

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105352	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/03/2024
NAME OF PROVIDER OR SUPPLIER Vivo Healthcare Sebring		STREET ADDRESS, CITY, STATE, ZIP CODE 3011 Kenilworth Blvd Sebring, FL 33870	

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)
<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40775</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure a medication administration error rate of less than five percent. A total of twelve medication administration opportunities were observed with four errors for two (#4 and #5) of four residents sampled for medication administration, which resulted in a medication administration error rate of 33.33%.</p> <p>Findings included:</p> <p>A review of Resident #4's medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses of hypertension and nontraumatic intracranial hemorrhage.</p> <p>A review of Resident #4's physician orders revealed the following orders:</p> <ul style="list-style-type: none"> - An order dated 4/23/2024 for levetiracetam 1000 milligrams (mg) one tablet by mouth (PO) every 12 hours at 8:00 AM and 8:00 PM for seizures. - An order dated 5/10/2024 for metoprolol tartrate 50 mg one tablet PO two times a day at 8:00 AM and 9:00 PM for hypertension. <p>An observation of medication administration was conducted on 9/3/2024 at 9:12 AM with Staff A, Licensed Practical Nurse (LPN). Staff A, LPN prepared the following medications for administration to Resident #4:</p> <ul style="list-style-type: none"> - levetiracetam 1000 mg, one tablet. - metoprolol tartrate 50 mg, one tablet. <p>After preparing the medications Staff A, LPN entered Resident #4's room and administered the two medications. Staff A, LPN did not notify Resident #4 or Resident #4's physician prior to administering the two medications late.</p> <p>A review of Resident #5's medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses of cerebral infarction, atherosclerotic heart disease of coronary artery, and depression.</p> <p>A review of Resident #5's physician orders revealed the following orders:</p> <p>(continued on next page)</p>

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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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - An order dated 6/26/2024 for aspirin delayed release 81 mg 1 tablet PO one time a day at 8:30 AM for coronary artery disease. - An order dated 6/26/2024 for amlodipine besylate 10 mg one tablet PO one time a day at 8:30 AM for hypertension. - An order dated 6/26/2024 for clopidogrel 75 mg one tablet PO one time a day at 8:30 AM for atrial fibrillation. - An order dated 6/26/2024 for indapamide 1.25 mg one tablet PO one time a day at 8:30 AM for fluid retention. - An order dated 6/26/2024 for paroxetine hydrochloride (HCl) 30 mg one tablet PO one time a day at 8:30 AM for depression. - An order dated 6/26/2024 for levetiracetam 500 mg one tablet PO two times a day at 8:30 AM and 9:00 PM for seizures. - An order dated 6/26/2024 for magnesium oxide 400 mg one tablet PO two times a day at 8:30 AM and 9:00 PM for supplementation. - An order dated 8/31/2024 for depakote sprinkles 125 mg 3 capsules PO three times a day at 8:30 AM, 4:30 PM, and 9:00 PM for mood disorder. <p>An observation of medication administration was conducted on 9/3/2024 at 9:18 AM with Staff A, LPN. Staff A, LPN prepared the following medications for administration to Resident #5:</p> <ul style="list-style-type: none"> - Aspirin 81 mg chewable 1 tablet. - Amlodipine besylate 10 mg one tablet. - Clopidogrel 75 mg one tablet. - Indapamide 1.25 mg one tablet . - Levetiracetam 500 mg one tablet. - Depakote sprinkles 125 mg 3 capsules. <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>After removing the medications from the medication cart Staff A, LPN crushed each medication individually and placed the medication in a small amount of pudding per Resident #5's preference. After preparing the medications Staff A administered the six medications to Resident #5 and returned to the medication cart. Staff A, LPN accessed Resident #5's electronic medication administration record (eMAR) and signed off the six medications as administered. Staff A, LPN also signed off paroxetine HCl 30 mg one tablet as administered but did not pull the medication from the medication cart to administer to Resident #5. After saving the data, the order for magnesium oxide 400 mg one tablet appeared as not being administered. Staff A, LPN removed magnesium oxide 400 mg one tablet, crushed the tablet, added the crushed tablet to a small amount of pudding, and administered the medication to Resident #5. After administering the medication Staff A, LPN accessed Resident #5's eMAR and marked the magnesium oxide 400 mg one tablet as administered. Staff A, LPN did not administer paroxetine HCl 30 mg one tablet to Resident #5.</p> <p>Following the observation of medication administration, an interview was conducted with Staff A, LPN at 9:38 AM. Staff A, LPN accessed Resident #5's eMAR and reviewed the physician order for aspirin delayed release 81 mg. Staff A, LPN removed the bottle of aspirin 81 mg chewable tablets and stated she administered the chewable form of the medication to Resident #5 because he's a crush, I had to give the chewable. Staff A, LPN addressed Resident #5's physician order for aspirin 81 mg delayed release did not match what she removed from the medication cart and stated I'm not sure what to do after the fact. Staff A, LPN reviewed Resident #5's eMAR and observed the physician order for paroxetine HCl 30 mg. Staff A, LPN was not aware she did not remove the medication to administer to Resident #5 before signing the medication off as administered in the eMAR. During the interview with Staff A, LPN, Staff B, Registered Nurse (RN) and Unit Manager (UM) approached the medication cart and was interviewed. Staff B, RN UM stated Resident #5's physician order for aspirin 81 mg should be for the chewable form of the medication and not the extended release form. Staff B, RN UM also stated if a different form of a medication was administered and did not match the physician order, it would be considered a medication error. Staff B, RN UM stated medications should be administered between an hour before and an hour after the scheduled time and if a medication is going to be administered late, the nurse should notify the resident's physician before administering the medication. Staff A, LPN stated she was aware the resident's physician needed to be notified when a medication is administered late, but was not sure if the physician needed to be notified prior to administering the medication or after administering the medication. Staff A, LPN also stated, maybe I wouldn't have made the error if you weren't watching me.</p> <p>An interview was conducted on 9/3/2024 at 1:57 PM with the facility's Director of Nursing (DON). The DON stated facility nursing staff were educated at orientation and at skills fairs on the rights of medication administration, which included the right medication, right dose, right resident, right time, and right route. The DON also stated nursing staff should notify the resident's physician if a medication was going to be administered late and the notification should occur prior to the late administration. The DON stated medications should be administered between an hour before and an hour after the scheduled time.</p> <p>A review of the facility policy titled Medication Administration, last revised on 9/1/2023, revealed under the section titled Policy, medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice. The policy also revealed the following steps under the section titled Policy Explanation and Compliance Guidelines:</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Review MAR to identify medication to be administered. - Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. - Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician. - Administer medications as ordered in accordance with manufacturer specifications. - If any medication is not available, or the possibility of late administration, the Nurse will contact the Attending Physician. - Sign MAR after administered. 		