STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105307	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Rehabilitation Center at Winter Park	2075 Loch Lomond Drive Winter Park, FL 32792

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32131 Based on observation, interview, and record review, the facility failed to ensure scheduled medications were administered as per physician's orders and according to accepted professional standards of practice for 5 of 5 residents reviewed for medication administration, of a total sample of 9 residents, (#5, #6, #7, #8, & #9). Findings: On 8/08/24 at 12:07 PM, Licensed Practical Nurse (LPN) A was at her medication cart preparing medications. The LPN stated she was still giving her morning medications and had three more residents to give morning medications to. The 1st floor Unit Manager (UM), and Registered Nurse (RN) Supervisor were seen sitting at the nurse's station. LPN A stated the UM was aware she was still giving morning medications after 12:00 PM. On 8/08/24 at 12:34 PM, and at 12:40 PM, LPN A was still administering her morning medications. On 8/08/24 at 12:50 PM, the 1st floor UM stated staff had a four-hour window to administer morning medications as directed by the facility's medication administration schedule. The UM stated he did not know the facility's protocol if medications were administered out of that recommended timeframe. Review of the facility's undated Medication Administration Times revealed the following, one time a day: upon rising 6:00 AM to 10:00 AM. In the morning: 6:00 AM, in the afternoon: 12:00 PM to 5:00 PM or 2:00 PM. In the evening: prior to bed 6:00 PM to 10:00 PM. Two times per day: upon rising and prior to bed 6:00 AM to 10:00 AM and 6:00 PM to 10:00 PM. Review of the Medication Administration Audit Reports for the day shift on 8/08/24 revealed the following: Resident #5 received her scheduled morning medications late, between 11:58 AM to 12:16 PM, including Carvedilol 3.125 milligram (mg) twice daily for high blood pressure, and Eliquis 2.5 mg daily for clot prevention. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 received her scheduled morning medications late, between 12:19 PM to 12:34 PM, including Apixaban 5 mg every 12 hours for clot prevention, Amlodipine 5 mg daily for high blood pressure, Phenytoin 125 mg/5 milliliter (ml) give 8 ml twice daily for seizures, and Buspirone 5 mg twice daily for anxiety. Resident #7 received her scheduled morning medications late, between 12:36 PM to 12:40 PM, including Folic acid 1 mg daily. Resident #8 received her scheduled morning medications late, between 12:49 PM to 12:57 PM, including Apixaban 5 mg every 12 hours, Furosemide 40 mg daily, Diltiazem 120 mg daily, Losartan Potassium 25 mg daily, and Metoprolol extended release 50 mg daily for high blood pressure. Resident #9 received her scheduled morning medications late, between 12:41 PM to 12:47 PM, including Acetaminophen 325 mg- 2 tablets twice daily for pain, Furosemide 20 mg daily for congestive heart failure, Depakote 250 mg twice daily for mood disorder, Lisinopril 5 mg in the morning for high blood pressure, and Celebrex 200 mg daily for pain. On 8/08/24 at 12:29 PM, resident #5 stated she had just received her morning medications. The resident said only two nurses gave her medications on time, all the others gave them late. On 8/08/24 at 1:25 PM, the Assistant Director Of Nursing (DON) B stated the scheduled morning medication administration time was upon rising, and the window the medications were to be given was between 6:00 AM to 10:00 AM. She stated if medications were given after 11:00 AM, the medications were considered late. ADON B said the facility's protocol for late administration of medication was the nurse would notify the physician, and obtain orders as needed for the late medications. She stated the nurse should document the communication with the physician in the resident's electronic medical record (EMR). Review of medical records for residents #5, #6, #7, #8 and #9 revealed notification to the physician was not done until after the surveyor discussed the late medication administration with the facility. The policy Person- Centered Medication Administration Schedule adopted on 10/25/2021 and revised on 8/06/2024 read, Medications shall be administered according to established schedules.