DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 105176 | A. BUILDING _____ B. WING _____ | R 12/28/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **WINTER HAVEN HEALTH AND REHABILITATION CENTER** | **202 AVE O NE WINTER HAVEN, FL 33880** |

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| {F 000} | INITIAL COMMENTS<br><br>A Revisit to the recertification survey of 10/19-10/22/21 was conducted on 12/28/21 at Winter Haven Health and Rehabilitation Center. The facility was in compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities. | {F 000} | | |

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

Electronically Signed /2022

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

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| {N 000} | INITIAL COMMENTS<br><br>A revisit to the Relicensure survey of - was conducted at Winter Haven Health and Rehabilitation Center on . The facility had deficiencies at the time of the visit. | {N 000} | | |
| {N 052} SS=D | 59A-4.107(3), FAC Physician Orders<br><br>(3) Verbal orders, including telephone orders, must be immediately recorded, dated, and signed by the person receiving the order. All verbal treatment orders must be countersigned by the physician or other health care professional on the next visit to the facility.<br><br>This Statute or Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure that medications were administered in accordance with physician's orders for two (Residents #1 and #2) of three residents observed for medication administration.<br><br>Findings included:<br><br>A review of Resident #1's Medical Record revealed that Resident #1 was admitted to the facility on with diagnoses of Type 2, , ( ), Deficiency, and .<br><br>A review of Resident #1's Physician's Orders revealed the following orders:<br>- An order dated for , 325 milligrams (mg) 2 tablets (650 mg) by every 6 hours as needed.<br>- An order dated for , 10 mg by one time daily.<br>- An order dated for | {N 052} | 1. The practitioner and resident representative for resident # 1 was notified by the unit manager on of the medication dosage error, no new orders were received. The Practitioner and resident representative for resident # 2 was notified by the unit manager of the late administration of a medication on , no new orders were received.<br>The DON completed one on one education with staff A & staff B, medication administration observations were completed X 3 to confirm the nurses retained the education. Staff A completed post tests on . Staff B completed the post test on .<br>2. A facility wide MAR to Cart audit was completed on - by the DON/Designee to confirm all ordered medications were available on the medication carts for all current residents.<br>The medication administration audit report will be reviewed during the clinical meeting by the DON/Designee 3 X a week for 1 | |

AHCA Form 3020-0001

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| {N 052} | Continued From page 1<br><br>- 400 mg by two times a day.<br>- An order dated for Cranberry Tablet 450 mg by one time a day.<br>- An order dated for ( ) 500 mg by two times a day.<br>- An order dated for with 1 tablet by one time a day.<br>- An order dated for Oyster Shell 500 mg by one time a day.<br>- An order dated for 80 mg by three times a day.<br>- An order dated for 81 mg by one time a day.<br><br>An observation of medication administration for Resident #1 was conducted on at 08:35 AM with Staff A, Licensed Practical Nurse (LPN). Staff A prepared the following medications for administration to Resident #1:<br>- 650 mg by .<br>- 10 mg by .<br>- 250 mg by .<br>- Cranberry Tablet 450 mg by .<br>- 500 mg by .<br>- with 1 tablet by .<br>- Oyster Shell 500 mg by .<br>- 125 mg by .<br>- 81 mg by .<br><br>Staff A entered Resident #1's room and administered nine medications by to Resident #1. An interview was conducted with Staff A at 08:47 AM following the observation. Staff A observed the medication bottle for 250 mg and compared the bottle to Resident #1's order in the Medication Administration Record (MAR). Staff A addressed that Resident #1's order was for | {N 052} | month to ensure the medications were administered in the ordered timeframe, with intervention initiated as needed. The DON/Designee will review the new medication report & discontinued medication report during clinical meeting 3 days a week for 1 month. The report will be used by the Unit Managers to ensure new medications are available on the medication cart and discontinued medications are removed for the medication cart. The report will be returned by the unit manager to the DON at the end of the shift.<br>3. Nurses were educated on medication administration & timeliness of medication administration by the DON/Designee. The nurses completed a posttest following the education. Nurses were observed by the DON/Designee completing medication administration to confirm the retention of the education. Newly hired nurses and contract nurses will be educated on the medication administration policy and observed for competency by the SDC within the first week of employment.<br>4. A QAA meeting was held on to include floor nurses. The DON/Designee will complete medication administration observations 3 x weekly for 1 month and then at least weekly for 2 months. The DON/Designee will audit the Medication Administration report 3 X weekly for 1 month to confirm timeliness of medication administration. The results of the audits will be presented to the QA&A Committee for further recommendations for 3 months or until substantial compliance is achieved. | |

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| {N 052} | Continued From page 2<br><br>. . . . . 400 mg by . . . and she administered . . . 250 mg by . . . Staff A stated that she administered . . . . 250 mg because the facility did not have a 400 mg dosage and stated "they have to go buy the stuff". Staff A stated that she would normally verify dosages before administering medications to a resident. Staff A also observed the medication bottle for . . . . . 125 mg and compared the bottle to Resident #1's order in the MAR. Staff A addressed that Resident #1's order was for 80 mg by . . . and she administered . . . . . 125 mg by . . . . Staff A stated that the facility did not have the proper dosage for the medications and refused to answer any further questions related to the observation.<br><br>An interview was conducted on . . . . . at 08:52 AM with Staff B, Registered Nurse (RN) Unit Manager (UM). Staff B stated that she would expect nursing staff to check medication bottles and compare them to the resident's order to verify that they were administering the appropriate dosage. Staff B verified that Resident #1 received the wrong dose of . . . - . . . and . . . . . and stated that both administrations were medication errors.<br><br>A review of Resident #2's Medical Record revealed that Resident #2 was admitted to the facility on . . . . . with diagnoses of . . . . . , and . . . .<br><br>A review of Resident #2's Physician's Orders revealed the following orders:<br>- An order dated . . . for . . . . . 10 mg by . . . one time a day at 09:00 AM. | {N 052} | | |

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| {N 052} | Continued From page 3<br>- An order dated ... for ... 20 mg by ... one time a day for 3 days at 09:00 AM.<br>- An order dated ... for ... 20 mg by ... one time a day at 09:00 AM.<br>- An order dated ... for ... 40 mg by ... one time a day at 09:00 AM.<br>- An order dated ... for ... Extended Release (ER) 10 milliequivalents (mEq) by ... one time a day at 09:00 AM.<br>- An order dated ... for ... 25 mg by ... two times a day at 09:00 AM and 5:00 PM.<br>- An order dated ... for ... 1000 mg by ... two times a day at 08:00 AM and 5:00 PM.<br>- An order dated ... for ... with ... 1 tablet by ... two times a day at 09:00 AM and 5:00 PM.<br>- An order dated ... for ... Gel 1% apply to affected areas ..., four times a day at 09:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM.<br>- An order dated ... for ... liquid instill 1 drop in both ..., four times a day at 09:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM.<br><br>An observation of medication administration for Resident #2 was conducted on ... at 09:20 AM with Staff C, LPN. Staff C prepared the following medications for administration to Resident #2:<br>- ..., ..., 10 mg by ...<br>- ... 20 mg by ..., 2 tablets (40 mg).<br>- ..., 40 mg by ...<br>- ... ER 10 mEq by ...<br>- ... 25 mg by ...<br>- ... with ... 1 tablet by ... | {N 052} | | |

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| {N 052} | Continued From page 4<br>- 1% gel.<br>- liquid<br><br>During the observation, Staff C removed a medication cup with a large, oval shaped medication inside of it. Staff C stated that the medication was 1000 mg for Resident #2. Staff C stated that she had pulled the medication to prepare for administration and needed to tend to a resident in need. Staff C also stated that she placed the medication into the medication cart to tend to the resident. An observation of Resident #2's MAR revealed a highlighted "Y" next to the medication 1000 mg and the box surrounding the medication order was colored green. Staff C entered Resident #2's room and administered the 10 medications to Resident #2 at 09:32 AM. An interview was conducted with Staff C following the observation. Staff C stated that clicking the "Y" option in the MAR did not indicate that the medication was already given and only indicated that the medication was being prepared to be administered. Staff C addressed that Resident #2's 1000 mg was scheduled to be administered at 08:00 AM and stated that they were to administer medications within one hour before to one hour after the scheduled time.<br><br>An telephone interview was conducted on at 01:57 PM with the facility's Consultant Pharmacist (CP). The CP stated that she would expect for nursing staff to administer medications in accordance with the prescriber's orders.<br><br>An interview was conducted on at 3:04 PM with the facility's Director of Nursing (DON). The DON stated that if a medication was | {N 052} | | |

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| {N 052} | Continued From page 5<br>going to be administered late the resident's provider should be notified prior to administering the medication. Nursing staff should be administering medications within one hour before to one hour after the prescribed time. Nursing staff should discard and re-pull medications if they are not going to administer them at the time and should not be putting medications that were already pulled . . . into the medication cart. The DON stated that nursing staff were able to select the "Y" in the resident's MAR as they are pulling medications but should not save the selection until it is actually administered. Saving the selection would indicate that the medication was actually administered. The DON stated that she would expect nursing staff to follow the rights of medication administration, including the right medication and the right dose, before administering the medication to a resident.<br><br>A review of the facility policy titled "Medication Administration General Guidelines" dated . . . . . revealed under the section of the policy titled "Policy" that medications are administered in accordance with manufacturers' specifications, good nursing principles and practices, and only by persons legally authorized to do so. The Policy also revealed under the section titled "Medication Preparation" that nursing staff, prior to administration, review and confirm medication orders for each individual resident on the MAR. Compare the medication and dosage schedule on the resident's MAR with the medication label. The policy revealed the following under the section titled "Medication Administration":<br>- Medications are administered in accordance with written orders of the prescriber.<br>- Medications are to be administered at the time they are prepared.<br>- Verify medication is correct three (3) time before | {N 052} | | |

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| {N 052} | Continued From page 6<br><br>administering the medication: When pulling the medication package from the med cart, when dose is prepared, and before dose is administered.<br>- Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on meal times.<br>The policy revealed under the section titled "Documentation" that the individual who administers the medication dose records the administration on the resident's MAR immediately following the medication being given and that once removed from the package/container, unused medication doses shall be disposed of according to nursing care center policy.<br><br>Class III | {N 052} | | |