

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105707	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Fouraker Hills Rehab and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1650 Fouraker Rd Jacksonville, FL 32221	

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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43221</p> <p>Based on interviews, medical record review, and facility policy and procedure review, the facility failed to ensure residents were free from any significant medication errors, by failing to administer medications within the specified timeframe based on physicians' scheduling orders for four (Residents #1, #2, #3, and #6) of six sampled residents, from a total census of 111. Failure to administer medications in a timely manner can result in a resident's inability to maintain the proper level of medication in the bloodstream to be effective; reduced functional ability; lower quality of life; hospitalization, disease progression, and/or death.</p> <p>The findings include:</p> <p>On 7/15/24 at 9:30 AM, the administrator was requested to provide a copy of current Quality Assurance and Performance Improve (QAPI)/Performance Improvement Project (PIP) being conducted at the facility.</p> <p>On 7/15/24 at 4:30 PM, facility staff provided a copy of an Inservice Education that was given to nursing staff on 7/10/24 regarding Medication Administration policy and procedure. There was not an ongoing performance improvement project in place at the time of the survey.</p> <p>1. A review of Resident #1's medical record revealed an admitted [DATE] for respite care and discharge date of [DATE] with a diagnosis that included cerebellar ataxia, Diabetes Meletus type 2, seizures, and muscle spasms.</p> <p>On 7/15/24 at 3:40 PM, the Director of Nursing (DON) was requested to provide Resident #1's Medication Administration Audit (MAA) report for the period 6/13/24 through 6/16/24. The 11-page report was received at 3:57 PM. (Copy obtained)</p> <p>A review of Resident #1's MAA Report from 6/13/24 through 6/16/24, revealed that his medications were administered outside of the acceptable two-hour administration window (one hour before to one hour after) on 3 of 4 days as follows:</p> <p>On 6/14/24, the enteral water flushes of 150 milliliters (ml) were to scheduled hourly for 00:00, 1:00, 2:00, 3:00 AM, it was documented as administered at 2:47 AM.</p> <p>On 6/14/24, the enteral water flushes of 150 ml were scheduled hourly for 4:00, 5:00, 6:00 AM, it was documented as administered at 5:45 AM</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 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/14/24, the enteral water flushes of 150 ml were scheduled hourly for 8:00, and 9:00 AM, it was documented as administered at 9:29 AM.</p> <p>On 6/14/24, the following medications were scheduled for 9 AM, Sitagliptin (diabetes), Glucerna (feeding tube nutrition), Escitalopram (depression), Oxybutynin (bladder spasms), Levetiracetam (seizures), Levemir FlexPen (insulin), they were documented as administered between 10:02 AM and 11:05 AM.</p> <p>On 6/14/24, the Lispro Insulin was scheduled for 11:30 AM, it was documented as administered at 12:27 PM.</p> <p>On 6/14/24, the enteral water flushes of 150 ml were scheduled for 4:00 PM, it was documented as administered on 6/15/24 at 1:06 AM.</p> <p>On 6/14/24, the Lispro Insulin was scheduled for 4:30 PM, it and was documented as administered on 6/15/24 at 1:06 AM.</p> <p>On 6/14/24, the enteral water flushes of 150 milliliters (ml) were to scheduled hourly for 5:00 AM, 6:00 AM, 7:00 AM, 8:00 AM, 9:00 AM, and 10:00 AM, it was documented as administered on 6/15/24 at 1:06 AM.</p> <p>On 6/14/24, the following medications were scheduled for 9:00 PM, Levetiracetam and Glucerna, they were documented as administered on 6/15/24 at 1:06 AM.</p> <p>On 6/14/24, the enteral water flushes of 150 ml was scheduled hourly for 11:00 PM, it was documented as administered on 6/15/24 at 1:06 AM.</p> <p>On 6/15/24, the enteral water flushes of 150 ml were scheduled hourly for 00:00, 1:00, 2:00, 3:00, 4:00, 5:00 AM, it was documented as administered at 4:33 AM.</p> <p>On 6/15/24, the enteral water flushes of 150 ml were scheduled hourly for 9:00, 10:00, 11:00 AM, it was documented as administered at 10:07 AM.</p> <p>On 6/15/24, the enteral water flushes of 150 ml were scheduled hourly for 5:00 and 6:00 PM, it was documented as administered at 5:25 PM.</p> <p>On 6/15/24, the enteral water flushes of 150 ml were scheduled hourly for 7:00, 8:00, 9:00, 10:00, 11:00PM, it was documented as administered at 11:40 PM.</p> <p>On 6/15/24, the following medications were scheduled for 9:00 PM, Glucerna and Levetiracetam, they were documented as administered at 11:40 PM.</p> <p>On 6/16/24, the enteral water flushes of 150 ml were scheduled hourly for 00:00 and 1:00 AM, it was documented as administered at 1:05 AM.</p> <p>On 6/16/24, the enteral water flushes of 150 ml were scheduled hourly for 3:00, 4:00, 5:00 AM, it was documented as administered at 6:35 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/16/24, the enteral water flushes of 150 ml were scheduled hourly for 8:00 and 9:00 AM, it was documented as administered at 10:02 AM.</p> <p>On 6/16/24, the Lispro insulin was scheduled for 11:30 AM, it was documented as administered at 12:56 PM.</p> <p>On 6/16/24, the enteral water flushes of 150 ml were scheduled hourly for 12:00 and 1:00 PM, it was documented as administered at 12:56 PM.</p> <p>On 6/16/24, the enteral water flushes of 150 ml were scheduled hourly for 2:00 PM, it was documented as administered at 4:00 PM.</p> <p>On 6/16/24, the enteral water flushes of 150 ml were scheduled hourly for 7:00, 8:00 and 9:00 PM, it was documented as administered at 8:42 PM.</p> <p>On 7/15/24 at 5:00 PM, the Director of Nursing (DON) was requested to provide the Medication Administration Audit (MAA) report for the period 7/12/24 through 7/15/24 for Resident #2, #3, and #6. On 7/16/24, received Resident #2's 18-page report at 9:38 AM, Resident #3's 14-page report at 9:36 AM, and Resident #6's 6-page report at 10:57 AM.</p> <p>(Copy obtained)</p> <p>2. A review of Resident #2's medical record revealed an admitted [DATE] with diagnoses that included spondylosis without myelopathy or radiculopathy, lumbar region, type 2 diabetes mellitus, hypertension (HTN), polyneuropathy, major depressive disorder, and anxiety disorder.</p> <p>A review of Resident #2's MAA Report from 7/12/24 through 7/15/24, revealed that her medications were administered outside of the acceptable two-hour administration window (one hour before to one hour after) on 4 of 4 days as follows.</p> <p>On 7/12/24 the following medications were scheduled for 9:00AM, Azelastine (nasal spray for allergies), Amlodipine (HTN), Potassium Chloride ER (supplement), Meclizine (dizziness), Lisinopril (HTN), Cholecalciferol (Vitamin D), Furosemide (diuretic), Meloxicam (antispasmodic), Lidoderm patch (pain), Baclofen (anti-inflammatory), they were documented as administered between 10:08 and 10:10 AM.</p> <p>On 7/12/24, Meclizine was scheduled for 5:00 PM, it was documented as administered at 6:10 PM.</p> <p>On 7/13/24 the following medications were scheduled for 9:00AM, Azelastine (nasal spray for allergies), Amlodipine (HTN), Potassium Chloride ER (supplement), Meclizine (dizziness), Lisinopril (HTN), Cholecalciferol (Vitamin D), Furosemide (diuretic), Meloxicam (antispasmodic), Lidoderm patch (pain), Baclofen (anti-inflammatory), they were documented as administered between 10:21 and 10:24 AM.</p> <p>On 7/14/24 the following medications were scheduled for 9:00 AM, Azelastine (nasal spray for allergies), Potassium Chloride ER (supplement), Meclizine (dizziness), Cholecalciferol (Vitamin D), Furosemide (diuretic), they were documented as administered between 10:11 and 10:13 AM.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/14/24 the following medications were scheduled for 9:00 AM, Amlodipine (HTN), Lisinopril (HTN), Meloxicam (antispasmodic), Lidoderm patch (pain), they were documented as administered between 12:26 and 12:27 PM.</p> <p>On 7/14/24, Meclizine was scheduled for 5:00 PM, it was documented as administered at 7:28 PM.</p> <p>On 7/15/24, Meclizine was scheduled for 5:00PM, it was documented as administered at 6:45PM</p> <p>On 7/15/24 the following medications were scheduled for 9:00 PM, Melatonin (insomnia), Azelastine, Trazodone, (depression) Donepezil (dementia), Simvastatin (cholesterol control), Latanoprost drops (glaucoma), Removal of Lidoderm patch, Gabapentin (neuropathy), Baclofen (spasms), they were documented as administered at 11:20 PM.</p> <p>(Copy obtained)</p> <p>3. A review of Resident #3's medical record revealed an admitted [DATE] with diagnoses that included spinal stenosis, DM, and HTN.</p> <p>A review of Resident #3's MAA Report from 7/12/24 through 7/15/24, revealed that his medications were administered outside of the acceptable two-hour administration window (one hour before to one hour after) on 4 of 4 days as follows.</p> <p>On 7/12/24, the following medications were scheduled for 9:00 AM, Acarbose (anti-diabetic), Metoprolol (HTN), Clopidogrel (anticoagulant), Amlodipine (HTN), Aspirin (anticoagulant), and they were documented as administered at 12:00 PM.</p> <p>On 7/12/24, Metoprolol was scheduled for 5:00 PM, it was documented as administered at 7:51 PM.</p> <p>On 7/12/24, the following medications were scheduled for 9:00 PM, Atorvastatin (cholesterol) and Acarbose, and they were documented as administered at 11:39 PM.</p> <p>On 7/13/24, the following medications were scheduled for 9:00 AM, Metoprolol, Aspirin, Amlodipine, Clopidogrel, Acarbose, Cholecalciferol, and they were documented as administered between 12:41 and 12:42 PM.</p> <p>On 7/14/24, the following medications were scheduled for 9:00 PM, Atorvastatin and Acarbose, and they were documented as administered at 10:45 PM.</p> <p>On 7/15/24, the following medications were scheduled for 9:00 AM, Metoprolol, Aspirin, Amlodipine, Clopidogrel, Acarbose, Cholecalciferol, and they were documented as administered at 11:07 AM.</p> <p>On 7/15/24, Acarbose was scheduled for 1:00 PM, and it was documented as administered at 2:04 PM.</p> <p>On 7/15/24 the following medications were scheduled for 5:00 PM, Gabapentin, Tylenol, Metoprolol, and they were documented as administered between 8:41 and 8:43 PM.</p> <p>(Copy obtained)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. A review of Resident #6's medical record revealed an admitted [DATE] with diagnoses that included hypertensive heart disease without heart failure, other Alzheimer's disease, gout, and hyperlipidemia.</p> <p>A review of Resident #6's MAA Report from 7/12/24 through 7/15/24, revealed that his medications were administered outside of the acceptable two-hour administration window (one hour before to one hour after) on 3 of 4 days as follows.</p> <p>On 7/12/24 the following medications were scheduled to be administered at 9:00AM, Nuedexta (pseudobulbar disorder), Trazodone (depression), Prednisone (steroid), Depakote (antianxiety), Ferrous sulfate (supplement), Fluticasone (Rhinitis), Lisinopril (HTN), Aspirin (anticoagulant), and they were documented as administered 10:53 and 10:57 AM.</p> <p>On 7/12/24 the following medications were scheduled to be administered at 5:00 PM, Depakote (antianxiety) and Trazodone (antidepressant), and they were documented as administered at 6:32 PM.</p> <p>On 7/12/24, the following medications were scheduled to be administered at 8:00 PM, Allopurinol (gout), Amlodipine (HTN), Donepezil (dementia), Rosuvastatin (hyperlipidemia), and they were documented as being administered at 11:38 PM.</p> <p>On 7/12/24, Nuedexta was scheduled to be administered at 9:00 PM, and it was documented as being administered at 11:38 PM.</p> <p>On 7/14/24, the following medications were scheduled to be administered at 5:00 PM, Trazodone and Depakote, and they were documented as being administered at 6:10 PM.</p> <p>On 7/14/24, the following medications were scheduled to be administered at 8:00 PM, Allopurinol, Amlodipine, Donepezil, Rosuvastatin, and they were documented as being administered at 9:21 PM.</p> <p>On 7/15/24, the following medications were scheduled to be administered at 9:00 AM, Nuedexta, Depakote, Trazodone, Aspirin, Lisinopril, Fluticasone, Ferrous sulfate, and they were documented as being administered at 11:44 AM.</p> <p>On 7/15/24, Risperdal (sun downing) were scheduled to be administered at 4:00 PM, and it was documented as being administered at 5:28 PM.</p> <p>On 7/15/24, the following medications were scheduled to be administered at 8:00 PM, Rosuvastatin, Donepezil, (documented as being administered at 10:28 PM). Amlodipine and Allopurinol, were documented as being administered at 6:28 PM.</p> <p>On 7/15/24, the following medications were scheduled to be administered at 9:00 PM, Trazodone (documented as being administered at 6:29 PM) and Nuedexta (documented as being administered at 10:28 PM).</p> <p>(Copy obtained)</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of the medication administration audits for Resident #1 (6/13-6/17/2024), Resident #2, Resident #3, and Resident #6 (7/12-7/15/2024) revealed the following nursing staff (Employees: A, B, C, D, E, F, G, H, I, J, K, and L) had documented medication administration outside the policy statements of Page 1, Procedure, item #6. Medications are administered within one (1) hour before or after their prescribed time, unless otherwise specified (for example, before and after meal orders, at bedtime).</p> <p>A review of the employee roster, received on 7/15/24, revealed there were thirty-eight employees listed as either Registered Nurses (RN) or Licensed Practical Nurses (LPN).</p> <p>On 7/10/24, thirteen nurses had signed as having received an in-service education for Medication Administration. Employees: A, B, E, G, J, K, were identified as having received the training on July 10, 2024, and were identified as employee's who had evidence of late documentation of medication administration.</p> <p>On 7/15/24 at 11:22 AM, an interview was conducted with Employee C, LPN, which revealed the she had been at facility a couple of months. Employee C confirmed that medications were to be given up to an hour before to an hour after the scheduled time and documentation of administration was to be done at the time the meds were given. She also confirmed that she had received an in-service on the medication administration policy during her orientation.</p> <p>On 7/15/24 at 11:48 AM, during an interview with Employee F, LPN, she confirmed the medication administration window was an hour before to an hour after the ordered schedule and that medications are to be documented at the time the medication has been taken by the resident.</p> <p>On 7/15/24 at 4:30 PM, an interview was conducted with the Director of Nursing (DON) regarding the facility's medication administration practices. During this time the medication administration audit for Resident #1 was reviewed with the DON. The report revealed there were three days where medication administration was documented outside the policy of one hour prior to one hour after scheduled time. The DON stated, she had already identified two nurses who weren't documenting medication administration at the time of administration and had done 1:1 education with those nurses. The DON denied having an official Performance Improvement Project regarding medication administration within the policy of one hour prior to one hour scheduled time.</p> <p>On 07/16/24 at 11:15 AM, an interview was conducted with Employee M, LPN, which revealed she had worked at the facility for a month and a half. Employee M confirmed that scheduled medications can be administered up to hour before or an hour after the medication is scheduled to be given and medication administration should be documented in the electronic record as soon as the medication is given.</p> <p>On 07/16/24 at 11:20 AM, an interview was conducted with Employee N, LPN, which revealed she had worked at the facility for two and a half months. Employee N confirmed that scheduled medications were to be administered an hour before to an hour after the medication is scheduled and medication administration should be documented immediately after giving the medication.</p> <p>(continued on next page)</p>		

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