STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105738	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Solaris Healthcare Imperial	900 Imperial Golf Course Blvd Naples, FL 34110

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 - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 37256 Based upon interview and record review, the facility failed to ensure residents were free from significant medication errors by not administering medications in accordance with prescriber's orders for 1 (Resident #1) of 3 residents reviewed receiving anti-coagulant medications. The findings included: Record review of Resident #1's chart revealed he had been discharged to the facility from the hospital on 7/17/24. The hospital discharge indicated he was to continue receiving Lovenox 110 mg (milligrams) injections every 12 hours (anticoagulant medication that prevents blood clots from forming in the bloodstream). The hospital discharge paperwork also indicated the Lovenox injections were to continue for 1 month then likely convert to an oral anticoagulant after that. The Skilled Nursing facility physician progress note on 8/14/24 indicated Lovenox twice a day for 1 month (8/20/24) and change to Eliquis on 8/21/24. (Eliquis is an anticoagulant medication.) On 8/27/24 at 9:45 a.m., the Director of Nursing (DON) provided a witness statement from Staff A Registered Nurse (RN) that said on 8/14/24 Staff A had received a verbal order from the physician to transition Resident #1 from Lovenox injections to Eliquis by mouth to start on 8/21/24. A review of Resident #1's physician orders showed Eliquis 5 mg 1 tab twice a day was entered with a start date of 8/14/24. Lovenox was still ordered at this time. A review of the Medication Administration Record (MAR) for August 2024 showed Eliquis was given twice on 8/15/24, 8/16/24 and once in the morning of 8/17/24. The MAR also showed Lovenox 110 mg sq (subcutaneous) was given twice on 8/15/24, 8/16/24 and once in the morning of 8/17/24. A nursing progress note dated 8/17/24 indicated Resident was weak and had vomited a lot of blood. The doctor was notified, and Resident #1 was sent to the emergency room . He did not return to the facility. On 8/27/24 at 2:20 p.m., the DON said Staff A had received a verbal order from the physician. She said Staff A made an error in transference, the Eliquis ended up being entered with the wrong start date and Resident #1 ended up receiving 2 anticoagulant medications increasing the risk for bleeding/hemorrhage. She said Staff A no longer works at the facility and they have been doing in-servicing as well as audits and plan to do so for a while.

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