, but unintentionally given at a higher dose than was prescribed or intended. Brought in at acute encephalopathy (delirium and acute confused state)

with mental status changes. To be closely watched. Chief complaint: Decreased mental status and confusion (given 20 mg of Haldol rather than prescribed 0.25 mg.). Patient has generalized weakness and difficulty walking. Patient has been off medication for 2 days and is waking more but still confused, too weak to walk and hallucinating. This seems to be all medication induced."

ii. The hospital record indicated the resident was in the hospital for six (6) days.

11. That Petitioner's representative interviewed Respondent's licensed practical nurse "A" on January 2, 2018 as 12:15 p.m. regarding resident number one (1) and the nurse indicated:

a. He had entered the Haldol order into the electronic system with the wrong dose, 20 mg instead of 0.25 mg, and with the wrong times, 9:00 a.m. and 5:00 p.m. instead of 9:00 a.m. and bedtime and with no stop date.

b. He was unable to explain how the error occurred except that he was very busy.

c. He could not explain how he obtained the psychosis diagnosis for the Haldol.

d. Once an order is entered, it is the assigned task of the 11:00 p.m. to 7:00 a.m. nurse to verify each order against the written order to ensure the information has been entered correctly.

e. The night nurse reconciles the order, marks it with a red check mark, dates and initials the written order.

f. He verified the Haldol order had not been checked as there were no markings on the written order by the night nurse.

g. "The night nurse missed checking the order. If the order had been checked, the error could have been corrected immediately."

12. That Petitioner's representative interviewed Respondent's nurse "B" on January 3, 2018 at 7:30 a.m. regarding how physicians' orders are checked and the nurse indicated she had resident number one (1) assigned to her on the night shift on September 22, 2017, confirmed the order had been missed, and could not remember the resident or the order.

13. That Petitioner's representative interviewed Respondent's risk manager on January 2, 2018 as 1:10 p.m. regarding resident number one (1) and the manager indicated:

a. The resident was prescribed an order for 0.25 mg of Haldol at 2:00 p.m. and at bedtime for fourteen (14) days by the psychiatrist.

b. The order was transcribed for Haldol 20 mg at 9:00 a.m. and 5:00 p.m. with no stop date.

c. Four (4) incorrect doses of the medication were administered: September 22, 2017 at 9:00 a.m.; September 23, 2017 at 9:00 a.m. and 5:00 p.m.; and September 24, 2017 at 9:00 a.m.

d. Following her investigation for the medication error report, it was determined the nurse "made a medication transcription error."

e. At that time, the risk manager was unable to provide additional documentation of processes put in place to prevent future significant medication errors.

f. Only six (6) nurses received the education that was provided and the audit to review psychotropic medications occurred only once within a few days of the incident.

g. There was no evidence of any continued monitoring for sustained compliance

or any other education regarding medication errors.

14. That Petitioner's representative conducted a check of written physician orders with Respondent's unit manager of the north wing on January 4, 2018 at 1:30 p.m. and noted:

a. Of eleven (11) written physician orders checked, only two (2) had the mandated check marks, date, and initials by the order indicating that they had been checked by the night nurses.

b. The unit manager stated that the night nurses were responsible for checking the orders but added that the process was not being followed consistently.

15. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Medication Errors and Adverse Reactions," dated November 2017, that provided:

a. "Drug errors and adverse drug reactions should be reported to the resident's attending physician.

b. "Policy Interpretation and Implementation:

i. "1. Adverse drug reactions and drug errors with adverse clinical consequences should be reported to the resident's attending physician.

ii. "2. Nursing services should implement and follow the physician orders. The resident's condition should be closely observed for 72 hours or as may be directed...

iii. "4. Documentation of the resident's condition and response to treatment should be recorded during the observation period."

16. That the above reflects Respondent's failure to follow physician orders, and if not document the reason why, including Respondent's administration of medications to a resident in a total dosage in excess of eighty (80) times the prescribed amount.

17. That the above described noncompliance caused or is likely to cause serious injury, harm, impairment, or death to residents.

18. That the Agency determined that this deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility, and cited Respondent with an isolated Class I deficient practice.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(8)(a), Florida Statutes (2017).

COUNT II

19. The Agency re-alleges and incorporates paragraphs one (1) through five (5), as if fully set forth herein.

20. That pursuant to Florida law, the nursing home licensee must adopt procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident. Rule 59A-4.112(1), Florida Administrative Code.

21. That on January 5, 2018, the Agency completed a survey of Respondent and its facility.

22. That based upon observation, the review of records, and interview, Respondent failed to adopt procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident, including but not limited to the failure to implement procedures to prevent the appropriate prescribed parameters of a psychotropic medication resulting in a resident receiving eighty (80) times the prescribed dosage, the same being contrary to the mandates of law.

23. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted:

a. The resident was eighty-nine (89) years old and was admitted to the facility on the south wing on September 7, 2017 with diagnoses including chronic obstructive pulmonary disease, (COPD) and atrial fibrillation.

b. The resident had resided at home with an adult child and was receiving hospice care for end stage COPD.

c. The resident was admitted to the facility for respite care with plans to continue residing as a long term care resident with hospice care.

d. On September 21, 2017, the resident was transferred to the north wing.

e. A nursing progress note dated September 21, 2017 noted that the resident was moved to the north wing as previously agreed with family as the resident was to remain at the facility for long term care with hospice services.

f. On the day the resident was transferred to the north wing, an unknown nurse requested the consulting psychiatrist to see the resident despite no physician order for a consult and no documented behaviors.

g. The psychiatrist's note, dated September 21, 2017, read, "resident generally pleasant but appears distressed. Will trial Haldol 0.25 milligrams (mg) times 2 weeks and follow."

h. The order, dated September 21, 2017, prescribed Haldol 0.25 mg at 2:00 PM and at bedtime by mouth for 14 days.

i. The licensed practical nurse, nurse "A," processed the psychiatrist's written order and transcribed the order in the electronic medical record as Haldol 20

mg, give one (1) tablet by mouth two times a day at 9:00 a.m. and 5:00 p.m. for psychosis.

j. The resident received four (4) doses of Haldol 20 mg administered on September 22, 2017 at 9:00 a.m.; September 23, 2017 at 9:00 a.m. and 5:00 p.m.; and September 24, 2017 at 9:00 a.m.

24. That Petitioner's representative interviewed Respondent's licensed practical nurse "A" on January 2, 2018 as 12:15 p.m. regarding resident number one (1) and the nurse indicated:

a. He had entered the Haldol order into the electronic system with the wrong dose, 20 mg instead of 0.25 mg, and with the wrong times, 9:00 a.m. and 5:00 p.m. instead of 9:00 a.m. and bedtime and with no stop date.

b. He was unable to explain how the error occurred except that he was very busy.

c. He could not explain how he obtained the psychosis diagnosis for the Haldol.

d. Once an order is entered, it is the assigned task of the 11:00 p.m. to 7:00 a.m. nurse to verify each order against the written order to ensure the information has been entered correctly.

e. The night nurse reconciles the order, marks it with a red check mark, dates and initials the written order.

f. He verified the Haldol order had not been checked as there were no markings on the written order by the night nurse.

g. "The night nurse missed checking the order. If the order had been checked, the error could have been corrected immediately."

25. That Petitioner's representative conducted a check of written physician orders with

Respondent's unit manager of the north wing on January 4, 2018 at 1:30 p.m. and noted:

a. Of eleven (11) written physician orders checked, only two (2) had the mandated check marks, date, and initials by the order indicating that they had been checked by the night nurses.

b. The unit manager stated that the night nurses were responsible for checking the orders but added that the process was not being followed consistently.

26. That Petitioner's representative interviewed Respondent's clinical educator on January 5, 2018 as 3:15 p.m. regarding Respondent's process for the entry of physician orders into Respondent's electronic medical record and noted as follows:

a. The process was that when the physician wrote an order in the paper medical record, the order is flagged, and the nurse then transcribes the order into the electronic medical record system.

b. She showed how to enter Haldol into the system.

c. Once she selected Haldol for a resident, there was a drop down menu for the dosage.

d. There was no 0.25 mg dosage for Haldol with the smallest dose of 0.5 mg.

e. She stated that the nurse would have to select 0.5 mg and then in the narrative section, would write, "give ½ tablet," as there was no option to enter 0.25 mg.

f. When asked, if this was why the error was made, she stated "No," as the 20 mg was well below the 0.5 mg option.

g. "I don't know how [licensed practical nurse "A"] selected 20 mg."

h. There was no other double check system in the system in the computer system.

i. Once the order is transcribed into the computer system, it is directly transmitted to the pharmacy.

j. The double check was for the night shift staff to reconcile the written orders with the electronic orders.

27. That Petitioner's representative interviewed Respondent's risk manager on January 5, 2018 as 3:00 p.m. regarding resident number one (1) and the manager indicated:

a. She was the acting director of nursing during the time of the resident's medication error.

b. She confirmed that the medication error was discovered after the resident had received four (4) doses of the medication.

c. The resident's family became concerned on September 24, 2017 as the resident lethargic and was very confused.

d. The process for medication order reconciliation was that the night nurses working 11:00 p.m. to 7:00 a.m. shift would obtain an electronic report of all medication orders written during the day and compare the written orders to ensure that the electronic orders matched the physician orders.

e. "Unfortunately, this did not happen."

f. The medication should also have been checked during the morning meeting when all physician orders obtained in the last twenty-four (24) hours were reviewed.

g. "I don't know what happened. I guess the order was not checked."

h. She confirmed that their system for double checks failed.

i. When questioned as to how the licensed practical nurse "A" obtained a

diagnosis of psychosis for Haldol since there was no indication of psychosis in the resident's medical record, the risk manager was not able to provide an answer stating, "I am not sure."

j. When asked how medication orders were monitored to ensure residents received the correct medication in a safe manner, she stated that they are now working on implementing the double and triple check system as it was evident that it was not being done consistently.

28. That Petitioner's representative interviewed Respondent's pharmacy consultant on January 5, 2018 as 11:30 a.m. regarding resident number one (1) and the consultant indicated:

a. She was made aware of the Haldol medication error on the day it was discovered, September 24, 2017.

b. Once the written physician order is entered into the facility's computer system, it is automatically received at the pharmacy.

c. The facility is not required to fax the written order to the pharmacy.

d. The Haldol 20 mg twice daily order would not have caught the pharmacist's attention.

e. The pharmacy serviced many types of facilities and 20 mg of Haldol was not a red flag as high doses were used.

f. If she had seen the resident, an order for Haldol 20 mg would have caught her attention as it was an excessive dose for an eighty-nine (89) year-old geriatric resident.

g. The resident could have extra pyramidal symptoms to indicate toxicity such as lethargy, stupor and weakness.

29. That Petitioner's representative interviewed Respondent's registered nurse unit manager on January 4, 2018 as 1:30 p.m. regarding resident number one (1) and the manager indicated:

a. Night nurses were responsible for checking the orders but the process was not being done consistently.

b. When asked if she would question an order of Haldol 20 mg for a geriatric resident with no behaviors, she stated she would not.

c. She would not question the order, but would ensure the resident's vital signs were okay.

d. If it was an issue, "... pharmacy would alert us."

30. That Petitioner's representative interviewed Respondent's licensed practical nurse "B" on January 4, 2018 as 4:25 p.m. regarding resident number one (1) and the nurse indicated:

a. She would not question the order for Haldol 20 mg twice daily for a geriatric resident.

b. They were accustomed to seeing large doses of medications being used for some residents, especially residents receiving hospice care.

31. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Psychopharmacologic Drugs," dated November 2017, that provided:

a. The purpose is to provide guidelines for the use of psychopharmacologic drug treatment of a resident with a specific condition as diagnosed and documented in the clinical record.

b. Procedural Guidelines:

i. 1. Psychopharmacologic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotics, and "other" drugs that affect

behaviors.

ii. 2. Psychopharmacologic drugs shall be used only after alternative methods have been tried unsuccessfully and only upon the written order of a physician. Notification must be complete with the resident or his/her representative for antipsychotic drug therapy.

iii. 3. The resident or his/her representative will be given information regarding the need for, the desired effects and the potential side effects of the antipsychotic medication. This enables the resident or his/her representative to make an informed decision regarding the use of an antipsychotic medication.

iv. 4. Psychopharmacologic drugs will not be used to limit or control behavior...

v. 5. Nurses will observe for side effects and medical staff will reduce dosage to the minimum required...

vi. 6. Nurses will document episodes of behavior, the impact of the medication on behavior and the presence or absence of side effects.

vii. 7. Nursing services, social services and other members of the interdisciplinary team will address the behaviors on the care plan. Medication is not the sole approach for behavioral intervention. Other interventions will be identified on the care plan...

c. Unnecessary Drugs - Each resident's drug regimen must be free from unnecessary drugs.

d. Unnecessary drugs are any drugs when used:

i. a. In excessive dose...

ii. c. Without adequate monitoring, and

iii. d. Without adequate indications for its use.

e. The Antipsychotic Drugs section read, "1. Residents who have not used antipsychotic drugs will not be given such drugs unless antipsychotic drug therapy is necessary to treat a specific condition: a. Schizophrenia, b. Schizo-affective disorder, c. Schizophreniform disorder, d. Delusional disorder, e. Mood disorders, f. Psychosis in the absence of dementia..."

32. That Haldol has side effects and adverse reactions that may include: Neuroleptic malignant syndrome (NMS), manifested by fever, muscle stiffness/pain/tenderness/weakness, severe tiredness, severe confusion, sweating, fast/irregular heartbeat, dark urine, signs of kidney problems (such as change in the amount of urine), Extrapyramidal symptoms may occur including acute dystonic reactions, akathisia, tardive dyskinesia (facial/muscle twitching such as tongue thrusting, chewing movements, puffing or puckering of your mouth, or uncontrollable shaking), and pseudoparkinsonism, which may be permanent, Slow heartbeat, severe dizziness, chest pain, and fainting. (www.drugs.com)

33. That Haldol is listed by The 2015 American Geriatrics Society Updated Beers Criteria: Medications that Older Adults Should Avoid or Use with Caution. (http://www.healthinaging.org/medications-older-adults/).

34. That the above reflects Respondent's failure to adopt procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident, including but not limited to the failure to ensure its policies and procedures regarding the acquisition, including the need for the medication, receiving,

dispensing, and administration of medications ensured physician ordered medication needs are met.

35. That the above described noncompliance caused or is likely to cause serious injury, harm, impairment, or death to residents.

36. That the Agency determined that this deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility, and cited Respondent with an isolated Class I deficient practice.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(8)(a), Florida Statutes (2017).

COUNT III

37. The Agency re-alleges and incorporates paragraphs one (1) through five (5), as if fully set forth herein.

38. That pursuant to Florida law, all licensees of nursing homes facilities shall adopt and make public a statement of the rights and responsibilities of the residents of such facilities and shall treat such residents in accordance with the provisions of that statement. The statement shall assure each resident 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. § 400.022(1)(l), Fla. Stat. (2017).

39. That Florida law provides the following: "'Practice of practical nursing' means the

performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist. A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing." § 464.003(19), Fla. Stat. (2017).

40. That on January 5, 2018, the Agency completed a survey of Respondent and its facility.

41. That based upon observation, the review of records, and interview, Respondent failed to assure each resident 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, including but not limited to Respondent's failure to ensure a resident's drug regimen is free from unnecessary psychotropic drugs without documented evidence of an indication for use and in the absence of any behavioral symptoms and administered excess amounts of the medication to a resident, the same being contrary to the mandates of law.

42. That Petitioner's representative reviewed Respondent's records related to resident number one (1) during the survey and noted:

a. The resident was eighty-nine (89) years of age and was admitted to the facility on September 7, 2017 with diagnoses including chronic obstructive pulmonary disease (COPD) and atrial fibrillation.

b. Prior to admission, the resident resided at home with an adult child and was under the care of hospice for her end stage COPD.

c. The resident was admitted to the facility for respite care with plans to remain living there as a long term care resident under hospice care.

d. The Pre -Admission Screening and Resident Review (PASRR) dated September 7, 2017 indicated the resident had "no diagnosis or suspicion of serious mental illness."

e. The Admission Minimum Data Set (MDS) comprehensive assessment dated September 19, 2017 indicated:

i. The Brief Interview for Mental Status (BIMS) assessment was twelve (12) indicating the resident had moderated cognitive impairment.

ii. The resident was assessed to have the ability to understand others and to make self understood.

iii. The resident was assessed to have no behavior symptoms present.

iv. The resident needed extensive assistance for bed mobility, transfers, locomotion on and off the unit, dressing, toilet use, personal hygiene and bathing.

v. The resident needed limited assistance to eat and was occasionally incontinent of bowel and bladder.

f. The Minimum Data Set Care Area Assessment (CAA) Summary indicated that any concerns for Psychosocial Well-Being, Mood State, and Behavioral Symptoms did not trigger and a care plan was not developed for these areas.

g. The resident's September 2017 Medication administration record (MAR) for 9/1/17- 9/30/17, indicated the resident was receiving the following medications that were ordered upon admission on September 7, 2017:

i. Clopidogrel Bisulfate 75 milligrams (mg) 1 tablet by mouth daily for atrial fibrillation.

ii. Levothyroxine Sodium 88 micrograms (mcg) 1 tablet by mouth once a day for hypothyroidism.

iii. Ipratropium-Albuterol Solution 0.5-2.5 mg/3 milliliter (ml) inhale every 4 hours as needed for shortness of breath (SOB)/wheezing via nebulizer.

iv. Lopressor 50 mg by mouth 1 tablet every 12 hours for hypertension.

v. Senna-Plus tablet 8.6-50 mg 2 tablets at bedtime for constipation.

vi. Trazadone Hydrochloride (HCL) 50 mg tablet at bedtime for sleep.

h. An Interim care plan, dated September 7, 2017, reflected:

i. There was a check mark next to "Behavior Problem" with areas to indicate "related to" and "as evidenced by."

ii. None of the "related to" areas were checked and the area for "evidenced by" was handwritten, "insomnia."

iii. The goal of the care plan was not checked.

iv. The approach was checked to "administer and observe the effectiveness and side effects of medication as ordered (see physician orders/MAR)."

v. The care plan did not identify any other behaviors or symptoms and did not include any non-pharmacological approaches.

i. An Admission Progress Note, dated September 7, 2017 by the licensed nurse, indicated, "Resident arrived on the South Unit at approximately 7 PM with some forgetfulness. Resident denies any pain, very pleasant, diagnosis: end stage COPD."

j. A Hospice Interdisciplinary Note, dated September 12, 2017, indicated a visit to the resident in the facility noting the resident "...sitting up in wheelchair and denies pain. Resident smiling and in good spirits. No needs at this time".

k. A Progress Note, dated September 12, 2017 at 2:15 p.m., indicated "Resident's room changed to 12 D (North Unit) as previously agreed with family due to resident staying with us for LTC and hospice. Resident tolerated move well. All belongings and medications moved with resident. MD aware."

l. Respondent's documentation in progress notes is by exception only, meaning nurses do not document daily unless there is an exception to the resident's usual state.

m. Progress notes did not contain any documentation of any behaviors or symptoms of distress or insomnia.

n. A Psychiatric Initial Mental Status Exam, dated September 21, 2017, indicated:

   i. The resident was alert and clean, the mood/affect was sad, increased sleep, decreased appetite, thought content was confused and the resident did not have any delusions or hallucinations.

   ii. The Assessment/Diagnosis was listed as 32.2 meaning major depressive disorder (www.icd10data.com).

   iii. The recommendation was hand written as, "generally pleasant, but appears distressed. Will trial Haldol (0.25 mg) times 2 weeks and follow."

o. The psychiatrist wrote a new order for Haldol 0.25 mg every 2 PM and HS (bedtime) for 14 days. The indication-diagnosis was listed as 32.2 meaning

major depressive disorder (www.icd10data.com). The resident already had an order for and antidepressant medication, Trazadone Hydrochloride (HCL) 50 mg.

p. A Medication Order Summary, dated September 1 through January 31, 2018, showed an order 9/21/17, for "Haldol tablet 20 MG-Give 1 tablet two times a day for psychosis." It did not include any times for administration.

q. Psychosis was not listed as the diagnosis on the handwritten order written by the psychiatrist on September 21, 2017.

r. The medical record did not contain any evidence of any other evaluation from the interdisciplinary team (IDT) reading the initiation of a new antipsychotic medication.

s. A plan of care was not developed for any individualized, non-pharmacologic interventions.

t. The record for Behaviors, from September 1 through 30, 2017, listed the following behaviors

   i. Hallucination, paranoia, delusions, restlessness starting September 22, 2017 for three (3) shifts each day.

   ii. The record documented that the behaviors did not occur from September 22, 2017 to the day the resident went to the hospital on September 27, 2017

   iii. The record also included areas to document any of the side effects for Haldol which included, but were not limited to: sedation/drowsiness, anxiety/agitation, weakness, appetite change/weight change, insomnia,

confusion, and Akathisia-restlessness.

iv. The record documented that no side effects occurred from September 22, 2017 through the day the resident went to the hospital on 9/27/17.

u. The resident's September 2017 medication administration record reflected the resident was administered four (4) doses of Haldol 20 MG on: September 22, 2017 at 9:00 a.m.; September 23, 2017 at 9:00 a.m. and 5:00 p.m.; and September 24, 2017 at 9:00 a.m.

v. A Progress Note dated September 24, 2017 at 1:17 p.m., indicated the resident was experiencing side effects. "Upon observation, resident lethargic, vitals stable, family stated resident is not at [] baseline less communicative. Reviewed resident orders with MD [resident's attending doctor and medical director] and hospice, received orders from MD to d/c [discontinue] Haldol. Hospice here this afternoon observed resident and will place resident on crisis care for further observation for any changes."

w. A Physician Order dated September 24, 2017 (no time) was written to discontinue the Haldol per attending physician.

x. A telephone Physician Order dated September 24, 2017, (no time) was written for hospice to "Start crisis care for change in LOC [level of condition] due to Haldol."

y. A hospice Continuous Care Shift Care Note dated September 25, 2017, following the administration of Haldol, indicated the resident was experiencing the side effects from the high doses of Haldol. "Restless, attempting to get out of bed, confused, agitated, kicking all the pillows out,

encourage heels up 2 inches from bed due to restless movement on bed and calling out repeatedly. Pt is bed bound with weakness and requires total care with all activities of daily living [ADLs]."

z. A hospice Continuous Care Shift Care Note dated September 26, 2017, indicated the resident was experiencing side effects, "rubbing hands on pillow, kicking at sheets and resident sliding her heels over the bed all night nearly causing blisters."

aa. A hospice Visit Summary dated September 27, 2017, indicated "Resident to be discontinued from continuous crisis care. No longer non-responsive with less daytime anxiety/agitation." Family requests that resident be sent to the hospital for evaluation. Resident still confused and anxious.

bb. A Progress Note dated September 27, 2017 indicated the resident was sent to the hospital emergency room for evaluation and further documenting the resident "Given Haldol, but unintentionally given at a higher dose than was prescribed or intended. Brought in at acute encephalopathy (delirium and acute confused state) with mental status changes. To be closely watched. Chief complaint: Decreased mental status and confusion (given 20 mg of Haldol rather than prescribed 0.25 mg.). Patient has generalized weakness and difficulty walking. Patient has been off medication for 2 days and is waking more but still confused, too weak to walk and hallucinating. This seems to be all medication induced. Family does not want pt [patient] back at facility. Will look for placement at different long term care facility [LTCF]."

cc. Hospital Progress Notes dated September 28 and 29, 2017 indicated "No

change in progress. Patient still confused and groggy."

dd. Hospital Progress Notes dated October 1, 2, 3, and 4, 2017 indicated "Patient oriented frequently to place and time. No change."

ee. A hospital Progress Note dated October 5, 2017, indicated "Patient confused and disoriented. Calling out at times. Transportation via stretcher to new LTCF."

43. That Petitioner's representative interviewed on January 2, 2018 at 4:05 p.m. the psychiatrist who completed the examination of resident number one (1) on September 21, 2017 and the doctor indicated:

a. "On the 21st [September], I was asked by a nurse, I can't remember who, to see a resident because [the resident] was having behaviors. After seeing the resident, [the resident] appeared anxious, so I prescribed a low dose of Haldol 0.25 mg to calm the resident. I would never have ordered Haldol 20 mg twice a day for this resident. The plan was to give a very low dose for therapeutic calming effect."

b. The psychiatrist said he was not aware of any other behaviors other than yelling out when staff provided care.

c. He was unaware if any other non-pharmacological interventions were attempted prior to initiating an antipsychotic medication

44. That Petitioner's representative interviewed on January 2, 2018 at 12:15 p.m. Respondent's nurse "A" regarding resident number one (1) and the nurse indicated:

a. He entered the Haldol order into the computer for the wrong dose for 20 mg instead of 0.25 mg and entered the wrong times as 9:00 a.m. and 5:00 p.m.,

instead of 2:00 p.m. and bedtime, and did not include the stop date after fourteen (14) days.

b. He was unable to explain how the error occurred except that he was very busy.

c. He stated the resident had behaviors, but could not state specific times and types of behaviors.

d. He was unable to explain why no behaviors were documented.

45. That Petitioner's representative interviewed on January 1, 2018 at 7:00 p.m. the adult child of resident number one (1) and the adult child indicated:

a. The child was never contacted regarding any behaviors that required a visit by a psychiatrist for antipsychotic medication.

b. The child visited the parent on September 22, 2017 and the parent appeared to be "drugged up."

c. The child asked the nurse at that time if the resident had any new medications and, after checking the computer, the nurse told the child there were no new medications.

d. When visiting again two days later, on September 24, 2017, the resident was in "bad shape."

e. Again the nurse was asked what was happening to the resident and it was discovered that the resident was receiving large doses of Haldol.

f. The resident was agitated and more confused.

g. The resident did not sleep and had been moving the legs in a repeated bicycle motion so much that the skin on the heels was rubbed red and raw.

46. That Petitioner's representative interviewed on January 2, 2018 at 12:45 p.m. Respondent's risk manager regarding resident number one (1) and the manager indicated:

a. Following the investigation regarding the excessive dose of Haldol, it was determined the nurse "made a medication transcription error."

b. The manager was unable to explain the absence of documentation of any the resident's behaviors before the Haldol was ordered, the nurses' failure to question the excessive dose and the lack of monitoring/reporting the adverse drug reactions the resident demonstrated following the administration of Haldol.

47. That Petitioner's representative interviewed on January 2, 2018 at 2:50 p.m. Respondent's nurse "D" regarding resident number one (1) and the nurse indicated, "I remember the resident but do not remember [the resident] having any behaviors. [The resident] was very quiet. I would not have questioned the 20 mg Haldol order unless I had issues with vitals. Since the resident is on hospice, they sometimes order extreme doses. If there was an issue, the pharmacy would have informed us."

48. That Petitioner's representative interviewed on January 2, 2018 at 4:35 p.m. Respondent's pharmacist regarding resident number one (1) and the pharmacist indicated that the pharmacy would immediately receive the order when placed electronically and, "The pharmacist filling the order would not have gotten a warning as 20 mg of Haldol is an order that can be prescribed."

49. That Petitioner's representative interviewed on January 2, 2018 at 5:15 p.m. the attending physician for resident number one (1) and the physician indicated:

a. "When I was informed of the wrong dose, I immediately stopped the Haldol

and had hospice provide crisis care to monitor the resident and the effects of the medication. The 20 mg dose of Haldol is a dose that can be prescribed."

b. The psychiatrist "sees residents all the time and his intent was to prescribe 0.25 mg not 20 mg."

c. The attending physician did not acknowledge the antipsychotic medication, Haldol, as an unnecessary drug for the resident.

50. That Petitioner's representative interviewed on January 2, 2018 at 2:15 p.m. Respondent's director of nursing regarding resident number one (1) and the nurse indicated that she was the Assistant Director of Nursing (ADON) at the time and remembers the resident to be very quiet with no behaviors.

51. That the census and condition report completed by Respondent's director of nursing on January 2, 2018 indicated the facility had sixty-seven (67) residents receiving psychoactive medication and thirty-two (32) residents receiving antipsychotic medication.

52. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Psychopharmacologic Drugs," dated November 2017, that provided:

a. The purpose is to provide guidelines for the use of psychopharmacologic drug treatment of a resident with a specific condition as diagnosed and documented in the clinical record.

b. Procedural Guidelines:

i. 1. Psychopharmacologic drugs include antianxiety agents, antidepressants, sedatives, hypnotics, antipsychotics, and "other" drugs that affect behaviors.

ii. 2. Psychopharmacologic drugs shall be used only after alternative methods

have been tried unsuccessfully and only upon the written order of a physician. Notification must be complete with the resident or his/her representative for antipsychotic drug therapy.

iii. 3. The resident or his/her representative will be given information regarding the need for, the desired effects and the potential side effects of the antipsychotic medication. This enables the resident or his/her representative to make an informed decision regarding the use of an antipsychotic medication.

iv. 4. Psychopharmacologic drugs will not be used to limit or control behavior...

v. 5. Nurses will observe for side effects and medical staff will reduce dosage to the minimum required...

vi. 6. Nurses will document episodes of behavior, the impact of the medication on behavior and the presence or absence of side effects.

vii. 7. Nursing services, social services and other members of the interdisciplinary team will address the behaviors on the care plan. Medication is not the sole approach for behavioral intervention. Other interventions will be identified on the care plan...

c. Unnecessary Drugs - Each resident's drug regimen must be free from unnecessary drugs.

d. Unnecessary drugs are any drugs when used:

i. a. In excessive dose...

ii. c. Without adequate monitoring, and

iii. d. Without adequate indications for its use..

iv. e. In the presence of adverse consequences that indicate the dose should be reduced or discontinued…

e. The Antipsychotic Drugs section read:

i. "1. Residents who have not used antipsychotic drugs will not be given such drugs unless antipsychotic drug therapy is necessary to treat a specific condition .

ii. "2. Unless the resident's medical record clearly indicated that the resident has one or more of the following 'specific conditions,' antipsychotic drugs should not be used.

f. "Specific conditions" include: Schizophrenia; Schizo-affective disorder; Schizophreniform disorder; Delusional disorder; Mood disorders (e.g. bipolar disorder); psychosis in the absence of dementia; medical illnesses with psychotic symptoms; Tourette's disorder; Huntington's disease; Hiccups; Nausea and vomiting associated with chemotherapy; behavioral and psychological symptoms of dementia.

g. The policy contained a letter to inform the resident and/or representative of the use of antipsychotic drug therapy with the possible negative outcomes including cognitive/behavior impairment and Akathisia (restlessness/constant movement).

53. That the above reflects Respondent's failure to assure each resident 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 by the failure to ensure a resident's drug regimen is free from unnecessary psychotropic drugs without documented evidence of an indication for use and in the absence of any behavioral symptoms and the administration of excess amounts of the medication to a resident.

54. That the above described noncompliance caused or is likely to cause serious injury, harm, impairment, or death to residents.

55. That the Agency determined that this deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility, and cited Respondent with an isolated Class I deficient practice.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(8)(a), Florida Statutes (2017).

COUNT IV

56. The Agency re-alleges and incorporates paragraphs one (1) through five (5), as if fully set forth herein.

57. That Florida law provides:

> Every facility shall, as part of its administrative functions, establish an internal risk management and quality assurance program, the purpose of which is to assess resident care practices; review facility quality indicators, facility incident reports, deficiencies cited by the agency, and resident grievances; and develop plans of action to correct and respond quickly to identified quality deficiencies. The program must include:
> (a) A designated person to serve as risk manager, who is responsible for implementation and oversight of the facility's risk management and quality assurance program as required by this section.
> (b) A risk management and quality assurance committee consisting of the facility risk manager, the administrator, the director of nursing, the medical director, and at least three

other members of the facility staff. The risk management and quality assurance committee shall meet at least monthly.
(c) Policies and procedures to implement the internal risk management and quality assurance program, which must include the investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to residents.
(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.
(e) The development of appropriate measures to minimize the risk of adverse incidents to residents, including, but not limited to, education and training in risk management and risk prevention for all nonphysician personnel, as follows:
1. Such education and training of all nonphysician personnel must be part of their initial orientation; and
2. At least 1 hour of such education and training must be provided annually for all nonphysician personnel of the licensed facility working in clinical areas and providing resident care.
(f) The analysis of resident grievances that relate to resident care and the quality of clinical services.
§ 400.147(1), Florida Statutes (2017).

58. That on January 5, 2018, the Agency completed a survey of Respondent and its facility.

59. That based upon observation, the review of records, and interview, Respondent failed to implement and maintain an effective Quality Assessment and Assurance Committee (QAAC) to identify and address quality deficiencies, including, but not limited to the failure to implement processes to examine and address a known medication error, the same being contrary to the mandates of law.

60. That Petitioner's representative reviewed Respondent's policy and procedure entitled "Psychopharmacologic Drugs," dated November 2017, that provided:

a. Unnecessary Drugs - Each resident's drug regimen must be free from unnecessary drugs.

b. Unnecessary drugs are any drugs when used:

i. a. In excessive dose...

ii. c. Without adequate monitoring, and

iii. d. Without adequate indications for its use..

iv. e. In the presence of adverse consequences that indicate the dose should be reduced or discontinued…

c. The Antipsychotic Drugs section read:

i. "1. Residents who have not used antipsychotic drugs will not be given such drugs unless antipsychotic drug therapy is necessary to treat a specific condition .

ii. "2. Unless the resident's medical record clearly indicated that the resident has one or more of the following 'specific conditions,' antipsychotic drugs should not be used.

d. "Specific conditions" include: Schizophrenia; Schizo-affective disorder; Schizophreniform disorder; Delusional disorder; Mood disorders (e.g. bipolar disorder); psychosis in the absence of dementia; medical illnesses with psychotic symptoms; Tourette's disorder; Huntington's disease; Hiccups; Nausea and vomiting associated with chemotherapy; behavioral and psychological symptoms of dementia.

61. That Petitioner's representative reviewed Respondent's reco4rds relate to resident number one (1) during the survey and noted that the resident did not have any of the "specific conditions" diagnoses listed in the medical record, yet the resident received an excessive dose of an antipsychotic medication on September 22, 23, and 24, 2017 without any documented or reported indications and without monitoring.

62. That Petitioner's representative interviewed on January 3, 2018 at 4:15 p.m. Respondent's administrator and director of nursing regarding the medication error involving

resident number one (10 who indicated:

a. Although they identified the medication error as a serious event, they did not have an emergency risk management quality assurance meeting following the incident.

b. A risk management quality assurance meeting was held on September 27, 2107 after the medication error was identified, but the incident was not discussed formally until thirty-two (32) days later at the October 26, 2017 meeting.

c. The director stated that the measures put in place were decided by the risk management quality assurance team including herself, the administrator and the medical director.

d. These measures included providing education to the nurse involved in the transcription error and conducting an audit of all antipsychotic medications to ensure the order was transcribed into the electronic system accurately as per physician orders.

63. That only six (6) nurses received the education that was provided and the audit to review psychotropic medications occurred only once within a few days of the incident.

64. That there was no evidence of any continued monitoring for sustained compliance.

65. That although the pharmacy consultant was informed of the significant medication error, there was no evidence that she was involved in any efforts to assist the facility to identify, evaluate and resolve pharmaceutical concerns.

66. That Petitioner's representative telephonically interviewed on January 5, 2018 at 2:00 p.m. Respondent's consulting psychiatrist regarding resident number one (1) and the psychiatrist

indicated:

a. He was aware of the Haldol medication error.

b. He was not scheduled to see the resident; a nurse asked him to see the resident as the resident was new.

c. He could not recall which nurse.

d. When asked if he ensured that there was a physician consult order, he stated he did not check for the consult order.

e. When he saw the resident, the resident was being resistive to morning care and shouting at the staff.

f. "I was told [the resident] would not allow staff to provide morning care and repositioning."

g. He was not aware of any other behaviors, but the resident appeared distressed during care times.

h. When asked if any non-pharmacological interventions were attempted to calm the resident, he stated he was not aware of any.

i. He prescribed a very small dose of Haldol as it would calm the resident and not cause sedation.

j. He would have increased the Haldol to 0.5 mg, but no more than that.

k. The Haldol 20 mg was an excessive dose, something he never would have considered.

l. When asked if he ordered the Haldol for staff convenience, he stated that the resident appeared distressed during care times.

67. That Petitioner's representative interviewed on January 2, 2018 at 4:10 p.m.

Respondent's licensed practical nurse "A" regarding resident number one (1) and the nurse indicated:

a. He transcribed the order into the electronic system incorrectly which caused the error.

b. He was in a hurry and mistakenly entered 20 mg from the drop down menu.

c. He did not offer any other explanation other than the error should have been identified on the night shift during order checks.

68. That Petitioner's representative interviewed Respondent's risk manager during the survey regarding resident number one (1) and the manager indicated:

a. She was the acting director of nursing during the time of the medication error.

b. She confirmed that their root cause of the incident was the nurse made a transcription error.

c. She was not able to provide an answer as to why the resident was seen by the psychiatrist despite no documentation of any behaviors or a physician consult order.

d. She confirmed that a physician order for consult is required for the psychiatrist to assess a resident.

e. The medication error was discovered after the resident had received four (4) doses of the medication.

f. The resident's family became concerned as the resident was lethargic and was very confused.

g. The nurse who made the transcription was provided education as soon as the error was discovered.

h. The process for medication order reconciliation was that the night nurses working 11:00 p.m. to 7:00 a.m. would review all medication orders written during the day and double check to ensure that the electronic orders matched the written physician orders.

i. "Unfortunately, this did not happen."

j. The medication should have also been checked during the morning meeting when all written physician orders were reconciled to ensure they matched with what was entered in the computer system, "... but I don't know what happened. I guess the order was not checked."

k. She confirmed that their system for double checks failed as it was not followed consistently.

69. That Petitioner's representative telephonically interviewed on January 5, 2018 at 11:50 a.m. Respondent's medical director who indicated:

a. He was the attending physician for resident number one (1

b. He only saw the resident at admission and did not see the resident after that, as there were no issues with the resident.

c. He was not informed of any behaviors otherwise he would have assessed the resident again.

d. He was aware that the resident had received an excessive amount of Haldol.

e. He was made aware of the error the day after it happened, but it was not discussed formally until the October risk management quality assurance meeting.

f. He was informed of the plan to educate the staff and the antipsychotic

medication audits.

g. He did not recall getting any reports at the subsequent monthly risk management quality assurance meetings as to the progress of the education or the results of the audits.

h. The psychiatrist was not included in the risk management quality assurance meetings, but it would be a good idea to include him in the meetings.

70. That Petitioner's representative interviewed on January 5, 2018 at 11:30 a.m. Respondent's pharmacist consultant regarding resident number one (1) and the pharmacist indicated:

a. She was made aware of the Haldol medication error on the day it occurred.

b. If she had seen the resident, the order for Haldol 20 mg would have caught her attention as it was an excessive dose for an eighty-nine (89) year-old geriatric resident.

c. The resident could have extra pyramidal symptoms to indicate toxicity such as lethargy, stupor and weakness.

71. That Petitioner's representative interviewed on January5, 2018 at 12:20 p.m. Respondent's director of nursing, acting administrator, and risk manager and noted:

a. The initiative to reduce antipsychotic medications was very much a part of their risk management quality assurance process.

b. The only evidence they provided to reduce antipsychotic medications was the pharmacy consultant's monthly reviews with recommendations for gradual dose reductions.

c. The facility had a high population of younger, mental health residents on

antipsychotic medications.

d. They could not provide an answer when asked how they educate their staff on proper dosages and what clinical symptoms to observe for with geriatric residents verses younger population.

e. It was pointed out to them that interviews with licensed nurses revealed that they would not question an order of Haldol 20 mg twice daily for a geriatric resident as both the unit manager of north wing revealed that she would not question an order for Haldol 20 mg for an elderly resident with no behaviors and would not question it as long as the resident's vital signs were within normal, and licensed practical nurse "B" stated that she would not question an order for Haldol 20 mg twice daily for a geriatric resident as she was accustomed to seeing large doses of medications being used for some residents, especially residents on hospice care.

f. The director, administrator, and manager stated that it was obvious they had a lot of work to do.

72. That the above reflects Respondent's failure to utilize its quality assurance mechanisms to review and implement interventions if necessary to address identify and address quality deficiencies, including, but not limited to:

a. The medication error incident involving resident number one (1) was serious yet Respondent failed to recognize the root cause of the incident.

b. Respondent focused on the transcription error as the root cause and did not identify the deficiencies in the medication system as a whole.

c. There was no psychiatric consult ordered from the primary physician therefore

no reason for the psychiatrist to see the resident.

d. There were no identified indications as to why the psychiatrist ordered the medication, Haldol.

e. The resident's medical record did not show the resident exhibiting any behaviors.

f. There were no care plans indicating any behaviors or the resident's usual behavior.

g. Nursing did not follow standards of practice for medication transcription and entered the wrong dose into the electronic system.

h. Nursing administered the excessive dose of Haldol to a geriatric resident who was not exhibiting any behaviors without questioning the order.

i. Respondent failed to recognize that their system for order reconciliation was not being followed.

j. Respondent's risk management quality assurance committee failed to fully investigate this error that occurred on September 24, 2017.

73. That the above described noncompliance caused or is likely to cause serious injury, harm, impairment, or death to residents.

74. That the Agency determined that this deficient practice presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility, and cited Respondent with an isolated Class I deficient practice.

WHEREFORE, the Agency seeks to impose an administrative fine in the amount of ten thousand dollars ($10,000.00) against Respondent, a skilled nursing facility in the State of

Florida, pursuant to § 400.23(8)(a), Florida Statutes (2017).

COUNT V

75. The Agency re-alleges and incorporates paragraphs one (1) through five (5) and Counts I through III of this Complaint as if fully set forth herein.

76. Based upon Respondent's four (4) State Class I deficiencies, it was not in substantial compliance at the time of the surveys with criteria established under Part II of Florida Statute 400, or the rules adopted by the Agency, a violation subjecting it to assignment of a conditional licensure status under § 400.23(7)(a), Florida Statutes (2017).

WHEREFORE, the Agency intends to assign a conditional licensure status to Respondent, a skilled nursing facility in the State of Florida, pursuant to § 400.23(7), Florida Statutes (2017) commencing January 5, 2018.

COUNT VI

77. The Agency re-alleges and incorporates paragraphs one (1) through five (5), and Counts I through IV of this Complaint as if fully recited herein.

78. That Respondent has been cited with four (4) State Class I deficiencies and therefore is subject to a six (6) month survey cycle for a period of two years and a survey fee of six thousand dollars ($6,000) pursuant to Section 400.19(3), Florida Statutes (2017).

WHEREFORE, the Agency intends to impose a six (6) month survey cycle for a period of two years and impose a survey fee in the amount of six thousand dollars ($6,000.00) against Respondent, a skilled nursing facility in the State of Florida, pursuant to Section 400.19(3), Florida Statutes (2017).

Respectfully submitted this 7 day of May, 2018.

Thomas J. Walsh II, Esquire
Fla. Bar. No. 566365
Agency for Health Care Admin.
525 Mirror Lake Drive, 330G
St. Petersburg, FL 33701
727.552.1947 (office)
walsht@ahca.myflorida.com

DISPLAY OF LICENSE

Pursuant to § 400.23(7)(e), Fla. Stat. (2017), Respondent shall post the most current license in a prominent place that is in clear and unobstructed public view, at or near, the place where residents are being admitted to the facility.
Respondent is notified that it has a right to request an administrative hearing pursuant to Section 120.569, Florida Statutes. Respondent has the right to retain, and be represented by an attorney in this matter. Specific options for administrative action are set out in the attached Election of Rights.

All requests for hearing shall be made to the attention of: ***The Agency Clerk, Agency for Health Care Administration, 2727 Mahan Drive, Bldg #3, MS #3, Tallahassee, Florida, 32308, (850) 412-3630.***

RESPONDENT IS FURTHER NOTIFIED THAT A REQUEST FOR HEARING MUST BE RECEIVED WITHIN 21 DAYS OF RECEIPT OF THIS COMPLAINT OR WILL RESULT IN AN ADMISSION OF THE FACTS ALLEGED IN THE COMPLAINT AND THE ENTRY OF A FINAL ORDER BY THE AGENCY.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been served by U.S. Certified Mail, Return Receipt No. 7004 2510 0001 4448 4637 on May 7, 2018, to Shegetta Williams, Administrator, SF Carnegie, LLC d/b/a Wave Crest Health and Rehabilitation Center, 1415 South Hickory Street, Melbourne, Florida 32901, and by Regular U.S. Mail to Corporation Service Company, Registered Agent for SF Carnegie, LLC, 1201 Hays Street, Tallahassee, Florida 32301.

Thomas J. Walsh, II, Esquire

Copy furnished to:
Theresa DeCanio
Field Office Manager
Agency for Health Care Admin.

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

RE: SF Carnegie, LLC d/b/a **AHCA No. 2018004847**
Wave Crest Health and Rehabilitation Center

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed agency action by the Agency for Health Care Administration (AHCA). The title may be Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint. Your Election of Rights may be returned by mail or by facsimile transmission, **but must be filed within 21 days** of the day that you receive the attached proposed agency action. **If your Election of Rights with your selected option is not received by AHCA within 21 days of the day that you received this proposed agency action, you will have waived your right to contest the proposed agency action and a Final Order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your **Election of Rights** to this address:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #7
Tallahassee, Florida 32308.
Telephone: 850-412-3630 Facsimile: 850-921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) _____ I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint and I waive my right to object and to have a hearing. I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) _____ I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I wish to be heard at an informal proceeding (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) _____ I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing (pursuant to Section 120.57(1), Florida Statutes) before an dministrative Law Judge appointed by the Division of Administrative Hearings.

PLEASE NOTE: Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

License Type: _____ (ALF? Nursing Home? Medical Equipment? Other Type?)

Licensee Name: _____ License Number: _____

Contact Person: _____ Title: _____

Address: _____
Number and Street City Zip Code

Telephone No. _____ Fax No. _____

E-Mail (optional) _____

I hereby certify that I am duly authorized to submit this Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: _____ Date: _____

Print Name: _____ Title: _____

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

April 5, 2018

James R. Gilley, Administrator
Wave Crest Health And Rehabilitation Center
1415 S Hickory Street
Melbourne, FL 32901

File Number: 70502
License Number: 10740961
Provider Type: Nursing Home

RE: 1415 S Hickory Street, Melbourne

Dear Mr. Gilley:

The enclosed Nursing Home license with license number 10740961 and certificate number 21415 is issued for the above provider effective January 5, 2018 through December 3, 2018. The license is being issued for: approval of the Status Change to Conditional during licensure period application.

Review your certificate thoroughly to ensure that all information is correct and consistent with your records. If errors are noted, please contact the Long Term Care Services Unit.

Please take a short customer satisfaction survey on our website at ahca.myflorida.com/survey/ to let us know how we can serve you better. Additional licensure information can be found at http://ahca.myflorida.com/longtermcare.

If we may be of further assistance, please contact me by phone at 850-412-4458 or by email at Flora.Austin@ahca.myflorida.com.

Sincerely,

Flora M. Austin
Health Services and Facilities Consultant
Long Term Care Services Unit
Florida Agency for Health Care Administration
Division of Health Quality Assurance

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF10740961
CERTIFICATE #: 21415

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

CONDITIONAL

This is to confirm that SF CARNEGIE, LLC has complied with the rules and regulations adopted by the State of Florida, Agency For Health Care Administration, authorized in Chapter 400, Part II, Florida Statutes, and as the licensee is authorized to operate the following:

WAVE CREST HEALTH AND REHABILITATION
CENTER
1415 S Hickory St
Melbourne, FL 32901

TOTAL: 138 BEDS

STATUS CHANGE

EFFECTIVE DATE: 01/05/2018

EXPIRATION DATE: 12/03/2018

Deputy Secretary, Division of Health Quality Assurance

RICK SCOTT
GOVERNOR

JUSTIN M. SENIOR
SECRETARY

April 5, 2018

James R. Gilley, Administrator
Wave Crest Health And Rehabilitation Center
1415 South Hickory Street
Melbourne, FL 32901

File Number: 70502
License Number: 10740961
Provider Type: Nursing Home

RE: 1415 South Hickory Street, Melbourne

Dear Mr. Gilley:

The enclosed Nursing Home license with license number 10740961 and certificate number 21416 is issued for the above provider effective February 1, 2018 through December 3, 2018. The license is being issued for: approval of the Status Change to Standard during licensure period application.

Review your certificate thoroughly to ensure that all information is correct and consistent with your records. If errors are noted, please contact the Long Term Care Services Unit.

Please take a short customer satisfaction survey on our website at ahca.myflorida.com/survey/ to let us know how we can serve you better. Additional licensure information can be found at http://ahca.myflorida.com/longtermcare.

If we may be of further assistance, please contact me by phone at 850-412-4458 or by email at Flora.Austin@ahca.myflorida.com.

Sincerely,

Flora M. Austin
Health Services and Facilities Consultant
Long Term Care Services Unit
Florida Agency for Health Care Administration
Division of Health Quality Assurance

View current license information at: Floridahealthfinder.gov

LICENSE #: SNF10740961
CERTIFICATE #: 21416

State of Florida

AGENCY FOR HEALTH CARE ADMINISTRATION
DIVISION OF HEALTH QUALITY ASSURANCE

NURSING HOME

STANDARD

This is to confirm that SF CARNEGIE, LLC has complied with the rules and regulations adopted by the State of Florida, Agency For Health Care Administration, authorized in Chapter 400, Part II, Florida Statutes, and as the licensee is authorized to operate the following:

WAVE CREST HEALTH AND REHABILITATION
CENTER
1415 South Hickory Street
Melbourne, FL 32901

TOTAL: 138 BEDS

STATUS CHANGE

EFFECTIVE DATE: 02/01/2018

EXPIRATION DATE: 12/03/2018

Deputy Secretary, Division of Health Quality Assurance

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

2018 MAY 21 P 2:25

RE: SF Carnegie, LLC d/b/a
Wave Crest Health and Rehabilitation Center

AHCA No. 2018004847

ELECTION OF RIGHTS

This Election of Rights form is attached to a proposed agency action by the Agency for Health Care Administration (AHCA). The title may be Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine or Administrative Complaint. Your Election of Rights may be returned by mail or by facsimile transmission, **but must be filed within 21 days** of the day that you receive the attached proposed agency action. **If your Election of Rights with your selected option is not received by AHCA within 21 days of the day that you received this proposed agency action, you will have waived your right to contest the proposed agency action and a Final Order will be issued.**

(Please use this form unless you, your attorney or your representative prefer to reply according to Chapter120, Florida Statutes, and Chapter 28, Florida Administrative Code.)

Please return your **Election of Rights** to this address:

Agency for Health Care Administration
Attention: Agency Clerk
2727 Mahan Drive, Mail Stop #7
Tallahassee, Florida 32308.
Telephone: 850-412-3630 Facsimile: 850-921-0158

PLEASE SELECT ONLY 1 OF THESE 3 OPTIONS

OPTION ONE (1) ___X___ **I admit to the allegations of facts and law contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint and I waive my right to object and to have a hearing.** I understand that by giving up my right to a hearing, a final order will be issued that adopts the proposed agency action and imposes the penalty, fine or action.

OPTION TWO (2) _____ **I admit to the allegations of facts contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, but I wish to be heard at an informal proceeding** (pursuant to Section 120.57(2), Florida Statutes) where I may submit testimony and written evidence to the Agency to show that the proposed administrative action is too severe or that the fine should be reduced.

OPTION THREE (3) _____ **I dispute the allegations of fact contained in the Notice of Intent to Impose a Late Fee, Notice of Intent to Impose a Late Fine, or Administrative Complaint, and I request a formal hearing** (pursuant to Section 120.57(1), Florida Statutes) before an administrative Law Judge appointed by the Division of Administrative Hearings.

EXHIBIT 2

PLEASE NOTE: **Choosing OPTION THREE (3), by itself, is NOT sufficient to obtain a formal hearing. You also must file a written petition** in order to obtain a formal hearing before the Division of Administrative Hearings under Section 120.57(1), Florida Statutes. It must be received by the Agency Clerk at the address above **within 21 days** of your receipt of this proposed agency action. The request for formal hearing must conform to the requirements of Rule 28-106.2015, Florida Administrative Code, which requires that it contain:

1. The name, address, telephone number, and facsimile number (if any) of the Respondent.
2. The name, address, telephone number and facsimile number of the attorney or qualified representative of the Respondent (if any) upon whom service of pleadings and other papers shall be made.
3. A statement requesting an administrative hearing identifying those material facts that are in dispute. If there are none, the petition must so indicate.
4. A statement of when the respondent received notice of the administrative complaint.
5. A statement including the file number to the administrative complaint.

Mediation under Section 120.573, Florida Statutes, may be available in this matter if the Agency agrees.

License Type: Nursing Home (ALF? Nursing Home? Medical Equipment? Other Type?)

Licensee Name: Wave Crest Health and Rehabilitation Center License Number: 3NF1074096

Contact Person: Shegetta Williams Title: Administrator

Address: 1415 Hickory St, Melbourne, FL 32901
Number and Street City Zip Code

Telephone No. 321-723-1321 Fax No. 321-768-0403

E-Mail (optional) SMWilliams@GCHC.com

I hereby certify that I am duly authorized to submit this Election of Rights to the Agency for Health Care Administration on behalf of the licensee referred to above.

Signed: NHA Date: 5/21/2018

Print Name: Shegetta Williams, NHA Title: Administrator