STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105578	A. Building B. Wing	12/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspire at the Sea - Harbor Beach	1615 Miami Rd Fort Lauderdale, FL 33316

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38349 Based on review of policy and procedure, record review and interview, the facility failed to ensure that it followed physician's order for Intravenous (IV) antibiotic administration for 1 of 3 sampled residents observed, Resident #1. The findings included: Record review of the facility policy and procedure titled Physician's Orders provided by the Director of Nursing (DON) revised 03/03/21 documented in the Policy Statement: The center will ensure that Physician's orders are appropriately and timely documented in the medical record. Procedure: Admission Orders: Information received from the referring facility or agency to be reviewed, verified with the physician and transcribed to the electronic medical record .Routine Orders: A nurse may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner .For pharmacy orders, the nurse will notify the pharmacy per pharmacy policy by telephoning, faxing or completing the order electronically .to maintain an accurate medical record. Record review of the facility policy and procedure titled Administering Medications provided by the Director of Nursing (DON) revised April 2019 documented in the Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: 1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so .4. Medications are administered in accordance with prescriber orders, including any required time frame 7. Medications administered within one (1) hour of their prescribed time, unless otherwise specified 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending physician or the facility's Medical Director to discuss the concerns 21. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record (MAR) space provided for that drug and dose. Resident #1 was admitted to the facility on [DATE] with diagnoses which included Osteomyelitis---left ankle and foot, Anemia, Peripheral Vascular Disease (PVD), Infection of Multiple Drug Resistant Organism (MDRO)---Methicillin Resistant Staphylococcus Aureus (MRSA), Septicemia---Severe Sepsis without Septic Shock, Diabetes Mellitus Type II with Diabetic Polyneuropathy, Morbid Obesity, Gastroesophageal Reflux Disease (GERD), Neuralgia and Neuritis, Acidosis, Overactive Bladder, Rash/skin eruption, and Acute Respiratory Failure. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/29 the Patient Hospital Transfer Form documented, primary diagnosis: Severe Sepsis. Osteomyelitis needs IV antibiotics .Methicillin Resistant Staphylococcus Aureus (MRSA) of lower extremities . Contact Isolation Medication due near time of transfer/list last time administered Antibiotics date 10/10/24 time 1 PM pain level 7/10 on 10/10/24 at 12:40 PM .Skin condition: leg wounds A side-by-side record review of the Resident #1's Physician's Order Sheet for October 2024 was conducted with the Director of Nursing (DON) in which the following three IV antibiotics had been ordered by the Physician: 1) Originally, on 10/10/24 Cefiderocol Sulfate Tosylate (Fetroja) IV solution use 1.5 gm IV every eight hours for Sepsis administer over three hours; 2) On 10/13/24 Doxycycline Hyclate IV solution reconstituted 100mg use 100ml/hr. IV every twelve hours for Sepsis until 12/08/24---(substituted for Minocycline, per the DON); And, 3) originally on 10/10/24 Minocycline HCL IV solution reconstituted 100mg use 100 ml/hr. IV every twelve hours for Sepsis for four weeks---(substituted by Doxycycline, per the DON). Record review of the Nursing Progress Notes dated 10/13/24 by the DON, subsequently revealed the following: follow-up done on IV medication with pharmacy. Per Pharmacist they're out of Minocycline. Call placed to MD waiting on medication. Record review of the Resident #1's Base line Care plan initiated 10/10/24 indicated the following for Resident #1: Isolation for MRSA (wound) IV antibiotics Minocycline and Fetroja. Goals included: Infection will resolve . Medication and/or treatments as ordered and monitor for signs/symptoms or worsening of infection . However, further record review of Resident #1's Medication Administration Record (MAR) dated October 2024 did not document that any of the above IV antibiotic medications had been checked off, nor initialed/signed off to signify that any of the IV medications had been administered to Resident #1, as ordered by the physician, during the resident's three day facility stay, prior to her discharge from the facility. The only documentation recorded for any of these three IV medications was as: Other/See Nurse Notes---medication on order per pharmacy; with no further detailed information or explanation. Record review revealed that Resident #1 had the following abnormal lab work results dated 10/11/24, Complete Blood Count (CBC) with Differential---White Blood Cell (WBC) 17.2 High, Red Blood Cells (RBC) 2. 89 low, Hemoglobin 8.3 low, Hematocrit 26.7 low, Mean Cell Hemoglobin count (MCHC) 31.2 low, Red cell distribution width (RDW) 17.7 high, Neutrophil % 82.1 high, Lymphocyte % 8.4 low, Neutrophil # 14.1 high, Monocyte # 1.2 high, Comprehensive Panel---Glucose serum 51 low, Blood Urea Nitrogen (BUN) 41 high, Chloride 111 high, Osmolality calculated 305.5 high, Calcium total 7.33 low, Total Protein Serum 5.0 low, Albumin Serum 2.3 low, Albumin/Globulin (A/G) Ratio 0.9 low, Alkaline Phosphatase 129 high and C-Reactive Protein (CRP) Quantitative 5.3 high. An interview was conducted with Staff A, a Licensed Practical Nurse, (LPN) on 12/02/24 at 10:31 AM, regarding Resident #1's ordered IV antibiotic medications that were not received for administration to the resident, and he acknowledged that the resident had at least two IV antibiotics ordered by her physician. However, he stated that despite two attempts to contact the facility's pharmacy to have the medications delivered, the IV antibiotic medications, had still not been delivered to the facility for administration to the resident, during his work shift. He also added that he had not notified the ADON nor the DON regarding the fact that the IV antibiotics had not yet been delivered to the facility from the pharmacy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview conducted with Staff B, an LPN, on 12/03/24 at 10:53 AM regarding Resident #1's ordered IV antibiotic medications that were not received for administration to the resident, she also acknowledged that the resident had at least two IV antibiotics ordered by his physician. And, she stated that she, too, contacted the facility's pharmacy to have the medications delivered. However, the medications had still not been delivered to the facility for administration to the resident, during her work shift. She added that she did not document any notification of the ADON or DON anywhere in the resident's record, and she ended by saying that she had no explanation as to why she did not follow-through with trying to obtain Resident#1's IV antibiotic medications for administration. During an interview conducted on 12/03/24 at 11:13 AM with the ADON, she stated that the facility's Admission's Department requested that she contact the facility's pharmacy, to see if the IV antibiotics (Minocycline and the Fetroja) were in stock, prior to the resident's admission to the facility. And, the ADON added that she was told by the pharmacy that they both were in-stock, but high cost. The ADON indicated that she relayed this message back to the Admissions Department, prompting the resident's admission to the facility. However, the ADON did acknowledged that, according to the October 2024 MAR, none of Resident#1's IV antibiotic medications had been administered to her, for the three day facility stay period. An interview was conducted with Staff D, facility Pharmacist, on 12/03/24 at 12:58 PM regarding Resident #1's ordered IV antibiotic medications that were not delivered to the facility for administration, she explained, in detail, by saying that the order for high-cost Fetroja 1.5 gm IV every eight (8) hours for Sepsis over 3 hours was sent to them via electronic order via Point-Click-Care (PCC) on 10/10/24 at 11:37 PM. Subsequently, she stated that the pharmacy received a cancellation order for the Fetroja by 10/11/24 at 5:54 PM, and another order was entered again and updated, due to non-delivery. The pharmacist stated that this medication was a high cost medication, and she went on to say that the pharmacy did send out the high-cost limit form via fax to the facility on [DATE]. However, she acknowledged that there was no specific staff attention noted on it; only a fax confirmation was received back to the pharmacy, that it was sent. The pharmacist stated that if this form is not completed and signed by the facility, and returned back to the pharmacy, then the pharmacy cannot send the medication to the facility. The high-cost authorization signed form was not e-mailed to the pharmacy, from the facility until the resident's last day in the facility on 10/13/24, by the facility's DON, as verbally corroborated by her, as well. The pharmacist stated that it learned that the Minocycline medication was not made available for the pharmacy. And, as result of this, the pharmacy recommended for the physician to switch to Doxycycline, which was not delivered to the facility until after the resident had already been discharged from the facility, according to the pharmacist. The pharmacist ended by saying that, she was not aware of any of the above until today. An interview was conducted on 12/03/24 at 1:15 PM with the facility's Medical Director and Attending Physician for Resident #1 regarding Resident #1's ordered IV antibiotic medications that were not delivered by the pharmacy and received into the facility for administration to the resident. The Medical Director stated that he didn't receive notification from the DON until 10/13/24, the third day of the resident's facility stay, in which he said that he was told that they were having difficulty getting the medication from the pharmacy. The Medical Director went on to say that he learned from the facility that the IV antibiotic had never arrived at the facility even after he switched the antibiotic. The Medical Director acknowledged that no IV antibiotic therapy treatment was administered by the facility to this resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no detailed documentation in the facility's notes to indicate exactly why Resident #1's ordered IV antibiotics were not delivered and administered during her three day facility stay. The DON further recognized and acknowledged on 12/03/24 at 2:45 PM that none of Resident #1's IV antibiotic medications had been administered to Resident #1, as per the physician's orders; when they should have been.