Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105548	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Moultrie Creek Nursing and Rehab Center	200 Mariner Health Way Saint Augustine, FL 32086

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51228 Based on resident record review, observations, interviews with the resident and staff, and a review of the facility's policy and procedure, the facility failed to ensure that the resident's environment remained as free of accident hazards as was possible for one (Resident #17) of two residents reviewed for accident hazards, from a total survey sample of 33 residents. The findings include: An observation was made of Resident #17 on 9/30/2024 at 1:55 PM in his room. He was awake and lying in bed under the covers watching television. During the observation of the resident's room, one shaving razor was observed inside of a plastic container on the bedside table located over the resident's bed. No facility staff were present. (Photographic evidence obtained) On 10/1/2024 at 9:39 AM, Resident #17 was observed again, lying in bed under his covers and watching television. During observations of the surrounding area, one shaving razor (same razor observed the previous day), was still inside of a plastic container on the bedside table next to the resident's bed. No facility staff were present. (Photographic evidence obtained) A return visit and interview on 10/2/2024 at 9:40 AM found that Resident #17 was in his room lying in bed under his covers and watching television. During the observation of the surrounding area of the bed, one shaving razor (same razor observed on previous days) was observed inside of a plastic container on the bedside table next to the resident's bed, and one shaving razor (second shaving razor found) was observed on top of the nightstand behind the resident's oxygen concentrator equipment, next to the bed. (Photographic evidence obtained) When asked if the facility allowed residents to store shaving razors inside their rooms, Resident #17 stated the certified nursing assistants (CNAs) were supposed to remove the razors from the rooms after shaving the residents. No facility staff were present. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #17's medical record found that he was admitted to the facility on [DATE] with a previous admission on 6/19/2013. He had diagnoses including, but not limited to, hemiplegia and hemiparesis following cerebral infarction affecting his left non-dominant side, anemia, chronic respiratory failure, diabetes mellitus with diabetic polyneuropathy, peripheral vascular disease, chronic kidney disease - stage 2, anxiety disorder, cervical disc disorder with myelopathy, and fusion of the spine - cervical region. There was no indication in the record that the resident could safely shave himself. There were no physician's orders permitting Resident #17 to independently engage in personal hygiene tasks such as shaving. A review of the resident's Annual Minimum Data Set (MDS) assessment, dated 9/20/2024, revealed that Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 possible points, indicating intact cognition. There were no documented signs of psychosis, behavioral symptoms, or rejection of care. Impairments in both upper and lower extremities, limitations in Activities of Daily Living (ADLs), and a need for substantial to maximal assistance for oral hygiene, toileting, and personal hygiene were also documented. Resident #17's care plan was reviewed on 9/24/2024 (Photographic evidence obtained) and revealed that he was at risk for decreased mobility, skin integrity issues, visual deficits, and communication deficits due to a history of cerebrovascular accident (CVA) with left hemiplegia. The goal was to ensure that he remained free from injury and skin breakdown. Interventions included providing substantial to maximal assistance with bathing, personal hygiene, dressing, nail care, and grooming on a daily basis, and as needed. CNA D was interviewed on 10/03/2024 at 1:45 PM. When asked which supplies were maintained inside of the residents' rooms, CNA D replied, Soap, lotion, and basins are kept in the residents' rooms. When asked where shaving razors or nail clippers were kept, CNA D stated items such as razors and nail clippers were kept in the central supply room. CNA D also stated after the CNAs finished shaving the residents, the razors were removed from the residents' rooms and disposed of inside of a sharps container. An interview was conducted with CNA C on 10/3/2024 at 2:12 PM. She was assigned to Resident #17 on 10/3/2024. When asked which items were allowed to be kept inside of residents' rooms, CNA C stated, Hairbrushes, lotions, basins, blue barrier cream, and items brought by family members such as body wash are allowed to be stored in the rooms. When asked about the process of shaving a resident at bedside, CNA C stated, I bring a razor from the central supply room and assist the resident with the shave. Once finished, I remove the razor from the resident's room and dispose of the razor in the sharps container. CNA C also stated sharps containers were located in the medication administration carts and in the shower rooms. On 10/3/2024, at 2:22 PM, CNA C was accompanied to Resident #17's room and was advised of the observation of the razors. CNA C observed two shaving razors that were left inside of the room: One shaving razor was in a plastic container on the bedside table, and one shaving razor was located behind the oxygen concentrator equipment, next to the bed, on top of the nightstand. CNA C confirmed that the shaving razors should not have been left inside of the resident's room. She acknowledged the oversight and promptly removed both razors from the room for disposal in a sharps container. A review of the facility's policy and procedure titled Procedural Guidelines (effective 1/2023 and updated 9/2023), revealed the following: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	18. Tidy environment, remove supplies and store appropriately. A review of the facility's procedural guidelines found no evidence that the facility had established procedures to address sharp objects such as shaving razors and the proper storage and handling of them. (Photographic evidence obtained)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42442 Based on observations, record reviews, and staff interviews, the facility failed to ensure a medication error rate of 5% or less, based on three errors from 27 opportunities for error, resulting in an error rate of 11%, and impacting three (Residents #48, #259 and #33) of five residents observed for medication administration, from a total survey sample of 33 residents. Failure to administer medications appropriately as ordered, could result in side effects and/or potential harm to the residents. The findings include: 1. During medication administration observation on 10/2/24 at 8:35 a.m., Licensed Practical Nurse (LPN) A was preparing medication for Resident #48. After reviewing the medication administration record (MAR), she stated she did not have Vitamin D3 1.25 milligrams (mg) equivalent to 5000 international units (IU) that was ordered for the resident. She checked the medication cart and obtained an over the counter (OTC) container of Vitamin D3, stating it was the wrong dosage because it contained Vitamin D3 25 microgram (mcg)(1000IU) tablets (Note: 1000 mcg = 1 mg, therefore 1.25 mg = 1250 mcg or 5 tablets of 25 mcg). On 10/2/24 at 8:47 a.m., LPN A notified Resident #48 that she did not have the Vitamin D3 and she would bring them to him once it was available. She proceeded to the nurses' station and contacted the pharmacy to see when the medication would be delivered. She stated the pharmacy representative explained to her that the medication was an OTC, therefore the facility was responsible for providing it. She then contacted the facility's central supply room and was notified that only Vitamin D3 25 microgram (mcg) tablets were available. LPN A stated she would check with another nurse to see whether she had the medication in her cart. Shortly thereafter, she returned and stated that medication was not available, and she would have to notify the physician to see what he would like to do. A review of Resident #48's active physician's orders revealed an order dated 6/6/24 for Vitamin D3 (Cholecalciferol) 1.25 mg (5000IU) by mouth one time a day (QD) every two weeks on Wednesday as a supplement. 2. During medication administration observation on 10/2/24 at 9:20 a.m., Registered Nurse (RN) B was observed preparing medication for Resident #259. She obtained an Aspirin 81 mg enteric coated (EC) tablet, crushed it, and mixed it with applesauce. She proceeded to the resident's room and administered the medication to the resident. A review of Resident #259's active physician's orders revealed an order dated 9/21/24 for Aspirin EC delayed release 81 mg one time a day for analgesic (pain). In an interview on 10/2/24 at 11:03 a.m., RN B confirmed that the medication was enteric coated and should not have been crushed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During medication administration observation 10/2/24 at 8:23 a.m., Licensed Practical Nurse (LPN) A was observed preparing medications for Resident #33. She obtained the resident's vital signs and reported a blood pressure (BP) of 114/73 millimeters of mercury (mmHg) and a pulse of 114 beats per minute. She reviewed the Medication Administration Record (MAR) and obtained Aspirin 81 milligrams (mg), one tablet of Probiotics, Magnesium 500 mg, Metformin 500 mg, Clopidogrel 75 mg, Lasix 20 mg, Potassium 10 milliequivalent (mEq), and Protonix 40 mg from the medication cart. She stated she would be holding the Nifedipine 60 mg and Atenolol 25 mg because of the low blood pressure reading. She went to the resident 's room, administered the medication and notified the resident that she was holding her blood pressure medication because her blood pressure was low. A review of Resident #33's active physician's orders revealed an order dated 7/16/24 for routine Atenolol 25 mg one time a day for hypertension (high blood pressure) and routine Nifedipine Extended Release (ER) 24 hours 60 mg one time a day for blood pressure. In an interview on 10/2/24 at 8:47 a.m., LPN A was asked if the medication she held included parameters for when it should be held. She replied, No. She was then asked if she had an order to hold the medication and again, she answered, No, I was just using nursing judgement. She added that she normally held the medication when the resident had a systolic blood pressure (SBP) of less than 120 mmHg. During an interview on 10/3/24 at 2:48 p.m., the Director of Nursing (DON) confirmed that medication should not be held unless there is an order to hold it. If there were concerns with a resident's vital signs and the resident had scheduled medication, the expectation was that the nurse should notify the resident's physician. A review of the facility's policy and procedure titled Medication Pass and Med Pass with Medication Cart (Effective 1/2023, Updated 8/14/2024), revealed: Purpose: To assure the most complete and accurate implementation of physicians' medication orders and to optimize drug therapy for each resident by providing for administration of drugs in an accurate, safe, timely, and sanitary manner. To systemically distribute medications to residents in accordance with state and federal guidelines. Fundamental Information: Physicians' Orders: Medications are administered in accordance with the written orders of the attending physician. If the dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, contact the physician for clarification prior to administration of the medication. Document the interaction with the physician in the progress notes and elsewhere in the medical record, as appropriate.