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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>105448 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                      | (X3) DATE SURVEY COMPLETED<br><br>06/07/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Titusville Rehabilitation & Nursing Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1705 Jess Parrish CT<br>Titusville, FL 32796 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 13252</p> <p>Based on interview and record review the facility failed to report potential abuse and/or neglect violations with respect to a delay in cardio-pulmonary resuscitation (CPR) due to inaccurate and incomplete investigation, for 1 of 1 resident reviewed for reporting of alleged abuse and/or neglect, of a total sample of 68 residents, (#100).</p> <p>Findings:</p> <p>Resident #100 admitted to the facility on [DATE] with diagnoses including anemia, diabetes type II and muscle wasting. Review of the Minimum Data Set, dated dated [DATE], the resident scored a 13 out of 15 on the Brief Interview for Mental Status, indicating his cognition was intact. There was no evidence resident #100 could not make his own health care decisions. Resident #100 was placed on hospice care on [DATE] with a terminal diagnosis of moderate protein calorie malnutrition.</p> <p>A progress note dated [DATE] revealed a care plan meeting was held to discuss the resident's Advanced Directives/code status. The resident chose to be a Full Code which meant he wanted to be resuscitated including CPR.</p> <p>On [DATE] at 6:29 AM, Licensed Practical Nurse (LPN) A, documented in the medical record, Patient has expired Hospice notified MD.</p> <p>During a telephone interview on [DATE] at 6:13 PM, LPN A said she worked the overnight shift, from 11 PM to 7 AM, on the evening of [DATE] which ended on the morning of [DATE]. LPN A recalled that on or about 5:30 AM, on [DATE], Certified Nursing Assistant (CNA) B, notified her that resident #100 appeared expired. LPN A remembered she entered the resident's room and he did not have a pulse and was not breathing. LPN A expressed she called the hospice to verify the resident's code status, then made additional calls to the physician, then to the facility's Director of Nursing (DON) before initiating CPR and calling 911 for transport to the hospital.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On [DATE] at 1:47 PM, a meeting was conducted with Director of Risk Management (RM), Regional Nurse Consultant, Regional [NAME] President of Operations, Interim Administrator and Interim Director of Nursing. The RM presented the facility's investigation regarding resident #100's CPR incident. The RM discussed the Code Blue worksheet and how it was used to formulate the facility's time line of events for [DATE]. The RM said on the morning of [DATE] CNA B found resident unresponsive at 6:15 AM. They continued with the timeline, at 6:17 AM, 911 was called and LPN A initiated CPR. The discussion turned to what time LPN A called both the physician and hospice provider. The RM indicated it was standard practice to notify the physician and hospice provider and expressed that LPN A called hospice while she performed CPR on resident #100. The RM explained at first hospice incorrectly identified resident #100 as a Do Not Resuscitate (DNR) and then the hospice called back later to say the resident was a Full Code. The RM said Emergency Medical Service (EMS) arrived at the facility, took over CPR and transferred the resident to a nearby hospital. The RM explained the Administrator was supposed to make sure statements were obtained by all of the staff involved. The RM added she had a follow up phone call within a week of the event with the Administrator who indicated there were no additional concerns. The RM described that the facility's investigation needed to be completed within 5 business days in order to adhere to the regulatory requirement for the reporting of Abuse, Neglect and Exploitation (ANE). The RM confirmed the facility did not submit an Immediate or 5-Day Report in regards to possible ANE, to the State Survey Agency. The Risk Manager maintained the facility staff, on the morning of [DATE], performed CPR in accordance with the facility's policy &amp; procedures and the staff's training.</p> <p>Review of the EMS report dated [DATE] read, .Staff relates delay in initiating CPR over confusion involving pt's [patient's] DNR-staff initially believed DNR was current, however realized shortly after that DNR was rescinded by pt . The EMS report indicated a 911 call was received at 6:35 AM and EMS arrived to the facility at 6:41 AM.</p> <p>On [DATE] at 4:40 PM, CNA B confirmed she had not been asked to provide a statement for the investigation until the Interim Administrator had called her yesterday on [DATE]. She recalled she had worked on the 11 PM to 7 AM shift and resident # 100 was on her assignment. CNA B remembered she had checked on the resident sometime between 2:30 AM and 3:00 AM, and found him unresponsive. She then informed LPN A who checked the computer for physician orders for his code status. CNA B stated the LPN then looked in the hospice binder and said it indicated the resident was a DNR, so LPN A called the hospice who incorrectly told her the resident was a DNR. CNA B recalled the hospice called back later and said the resident was a Full Code, so LPN A then went to resident #100's room and initiated CPR. CNA B did not have a reason as to why she had not given a statement immediately after the incident but instead over 2 months later.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On [DATE] at 11:44 AM, another meeting was conducted with the RM, Interim Administrator, Interim DON, Regional Nurse Consultant, and Regional [NAME] President of Operations. The RM explained her role was not to review all of the facility's incidents, only the incidents required to be reported to the State Survey Agency which included Immediate and 5-day Reports. The RM stated the former Administrator and former DON reported to her they had a conflicting code status but the staff still initiated CPR timely. CNA B's statement from [DATE] was reviewed and the facility determined resident #100 could not had been found unresponsive at 2:30 AM, based on the EMS report. The RM could not explain why it had taken several months to obtain CNA B's statement. The RM stated she was informed by the former Administrator and former DON, they had completed all of the witness interviews. The RM was not aware there was a transcript of the call to hospice made on the morning of [DATE] when LPN B called for clarification of resident #100's code status. The survey team presented the transcript of LPN A's telephone call to the hospice from [DATE]. The RM was asked to read the transcript aloud.</p> <p>The transcript of the call from the facility to hospice on [DATE]:</p> <p>6:09 AM- Call comes into triage with report patient expired at 6:00.</p> <p>LPN A: We went to the patient's room, he is not breathing, we are starting CPR and sending him out. He is still a full code?</p> <p>Triage RN: He is still a full code?</p> <p>LPN A: I believe he is a full code, unless you have something different.</p> <p>Triage RN: I work in a different system and do not have access to that information but I can call the on call staff member to find out.</p> <p>LPN A: Ok thank you.</p> <p>6:12 AM Triage places LPN A on HOLD to talk to On Call Nurse (see call below*)</p> <p>6:15 AM Triage RN returns to state On Call Nurse will need to get access to the chart. On Call Nurse will follow up with a call and will be making a visit with appropriate paperwork if it is there.</p> <p>LPN A: Well I do not have an actual DNR but I am looking at his hospice book you guys give and under the medicare thing (the election of benefit) it says 'I request no cardiopulmonary resuscitative measures (CPR) at the time of my death.' I mean he is gone at this point so there is nothing I can do anyway. I just need to know whether he is a full DNR or not.</p> <p>6:17 AM call is ended after long pause between callers.</p> <p>*6:12 AM Triage RN places message to On Call Nurse (our employed LPN) On Call Nurse indicates she needs to be added to the chart to verify code status. Discussion to the ability to add On Call Nurse, determine she needs to call Point On Call.</p> <p>6:15 AM On Call Nurse calls point on call to get added to chart. Looks at attachments and does see a DNR.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>6:23 AM On Call Nurse calls LPN A (facility nurse) stating she sees a DNR but LPN A says, our records state full code On Call Nurse let her know she is on the way to the facility to make visit and told LPN A if you know if your records show full code, then continue to do CPR and call 911.</p> <p>6:32 AM On Call Nurse reads notes and point care alert and see where it does state patient full code. On Call Nurse called to speak to PCM [Patient Care Manager] to verify and PCM noted in the comments of attachments that patient rescinded DNR.</p> <p>6:34 AM On Call Nurse called LPN A back to confirm patient was in fact a full code .</p> <p>After the reading of the transcript the RM said she could not come to a conclusion about what happened because more information was required. The RM indicated she was not confident to say there was a delay in CPR. She said the facility's investigation was reopened during the current survey because of discrepancies which demonstrate the investigation was not complete and thorough. She indicated the facility would be file an immediate report to the State Agency as more/new information had come to light.</p> |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32131</p> <p>Based on interview, and record review, the facility failed to follow policy and procedure related to Full Code status leading to a delay in initiating Cardiopulmonary Resuscitation (CPR) for 1 of 5 residents reviewed for Advance Directives of a total sample of 68 residents, (#100).</p> <p>Resident #100 a-[AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included anemia, type II diabetes, occlusion and stenosis of the carotid artery. The resident was admitted to Hospice services on [DATE] with diagnosis of moderate protein-calorie malnutrition. The resident's physician's order dated [DATE] noted full resuscitation. Progress note dated [DATE] at 6:30 AM, documented by Licensed Practical Nurse (LPN) A read, Patient has expired Hospice notified MD (Medical Doctor) notified. Resident #100 died at the hospital on [DATE].</p> <p>The facility's failure to provide CPR in a timely manner as per resident #100's wishes and physician's order placed all residents in the facility at risk, and could lead to potential injury/impairment or death if code status is not identified and addressed immediately in an emergent situation. This failure resulted in Immediate Jeopardy starting on [DATE]. The Immediate Jeopardy was removed on [DATE].</p> <p>Findings:</p> <p>Cross Reference F609</p> <p>Review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognition was intact with a Brief Interview For Mental Status score of 13 out of 15.</p> <p>The resident's physician's order dated [DATE] noted his code status to be Full Resuscitation. Orders entered by LPN A on [DATE] at 6:29 AM, noted two contradictory orders, one for Full Resuscitation, and another for Do Not Resuscitate (DNR).</p> <p>A progress note dated [DATE] read, Advance care plan meeting held discussed code status wishes. Resident chooses to remain a full code at this time . hospice is caring for resident at this time for palliative comfort care.</p> <p>The Hospice Certification and Plan of Care with certification period [DATE] to [DATE] revealed his hospice diagnosis was moderate protein-calorie Malnutrition. Review of hospice orders for Advance Directive on [DATE] read, Do Not Resuscitate, and a different order dated two days later on [DATE] noted Resuscitate.</p> <p>Review of Hospice Note Reports dated [DATE], and [DATE] revealed the resident's code status was Full code.</p> <p>A progress note documented by LPN A, dated [DATE] at 6:29 AM, read, Patient has expired Hospice notified, MD notified.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On [DATE] at 5:25 PM, the 200 Wing Registered Nurse/Unit Manager (RN/UM) stated he recalled resident #100 was on hospice services and had a full code status. He stated he was not at the facility when the resident coded but heard there may have been some confusion by hospice whether the resident was a DNR or full code. The resident's clinical records were reviewed with the RN/UM and he acknowledged the only documentation pertaining to the resident's change in condition was on [DATE] at 6:29 AM, that indicated the resident expired. The RN/UM stated the normal process when a resident passed was for staff to call the Director of Nursing (DON) who would instruct the staff on what to do. He said the facility's protocol for code status was to go by what was in the resident's medical record.</p> <p>On [DATE] at 5:43 PM, an interview was conducted with the DON, and the Regional Consultant Risk Management Specialist. The DON explained the facility's process regarding advance directives. She stated on admission if the resident was alert and oriented, staff would verify the resident's wishes for advanced directives, notify the physician, and place a physician order in the facility's electronic medical record (EMR). If the resident was not alert and oriented, code status would be confirmed with the responsible party. She explained the order for code status would be entered in the EMR, printed and placed at the front of the resident's physical chart. The DON said if a resident was found unresponsive, the nurse should verify the resident's code status in the physical chart, and the physician order in the EMR. She noted the code status orders were usually verified by two nurses. She explained if the resident was without pulse and respiration and was a Full Code, CPR should be initiated immediately. The DON described a code worksheet on the crash cart, that directed staff to record the time the resident was found without unresponsive, the time 911 was called, and who initiated CPR. The code worksheet included staff who assisted in CPR, 911 response time, and the time 911 assumed care of the resident. She said the code worksheet was a tool to guide documentation for the resident's clinical record. The DON and the Regional Consultant Risk Management Specialist reviewed the resident's physician's order, and progress note, and stated documentation on [DATE] at 6:29 AM, indicated the resident expired, and the physician and hospice services were notified. They acknowledged there was no other documentation other than the resident expired and notifications made. The DON stated a DNR order was initiated for the resident on [DATE] at 6:29 AM, discontinued at 8:44 AM, and a Full code order was initiated at 6:45 AM after resident 100 had expired. She said the following day, post code, the Interdisciplinary Team (IDT) usually reviewed code status and identified who initiated CPR. She stated she would have questioned the DNR, and Full Code orders both entered on [DATE].</p> <p>On [DATE] at 6:13 PM, in a telephone interview, LPN A stated she worked at the facility full-time for six months on the 11 PM to 7 AM shift. She confirmed she was resident #100's primary nurse on [DATE], and noted the resident was very sick. LPN A recalled on [DATE] to [DATE] on the 11 PM to 7 AM shift, she did rounds between 12 AM to 1 AM, and at that time resident #100 was okay. She recalled Certified Nursing Assistant (CNA) B provided hygiene care for the resident, and when CNA B did her last round at about 5:30 AM, the resident was unresponsive. LPN A explained when she went into the resident's room, the resident appeared to have expired, he had no pulse, and was not breathing. The LPN said the resident was a full code, but in the hospice chart he had a DNR order. She recalled she called the hospice service, and was told the resident was a DNR. She remembered the hospice nurse on call was not familiar with the resident, and by the time she called back to say the resident was a full code, she had already verified the resident was a full code. LPN A said she called the physician to verify the resident's code status, reached out to the former DON, and she verified the resident had rescinded his DNR, and was a full code. She said CPR was initiated immediately after the resident's code status was confirmed by the physician. The LPN noted the facility had a CPR log, and information was documented on the log which was given to the former DON.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On [DATE] at 6:42 PM, the DON and Administrator stated an investigation was initiated by the former Administrator and DON. They shared the former Administrator put together a file with timeline on the Code Blue, and included statements from LPN A, and CNA C. There were no statements obtained from other nurses on shift, or from CNA B who initially found the resident unresponsive. They shared the Code Blue Worksheet dated [DATE] identified the resident was found unresponsive at 6:15 AM by CNA B. The worksheet timeline indicated the Emergency Code cart arrived at the resident's room at 6:17 AM. LPN A checked the resident's chart for code status at 6:17 AM, initiated CPR and called 911 at 6:17 AM. The Worksheet indicated Emergency Medical Service (EMS) arrived at 6:27 AM. They acknowledged statements were obtained on [DATE] from LPN A, CNA C, and the Director of Rehabilitation, but not from CNA B. Review of the Code Blue Worksheet revealed staff involved in the code were LPN A, CNA B, and CNA C.</p> <p>On [DATE] at 11:28 AM, an interview was conducted with the Regional Nurse Consultant, DON, Regional Risk Management Specialist, Regional [NAME] President (VP) of Operations, and Administrator. The DON stated the facility called all parties involved in the code, and staff present at the time of the incident. The Administrator stated LPN A had called 911 from her personal phone and completed a post event report. The Administrator said LPN A identified resident #100 was found unresponsive on [DATE] at 6:15 AM. The resident's chart and crash cart were brought to the resident's room at 6:17 AM. The Administrator said a statement was obtained from CNA B the resident's assigned CNA on [DATE] during the survey. She verbalized that during the interview with CNA B, the CNA voiced that she spoke with the DON after the event but was not asked to write a statement.</p> <p>On [DATE] at 11:28 AM, the conflicting information from interviews and the Code Blue Worksheet timeline as to when the resident was found unresponsive was discussed with the Administrator and DON. They did not have a response, and stated the facility's Corporate staff reviewed the previous Administrator and DON's investigation after the event. The Administrator provided documentation of the interview conducted with CNA B on [DATE] that revealed the CNA found resident #100 unresponsive at approximately 2:30 AM to 3 AM which contradicted previous interviews with Administration and the Code Blue Worksheets which noted the resident was found unresponsive at 6:15 AM. The Administrator stated the facility had statements to refute the CNA's statement. The Administrator stated LPN F worked on the 300 Wing on [DATE], and in her statement obtained yesterday on [DATE], LPN F stated that on [DATE], the ambulance left the facility at approximately 6:30 AM to 7:00 AM. The Administrator said at the time resident #100 was found unresponsive, his code status in the facility's EMR was Full Code, and she was not aware of any DNR order in the hospice binder for the resident. She stated the facility follows the orders in the EMR. The Regional Nurse Consultant stated that based on the resident's physician's order, the resident was a full code from [DATE] and had never had a DNR order in place. She verbalized that based on new statement given today by LPN A, the LPN had looked in the resident's hospice binder that morning and the resident was a DNR. However, the facility could not identify any DNR order in the closed clinical records for resident #100.</p> <p>Review of statements obtained by the current Administrator between [DATE], and [DATE], revealed LPN A reported she was made aware resident #100 was unresponsive around 5 AM to 6 AM. She checked the electronic record for the resident's code status, called a code and started CPR by herself for approximately ten minutes. CNA B's statement indicated the resident was found unresponsive by the CNA between 2:30 AM and 3 AM. The typed statement read, Told (LPN A's name) he wasn't breathing. She checked the computer and she said he was a DNR. She called the hospice and they confirmed he was a DNR. Then about an hour later hospice called back and said he was a full code, so she went back to the room and started doing CPR.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>Review of the transcript of the call from the facility to hospice on [DATE] revealed the following: 6:09 AM call comes into triage with report patient expired at 6: 00 AM. LPN A We went into patients' room; he is not breathing. We are starting CPR and sending him out. He is still a full code. Triage RN: He is still a full code? LPN A I believe he is a full code unless you have something different 6:15 AM Triage RN returns to state will need to get access to the chart will follow up with a call and will be making a visit with appropriate paperwork if it is there. LPN A Well I do not have an actual DNR, but I am looking at his hospice book you guys give and under the Medicare thing (the election of benefit) it says, 'I request no cardiopulmonary resuscitative measures at the time of my death'. I mean he is gone at this point so there is nothing I can do anyway. I just need to know whether he is a full DNR or not. 6:23 AM hospice nurse calls LPN A stating she sees a DNR, but LPN A says, our records state full code. The hospice nurse let her know she was on the way to the facility to make a visit and told LPN A if you know if your records show full code, then continue to do CPR and call 911. 6:34 AM hospice nurse called LPN A back to confirm patient was in fact a full code which confirms what LPN A stated at 6:09 AM</p> <p>Review of the report from Emergency Medical Services (EMS) provided by the Administrator revealed EMS arrived at the hospital from the facility on [DATE] at 7:09 AM.</p> <p>On [DATE] at 1:47 PM, the Corporate Director of Risk Management (RM) stated she was made aware by the facility there was a code blue on [DATE]. She said CPR was performed after the code status was identified, and in the middle of the code when hospice was made aware, hospice reported they had record of the resident being a DNR but instructed the nurse to follow physician orders on file. The nurse, LPN A, called the DON during the code, and the DON reassured her that once CPR was started, CPR could not be stopped. Later hospice called back and verbalized they made a mistake, and the resident's code status was not DNR, he was a full code. EMS arrived and assumed care for the resident, he was transferred to the hospital, and passed away. The RM said she provided guidance to facility leadership to investigate the event, interview all staff present, and validate there was no pause in CPR. She recalled she reviewed some statements, and there were no concerns, CPR continued until EMS arrived. The RM said the facility was concerned hospice had an incorrect order for the resident's code status that could have resulted in a potential negative effect. She recalled she had a follow-up phone call within the week of the event with the Administrator, and there were no additional concerns. She stated it was her understanding the facility did a thorough investigation. The RM said the statement obtained from CNA B on [DATE] had errors in the timeline, as evidenced by the resident's clinical condition when he arrived to the emergency room (ER). She said the statement from the assigned LPN A indicated she was made aware of the resident's condition at 6:15 AM. The RM explained the statements, code blue timeline, and verbal interviews were used to determine the timeline of the event was correct. She acknowledged there were conflicts between the statements obtained, interviews, and the timeline on the Code Blue Worksheet. She stated review of the progress note documented on [DATE] at 6:29 AM, indicated the resident expired, but the resident expired in the hospital. The RM said the hospital had documentation that conflicted with the facility's documentation, and the review left her with questions.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On [DATE] at 3:41 PM, the RM provided the Fire Rescue Patient Care Record dated [DATE]. Documentation on the EMS Patient Care Record-Admin/Hospital form indicated the initial call from the facility was received by EMS on [DATE] at 7:35 AM. The report revealed EMS arrived to the facility a few minutes later at 6:41 AM and arrived to the resident at 6:48 AM. The report read, Rehab staff relates pt (patient) was last seen normal @-1:00 AM during medication administration with no issue noted at that time. Staff relates coming in @-6:30 AM to find pt unresponsive, pulseless, apneic. Staff relates delay in initiating CPR over confusion involving pt's DNR- staff initially believed DNR was current, however realized shortly after that DNR was rescinded by pt. Staff relates CPR was initiated ~ ,d+[DATE] mins PTA [Prior to arrival] of EMS.</p> <p>The emergency room Record dated [DATE] revealed, Patient was found last seen around 2 AM found unresponsive and asystole [heart not beating] no bystander CPR. Documentation indicated the time of death was 7:13 AM.</p> <p>Information from EMS, and the ER conflicted with the statements obtained from LPN A, CNA B, the Code Blue Worksheet timeline, and the Triage call to the hospice. The EMS record indicated CPR was provided by facility staff approximately 5 to 10 minutes prior to their arrival on scene at 6:48 AM. This would indicate CPR was initiated by facility staff at approximately 6:30 to 6:35 AM and not at 6:17 AM, as documented on the Code Blue worksheet. This was acknowledged by the RM.</p> <p>On [DATE] at 4:40 PM, CNA B stated she had worked at the facility for four years, on the 3 PM to 11 PM shifts, and on the 11 PM to 7 AM shifts, twice weekly. She confirmed she worked on the 11 PM to 7 AM shift on [DATE] through [DATE], and resident #100 was in her assignment. CNA B recalled she checked on the resident between 2:30 AM to 3 AM, found him unresponsive, and immediately alerted LPN A. She recalled LPN A went to the computer to check the resident's code status, and said the resident was DNR. The LPN checked the book, CNA B said she was not sure of which book, and LPN A said it showed DNR. CNA B related CPR was not initiated at that time. CNA B said LPN A instead called hospice, and was told resident #100 was a DNR. She related hospice called back about one hour later and said the resident was a full code, so LPN A then went into the room and started CPR. CNA B stated LPN A performed compressions until EMS arrived and took over. The CNA stated LPN A called 911 before she initiated CPR, and thought CPR was started somewhere between 3:30 AM to 4 AM. She said she would not forget this event, because it was her first death. CNA B stated the Code Blue Worksheet timeline was inaccurate, and the resident was not found unresponsive at 6:15 AM, as documented. She stated her statement was obtained yesterday on [DATE] when the Administrator called her.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>               | <p>On [DATE] at 11:44 AM, another interview was conducted with the Regional Nurse Consultant, DON, Regional Risk Management Specialist, Regional VP of Operations, Corporate Director of RM, and the Administrator. The RM stated the facility identified the need for additional investigation, because of the discrepancies identified on the Code Blue worksheet, the documentation in the resident's EMR, the hospital records, and the EMS run report. When asked if CPR was provided timely, or delayed, the RM stated documentation from the hospice triage call indicated LPN A called at 6:09 AM to notify the resident expired at 6:00 AM. She said in the event report 6:00 AM was when the resident expired as per documentation and if 6:09 AM was when CPR was started, it would indicate a nine-minute delay. The RM stated staff were taught to follow physician orders in the EMR regarding code status, not to look at the hospice book. She stated after they received the EMS report, it confirmed the Code Blue Worksheet was not accurate. The RM said the EMS run report showed they arrived at the facility on [DATE] at 6:35 AM, and it appears there may have been a delay in providing CPR based on the EMS run report. (This statement of the EMS arrival time was found to be inaccurate per the EMS record, which indicated 911 call to EMS was at 6:35, with actual arrival time on scene at 6:41 AM.)</p> <p>On [DATE] at 3:12 PM, the Medical Director stated he was not aware of the concern with the discrepancy in code status for resident #100 until today ([DATE]). He stated proper documentation of code status should be in the resident's chart, and if there was no documentation, the resident remained as a full code. He stated the education to the nurse was lacking, and the facility needed to review and put some education in place. The Medical Director said some of the new nurses believed if a resident received hospice services, then the resident would be DNR, which was not always the case. He stated he was not the physician LPN A was reported to have called. He explained it would take the nurse approximately 15 minutes to complete a call to the physician in his opinion. The potential delay in providing CPR to resident #100 was discussed with the Medical Director. He said the facility did not have an AD Hoc Quality Assurance Performance Improvement meeting for this incident.</p> <p>Essential duties and responsibilities listed on the Job description for Licensed Practical Nurse with date of [DATE] included, Handles emergency situations in a prompt, precise, and professional manner. Perform CPR as required .Maintains accurate, detailed reports and records.</p> <p>The policy CPR Code Status Orders &amp; Response updated February 2023, revealed the procedure for initiating CPR directed that Code Status and resident will be verified by 2 identifiers .with another nursing care center personnel, if resident is a full code CPR will be initiated.</p> <p>Review of the immediate actions to remove the Immediate Jeopardy implemented by the facility as stated in their accepted Immediate Jeopardy Removal Plan revealed the following, which were verified by the surveyor:</p> <p>*[DATE] CPR was initiated for resident #100 and resident was transferred from the facility with a rhythm via EMS and passed away at the hospital.</p> <p>*[DATE] Assistant DON initiated staff education on Code Status Orders and Response Policy and Procedure to include procedure for initiating CPR and documentation of the event. 31 out of 31 licensed nurses were educated as of [DATE]. Re-education was initiated for licensed nursing clinical staff to be completed [DATE].</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0678</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>*[DATE] Facility audit of 100 out of 100 residents advance directives was completed, to confirm accuracy of code status present in the front of the medical records and that it matched the physician's orders in the EMR.</p> <p>*[DATE] additional audit of 21 out of 21 residents receiving hospice services conducted to confirm code status of record with hospice matches the facility's record. The hospice chart stored at the facility was combined with the facility's hard chart, removing individual hospice binders.</p> <p>*[DATE] the Regional [NAME] President provided education to the Administrator and Interim DON on their essential core functions and the code of conduct.</p> <p>*[DATE] the Risk Management Consultant provided education to the Administrator and DON on the Abuse Prevention Program and conducting through investigations.</p> <p>*A total of 9 Code Blue Drills has been completed since [DATE] covering all shifts in order to ensure staff are knowledgeable and prepared to accurately verify resident code status in an emergency and ensure staff provide CPR in a timely manner.</p> <p>*[DATE] Ad Hoc Quality Assurance and Compliance committee reviewed removal plan.</p> <p>Review of the in-service attendance sheets revealed evidence to reflect staff participation in education on CPR &amp; Advance Directives.</p> <p>Between [DATE] and [DATE], interviews were conducted with 4 RNs, 4 LPNs, and 3 CNAs. They all verbalized understanding of the education provided.</p> <p>Interviews, and record reviews revealed no concerns for residents #1, #11, #25 and #87 related to Advance Directives and code status.</p> |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32131</p> <p>Based on interview, and record review, the facility failed to ensure Medical Records were complete and accurate pertaining to a change in condition for 1 of 5 residents reviewed for Advance Directives, (#100), and failed to accurately document medication administration for 1 of 1 resident reviewed for accuracy of medical record, (#25), of a total sample of 68 residents.</p> <p>Findings:</p> <p>1. Resident #100, a-[AGE] year-old male was admitted to the facility on [DATE]. His diagnoses included anemia, type II diabetes, stenosis of the carotid artery, and repeated falls. The resident was admitted to hospice services with start of care date of [DATE] with a diagnosis of moderate protein-calorie malnutrition.</p> <p>A progress note documented by Licensed Practical Nurse (LPN) A was dated [DATE] at 6:29 AM, and read, Patient has expired Hospice notified MD (Medical Doctor) notified.</p> <p>Review of the resident's clinical records revealed there were no other documentation to indicate when the change in condition was identified for resident #100. No documentation was noted regarding the actions taken prior to the progress note documented on [DATE] at 6:29 AM.</p> <p>On [DATE] at 5:25 PM, the 200 Wing Registered Nurse/Unit Manager (RN/UM) stated if a resident was found unresponsive, after staff assessment and response, a progress note was to be documented in the resident's electronic medical record (EMR) with the relevant information. Resident #100's clinical records were reviewed with the RN/UM, he acknowledged the progress note dated [DATE] at 6:29 AM, and confirmed no additional documentation could be identified, prior to the progress note which indicated the resident expired.</p> <p>On [DATE] at 6:13 PM, in a telephone interview, LPN A confirmed she was resident #100's primary nurse on [DATE]. She recalled Certified Nursing Assistant (CNA) B did her last round on the resident about 5:30 AM and reported to her the resident appeared expired. The LPN stated when she went into the resident's room he did not have a pulse. She stated information and actions taken regarding resident #100's change in condition were documented on the Cardiopulmonary Resuscitation (CPR) log and given to the former DON. She acknowledged the information was not documented in the resident's clinical record.</p> <p>On [DATE] at 4:40 PM, CNA B confirmed she worked on the 11 PM to 7 AM shift on [DATE] through [DATE], and resident #100 was in her assignment. She recalled she checked on the resident somewhere between 2:30 AM and 3 AM, found him unresponsive, and reported the change in condition to LPN A.</p> <p>Review of the medical record revealed this information was not documented in the resident's clinical records.</p> <p>Review of the Code Blue Worksheet for resident #100 dated [DATE] revealed documentation which indicated resident 100 was found unresponsive at 6:15 AM.</p> <p>(continued on next page)</p> |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of the hospice transcript of the call from the facility on [DATE] revealed LPN A called at 6:09 AM to report patient expired at 0600.</p> <p>Interviews conducted with LPN A, and CNA B, review of the Code Blue Worksheet, and statements obtained from LPN A and CNA B revealed information pertaining to the resident's change in condition, and LPN A's communication between the facility and providers was not documented in the resident's clinical records.</p> <p>On [DATE] at 5:43 PM, the Director of Nursing (DON), and the Regional Consultant Risk Management Specialist explained the facility had a code worksheet on the crash cart staff would utilize to record pertinent details of the code event, including the time the resident was found without pulse and respiration, the time 911 was called, who initiated CPR, who assisted, 911 response time, and time 911 assumed care of the resident. They stated the code sheet was a tool to aid documentation in the resident's clinical record. The resident's clinical records were reviewed with the DON, and she acknowledged the progress note documented on [DATE] at 6:29 AM, was the only documentation by nursing staff identified regarding the change in the resident's condition.</p> <p>On [DATE] at 11:28 AM, and on [DATE] at 11:44 AM, the Corporate Director of Risk Management (RM) stated that in reviewing the incident, the facility identified an opportunity for improved documentation. The Regional Consultant Nurse stated LPN A verbalized information in her documentation was in error and should have been documented appropriately in the resident's clinical record. When asked why documentation was not completed, LPN A said she was tired. The RM stated the facility identified discrepancies on the Code Blue worksheet, documentation in the resident's EMR, hospital records, and the Emergency Medical Services run report. She acknowledged the facility had a responsibility to ensure documentation was complete and accurate.</p> <p>Essential duties and responsibilities listed on the Job description for DON dated [DATE] indicated the DON was to ensure, Adherence by staff pertaining to proper documentation of patient care.</p> <p>Essential duties and responsibilities listed on the Job description for LPN with date of [DATE] included, Maintains accurate, detailed reports and records.</p> <p>45646</p> <p>2. Resident #25 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, chronic atrial fibrillation, cardiac arrhythmia, unspecified glaucoma, hypertension and generalized anxiety disorder.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date of [DATE] revealed resident #25 had a Brief Interview for Mental Status score of 13 which indicated she was cognitively intact. She did not exhibit any behavioral symptoms and did not reject care that was necessary to achieve her goals for health and well-being. The document revealed resident #25 had a diagnosis of unspecified glaucoma.</p> <p>A care plan for potential for impaired visual function related to history of glaucoma was initiated on [DATE] and revised [DATE]. Interventions included, Administer medication as ordered.</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Review of resident #25's EMR revealed a physician order dated [DATE] for 1 drop of Combigan Ophthalmic solution 0XXX,d+[DATE].5% (Brimonidine Tartrate-Timolol Maleate) to be instilled in both eyes two times a day for glaucoma.</p> <p>On [DATE] at 12:00 PM, daughter to resident #25 stated she did not receive medications in a timely manner. She stated the resident was supposed to get eyes drops 3 times a day. Resident #25 confirmed she had not received any eye drops today. She stated the nurse told her there were no eyes drops on her list of medications to be administered.</p> <p>Review of the Medication Administration Record (MAR) for [DATE] at approximately 12:25 PM, revealed eye drops were documented as given for the 9:00 AM administration.</p> <p>On [DATE] at 1:05 PM, LPN G was observed on 100 unit. LPN G verified she had a split assignment between 100 and 200 units. She explained she had left the 200 unit and was on the 100 unit passing medications. LPN G stated she had not administered the eyes drops to resident #25. She explained she preferred to administer eye drops at the end of her medication pass. LPN G reviewed her MAR documentation and verified she documented the eyes drops were already administered. She stated she did not remember documenting the administration. LPN G acknowledged it was not good practice to check off medications as given prior to actual administration.</p> <p>On [DATE] at 3:31 PM, the DON stated she spoke to LPN G and provided one on one education. The DON verified LPN G should not have documented administration of medication when she had not given the medication. The DON acknowledged by doing so, you would not be able to accurately identify which medications had or had not been administered.</p> <p>The facility's policy and procedure for Medication Administration dated [DATE] indicated medications were to be administered within 60 minutes of scheduled times. The policy read, The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given.</p> |   |  |