

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  105430	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/25/2024
NAME OF PROVIDER OR SUPPLIER  Bedrock Rehabilitation and Nursing Center at Winte		STREET ADDRESS, CITY, STATE, ZIP CODE  1700 Monroe Ave Maitland, FL 32751	

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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49840</b></p> <p>Based on observation, interview and record review the facility failed to ensure the availability of routine medications to enable continuity of care for a newly admitted resident (#4), resulting in resident leaving the facility Against Medical Advice (AMA). The facility also failed to administer medications as ordered, resulting in resident (#12) receiving incorrect medication, for 2 of 2 residents reviewed for medication administration, of a total sample of 12 residents.</p> <p>Findings:</p> <p>1. Resident #4 was admitted to the facility on [DATE] with diagnoses that included cellulitis of the right lower limb, acute respiratory failure with hypoxia, pneumonia, chronic lung disease, and tobacco use. She was promptly discharged , Against Medical Advice (AMA), the next day on 4/10/24 at 2:00 PM.</p> <p>Review of the medical record for resident #4 revealed she had a Brief Interview for Mental Status Score (BIMS) of 15/15 which meant she was cognitively intact.</p> <p>Review of the Order Summary Report revealed resident #4 had 12 routine medications ordered on 4/10/24. Further review of the Medication Administration Record (MAR) revealed resident #4 never received 8 of the 12 routine medications scheduled for twice a day while at the facility. Some of the medications not given included Calcium-Vitamin D for supplementation, Fenofibrate for cholesterol, Prednisone for swelling, Trelegy Ellipta Inhaler for asthma, Amoxicillin for cellulitis of right lower limb, Lisinopril for hypertension, Verapamil for hypertension and chest pain, and Gabapentin for nerve pain.</p> <p>On 6/24/24 at 10:31 AM, in a phone interview with resident #4, she confirmed she was admitted to the facility from the hospital around 3:00 PM on 4/09/24, due to an infection of her right lower limb that required skilled nursing care. She said the facility did not have any of her evening medications and was told by staff they were working on getting the ordered medications from the pharmacy. Furthermore, on the morning of 4/10/24, she asked her husband to bring her own home medications to the facility because the facility still did not have them for her to take. When the facility found out she had her home medications, she was told by a nurse and the Director of Nursing (DON), she could not have her home medications at the bedside due to safety concerns. Resident #4 said she was very upset and decided to leave AMA that same day at around 2:00 PM.</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 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Progress Notes for resident #4 revealed on 4/10/24 at 10:53 AM, the Unit Manager (UM) and DON were notified resident #4 was observed with her home medications at the bedside and was encouraged to allow nursing to secure the medications until she was discharged home. The note described resident #4 had refused the education and told staff she was leaving AMA at 02:00 PM that day. An entry at 1:11 PM revealed resident #4 told the Advanced Practice Registered Nurse (APRN) she would be leaving the facility AMA and would get her medications from the pharmacy.</p> <p>On 6/24/24 at 2:41 PM, Registered Nurse (RN) A, revealed on the morning of 4/10/24 resident #4 told her she had not received some of her medications that morning so she left AMA that afternoon. RN A stated they were trying to get the pharmacy to deliver the medications but were having issues with the orders. She further explained when a resident arrived from the hospital, they waited to receive the medication orders, then the pharmacy would deliver to the facility at 6:00 AM and 2:00 PM. The facility had an automated medication dispensing cabinet, which the nurses were allowed to pull certain medications from if available. She said for resident #4, there were some medications they pulled from the automated medication dispensing cabinet but had to wait on the others.</p> <p>On 6/24/24 at 3:10 PM, RN B said she did not remember resident #4 but based on the time of her admission, she would have been on shift. She stated when a resident arrived at the facility, medications were not always available right away and the pharmacy delivered them early in the morning. She further explained the facility had an automated medication dispensing cabinet, but not all nurses had access to it.</p> <p>On 6/24/24 at 3:52 PM, the DON stated she did not remember resident #4. She explained the facility had asked the hospital to medicate the residents prior to the transfer to the facility due to the pharmacy cutoff of 5:00 PM. She said they had an automated medication dispensing cabinet machine but there were certain medications that needed a prescription or a pharmacy code to be taken out of the machine. She also stated there were occasions when the pharmacy would deliver medications at 3:00 AM. A short time later at 5:29 PM, the DON reported that based on review of the MAR and progress notes for resident #4, she was unsure why her evening medications on 4/09/24 and some of her morning medications on 4/10/24 were not given. There was no documentation in the medical record to explain why the medications were still not available. She explained that their admissions process was to obtain medication orders as soon as the resident arrived at the facility. If there were any issues with obtaining the medications from the pharmacy, a call should be made to the doctor and a note would be written in the medical record. Regarding residents bringing medications from home, the DON explained in situations where the facility had made every attempt to obtain the medication from the pharmacy, the resident was allowed to bring medications from home, but nursing staff would need to administer and store the medications based on the facility policy.</p> <p>2. Resident #12 was admitted to the facility on [DATE] with diagnoses that included muscle wasting and atrophy, history of transient ischemic attack (TIA), stroke affecting left side, and type II diabetes.</p> <p>Review of the medical record for resident #12 revealed he had a BIMS of 12/15 which indicated mild cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/25/24 at 9:39 AM, RN C was observed in the hall at the medication cart administering medications to resident # 12. She performed hand hygiene and proceeded to administer Refresh Tears eye drops in both of his eyes. Then she pulled out a medication cup and added one tablet of Amlodipine 5 milligram (mg), one tablet of Metformin 500 mg, and one tablet of Vitamin C. RN C handed the medications to resident #12 and he took them with a sip of water.</p> <p>Review of resident #12's medical record revealed he had an order for Cholecalciferol (Vitamin D-3)125 micrograms (5000 UT) one tablet given daily. Resident #12 did not have a physician's order for Vitamin C.</p> <p>On 6/25/24 at 11:00 AM, RN C was notified by the DON she had incorrectly administered Vitamin C instead of Vitamin D as ordered by the physician to resident #12. RN C explained she was not resident #12's usual nurse since she worked at the facility on an as needed basis. The DON stated the process for reporting medication errors was to complete an incident report, contact the physician, and monitor the resident for any adverse reaction.</p> <p>Review of the policy and procedure for Administering Medications, revised 6/18/24, revealed a protocol that the individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method of administration before giving the medication.</p>