

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105526	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/17/2024
NAME OF PROVIDER OR SUPPLIER Terrace at Bishop's Glen, The		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Lpga Blvd Holly Hill, FL 32117	

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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30969</p> <p>Based on record review and interview, the facility failed to ensure as-needed (PRN) orders for psychotropic medications prescribed were limited to 14 days, except when extended by the physician beyond 14 days with documented rationale in the resident's medical record for 1 (Resident #1) of 1 resident reviewed for PRN psychotropic medication use, out of 5 sampled residents. Failure to obtain a 14-day stop order on PRN psychoactive medications presents a risk of overuse, and of improper monitoring by the prescribing practitioner for the appropriateness of that medication.</p> <p>The findings include:</p> <p>A review of Resident #1's medical record revealed she was admitted to the facility on [DATE], with a readmitted [DATE]. Diagnoses included, but were not limited to, encephalopathy (a brain disorder caused by disease or damage that affects brain structure or function), non-Alzheimer's dementia, and cognitive communication deficit.</p> <p>A review of Resident #1's physician orders revealed an order started on 8/15/24 for an emergency order of ABH gel (a combination of Ativan, an anti-anxiety medication, Benadryl, an antihistamine, and Haldol, which is an anti-psychotic medication) 1/25/1 milligrams/milliliters (ml), apply 1 ml to wrist, alternation inner side of wrist every 4 hours as needed for unspecified dementia, unspecified severity with psychotic disturbance. The end date was noted as indefinite.</p> <p>Resident #1 was care planned on 8/22/24 for her multiple medical needs and for her behaviors of screaming and hollering.</p> <p>A review of Resident #1's quarterly minimum data set (MDS) assessment with a reference date of 8/25/24 revealed she was rarely, if ever, understood. She had short and long-term memory loss and moderately impaired cognition for daily decision making. The resident also received antipsychotic medications on 7 days over the assessment's lookback period.</p> <p>A review of the medication administration records (MAR) for Resident #1 revealed the following:</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 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>ABH gel was applied in August 2024 on the following days: August 16th- 6 times and August 17th- 4 times. The order was held on 8/17/24, then re-ordered again 8/17/24 and used once daily on August 22nd, 24th, 25th, 28th and 30th, and two times each day on August 29th and 31st. In September 2024, the gel was applied once each day on the 2nd, 3rd, 5th, 6th, 7th, 8th and 10th, 14th, 16th, 21st, 22nd, 23rd and 30th and twice on September 1st, 11th, 17th, 20th and 26th. In October 2024, ABH gel was used once on the 1st, 4th, 5th and 9th and twice on the 6th. (Photographic evidence was obtained)</p> <p>An interview was conducted with Licensed Practical Nurse (LPN) A on 10/17/24 at 1:20 pm. She stated Resident #1 had been on the long-term care hallway for a little while. Her behaviors are more well-managed now. Resident #1 has a PRN order for ABH if she does not take her medication. PRNs are given only as needed. When asked about the stop orders for psychoactive PRN medications, LPN A stated Resident #1 takes Lorazepam (anti-anxiety) PRN, which has a stop order of 14 days. If it is still needed after that time, the physician reorders the medication. LPN A was shown the order for the ABH gel. She said she didn't realize it had no 14-day stop order. She stated the Director of Nursing (DON) usually catches that, but this job takes a village. LPN A acknowledged the requirements for a 14-day stop order on any prescribed PRN psychoactive medication.</p> <p>The DON was interviewed on 10/17/24 at 1:30 pm. He was asked about the ABH gel order for Resident #1. The DON reviewed the records and confirmed the lack of a 14-day stop order, calling it a miss. He stated he usually catches that and will notify the prescriber. The DON confirmed Resident #1 received this medication often.</p>