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 11/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Terrace at Bishop's Glen, The	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43221 Based on interviews, medical record review, facility documents review, and facility policy review, the facility failed to ensure residents were free from significant medication errors for one (Resident #1) of three residents reviewed for medication administration. This action resulted in Resident #1 requiring a transfer to a higher level of care and hospital admission. The findings include: A review of Resident #1's medical record revealed she was a [AGE] year-old female admitted to the facility with a diagnosis of chronic obstructive pulmonary disease, morbid obesity, muscle weakness, transient ischemic attacks, and dementia. Review of the Minimum Data Set (MDS) assessment for Resident #1 dated 8/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating severe cognitive impairment. A review of Resident #1's physician's orders revealed that on 10/19/24 at 9:00 AM, staff was to administer the following medications: Aricept 5 milligram (mg) tablet (to treat dementia caused by Alzheimer's) Calcium 600/Vit D3 20 microgram (mcg) (to increase low calcium levels) Furosemide 20 mg (to lower fluid levels) Lisinopril 10 mg daily (for hypertension) Namenda 10 mg (to treat dementia caused by Alzheimer's) Potassium 40 mili equivelants (mEq) (to treat low potassium levels) Artificial tears (to treat dry eyes) Docusate 100 mg (to soften stools) Further record review revealed that on 10/19/24, Resident #1 was administered Resident #2's medications (listed below) in error. (continued on next page)

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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F 0760

Level of Harm - Actual harm

Residents Affected - Few

Bupropion extended release 150 mg (extended release for treatment of depression)

Citalopram 10 mg (for treatment of depression)

Cranberry 450 mg daily (urinary tract infection prevention)

Fenofibrate 160 mg (used to treat elevated cholesterol levels)

Losartan Potassium-Hydrochlorothiazide 50-12.5 mg (used to treat high blood pressure)

Metformin 500 mg daily (used to treat type 2 diabetes mellitus)

Metoprolol extended release 2 5mg daily (used to treat high blood pressure)

A review of Resident #2's medical record revealed she was the [AGE] year-old roommate of Resident #1. Her MDS assessment dated [DATE] revealed a BIMS score of 3 out of 15, indicating severe cognition deficit.

A review of Resident #2's physician's orders revealed the following medications were to be administered on 10/19/24 at 9:00 AM:

Bupropion extended release 150 mg (extended release for treatment of depression)

Citalopram 10 mg (for treatment of depression)

Cranberry 450 mg daily (urinary tract infection prevention)

Fenofibrate 160 mg (used to treat elevated cholesterol levels)

Losartan Potassium-Hydrochlorothiazide 50-12.5 mg (used to treat high blood pressure)

Metformin 500 mg daily (used to treat type 2 diabetes mellitus)

Metoprolol extended release 2 5mg daily (used to treat high blood pressure)

A review of the October 2024 Medication Administration Record (MAR) revealed documentation of Resident #2 receiving her medications.

A review of nursing progress note dated 10/19/24 at 12:14 PM read: Employee A, Licensed Practical Nurse (LPN)-at 10:00 am medication pass completed when patient was noted to be given wrong medications, patient alert, oriented to person and surroundings, the resident is not in acute distress at this time, vital signs 90/58- heart rate 60- respiratory rate 18- 95% oxygen (O2) saturation and temperature 98.5, recheck of blood pressure one hour after medication given 89/54-59 call to on-call for Doctor spoke with Nurse Practitioner (NP) on call who gave orders for resident to be sent to hospital for evaluation and possible intravenous (IV) fluids, call to daughter and son-in-law who agree patient should go to the emergency room (ER) for evaluation. Call to emergency medical transport (EMT) for transport to Hospital. EMT here to transport at 12:30 pm with son-in-law at bedside. Sent to hospital, call placed to hospital for report spoke with. Director Of Nursing (DON) aware.

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NAME OF PROVIDER OR SUPPLIER Terrace at Bishop's Glen, The		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Lpga Blvd Holly Hill, FL 32117	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Actual harm Residents Affected - Few	A review of nursing progress note dated 10/20/24 at 9:30 AM read: Employee B, Registered Nurse (RN)-Called hospital for report and was informed that patient is doing well and Blood Pressure is a little low and should be back tonight or tomorrow. Record review of Resident #1's Vital signs revealed: 09/01/2024 12:37 122 /68 mmHg Sitting left/arm 10/19/2024 12:17 89 /54 mmHg Lying left/arm 10/22/2024 20:43 98 /63 mmHg Lying left/arm Record review of Resident #1's O2 saturation/Respiratory Rate revealed: 09/01/24 96%/20 respirations per minute (RPM) 10/22/24 96%/18 RPM 11/04/24 97%/18 RPM A review of hospital note dated 10/22/24 read: Chief complaint: gave wrong medication at facility. [AGE] year-old female who came from facility for evaluation after she was given wrong medications from another resident. She received metoprolol, metformin and lisinopril. Facility notified family members and patient was sent to hospital for evaluation due to hypotension. During emergency she received IV fluids due to hypotension. Blood pressure improved. Also noticed increased oral secretions, Chest x-ray with small left-sided pleural effusion. Mild bilateral interstitial opacity, potentially representing chronic interstitial changes versus mild pulmonary vascular congestion. Family members at bedside. Reported the patient is bedbound. Laboratories with elevated [NAME] Blood Cells 13.6, glucose 160. Breath sounds with Bilateral (both sides) rhonchi (low pitched, coarse, loud lung sounds). Diagnosis: aspiration pneumonia (lung infection caused by inhaling food, liquid, or vomit), hypotension (low blood pressure) due to overmedication by mistake, history of hypertension (high blood pressure), chronic dementia. A review of investigation statements from facility staff revealed the following: Employee A, LPN -On Saturday 10/19/24, I came in to assist with Med pass while helping Employee B, I pulled medications for Resident #2, another nurse Employee C, asked to take them to the patient. and I handed them to her telling her room [ROOM NUMBER] (actual room number was 212), Resident #2. When the nurse returned, I was done pulling meds for the roommate Resident #1 and when Employee C was told who the meds were for she stated, Oh I already gave her (Resident #1) the other pills. Stating she thought it was for 112B bed (Resident #1)! This nurse did not see her give the medications. (Signed) Employee A, LPN. (Photographic evidence obtained) On 10/19/24 Saturday During med pass it was reported that (Resident #1) received her roommates' medications this nurse assessed the Resident and notified Doctor on-call and family. Patient sent to hospital for evaluation. (Signed) Employee A, LPN. (Photographic evidence obtained) (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 10/19/24 Employee C, RN-This nurse offered assistance to nurse (Employee B) on the East cart. Employee A (wound care nurse) was pulling meds (Employee B was standing by passing meds as well). Employee A put some meds in a cup to be passed and this nurse repeated 212B to question and confirm the room I was to pass meds to. There was no contradiction to my statement, so this nurse passed the meds to 212B. This nurse explained that I gave them to 212B and Employee A stated, we have to do a med error. An incident report was done and Employee A showed me what was noted. Employee A later told me that upon recommendation of NP, resident was sent out to hospital. Employee B later told me the next day that resident would probably be coming back on Monday, but they were still monitoring her Blood pressure. (Signed) Employee C, RN. (Photographic evidence obtained) On 11/5/24 at 10:55 AM, an interview was conducted with Employee D, LPN. Employee D stated she would never give medications to a resident pulled by another nurse. She was unaware of an incident involving meds being pulled by one nurse and delivered to resident by another nurse. When describing the med pass process, she said, We get the cart from the other shift, then do the narc count and get the keys. I usually roll my cart to the room when I'm getting ready to give meds. I pull the meds from the cart, greet my resident, then either hand them to the resident or feed them to the resident, then go back and chart as given. When asked if meds are left at the bedside if the resident refused to take them at the time of delivery, Employee D replied, No, if the resident couldn't be coaxed into taking them, the meds would be discarded, and Medication Administration Record (MAR) marked as refused, and the Doctor or NP would be notified. On 11/5/24 at 11:05 AM, an interview was conducted with Employee E, Licensed Practical Nurse (LPN). Employee E stated she would only deliver medications to a resident that she actually pulled from the cart, that's one of the first things they teach in nursing school. She verbalized the facilities practice for medication administration as, using the MAR to pull the residents medications, delivering the medications to the resident, after verifying the resident, then documenting the resident took the medications. On 11/5/24 at 11:20 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who was also responsible for Staff development/Clinical Education. She stated she was aware of the incident involving Resident #1 receiving another residents' medications. She explained that Unit Managers can step in to cover a medication cart if there is a nurse who has called out, while they look for another nurse to come in. On this particular day, there had been a call out, Employee B, who was the Unit Manager (UM) for the 200 hall, started doing med pass. Employee A came in to relieve Employee B. A nurse from the other unit (100 hall) came over to assist which was when the error happened. The ADON stated, this was not a standard of practice for one nurse to pull medications and another nurse administer the medications. Adding, 1:1 education was done with Employee A and Employee C and she was in the process of conducting Read and Signs for the 11-7 shift, and education during huddles for the remainder of the nursing staff. On 11/5/24 at 11:35 AM, an interview was conducted with the DON. The DON stated that during the investigation they found Employee B who was the Unit Manager was on the med cart due to a callout. Employee A came in to relieve Employee B. Employee A put Resident #2's meds in a med cup, at that time Employee C came over from the 100 hall to assist. Employee A handed Resident #2's med cup to Employee C telling Employee C to give to 212A (Resident #2). DON added, Employee A was just trying to get the meds out and accepted Employee C's help. Employee C was just trying to help but did not know the residents on that hall. When asked if there had been any documented reprimands, DON replied, I haven't done any yet, still considering it. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 11/5/24 at 12:42 PM, a telephone interview was conducted with Employee A, LPN. Employee A said, I came in to relieve the Unit Manager (UM) Employee B, RN - I took over the cart from Employee B, RN. I was pulling Resident #2's meds, Employee C, RN came over to help, told her patient's name, she took the meds and walked away. I started pulling Resident #1's meds, Employee C, RN returned and said she had given the meds to B bed (Resident #1). I reported this to the NP, was told to send resident to the emergency room for evaluation. When asked if resident was assessed, Employee A replied, yes, her blood pressure was slightly low and she complained of nausea. When asked, how was the rest of the med pass completed, Employee A replied, Employee B and I completed the med pass pulling and passing. This was not a normal situation nor normal practice. A review of the facility's policy and procedure titled: Medication Administration-General Guidelines (May 2022); pages 152-158 revealed the following: Page 156, item B Administration: 7) The person who prepares the dose for administration is the person who administers the dose. 8) Resident are identified before medication is administered using two methods of identification. Methods of identification include: a. Checking photograph attached to medical record. b. Checking the resident's wristband. c. Calling resident by name (except with cognitive impairment). d. Having the resident verify his/her last name. e. If necessary, verifying resident identification with other facility personnel. (Copy obtained)