

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024
NAME OF PROVIDER OR SUPPLIER Lourdes-Noreen McKeen Residence for Geriatric Care		STREET ADDRESS, CITY, STATE, ZIP CODE 315 S Flagler Dr West Palm Beach, FL 33401	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39026</p> <p>Based on observation, interview, policy and record review, the facility failed to ensure accessibility of call lights for 3 of 4 sampled residents reviewed for accommodation of needs (Resident #56, #101, and #71).</p> <p>The finding included:</p> <p>The facility's policy titled, Call System, Resident dated September, 2022 revealed Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. The resident call system remains functional at all times.</p> <p>1) Resident # 56 was admitted to the facility on [DATE] with diagnoses that included Obstructive and Reflux Uropathy, Benign Prostatic Hyperplasia with Lower Urinary Tract symptoms, and Abdominal Aortic Aneurysm. The Brief Interview for Mental Status (BIMS) score for the resident on the quarterly Minimum Data Set with an assessment reference date of 03/24/24 was 9. This indicated the resident had mild cognitive impairment.</p> <p>On 05/06/24 at 11:43 AM, an interview was conducted with Resident #56 with his son present. The resident was observed in a wheelchair next to his bed with his call light on the bed. The resident was asked if he could reach his call light and he stated he could not. Further observation of the call light revealed it was not plugged into the wall. The resident's son stated that he visits his father daily and half of the week the call light cord is tied around the side rail and not within reach of his father.</p> <p>2) Resident #101 was admitted to the facility on [DATE] with diagnoses that included Congestive Heart Failure, Urinary Tract Infection, and Diabetes Mellitus. The resident currently has Cellulitis of the Right Arm. Cellulitis is a bacterial skin infection that causes swelling, pain, warmth and redness of the affected area. The resident had a Brief Interview for Mental Status (BIMS) score of 14 on the quarterly Minimum Data Set with an assessment reference date of 04/24/24. This indicated the resident was cognitively intact.</p> <p>On 05/06/24 at 10:00 AM, an observation and interview was conducted of Resident #101. The resident was observed in bed with his call light on the floor next to the right side of the bed. The resident was asked if he could reach his call light. The resident stated his right arm was so painful he could not move it and he has not been getting out of bed. He stated he was not able to reach the call light.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41837</p> <p>3) Record review for Resident #71 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 01/13/24. The resident had diagnoses that included: Encephalopathy, Parkinson's Disease, and Need for Assistance with Personal Care.</p> <p>Review of the Minimum Data Set for Resident #71 dated 02/18/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 14 indicating a cognitive response.</p> <p>Review of the Physician's orders for Resident #71 revealed an order dated 01/13/24 for enablers which are used for bed mobility and safe transfers as tolerated every shift</p> <p>On 05/06/24 at 10:05 AM an observation was made of Resident #71 sitting up in bed with a staff member in the room (Later identified as Staff A, Certified Nursing Assistant (CNA). The resident's call bell was wrapped around the enabler bar located on right side, near the top of the bed. Staff A left the room. The resident was unable to reach for the call light.</p> <p>During an interview conducted on 05/06/24 at 10:10 AM with Resident #71, who was asked if she had any concerns about her care, she said, I can't call for help sometimes because I don't know where the call bell is.</p> <p>During an interview conducted on 05/06/24 10:13 AM with Staff A, who stated she has worked per diem (as needed) at the facility since 2017. When asked about the call bell wrapped around the enabler bar on the side of Resident #71's bed, she said they probably put it there when the breakfast was served to her in bed this morning.</p> <p>During an interview conducted on 05/09/24 at 11:40 AM with Staff B, Registered Nurse (RN) who stated she has worked at the facility for about a year. When asked about call bells, she stated when she first comes on to work, she always makes sure the call bells are in the bed for the resident to use for safe and effective communication. She stated one call can save a life. When asked if the call bell can be wrapped around the bed rail, she said no, it is placed on the bed.</p> <p>An interview was conducted on 05/09/24 at 12:00 PM with Staff C, Licensed Practical Nurse (LPN) who stated she has worked at the facility for [AGE] years. When asked about call bells, she stated the call bells are kept on the bed in reach of the resident. When asked if they can be wrapped around the bed rail, she said no we are not supposed to wrap anything around the bed rails.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</p> <p>Based on record review and interviews, the facility failed to ensure medications were being administered timely for 1 of 1 sampled resident (Resident #71).</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Medication Administration - General Guidelines dated May 2022 included in part:</p> <p>B. Administration</p> <p>2) Medications are administered in accordance with written orders of the prescriber.</p> <p>12) Medications are administered within (60 minutes) of scheduled time, except before, with or after meal orders, which are administered (based on mealtimes). Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the facility.</p> <p>Record review for Resident #71 revealed the resident was originally admitted to the facility on [DATE] with the most recent readmission on 01/13/24. The resident had diagnoses that included: Encephalopathy, Parkinson's Disease, and Need for Assistance with Personal Care.</p> <p>Review of the Minimum Data Set assessment for Resident #71 dated 02/18/24 revealed in Section C a Brief Interview of Mental Status (BIMS) score of 14, indicating a cognitive response.</p> <p>Review of the Physician's Orders for Resident #71 revealed an order dated 01/13/24 for Carbidopa-Levodopa Oral Tablet 25-100 MG (Carbidopa-Levodopa); Give 1 tablet by mouth three times a day related to Parkinson's Disease.</p> <p>Review of the Physician's Orders for Resident #71 revealed an order dated 01/14/24 for Droxidopa Oral Capsule 200 MG (Droxidopa); Give 1 capsule by mouth three times a day for Orthostatic Hypotension; Monitor blood pressure supine before administration.</p> <p>Review of the Medication Administration Record for Resident #71 for 05/01/24 to 05/07/24 documented the medications to include, Carbidopa-Levodopa 25-100 mg and Droxidopa 200 mg had been signed off as given three times a day (9:00 AM, 1:00 PM, and 5:00 PM)</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medication Administration History Report (Showing Actual Time Medication Given) for Resident #71 from 05/01/24 to 05/07/24 for the medication Carbidopa-Levodopa 25-100 mg revealed for 7 out of 21 opportunities the medication had been given outside of the 60 minutes before/60 minutes after medication scheduled time. On 05/02/24 the 9:00 AM dose was administered at 11:36 AM and the 1:00 PM dose was administered at 1:33 PM indicating the doses were administered less than 2 hours apart. On 05/02/24 the 9:00 AM dose was administered at 11:10 AM and the 1:00 PM dose was administered at 1:58 PM indicating the doses were administered less than 3 hours apart. On 05/07/24 the 9:00 AM dose was administered at 11:47 AM and the 1:00 PM dose was administered at 1:23 PM indicating the doses were administered less than 2 hours apart.</p> <p>Review of the Medication Administration History Report (Showing Actual Time Medication Given) for Resident #71 for 05/01/24 to 05/07/24 for the medication Droxidopa 200 mg revealed for 9 out of 21 opportunities the medication had been given outside of the 60 minutes before/60 minutes after medication scheduled time. On 05/02/24 the 5:00 PM dose was administered at 9:03 PM and on 05/03/24 the 5:00 PM dose was administered at 10:08 PM indicating twice the medication was administered at bedtime.</p> <p>During an interview conducted on 05/06/24 at 10:10 AM with Resident #71 who stated she would like to get her Parkinson's medication a little earlier otherwise she does not eat until noon time.</p> <p>During a telephone interview conducted on 05/07/24 at 8:43 AM with the daughter of Resident #71, the daughter said she thinks the Parkinson's medication is supposed to be given 1 hour before meals, but they are usually about 1 hour late giving the Parkinson's medication. The daughter said the medications makes it so her mother can feed herself.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 05/08/24 at 10:15 AM with the Consultant Pharmacist (CP) who has been working with this facility since 2011, and on and continuous since 2018. The CP stated that in this facility, a medication ordered for three times a day has a default to be given at 9:00 AM, 1:00 PM, and 5:00 PM. Additionally she said the nurse has an hour before and an hour after the scheduled time to administer the medication. The CP stated the Carbidopa-Levodopa does not need to be every so many hours, as this may be what the resident is used to in the community and if the resident is stable, it would not be an issue. When asked about Resident #71 specifically about the medication Carbidopa-Levodopa 25-100 mg ordered three times a day to be given at 9:00 AM, 1:00 PM, and 5:00 PM, the CP stated when she looked at the Medication Administration in May for this medication for Resident #71, she verified it was given as ordered. When the CP was shown the report for the Carbidopa-Levodopa 25-100 mg for Resident #71 with the actual time documented given in the month of May 2024, the CP said she was unaware of this report and acknowledged the medication was given too close at times. The CP said it should have at least 3 to 4 hours between administration times. If it is given too close, it may cause agitation. When asked if the medication could be given 1 hour before meals per a family/resident request, the CP said it most likely would not make a difference in the resident's movement but may decrease the appetite, she also added the medication can be taken with or without food. The CP stated if the family wanted to have the medications scheduled to be given an hour before meals, they would work with the family. When asked about Resident #71 specifically about the medication Droxidopa 200 mg ordered three times a day to be given at 9:00 AM, 1:00 PM, and 5:00 PM, the CP said if the medication is generally given closer at times during the day but not close to bedtime, because if given too close to the bedtime, it may cause orthostatic hypotension. The CP said ideally, the Droxidopa should be given 3 hour before bedtime and not like to see given past 6:00 PM or 7:00 PM. When shown the report for the Droxidopa 200 mg for Resident #71 with the actual time documented given in the month of May 2024, the CP acknowledged the Droxidopa was given too close to bedtime on some days. The CP stated it may be better if the facility staff signing off on the medication would put in a code indicating to see a nurses note and describe in the note why the medication was not given within the 1 hour before or 1 hour after the medication scheduled time.</p> <p>During an interview conducted on 05/08/24 at 11:30 AM with the Director of Nursing (DON), who was asked about Resident #71 and the actual medication administration times for the medications Carbidopa-Levodopa and Droxidopa, she acknowledged she just became aware of the medications not being administered as ordered and will start educating staff.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41837</p> <p>Based on observations, interviews, and record review, the facility failed to safely store medications for 1 of 1 sampled resident (Resident #54).</p> <p>The findings included:</p> <p>Review of the facility's policy titled, Bedside Medication Storage dated May 2022 included in part: Bedside medication storage is permitted for residents who wish to self-administer medications, upon the written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team.</p> <p>Procedures</p> <p>C. For residents who self-administer medications the following conditions are met for bedside storage to occur:</p> <p>1) The manner of storage prevents access by other resident. Lockable drawers or cabinets are required only if unlocked storage is deemed inappropriate. Facility management should have a copy of the key in addition to the resident.</p> <p>Record review for Resident #54 revealed the resident was admitted to the facility on [DATE] with diagnosis of Heart Failure, Vitamin Deficiency, Dry Eye Syndrome, Candidal Stomatitis, and Personal History of Urinary (Tract) Infections.</p> <p>Review of the Minimum Data Set (MDS) assessment for Resident #54 dated 02/04/24 documented in Section C a Brief Interview of Mental Status score of 15, indicating a cognitive response.</p> <p>Review of Resident #54's records revealed no assessment for self-administration of medications.</p> <p>Review of the Physician's orders for Resident #54 revealed no order to self-administer any medications.</p> <p>On 05/06/24 at 10:58 AM, an observation was made in the semi-private room of Resident #54 of a nightstand between the 2 beds with the top drawer open, and inside the drawer was 3 bottles of Systane lubricant eye drops, a bottle of probiotics, a bottle of organic cranberry 500 mg, and a bottle of urinary harmony supplement capsules. Further observations revealed on top of the nightstand was the Fluorouracil topical cream 5%. Resident #54 was not in the room, but the roommate (Resident #31) was in the room lying in the bed (Photographic Evidence Obtained).</p> <p>On 05/08/24 at 3:00 PM, an observation was made of Resident #54 sitting in her wheelchair with her laptop in front of her on an overbed table. On the overbed table next to the laptop was Fluorouracil topical cream 5%.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview conducted on 05/06/24 at 11:54 AM with Resident #54, who was in the day room, and was asked about the medications in and on her nightstand in her room, she said the prescription cream she puts on herself and the staff keep it at the nursing station. She said some nurses are a bit skittish to put it on because it goes in the []. She said last night the head nurse came to her to tell her she did not have the cream, she said maybe I forgot to give it back to them. When asked about the supplements, she said those may be hers because sometimes she takes them. When asked about the eye drops, she said those are hers as well and were prescribed by the ophthalmologist for her and she uses them several times a day.</p> <p>During an interview conducted on 05/08/24 at 3:05 PM, when Resident #54 was asked about the Fluorouracil topical cream 5%, she said that is her dermatological cream she uses on her face, she said her doctor prescribed it for her. When asked if she still has supplements and eye drops in the nightstand, she said yes.</p> <p>During an interview conducted on 05/08/24 at 3:30 PM with the Director of Nursing (DON) who was asked if Residents can have meds at the bedside, she said no, they can be assessed for self-administration, but the nurse will hold the medication locked in the med cart. When the DON was shown the photographic evidence of the medications at the bedside for Resident #54, the DON acknowledged the residents are not supposed to have the medications in the room at the bedside. The DON said she would address the matter.</p>		