STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105259	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicana Nursing and Rehab Center	1710 Lake Worth Road Lake Worth, FL 33460

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39167 Based on policy review, record review, and interview, the facility failed to ensure a safe discharge, as evidenced by failing to provide necessary medications and reconciliation of all pre-discharge medications with the resident's post-discharge medications, upon discharge for 1 of 1 sampled resident reviewed for discharge (Resident #396). The findings included: The policy titled transfer, and discharge, dated 08/2023, indicated the transfer, and discharge process is designed to provide a safe, orderly transfer, or discharge from the center. The discharge planning process: the center will develop and implement discharge planning process that focuses on the resident's discharge goals and preparing residents to be active partners in post-discharge care, effective transition of the resident from SNF to post-SNF care, and the reduction of factors leading to preventable readmissions. The interdisciplinary team will involve the resident and resident representative in the development of the discharge plan, and communicate to the resident, and resident representative of the final plan encompassing the resident's goals to the extent possible. Documentation of a resident's interest in receiving information regarding returning to the community shall be completed and entered into the clinical record. A discharge order is obtained by nursing from the physician indicating where the resident is being discharged . Why is the resident being discharged , and if the resident is to be discharged with, or without medication. The interdisciplinary team discusses the discharge so that appropriate procedures can be implemented. Provide preparation, and orientation to the residents to ensure safe, and orderly transfer/discharge from the center. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the counter). Record review revealed Resident #396 was admitted to the facility on [DATE] and 09/28/24, and she was discharged on [DATE]. The quarterly comprehensive assessment reference date 11/20/24 recorded Resident #396 had pertinent diagnoses, including hypertension (high blood pressure), End Stage Renal Disease, and diabetes. The comprehensive assessment recorded a brief interview for a mental status score of 15, which indicated Resident #396 was cognitively intact. Further review of the clinical record showed evidence of a physician order dated 12/26/24 for Resident #396 to be discharged . An additional review of the records showed the following physician orders: (continued on next page)

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.

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

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	09/30/24 Gabapentin Capsule 300 MG give 1 capsule by mouth at bedtime for Neuropathy. 09/30/24 Rosuvastatin Calcium Tablet 5 MG: Give 1 tablet orally at bedtime related to Hyperlipidemia. 10/28/24 Carvedilol Oral Tablet 6.25 MG (Carvedilol) Give 1 tablet by mouth thrice daily every Tue (Tuesday) and Thu (Thursday) and related to essential (primary) hypertension. 10/28/24 Insulin Lispro Injection Solution (Insulin Lispro) injected as per sliding scale. 10/29/24 Protonix Tablet Delayed-Release 40 MG (Pantoprazole Sodium) Give 1 tablet by mouth in the morning every Tue, Thu, Sat (Saturday), Sun (Sunday) related to gastroesophageal reflux disease. 10/29/24 Calcium Acetate Tablet 667 MG Give 1 tablet by mouth with meals every Tue, Thu, Sat, and for End Stage Renal Disease. 10/29/24 Levoxyl Tablet 50 MCG (Levothyroxine Sodium) Give 1 tablet by mouth in the morning every Tue, Thu, Sat, and Sun for Hypothyroidism and give 1 tablet by mouth in the morning every Mon (Monday), Wed (Wednesday), and Fri for Hypothyroidism. It was determined that Resident #396 was scheduled to receive the following medications: Rosuvastatin 5 mg on January 1st and 2nd at Bedtime. Carvedilol 6.25 MG on January 2nd, 3 times a day. Insulin on January 1st and 2nd as per sliding scale. Protonix 40 mg January 2nd in the morning. Calcium Acetate 667 mg on January 2nd with meals. Levoxyl 50 mg on January 1st in the morning. Review of Nursing progress notes dated 01/03/2025 at 2:25 PM, it was documented, (the writer) received a call from the insurance representative regarding Resident (#396's) medications; as per the resident's family, all her medications were refilled with the exception of 2 medications: Coreg and Rosuvastatin due to recent refills with the pharmacy. The writer informed the insurance representative that the family could come to the facility to pick up the resident's remaining medications for continuity of care. Resident #396's family member arrived at the facility and was provided with all active medications and diabetic supplies, which the resident received while residing at the facility, with additional discharge paperwork, education, and medication instructions. Resident #396's family member verbalized understanding of medications and their use. (continued on next page)

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F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/16/25 at 9:12 AM, an interview was held with the Director of Nursing (DON); when asked to explain the discharge-to-home process, she revealed the nurses are to obtain an order first, then social services do their part if the resident needs continuity of care. When the resident is ready, the facility provides scripts and medication if needed. Provide patient teaching and present with medication review. If the resident/representative requests the medications, we'll give them to them; for most Medicare patients, we give them their medications. The DON said she received a call from the insurance company; a representative stated, The resident's family member called them about her medications; the family member informed the insurance that Resident (#396) had medications filled upon discharge except for 2 (Rosuvastatin and Coreg). The insurance called the facility on January 3rd, around 10 AM, on behalf of the resident; the insurance indicated the medications were already filled for the month and paid by the insurance company, and the facility told the insurance company the family could come to get the medications from the facility. Resident #396's family member came to the facility and picked up the medications. On 01/16/25 at 10:40 AM, a phone call was placed to Resident #396's family member. She explained that no medications were given to the resident upon discharge, and the facility provided only a paper script; she came on 01/03/25 to pick up the medications, and the resident did not get any medications from 12/31/24 until 01/03/25. She stated, The facility provided the medications on 01/03/25 because the insurance company called them. When she went to the pharmacy, they informed her the script couldn't be refilled; they had already been refilled for the month.