

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105685	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2024
NAME OF PROVIDER OR SUPPLIER Menorah House		STREET ADDRESS, CITY, STATE, ZIP CODE 9945 Central Park Blvd N Boca Raton, FL 33428	
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 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p>39142</p> <p>Based on interview and record review, the facility failed to verify if an IV (Intravenous) antibiotic needed to be ordered and administered on a scheduled basis for 1 of 1 sampled resident reviewed (Resident #1).</p> <p>The findings included:</p> <p>Record review for Resident #1 revealed the hospital sent a physician order dated 05/25/24, to the facility for Vancomycin IV (Intravenous) upon discharge, that was intended for Home Health Care (HHC). The orders on the hospital Social Service Requisition, Consult Social Service Order form that was sent to the facility, had the order as follows: Vancomycin 1g IV with each dialysis until June 25th.</p> <p>On 07/29/24 at 12:13 PM, an interview was conducted with Staff A, Registered Nurse (RN), who was one of the nurses who worked with Resident #1. The RN explained that the orders from the hospital would be entered into PCC by either the floor nurse or the unit manager. The RN determined that the hospital did not include the Vancomycin as part of the discharge orders that are reconciled by the nurses upon admission.</p> <p>On 07/29/24 at 12:51 PM, an interview was conducted with Staff B, Social Services Coordinator. Staff B stated that there is a meeting every morning with the DON (Director of Nursing), ADON (Assistant Director of Nursing), Administrator, and Social Services. She stated they discuss the new admissions and review the residents' needs. Staff B stated the document that indicated the vancomycin had come to her attention because it was sent as a Home Health Care (HHC) request for the antibiotic to be given intravenously in dialysis. This was not a nursing order according to Staff B.</p> <p>On 07/30/24 at 8:47 AM, an interview was conducted with a Registered Nurse (RN) from the Dialysis Center. The Dialysis Center is contracted to provide services at the facility. The RN explained that when Resident #1 was admitted, the resident's spouse told the Dialysis nurse that Resident #1 was to receive Vancomycin in dialysis by IV. When the Dialysis nurse asked the on-duty nurse for the Vancomycin the on-duty nurse told the Dialysis Nurse that Resident #1 was getting oral Vancomycin, and the on-duty nurse would be providing the medication. The Dialysis nurse was unable to provide the date of the interaction with the spouse. It was unclear if the Vancomycin was discussed when Resident #1 was admitted or afterward.</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 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>There was no evidence the Vancomycin IV order from the hospital was clarified with the physician. There was no evidence the order for the Vancomycin IV was reviewed in the morning meeting for the newly admitted resident.</p>